COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Non-Hospital Medical and Surgical Facilities Accreditation Program

ACCREDITATION STANDARDS

Medical Records and Documentation

Non-Hospital Medical and Surgical Facilities Accreditation Program
College of Physicians and Surgeons of British Columbia
300–669 Howe Street
Vancouver BC V6C 0B4

Introduction

Whether in paper or electronic format, the medical record must contain comprehensive documentation of the clinical care provided to the patient and personal information that must be protected.

British Columbia's *Personal Information Protection Act* (*PIPA*) applies to private organizations such as physician offices and non-hospital facilities and governs how personal information about patients and employees may be collected, used and disclosed. Other relevant legislation includes but is not limited to the *Personal Information Protection and Electronic Documents Act* (*PIPEDA*), *Privacy Act*, *Access to Information Act,* BC's *Limitation Act*, and BC's *Freedom of Information and Protection of Privacy Act* (*FIOPPA*).

Medical records and documentation

No.		Description	Reference	Risk	Change
DOC1.0		**MEDICAL RECORDS AND DOCUMENTATION**			
DOC1.1		**The patient's medical record provides an accurate and comprehensive account of the care provided.**			
DOC1.1.1	**M**	The medical record is a single, comprehensive file containing all information and documentation related to the patient's medical/surgical encounter.		M	
DOC1.1.2	**M**	The patient's medical record includes patient identification and demographic information. *Guidance: Patient identification and demographic information includes the patient's legal name (e.g. name on government identification or CareCard), name used (i.e. the name specified by the patient that should be used in the context of health care; this may be different from their legal name, sex assigned at birth, date of birth, Personal Health Number (PHN), and contact information (i.e. address and telephone number). Documentation of the patient's emergency or next of kin contact information is recommended. Medical or claim record numbers (e.g. health authority, WorkSafe BC, ICBC) should also be documented as necessary. This information should be contained on a "face sheet" at the front of the medical record. If a face sheet is utilized, it is recommended that the face sheet also contain the name of the surgeon, patient diagnosis, planned surgery, and date of surgery. Under PIPA, implied consent (i.e. the patient provided information for the purposes of care and treatment) is sufficient for the collection, use and disclosure of personal information for direct health-care purposes and may extend to parties who provide care to the patient as part of the patient's care team (i.e. referring physicians, lab technicians, nurses).*		M	V5.0

No.		Description	Reference	Risk	Change
DOC1.1.3	**M**	The medical record is organized in a standardized and chronological order. *Guidance: The medical record is organized in sections, and the information in each section is organized in chronological order. Sections include but are not limited to patient identification and demographic information, consent, history, physical, progress notes, forms/records (e.g. intraoperative (nursing), anesthesia record, post-anesthesia recovery), consultations, orders, diagnostic testing, radiologist examination results. Each section of the medical record (paper or electronic) should be tabbed for ease of review. The order of the medical record is at the discretion of the facility, as per facility policy.*		M	
DOC1.1.4	**M**	Standardized forms/records are used by each of the health professionals. *Guidance: All facility staff (physicians and nurses) document the care provided using the facility's standardized forms/records.*		M	
DOC1.1.5	**M**	Each form in the medical record clearly identifies the patient. *Guidance: At minimum, there are two unique patient identifiers (i.e. full name and date of birth) on each form. In circumstances where a multi-page document is separated into individual sheets (i.e. scanning to an electronic medical record system), each page clearly identifies the patient with two unique patient identifiers.*		C	
DOC1.2		**Medical records and patient information are kept secure, held confidential and protected from unauthorized disclosure.**			
DOC1.2.1	**M**	There is a privacy officer. *Guidance: In accordance with PIPA, there is a staff member who is responsible for establishing and maintaining the facility's privacy management program. All components of the facility's privacy management program should be reviewed and assessed by the privacy officer on a regular basis and revised as necessary.*		L	

No.	Description	Reference	Risk	Change
DOC1.2.2	**M** A confidentiality or non-disclosure agreement is on file for each staff member and any contractors. *Guidance: Contractors include but are not limited to any person who may come into contact with patients and/or patient information (e.g. information management/information technology personnel/companies, external environmental cleaning personnel/companies). A sample confidentiality/non-disclosure agreement is available from the Canadian Medical Protective Association.*		L	
DOC1.2.3	**M** Paper medical records are located in a secure area where there is no public access and are accessible to authorized personnel only. *Guidance: Paper medical records are stored in a location that prevents members of the public from viewing the records (i.e. avoid leaving medical records at the reception desk where other patients can see them) and are returned to the filing location as soon as possible after use. Paper records should also be retrieved promptly from fax machines and photocopiers. Facility policies and procedures outline who may access patients' medical records. Access to patient information and medical records is based on the role, responsibility and function of the individual.*		M	
DOC1.2.4	**M** The electronic medical record server is located in a secure area where there is no public access and is accessible to authorized personnel only. *Guidance: Cloud computing is acceptable provided the facility has addressed privacy and security considerations before storing data with a cloud service provider such as preventing secondary use of personal health information, audit trails, restricted access, strong password protection, encryption, notification in the event of a privacy breach, backup procedures to prevent data loss, system outages, and ensuring access to medical records at all times.* *Note: Standard cloud service terms of use agreements may not be sufficient for regulated health professionals to fulfill all of their privacy and confidentiality obligations.*		M	

No.		Description	Reference	Risk	Change
DOC1.2.5	**M**	Electronic medical record workstations are positioned away from public view and is accessible to authorized personnel only. *Guidance: Workstations have an automatic log off feature. Facility policy and procedures outline who may access patients' medical records. Access to patient information and medical records is based on the role, responsibility and function of the individual. For electronic medical record systems, each authorized user has a unique log-in and password, and each authorized user has a documented access level based upon the individual's role. Access levels should be based on the "need to know" and "least privilege" principles. The electronic medical record system is configured to identify who has accessed the record. User accounts are maintained on a regular and timely basis including adding, modifying and de-activating accounts.*		M	
DOC1.2.6	**M**	Electronic medical record systems have their audit log capability activated. *Guidance: The electronic medical record system is configured to identify who has accessed the record. The audit log capability ensures that the system tracks all user access to patient information for the purposes of compliance monitoring and incident investigation. The audit system should identify who has accessed the medical record, what, if any, alterations have been made to the medical record, who made the specific alteration and when, as well as the option to print and view a copy of the unedited, original version of the record. Any amendments should be separately visible without permanently deleting the original entry. These features demonstrate that the chain of custody of the medical record or entry is sound.*		M	

No.	Description		Reference	Risk	Change
DOC1.2.7	**M**	Express consent is obtained before using email to communicate with patients and/or transmit their health information. *Guidance: Email communication is acceptable provided there has been a discussion with the patient about the inherent risks of email communication (i.e. privacy, security, timeliness of response, clarity of communication). This discussion is documented in the patient's medical record and a written consent form has been completed and is on file. A "Consent to use electronic communications" form is available through the Canadian Medical Protective Association. Confidential and sensitive patient information sent by email is encrypted or, at a minimum, password protected.*		M	
DOC1.3	**Electronic medical record systems comply with professional and regulatory documentation and medical records practices.**				
DOC1.3.1	**M**	Electronic medical records can be visually displayed and printed for each patient promptly and in chronological order. *Guidance: An individual patient's electronic medical record can be accessed by entering their name.*		L	
DOC1.3.2	**M**	The electronic medical record system records the date, time and identity of the user when records are accessed. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	
DOC1.3.3	**M**	The electronic medical record system records the date and time of each entry made for each patient and the identity of the user making the entry. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	
DOC1.3.4	**M**	The electronic medical record system indicates any changes in the recorded entry and the identity of the user making the change. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	
DOC1.3.5	**M**	The electronic medical record system preserves the original entry when changed or updated.		M	

No.		Description	Reference	Risk	Change
DOC1.3.6	**M**	The electronic medical record system automatically backs up files or otherwise provides reasonable protection against information loss, damage and inaccessibility. *Guidance: System backup is performed daily (i.e. each surgical day). Restore processes should be regularly tested. An off-site backup system is recommended in case computer equipment is stolen, lost or damaged.*		M	
DOC1.3.7	**M**	Anti-virus, malware and spyware software is installed to protect patient information.		M	
DOC1.3.8	**M**	Encryption protection is installed on all computer systems containing personal health information. *Guidance: Computer systems include desktop and laptop computers.*		M	
DOC1.3.9	**M**	Secure networks are used to access and send patient information. *Guidance: Security controls are in place (i.e. local wireless network is encrypted and password-protected) to prevent unauthorized access.*		M	
DOC1.3.10	**M**	Paper records scanned into the electronic medical record system are in "read-only" format. *Guidance: Scanning procedures include some form of quality assurance (e.g. comparing the electronic copy to the original paper copy to ensure the information has been accurately converted before destruction of the paper record if appropriate).* *Note: Scanning and optical character recognition (OCR) are different. Scanning generates a non-editable electronic representation of an image. OCR converts handwritten or typewritten text into machine-editable text. Once a record has been converted using OCR, the text can be changed, searched or manipulated. OCR may be used in conjunction with scanning. Using OCR alone is contraindicated unless the original paper records are also scanned to "ready-only" format or the original paper record is retained.*		M	
DOC1.4		**Medical record access and retention practices comply with professional and regulatory standards.**			

No.		Description	Reference	Risk	Change
DOC1.4.1	**M**	There are agreements/contracts in place that address medical record ownership, custody, confidentiality and enduring access by individual physicians. *Guidance: In all situations where a physician is creating medical records in a group or shared medical record environment, a data-sharing agreement is in place that addresses medical record ownership, custody and enduring access by individual physicians and patients. In all situations where a physician creating a medical record is not the owner of the facility and/or of the electronic medical record license, a formal contract is in place that addresses medical record custody, confidentiality and enduring access.*		M	
DOC1.4.2	**M**	The electronic medical record system has robust backup and recovery procedures. *Guidance: Robust security features include but are not limited to encryption, use of passwords, and access controls to protect against unauthorized access.*		M	
DOC1.4.3	**M**	Medical records are retained for a minimum period of 16 years from the date of last entry. *Guidance: Where the patient is a minor, medical records are kept for at least 16 years from the age of majority. When transitioning to an electronic medical record, once the paper medical record has been fully transitioned to an electronic record, it is not necessary to retain the original paper record. If only part of the paper record is transitioned to the electronic system, then the remainder of the paper record must be retained as part of the original medical record. Medical records may be destroyed/deleted when the legal retention period has expired. Medical records must be destroyed using supervised cross-shredding, incineration, or by electronic- erasure of data, including any backup copies of the records. It is recommended that an accredited service provider be hired to destroy patient information maintained in electronic medical records. A wipe utility may not completely erase electronic information.*		M	
DOC1.5		**Medical record reviews ensure the integrity of the data and promote quality improvement.**			

No.	Description	Reference	Risk	Change
DOC1.5.1	**M** Medical record reviews are conducted quarterly. *Guidance: The medical record reviews represent a cross section of procedures and physicians (surgeons and anesthesiologists). At least 10% of all cases performed annually are reviewed. The audit results will have limited significance if not enough records are audited. The reviews are documented and specify the date of the review, the members of the review team, the number of charts reviewed, sufficient detail to demonstrate a cross section of procedures and physicians were reviewed, and a summary of the review findings and how these findings were addressed (i.e. corrective action plan(s)).*		L	
DOC1.5.2	**M** Medical record reviews utilize an audit tool. *Guidance: The audit tool used is at the discretion of the facility. The audit tool should assist the review team in identifying medical record and documentation practices that are inconsistent or in need of improvement.*		L	
DOC1.5.3	**M** Medical record reviews are completed by an interdisciplinary team. *Guidance: The interdisciplinary team for medical record reviews at class 1 facilities is comprised of a surgeon, an anesthesiologist and a registered nurse (although two RNs, 1 OR and 1 PACU is preferred). The interdisciplinary team for medical record reviews at class 2 and 3 facilities is comprised of a surgeon and a registered nurse.*		L	
DOC1.5.4	**M** Corrective action plan(s) address medical record deficiencies. *Guidance: Medical record reviews are documented and specify the date of the review, the members of the review team, the number of charts reviewed, sufficient detail to demonstrate a cross section of procedures and physicians were reviewed, and how review findings were addressed.*		L	
DOC1.6	**Pre-admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection.**			

No.		Description	Reference	Risk	Change
DOC1.6.1	**M**	Pre-admission documentation includes a current physical exam. *Guidance: The physical exam must include a systems review and full functional inquiry. It may be completed by a family physician, the surgeon or a nurse practitioner, and as appropriate, by an oral surgeon, podiatrist or osteopath. Patients with a BMI greater than or equal to 40 must have had the physical exam completed within 60 days of the surgery. For all other patients, the physical exam has been completed within 90 days of the surgery.*		M	
DOC1.6.2	**M**	Pre-admission documentation includes a current medical history. *Guidance: The medical history must include indication(s) for surgery, comorbidities, previous surgery, medications, allergies and sensitivities. The patient's referring physician may provide many of these elements. Patients with a BMI greater than or equal to 40 must have had their medical history completed within 60 days of the surgery. For all other patients, the medical history has been completed within 90 days of the surgery.*		M	
DOC1.6.3	**M**	Pre-admission documentation includes medication history. *Guidance: The medication history includes use of prescribed, non-prescribed, herbal and over-the-counter medication(s).*		M	
DOC1.6.4	**M**	Pre-admission documentation includes allergy status including a description of the reaction. *Guidance: Allergy and/or sensitivity to medication(s), food(s), latex, chemicals or adhesives is documented in the patient's medical record. The patient's allergy status should be documented on all referral and booking forms, admission forms, and the OR slate. In addition, the medical record of any patient with a sensitivity or allergy is labelled or flagged.*		M	
DOC1.6.5	**M**	Pre-admission documentation includes review of previous anesthetic history. *Guidance: The anesthetic history includes the patient's family history of any adverse reactions associated with anesthesia.*		M	

No.	Description	Reference	Risk	Change
DOC1.6.6	**M** Pre-admission documentation includes obstructive sleep apnea (OSA) screening using a validated tool (e.g. STOP-Bang), as appropriate. *Guidance: The following should be taken into account in determining whether the patient is suitable for the non-hospital setting: OSA severity, coexisting diseases, invasiveness of procedure, type of anesthesia, anticipated postoperative opioid requirements, and adequacy of post-discharge observation. All class 1 and class 2 facilities are required to screen patients for obstructive sleep apnea (OAS). Class 3 (local anesthesia only) facilities should also screen patients that receive pre-procedural oral sedation for obstructive sleep apnea.*		M	
DOC1.6.7	**M** Pre-admission documentation includes venous thromboembolism (VTE) screening, as appropriate. *Guidance: Thrombosis Canada provides resources to assist facilities in VTE screening and prophylaxis. Class 3 (local anesthesia only) facilities are not required to screen patients for VTE risk. VTE screening is not required for patients undergoing procedures performed using local anesthesia only in Class 1 or Class 2 facilities.*	15, 16, 17, 18	M	Rev. Guidance
DOC1.6.8	**M** Pre-admission assessment documentation includes specifying the recommended venous thromboembolism (VTE) prophylaxis based on the patient's VTE risk score. *Guidance: Thrombosis Canada provides resources to assist facilities in VTE screening and prophylaxis. If no prophylaxis is recommended this must be documented. If there is deviation from the prophylaxis recommended by a validated VTE screening tool (e.g. Caprini score), the rationale must be documented.*	15, 16, 17, 18	M	New

No.		Description	Reference	Risk	Change
DOC1.6.9	**M**	Pre-admission documentation includes a patient self-reported questionnaire. *Guidance: The self-reported questionnaire is an opportunity for the patient to provide information about their medical history, comorbidities, previous surgery, medications, allergies and sensitivities. Scientific literature suggests patient self-reported health information is a valid resource that assists in identifying pre-existing medical conditions that may require further clinical work-up, therefore, improving the provision of health care and supporting appropriate patient selection.*		M	
DOC1.6.10	**M**	'Name Used' is an entry field on the patient self-reported questionnaire. *Guidance: People may use different names in different settings to identify themselves, such as their legal name, nicknames, middle names, language specific alternatives (e.g., Bill, William) or names that affirm gender identity. 'Name Used' is the name specified by the patient that should be used in the context of health care. Both legal name and name used should appear on the medical record page headers. Where only one data field for name is available in the electronic medical records system, 'Name Used' in brackets should follow their legal name.*		M	V5.0
DOC1.6.11	**B**	Pronouns is an entry field on the patient self-reported questionnaire. *Guidance: Pronouns are linguistic tools used to refer to people instead of using their name. Gender pronouns are a type of pronouns that reference a person's gender identity and are part of their gender expression (e.g., he, she, they). A person's gender identity or sex does not determine the pronouns that should be used. Individuals should be asked to identify their personal pronouns. Pronouns must not be assigned by health-care workers.* ***If the person does not identify their personal pronouns, then only their name is used.*** *Pronouns are not to be referred to as "preferred pronouns." This entry field should include the option of "Prefer not to answer."*			V5.0

No.		Description	Reference	Risk	Change
DOC1.6.12	**B**	Gender identity is an entry field on the patient self-reported questionnaire. *Guidance: Gender identity is an individual's personal experience of being a woman, man, nonbinary or something else. This element represents the gender identity that a person identifies with for the purposes of health-care interactions. A person's current gender identity may align or differ from what is commonly assumed based on Sex Assigned at Birth (e.g., female, male) or by what is indicated on their current legal documents (e.g., administrative gender). This entry field should include the option of "Prefer not to answer."*			V5.0
DOC1.6.13	**M**	Sex assigned at birth is an entry field on the patient self-reported questionnaire. *Guidance: Sex assigned at birth is a data element that includes options for assignment of the sex of a person at birth based on biological characteristics. Sex assigned at birth is also frequently used to support clinical care such as interpreting imaging studies or laboratory tests.* ***Where only one data field for gender/sex is available in the electronic medical records system, sex assigned at birth is entered.***		C	V5.0
DOC1.6.14	**M**	Pre-admission assessment includes infectious diseases and antibiotic-resistant organism (ARO) screening. *Guidance: Screening questions may include: Have you ever been diagnosed (infection or colonization) with an ARO such as MRSA or VRE?; Has anyone in your household ever been diagnosed (infection or colonization) with an ARO such as MRSA or VRE?; Have you received health care in a facility outside of Canada in the last 12 months?; Have you ever been admitted to, or spent more than 12 continuous hours as a patient in, any health-care facility in the last 12 months?*		M	

No.		Description	Reference	Risk	Change
DOC1.6.15	**M**	Pre-admission documentation includes consultations as appropriate. *Guidance: These include but are not limited to surgeon, anesthesia, cardiology and internal medicine. An in-person preoperative anesthetic consultation must be completed before the day of surgery for American Society of Anesthesiologists' physical status classification (ASA) 3 patients, patients with a BMI greater than or equal to 40, and any patient scheduled for laparoscopic adjustable gastric banding surgery (BMI >30 and <50). An in-person preoperative anesthetic consultation should be completed prior to the day of surgery for patients with a low BMI (less than 18.5), patients with significant comorbidities, and as clinically indicated to ensure the appropriate work-up and consultation(s) are completed. For patients that reside outside of the geographic location of the non-hospital facility where the surgery/procedure will be performed, the in-person anesthetic consultation may be performed by an anesthesiologist where the patient resides (i.e. hospital or non-hospital facility local to the patient). Telemedicine does not satisfy the requirement for an in-person anesthetic consultation due to the physical examination limitations.*		M	
DOC1.6.16	**M**	Pre-admission documentation includes ASA classification. *Guidance: The ASA physical classification system is used by physicians (anesthesiologists, surgeons) to predict anesthetic and surgical risk prior to a procedure. The NHMSFAP ASA physical status classification system guideline provides information on the ASA classifications that may be considered for surgery in the non-hospital setting.*		M	
DOC1.6.17	**M**	Pre-admission documentation includes height, weight and BMI. *Guidance: Patients are screened using BMI. If actual height and weight measurements were not completed at time of booking and/or actual height and weight measurements were taken more than 14 days prior to the day of surgery, then height and weight measurements are to be measured upon admission and BMI calculated. The NHMSFAP obesity guideline provides information on the consideration of surgery and anesthesia for patients with elevated BMI.*		M	

No.		Description	Reference	Risk	Change
DOC1.6.18	**M**	Pre-admission documentation includes preoperative testing based upon the patient's clinical condition(s). *Guidance: These include but are not limited to laboratory testing and ECG. The Canadian Anesthesiologists' Society Guidelines refer to "Choosing Wisely" for recommendations related to preoperative testing.*		M	
DOC1.6.19	**M**	Pre-admission documentation includes radiologic examination results as appropriate.		M	
DOC1.6.20	**M**	Pre-admission documentation includes a summative view of sex parameters for clinical use (SPCU), as appropriate. *Guidance: In instances where sex assigned at birth may not correctly represent the patient's sex for health-care purposes and/or where specific additional context is needed to provide safe and affirming care, the pre-admission documentation includes a summative view of SPCU. The SPCU communicates the patient's "status" by organizing and referring clinicians to artefacts and clinical parameters such as sex-related anatomy (presence or absence of organs), a sex-related medication or hormonal inventory (historically and currently), a surgical inventory, or other useful artefacts necessary to support interpretation of results and clinical decision making. If a summative view does not exist, the summative view will need to be collected and organized such as by talking with the patient about their gender-affirming health care and interventions and by reviewing various progress notes and consult reports.*		H	V5.0
DOC1.7		**Consent documentation confirms that requirements for valid consent have been met.** *Guidance: Also see the NHMSFAP Consent standard.*			

No.		Description	Reference	Risk	Change
DOC1.7.1	**M**	The consent discussion is documented in the patient's medical record. *Guidance: The consent discussion explains the proposed treatment or course of treatment, the condition for which the health care is proposed, the nature of the proposed health care, the risks and benefits of the proposed health care that a reasonable person would expect to be told about, alternative courses of health care (and when indicated, the likely consequences of no treatment). Documentation of the consent discussion includes the nature of the health care proposed, the risks, benefits and alternative(s) discussed with the patient, and any specific additional issues or concerns that arose through the discussion and how they were addressed. The anesthesiologist should include documentation of the anesthesia consent discussion with the patient on the anesthetic record.*		M	
DOC1.7.2	**M**	The patient's medical record includes a written consent form. *Guidance: A written consent form is completed for surgical operations, invasive procedures, and when analgesic narcotic or anesthetic agents will affect the patient's level of consciousness during the treatment. This includes procedural pain management procedures performed for chronic pain. The consent form should be completed in the physician's office/consult office and sent to the non-hospital booking office prior to the patient's admission to the non-hospital facility. If this is not possible, then the consent form should be completed and signed upon patient arrival at the facility. For anesthesia associated with surgery/procedures, the written consent form is not required to contain acknowledgement by the patient that explanations have been given about the proposed/planned anesthesia. However, the anesthesiologist should include documentation of the anesthesia consent discussion with the patient on the anesthetic record.*		C	
DOC1.8		**Admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection.**			
DOC1.8.1	**M**	Admission documentation includes date and time of admission.		L	

No.	Description	Reference	Risk	Change
DOC1.8.2	**M** Admission documentation includes time of last intake of food and fluids. *Guidance: The admission assessment includes verifying fasting (NPO) status, as appropriate.*		M	
DOC1.8.3	**M** Admission documentation includes a baseline physical assessment. *Guidance: The baseline physical assessment should also include a pain assessment.*		M	
DOC1.8.4	**M** Admission documentation includes vital sign measurements. *Guidance: A full set of vital signs are taken and recorded upon admission (e.g. blood pressure, heart rate, respiratory rate, temperature and oxygen saturation).*		M	
DOC1.8.5	**M** Admission documentation includes allergy status including a description of the reaction. *Guidance: Allergy and/or sensitivity to medication(s), food(s), latex, chemicals or adhesives is documented in the patient's medical record. The patient's allergy status should be documented on all referral and booking forms, admission forms, and the OR slate.*		M	V6.0
DOC1.8.6	**M** The medical record of any patient with a sensitivity or allergy is labelled or flagged. *Guidance: A warning sticker or flag should appear on the front of the patient's medical record to alert staff that the medical record contains important information about the patient's sensitivity or allergy status.*		M	V6.0

No.	Description		Reference	Risk	Change
DOC1.8.7	**M**	Admission documentation includes height, weight and BMI if actuals not measured in the last 14 days. *Guidance: If actual height and weight measurements were not completed at time of booking and/or actual height and weight measurements were taken more than 14 days prior to the day of surgery, then height and weight measurements are to be measured upon admission and BMI calculated. If the patient's BMI is greater than or equal to 40, the anesthesiologist is notified to determine if the patient is appropriate for the non-hospital setting and the proposed surgery and anesthesia. Height, weight and BMI are not required for procedures in which* ***only topical eye drops*** *are administered* ***and*** *where there are no safety concerns with respect to equipment size (e.g. BP cuff), weight and/or height limits.*		M	
DOC1.8.8	**M**	Admission documentation includes current medication(s), including last dose taken. *Guidance: Medication(s) includes use of prescribed, non-prescribed, herbal and over-the-counter medication(s).*		M	
DOC1.8.9	**M**	Admission documentation includes blood glucose level, as indicated. *Guidance: Diabetic patients have their capillary blood glucose level tested as part of the admission assessment.*		M	
DOC1.8.10	**M**	Admission documentation includes smoking, alcohol and other substance use.		M	
DOC1.8.11	**M**	Admission documentation includes verifying venous thromboembolism (VTE) screening. *Guidance: Thrombosis Canada provides resources to assist facilities in VTE screening and prophylaxis. Class 3 (local anesthesia only) facilities are not required to screen patients for VTE risk. VTE screening is not required for patients undergoing procedures performed using local anesthesia only in Class 1 or Class 2 facilities.*	15, 16, 17, 18	M	New

No.	Description	Reference	Risk	Change
DOC1.8.12	**M** Admission documentation includes verifying VTE prophylaxis based upon the patient's VTE risk score. *Guidance: The recommended intervention for prophylaxis based on the patient's VTE risk score is documented and its implementation verified. Thrombosis Canada provides resources to assist facilities in VTE screening and prophylaxis. Class 3 (local anesthesia only) facilities are not required to screen patients for VTE risk. VTE screening is not required for patients undergoing procedures performed using local anesthesia only in Class 1 or Class 2 facilities.*	15, 16, 17, 18	M	New
DOC1.8.13	**M** The patient's medical record includes an orders form. *Guidance: No medication should be administered to a patient by authorized staff, other than a physician, without a pre-existing medication order. Medication orders are to be written on a physician order form such as a pre-printed order set. The medication order must contain the patient name, date and time the medication order was written, medication name, dosage, route of administration, frequency of dosing, prescriber signature (wet signature) and printed name.*		M	
DOC1.8.14	**M** The patient's medical record includes pre-printed orders to facilitate VTE risk assessment, thromboprophylaxis ordering and documentation. *Guidance: VTE risk assessment is a mandatory evaluation process that the surgeon must complete for each patient and where indicated, prescribe pharmacological or mechanical thromboprophylaxis. The rationale for any deviation from prophylaxis recommendations must be documented. Class 3 (local anesthesia only) facilities are not required to screen patients for venous thromboembolism (VTE) risk. VTE screening is not required for patients undergoing procedures performed using local anesthesia only in Class 1 or Class 2 facilities.*	15, 16, 17, 18, 19	M	New
DOC1.8.15	**M** Admission documentation includes preoperative medications administered. *Guidance: All medication(s) administered is documented in the patient's medical record. Medication administration documentation includes the medication name, date, time, dose, route, site (if applicable), and initials/signature of the person who administered the medication.*		M	

No.	Description		Reference	Risk	Change
DOC1.8.16	**M**	Admission documentation includes consultation, direction and/or orders from a health professional, as indicated. *Guidance: When another health professional is consulted or advised (i.e. anesthesiologist, surgeon), the following is documented: date, time and method of contact (e.g. phone call), health professional's name and title, information provided, health professional's response, any resulting order/interventions/agreed upon action plan.*		M	
DOC1.8.17	**M**	Admission documentation includes discharge planning information. *Guidance: Patients are accompanied from the facility by a responsible adult and if not accompanied by a responsible adult are assessed for discharge suitability by the most responsible physician (e.g. anesthesiologist, surgeon). Discharge planning information such as name and contact information of the responsible adult accompanying the patient upon discharge is documented in the patient's medical record. In circumstances where patients are unable or unwilling to arrange accompaniment from the facility by a responsible adult, the anesthesiologist and surgeon are made aware and this is documented in the patient's medical record.*		M	
DOC1.8.18	**M**	Admission documentation confirms that preoperative teaching has been reinforced and followed. *Guidance: Teaching is a process that begins when the decision to have surgery is made and continues upon admission through to patient discharge. Review of preoperative teaching supports safe patient care.*		L	

No.		Description	Reference	Risk	Change
DOC1.8.19	**M**	Admission documentation includes a completed preoperative checklist. *Guidance: A preoperative checklist is an essential step in identifying and meeting each patient's surgical needs and supports continuity of patient care as they transition from the admission/preoperative area to the operating room. The preoperative checklist should include but is not limited to: identification band, allergy band, signed consent, medical history and physical, previous medical record (as appropriate), vital signs, surgical site marked, preoperative test reports based upon the patient's clinical condition (e.g. ECG, laboratory testing), radiologic examination reports and/or imaging, medications including preoperative medications ordered, VTE screening and prophylaxis, fasting status, elimination status, surgical site preparation, medical and/or cosmetic implants location (e.g. breast implants, internal cardiac defibrillator), prosthetics and/or corrective devices location and/or removal (e.g. eye glasses, contact lenses, denture, dental work, hearing aids), body piercings and/or metal hair accessories location and/or removal, and jewelry and make-up removal. The preoperative checklist is signed and dated by the regulated health professional who completed the checklist.*	15, 16, 17, 18	L	Rev. Guidance
DOC1.9		**Anesthesia documentation provides an accurate account of the patient's status and outcome.**			

No.		Description	Reference	Risk	Change
DOC1.9.1	**M**	Anesthetic record documentation includes a preoperative anesthetic consultation, as indicated. *Guidance: If considering IV sedation/analgesia, regional block or general anesthesia for patients with an ASA 3 or patients with a BMI greater than or equal to 40, an in-person preoperative anesthetic consultation must be completed before admission for the surgical procedure not more than 28 days before surgery and, at minimum, one day prior to surgery. Patients scheduled for laparoscopic adjustable gastric banding surgery must also have an in-person anesthetic consultation completed not more than 14 days before surgery and, at minimum, one day prior to surgery. An in-person preoperative anesthetic consultation should be completed prior to the day of surgery for patients with a low BMI (less than 18.5), patients with significant comorbidities, and as clinically indicated to ensure the appropriate work-up and consultation(s) are completed.*		M	
DOC1.9.2	**M**	Anesthetic record documentation includes a pre-anesthetic assessment of the patient in the immediate preoperative period. *Guidance: The anesthesiologist's assessment includes but is not limited to an interview with the patient, review of the patient's medical record, medical, surgical, medication and anesthetic history, a physical exam, review of testing and medical consultations, and assigning of an ASA physical status classification. The pre-anesthetic assessment is documented on the anesthetic assessment record.*		H	
DOC1.9.3	**M**	Anesthetic record documentation includes an ASA physical status classification.		M	
DOC1.9.4	**M**	Anesthetic record documentation includes height, weight and BMI.		M	
DOC1.9.5	**M**	Anesthetic record documentation includes the name and role of each person involved in the anesthesia care.		L	
DOC1.9.6	**M**	Anesthetic record documentation includes the name of the surgeon.		L	
DOC1.9.7	**M**	Anesthetic record documentation includes confirmation of anesthesia safety checks. *Guidance: The anesthetic record indicates (i.e. checkbox) that anesthesia safety checks (e.g. check of equipment, medication supply, medical gas supply) have been completed.*		L	

No.		Description	Reference	Risk	Change
DOC1.9.8	**M**	Anesthetic record documentation includes procedure performed. *Guidance: The procedure performed matches the procedure noted on the intraoperative (nursing) record.*		L	
DOC1.9.9	**M**	Anesthetic record documentation includes anesthesia start and end times.		L	
DOC1.9.10	**M**	Anesthetic record documentation includes airway management technique(s). *Guidance: Airway management techniques include but are not limited to oral airway (size), nasal airway (size, nare), mask, supraglottic airway (size), endotracheal tube (type, size, cuffed/uncuffed), laryngoscope (blade type, size), fibre optic.*		M	
DOC1.9.11	**M**	Anesthetic record documentation includes ventilation mode and rate. *Guidance: Ventilation mode and rate includes but is not limited to spontaneous rate, assisted rate, pressure support, mechanical or pressure controlled, positive end expiratory pressure (PPEP), and continuous positive airway pressure (CPAP).*		M	
DOC1.9.12	**M**	Anesthetic record documentation includes anesthesia technique(s). *Guidance: Anesthesia techniques include but are not limited to general anesthesia, regional anesthesia and IV procedural sedation.*		M	
DOC1.9.13	**M**	Anesthetic record documentation includes placement and type of eye protection.		L	
DOC1.9.14	**M**	Anesthetic record documentation includes when items are inserted in the oropharynx and when items are removed from the oropharynx, as indicated. *Guidance: The insertion and removal of throat packs is documented.*		C	
DOC1.9.15	**M**	Anesthetic record documentation includes all medications and anesthetics administered by the anesthesiologist. *Guidance: Medication documentation includes but is not limited to name of the medication/solution, dose/concentration, volume, method of administration, and time.*		M	

No.		Description	Reference	Risk	Change
DOC1.9.16	**M**	Anesthetic record documentation includes all monitored physiologic variables. *Guidance: Monitored physiologic variables are documented at intervals appropriate to the clinical circumstances. Physiologic variables include but at not limited to heart rate, blood pressure, oxygen saturation and end-tidal carbon dioxide.*		M	
DOC1.9.17	**M**	Anesthetic record documentation includes heart rate and blood pressure measurements every five minutes at a minimum. *Guidance: Cardiac monitoring and blood pressure monitoring equipment is in continuous use throughout the administration of all general anesthesia, regional anesthesia and IV procedural sedation. Heart rate and blood pressure is documented every five minutes at a minimum.*		M	
DOC1.9.18	**M**	Anesthetic record documentation includes oxygen saturation monitoring at frequent intervals. *Guidance: Pulse oximetry equipment is in continuous use throughout the administration of all general anesthesia, regional anesthesia and IV procedural sedation. Oxygen saturation is documented at intervals appropriate to the clinical circumstances.*		M	
DOC1.9.19	**M**	Anesthetic record documentation includes end-tidal carbon dioxide concentration at frequent intervals. *Guidance: Capnography equipment is in continuous use throughout the administration of all general anesthesia, regional anesthesia and for all moderate and deep IV procedural sedation. End-tidal carbon dioxide concentration is to be documented at frequent intervals if the trachea is intubated. Capnography is required for all patients that remain intubated in the initial recovery phase.*		M	
DOC1.9.20	**M**	Anesthetic record documentation includes all fluids administered by the anesthesiologist. *Guidance: Fluid administration documentation includes but is not limited to line(s) insertion and location, type and volume of fluids administered, and time of administration.*		M	
DOC1.9.21	**M**	Anesthetic record documentation includes blood loss and other fluids lost (e.g. urine) where it can be measured or estimated.		M	

No.		Description	Reference	Risk	Change
DOC1.9.22	**M**	Anesthetic record documentation includes information about the anesthetic course. *Guidance: This includes any complications, or unusual or adverse events (e.g. difficult airway).*		M	
DOC1.9.23	**M**	Anesthetic record documentation includes the patient's status as first determined in the post-anesthesia care unit (PACU). *Guidance: The status assessment includes the patient's level of consciousness, heart rate, blood pressure, oxygen saturation and respiratory rate.*		L	
DOC1.10	**Sedation documentation provides an accurate account of the patient's status and outcome.** *Guidance: IV procedural sedation and analgesia administered by a non-anesthesiologist is recorded on a sedation record.*				
DOC1.10.1	**M**	Sedation record documentation includes an ASA physical status classification.		M	
DOC1.10.2	**M**	Sedation record documentation includes height, weight and BMI.		M	
DOC1.10.3	**M**	Sedation record documentation includes the name and role of each person involved in the IV procedural sedation care.		L	
DOC1.10.4	**M**	Sedation record documentation includes the name of the surgeon/procedure physician.		L	
DOC1.10.5	**M**	Sedation record documentation includes confirmation of the IV procedural sedation safety checks. *Guidance: Safety checks include but are not limited to monitoring equipment, suction equipment, oxygen equipment, emergency cart medication and equipment, and availability of medication reversal agents.*		L	
DOC1.10.6	**M**	Sedation record documentation includes procedure performed. *Guidance: The procedure performed matches the procedure noted on other procedural records.*		L	
DOC1.10.7	**M**	Sedation record documentation includes procedure start and stop times.		L	
DOC1.10.8	**M**	Sedation record documentation includes supplemental oxygen use, as indicated.		L	

No.		Description	Reference	Risk	Change
DOC1.10.9	**M**	Sedation record documentation includes all sedation and analgesia administered. *Guidance: Medication documentation includes but is not limited to the name of the medication, dose, route, time, and name/initials of person administering the medication.*		M	
DOC1.10.10	**M**	Sedation record documentation includes all monitored physiologic variables. *Guidance: Blood pressure, heart rate, respiratory rate, oxygen saturation and level of consciousness/sedation is documented every five minutes three times after initial and subsequent sedation and analgesia doses, and then every 15 minutes thereafter.*		M	
DOC1.10.11	**M**	Sedation record documentation includes all lines and fluids administered. *Guidance: Intravenous fluid administration including start and end time, solution, volume and rate is documented. The fluid balance (in and out) record is complete.*		M	
DOC1.11		**Intraoperative documentation provides an accurate account of the patient's status, the actions of the perioperative team, and the patient's outcome.**			
DOC1.11.1	**M**	Intraoperative (nursing) record documentation includes perioperative event times. *Guidance: Perioperative event times include but are not limited to patient entry into the operating room, surgical safety checklist briefing, time-out and debriefing, and patient exit from the operating room.*		L	
DOC1.11.2	**M**	Intraoperative (nursing) record documentation includes name and role of each person involved in the patient care provided in the operating room and any visitors. *Guidance: This includes but is not limited to health care professionals, students, residents, fellows, family and vendors (e.g. equipment reps). Documentation includes first and last name and role of each person. Nursing personnel documentation also includes their initials/signature.*		L	

No.	Description		Reference	Risk	Change
DOC1.11.3	**M**	Intraoperative (nursing) record documentation includes the surgical safety checklist briefing, time-out and debriefing. *Guidance: The time that the briefing, time-out and debriefing were completed and staff initials are clearly documented in the intraoperative (nursing) records to confirm that each part of the surgical safety checklist (SSCL), as posted in the operating/procedure room, was completed. Non-hospital facilities are not required to include a copy of the SSCL in the patient's medical record.*		L	
DOC1.11.4	**M**	Intraoperative (nursing) record documentation includes warming methods, as appropriate. *Guidance: Active warming (i.e. forced-air units) should be maintained throughout the procedure, as applicable. Active warming methods should be used for procedures longer than 30 minutes.*		L	
DOC1.11.5	**M**	Intraoperative (nursing) record documentation includes use of mechanical thromboprophylaxis devices, as appropriate. *Guidance: Thrombosis Canada provides resources to assist facilities in VTE screening and prophylaxis. The appropriate measuring, sizing and application of deterrent stocking applied in the operating room and the use of mechanical thromboprophylaxis devices are documented in the intraoperative (nursing) record.*	15, 16, 17, 18	M	Rev. Guidance
DOC1.11.6	**M**	Intraoperative (nursing) record documentation includes skin assessments. *Guidance: A preoperative skin and positioning needs assessment is performed to identify patient and procedure factors which may increase the patient's risk for positioning injury. Patient factors include age (i.e. pediatric, older adults > 65 years), nutritional status, skin condition, comorbidities (e.g. diabetes, peripheral vascular disease), BMI (i.e. underweight, obese), and physical/mobility limitations. Procedural factors include the type of procedure, length of procedure, procedural position and type of anesthesia. Any areas of existing skin breakdown, presence of a rash and/or dermatitis is documented. The patient is assessed postoperatively for signs and symptoms of skin breakdown, positioning injury and/or medical device related injury.*		M	

No.	Description	Reference	Risk	Change
DOC1.11.7	**M** Intraoperative (nursing) record documentation includes patient positioning. *Guidance: Positioning documentation includes a pre and postoperative skin assessment, the patient's position and any intraoperative position changes, the type and location of positioning devices (i.e. use of padding, pillows, safety straps, positioning devices) and the perioperative team members involved in positioning.*		M	
DOC1.11.8	**M** Intraoperative (nursing) record documentation includes pneumatic tourniquets, as indicated. *Guidance: Pneumatic tourniquet documentation includes but is not limited to location and size of the cuff(s), pressure setting(s), perioperative team member(s) applying the cuff(s), unit serial number and model (or facility identification number), time of inflation/deflation/re-inflation, surgeon notification of elapsed time, and condition of the skin under the cuff before and after tourniquet use.*		M	
DOC1.11.9	**M** Intraoperative (nursing) record documentation includes preoperative skin preparation. *Guidance: Skin preparation documentation includes but is not limited to method of hair removal (if performed), name and concentration of antiseptic agent(s) used, any skin reaction (if occurred), and the name of the person performing skin preparation.*		M	
DOC1.11.10	**M** Intraoperative (nursing) record documentation includes electrosurgery devices, as indicated. *Guidance: Electrosurgery device documentation includes but is not limited to type of device and serial number, location of dispersive electrode pad placement, cutting and coagulation settings, condition of the patient's skin before placement and removal of dispersive electrode pad, use of safety holster on the sterile field, and (as indicated) patient education if unable and/or refuses to remove jewelry, piercings.*		M	

No.		Description	Reference	Risk	Change
DOC1.11.11	**M**	Intraoperative (nursing) record documentation includes laser devices, as indicated. *Guidance: Laser documentation includes but is not limited to type of laser including the fiber and hand piece used, laser parameters/settings, treatment performed, on/off laser activation and deactivation time for head, neck and chest procedures, persons present in the laser room and all safety precautions taken (patient and staff).*		M	
DOC1.11.12	**M**	Intraoperative (nursing) record documentation includes use of equipment, as indicated. *Guidance: Use of equipment, such as insufflators and fluid management systems, is documented. The documentation includes but is not limited to equipment model and serial number of the unit, pressure setting(s), flow rate of the gas/fluid, total volumes of gas/fluid used, and smoke evacuation scavenging system used.*		M	
DOC1.11.13	**M**	Intraoperative (nursing) record documentation includes the surgical count. *Guidance: Any item that has the potential for being retained must be counted. The count is documented on the standardized count sheet. The count is documented in a manner that does not obliterate the clarity of each number. The number of items is counted as well as the name, initials and position/role of each regulated health professional involved in the count. The count sheet is included in the patient's medical record.*		C	
DOC1.11.14	**M**	Intraoperative (nursing) record documentation includes therapeutic packing, as indicated. *Guidance: Packing intentionally left in the patient at the end of surgery is documented in the intraoperative (nursing) record. Vaginal packing is documented in the intraoperative (nursing) record.*		C	
DOC1.11.15	**M**	Intraoperative (nursing) record documentation includes specimens and/or bloodwork, as indicated. *Guidance: Specimen and/or bloodwork documentation includes but is not limited to name of the specimen, date and time, and type of specimen.*		C	

No.	Description	Reference	Risk	Change
DOC1.11.16	**M** Intraoperative (nursing) record documentation includes all medications, solutions and irrigation solutions administered intraoperatively by the surgeon and/or nursing staff. *Guidance: Medications, solutions and irrigation solutions documentation includes but is not limited to name of the medication/solution, dose/concentration, volume, location, method of administration, time, and name of person who administered it. Medications, solutions and irrigation solutions include hemostatic agents, sealants, adhesives and dyes.*		M	
DOC1.11.17	**M** Intraoperative (nursing) record documentation includes drains and/or catheters, as indicated. *Guidance: Drain and/or catheter documentation includes the location of the drain(s)/catheter(s), the type of drain(s)/catheter(s), and the method of securing the drain(s).*		M	
DOC1.11.18	**M** Intraoperative (nursing) record documentation includes immediate-use steam sterilization (IUSS) incidents, including reason. *Guidance: IUSS (flash sterilization) is used only for situations where there is an urgent or unplanned need (i.e. dropped instrument on the floor during the procedure and there is no back-up instrument/set available). IUSS is not used to sterilize implants, complete sets or trays of instruments, or compensate for inventory shortages or scheduling difficulties. IUSS documentation includes but is not limited to the item (description of the device/instrument) that was sterilized using IUSS and the reason for IUSS.*		M	
DOC1.11.19	**M** Intraoperative (nursing) record documentation includes implant information, as indicated. *Guidance: Implant documentation includes the manufacturer, serial and lot number, size and quantity, and location. Implants include but are not limited to prostheses, screws, pins, plates, rods, artificial discs, allografts, intrauterine devices, artificial eye lenses.*		C	
DOC1.11.20	**M** Intraoperative (nursing) record documentation includes intraoperative imaging, as indicated. *Guidance: Imaging documentation includes but is not limited to type (e.g. mini C-Arm, full C-Arm), diagnostic/therapeutic dose and location, and use of patient shielding.*		M	

No.		Description	Reference	Risk	Change
DOC1.11.21	**M**	Intraoperative (nursing) record documentation includes the exact surgical procedure(s) performed.		M	
DOC1.11.22	**M**	Intraoperative (nursing) record documentation includes special considerations or precautions. *Guidance: Special considerations or precautions include but are not limited to latex allergy or sensitivity, antibiotic resistant organism (ARO), contact precautions.*		H	
DOC1.11.23	**M**	Intraoperative (nursing) record documentation includes unusual occurrences. *Guidance: This includes any complications, unusual or adverse events and near misses.*		M	V6.0
DOC1.12		**The operative report provides an accurate account of the surgery/procedure.**			
DOC1.12.1	**M**	The surgeon makes an operative note in the patient's medical record immediately following the procedure. *Guidance: The operative note includes but is not limited to the type of procedure performed, a description of the surgical findings/complications, and patient outcome. This is documented in the progress notes of the patient's medical record. In addition to making an operative note in the progress notes, the surgeon dictates an operative report that is later filed in the patient's medical record.*		M	
DOC1.12.2	**M**	The surgeon's operative report includes the preoperative and postoperative diagnoses.		L	
DOC1.12.3	**M**	The surgeon's operative report includes the date of the procedure(s).		L	
DOC1.12.4	**M**	The surgeon's operative report includes the exact surgical procedure(s) performed.		M	
DOC1.12.5	**M**	The surgeon's operative report includes the type of anesthesia.		L	
DOC1.12.6	**M**	The surgeon's operative report includes the name of the anesthesiologist.		L	
DOC1.12.7	**M**	The surgeon's operative report includes the name of the primary surgeon and any assistant.		L	
DOC1.12.8	**M**	The surgeon's operative report includes indication(s) for surgery.		L	

No.		Description	Reference	Risk	Change
DOC1.12.9	**M**	The surgeon's operative report includes detailed account of the procedure and findings. *Guidance: The detailed account includes but is not limited to patient positioning, procedure details/technique, relevant medications (i.e. antibiotics), specimens, drains and/or catheters, implants, sutures.*		M	
DOC1.12.10	**M**	The surgeon's operative report includes estimated blood loss. *Guidance: This includes any complications, unusual or adverse events and near misses.*		M	V6.0
DOC1.12.11	**M**	The surgeon's operative report includes any complications.		M	
DOC1.12.12	**M**	The surgeon's operative report includes the physician's signature. *Guidance: The operative report may be electronically signed.*		L	
DOC1.13		**Progress note documentation by physicians provides an accurate account of the patient's status, the actions of health professionals, and the patient's outcomes.**			
DOC1.13.1	**M**	Physicians document their encounters with patients including any assessments, treatments, complications, unusual or adverse events and near misses.		M	V6.0
DOC1.13.2	**M**	Anesthesiologists document their encounters with patients including any assessments, treatments, complications, unusual or adverse events and near misses.		M	V6.0
DOC1.14		**Post-anesthesia care unit (PACU) documentation provides an accurate account of the patient's status, the actions of the perianesthesia team, and the patient's outcome.**			
DOC1.14.1	**M**	PACU record documentation includes date and time of transfer/arrival to PACU.		L	

No.		Description	Reference	Risk	Change
DOC1.14.2	**M**	PACU record documentation includes a systems assessment upon admission to PACU. *Guidance: The patient is assessed and continually monitored in accordance with the National Association of PeriAnesthesia Nurses of Canada (NAPAN) Standards for Practice, which includes but is not limited to: respiratory – airway patency, airway adjuncts, respiratory rate, breath sounds, oxygen therapy, continuous pulse oximetry monitoring; cardiovascular – continuous cardiac monitoring, blood pressure, pulse rate and regularity; neurological/neurovascular/neuromuscular – level of consciousness, neuromuscular function, neurovascular assessment of distal pulse, sensation, colour, temperature, capillary refill and movement (vascular surgery, limb surgery, back surgery, IV regional anesthetic and axillary nerve blocks), dermatome sensory level (spinal/epidural anesthesia); on admission and as clinically indicated – pain, nausea and vomiting (assessment, management and response to treatment); intake and output – intravenous therapy including location of line(s), condition of IV site(s) and the amount, type and rate of solution(s) infusing, output from tube(s), catheter(s), drain(s) and voiding, as indicated; surgical site, dressings and drains – condition of visible incisions and dressings, drainage tube(s), catheter(s) and drain(s) including type, patency, security, drainage and installations. Also see the NHMSFAP Post-anesthesia Care standard.*		M	
DOC1.14.3	**M**	PACU record documentation includes vital signs upon admission to PACU. *Guidance: The following is assessed and documented: oxygen saturation with continuous pulse oximetry monitoring, respiratory rate, heart rate including rhythm and interpretation with continuous cardiac monitoring, and blood pressure.*		M	

No.		Description	Reference	Risk	Change
DOC1.14.4	**M**	PACU record documentation includes temperature upon admission to PACU. *Guidance: In accordance with the National Association of PeriAnesthesia Nurses of Canada (NAPAN) Standards for Practice, temperature is measured on admission and every 15 minutes until normothermic, then as clinically indicated and at discharge from PACU.*		M	
DOC1.14.5	**M**	PACU record documentation includes vital signs every 15 minutes at a minimum during phase I level of care. *Guidance: The following is assessed and documented: oxygen saturation with continuous pulse oximetry monitoring, respiratory rate, heart rate including rhythm and interpretation with continuous cardiac monitoring, and blood pressure.*		M	
DOC1.14.6	**M**	PACU record documentation includes vital signs every 30 minutes at a minimum during phase II level of care. *Guidance: The following is assessed: respiratory rate, oxygen saturation, blood pressure, pulse rate and regularity.*		M	
DOC1.14.7	**M**	PACU record documentation includes a discharge scoring system. *Guidance: A post-anesthesia discharge scoring system/discharge criteria is/are used continually to assess patient readiness for transfer to the next level of care. Examples of discharge scoring systems include aldrete, modified aldrete, bromage, and post- anesthetic discharge scoring system (PADSS).*		M	
DOC1.14.8	**M**	PACU record documentation includes neurological, neurovascular and/or neuromuscular assessments, as indicated.		M	
DOC1.14.9	**M**	The patient's medical record includes an orders form. *Guidance: No medication should be administered to a patient by authorized staff, other than a physician, without a pre-existing medication order. Medication orders are to be written on a physician order form such as a pre-printed order set. The medication order must contain the patient name, date and time the medication order was written, medication name, dosage, route of administration, frequency of dosing, prescriber signature (wet signature) and printed name.*		M	

No.		Description	Reference	Risk	Change
DOC1.14.10	**M**	PACU record documentation includes medications administered and their effect. *Guidance: All medication(s) administered are documented in the patient's medical record. Medication administration documentation includes the medication name, date, time, dose, route and (if applicable) site, and initials/signature.*		M	
DOC1.14.11	**M**	PACU record documentation includes lines, drains and/or catheters, as indicated. *Guidance: Intravenous fluid administration including start and end time, solution, volume, and rate is documented. Status of drains and catheters including their location and drainage amount and description is documented. The fluid balance (in and out) record is complete.*		M	
DOC1.14.12	**M**	PACU record documentation includes dressings. *Guidance: The location and status of dressings is documented.*		M	
DOC1.14.13	**M**	PACU record documentation includes voiding, if monitoring indicated. *Guidance: Patients who possess one or more at-risk-criteria must void post-operatively prior to discharge. Patients who do not possess any of the at-risk criteria are not required to void prior to discharge. At-risk criteria includes history of urinary retention, following a gynecological, spinal, rectal or urological procedure, post-spinal/epidural anesthesia, and older male patients.*		M	
DOC1.14.14	**M**	PACU record documentation includes consultation, direction and/or orders from a health professional, as indicated. *Guidance: When another health professional is consulted or advised (e.g. anesthesiologist, surgeon), the following is documented: date, time and method of contact (e.g. phone call), health professional's name and title, information provided, health professional's response, and any resulting order/interventions/agreed upon action plan.*		M	
DOC1.14.15	**M**	PACU record documentation includes unusual occurrences. *Guidance: This includes any complications, unusual or adverse events and near misses.*		M	V6.0

No.		Description	Reference	Risk	Change
DOC1.14.16	**M**	PACU record documentation confirms the completion of discharge teaching. *Guidance: Written discharge instructions are reviewed with and provided to the patient. It is recommended that the patient's responsible adult escort also be present during the completion of discharge teaching.*		L	
DOC1.14.17	**M**	PACU record documentation includes date and time of discharge and patient status. *Guidance: Patient status includes but is not limited to vital signs, general status, discharge instructions, prescription, and accompanying responsible adult.*		L	
DOC1.15		**Overnight stay unit (ONS) documentation provides an accurate account of the patient's status, the actions of the health professionals, and the patient's outcome.**			
DOC1.15.1	**M**	ONS documentation includes date and time of transfer/arrival to ONS.		L	
DOC1.15.2	**M**	ONS documentation includes initial and regular assessments. *Guidance: Assessment includes but is not limited to blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain, procedure site, and general status. The documentation should provide a clear picture of the patient's status, the health professional's actions, and the patient's response/outcome to interventions carried out. The frequency of assessment is in accordance with the facility's post-operative care plan(s).*		M	
DOC1.15.3	**M**	ONS documentation includes a discharge scoring system. *Guidance: A post-anesthesia discharge scoring system/discharge criteria is/are used continually to assess patient readiness for transfer to the next level of care. Examples of discharge scoring systems include aldrete, modified aldrete, bromage, and post- anesthetic discharge scoring system (PADSS).*		M	

No.	Description		Reference	Risk	Change
DOC1.15.4	**M**	ONS documentation includes medications administered and their effect. *Guidance: All medication(s) administered are documented in the patient's medical record. Medication administration documentation includes the medication name, date, time, dose, route and (if applicable) site, and initials/signature.*		M	
DOC1.15.5	**M**	ONS documentation includes lines, drains and/or catheters, as indicated. *Guidance: Intravenous fluid administration including start and end time, solution, volume, and rate is documented. Status of drains and catheters including their location and drainage amount and description is documented. The fluid balance (in and out) record is complete.*		M	
DOC1.15.6	**M**	ONS documentation includes dressings. *Guidance: The location and status of dressings is documented.*		M	
DOC1.15.7	**M**	ONS documentation includes voiding if monitoring indicated. *Guidance: Patients who possess one or more at-risk-criteria must void post-operatively prior to discharge. Patients who do not possess any of the at-risk criteria are not required to void prior to discharge. At-risk criteria includes history of urinary retention, following a gynecological, spinal, rectal or urological procedure, post-spinal/epidural anesthesia, and older male patients.*		M	
DOC1.15.8	**M**	ONS documentation includes consultation, direction and/or orders from a health professional, as indicated. *Guidance: When another health professional is consulted or advised (e.g. anesthesiologist, surgeon), the following is documented: date, time and method of contact (e.g. phone call), health professional's name and title, information provided, health professional's response, and any resulting order/interventions/agreed upon action plan.*		M	
DOC1.15.9	**M**	ONS documentation includes unusual occurrences. *Guidance: This includes any complications, unusual or adverse events and near misses.*		M	V6.0

No.		Description	Reference	Risk	Change
DOC1.15.10	**M**	ONS documentation confirms the completion of discharge teaching. *Guidance: Written discharge instructions are reviewed with and provided to the patient.*		L	
DOC1.15.11	**M**	ONS documentation includes date and time of discharge and patient status. *Guidance: Patient status includes but is not limited to vital signs, general status, discharge instructions, prescription, and accompanying responsible adult.*		L	
DOC1.16		**Documentation practices comply with professional and regulatory standards.**			
DOC1.16.1	**M**	Method of documentation used is in accordance with the facility's policy and procedures. *Guidance: Methods of documentation include but are not limited to focus charting, SOAP charting, and narrative charting. Charting by inclusion/narrative charting is the recording of all assessment findings (normal and abnormal), interventions, and patient outcomes. Charting by exception is the recording of all assessment findings, interventions, and patient outcomes that vary from established assessment norms or standards of care (e.g. care plan, clinical pathway). If charting by exception is used, then normal assessment findings are defined in facility policy, and procedures and written care plans/clinical pathways are in place. Care plans or clinical pathways outline patient care from admission to discharge including expected outcomes/goals, typical course of recovery, and interventions (e.g. knee arthroscopy care plan). The method of documentation used is at the discretion of the facility.*		L	
DOC1.16.2	**M**	Documentation is legible and written in English. *Guidance: Errors are appropriately corrected (i.e. do not erase or black out errors). Corrections are made using a simple line through the incorrect information with a date and initial. Entries are not squeezed between lines, and blank lines are not left between entries. Amendments to an electronic medical record are made in a similar fashion where the content of the entry being deleted/corrected must remain visible (i.e. digital striking-out of text, "tracked changes" or using addendums).*		M	

No.		Description	Reference	Risk	Change
DOC1.16.3	**M**	Entries are made directly into the patient's medical record at the time care is provided or as soon as possible afterward. *Guidance: Entries are made at the time care is provided or as soon as possible afterward. Entries are not made before providing care or completing an activity. Entries are not made on a transitory record (e.g. scrap piece of paper) for entry in the medical record at a later time.*		M	
DOC1.16.4	**M**	Late entries include the date and time of the late entry and the date and time of the actual event.		L	
DOC1.16.5	**M**	Each entry made in the medical record includes the health professional's signature/initials and title. *Guidance: Entries made in the electronic medical record are made using a unique identifier (i.e. login or username).*		L	
DOC1.16.6	**M**	Only facility-approved abbreviations are used. *Guidance: Facility policy and procedures for medical records and documentation includes a listing of acceptable abbreviations. In addition, a "do not use" list of abbreviations, acronyms, symbols and dose designation, such as the Institute for Safe Medication Practices Canada (ISMP Canada) list, is in place, and all handwritten communications, pre-printed orders and medication administration records are in compliance.*		M	
DOC1.17		**Policies and procedures contain all the information necessary for the safety of patients, staff and visitors.** *Intent: Policies and procedures ensure that activities/procedures are performed consistently and accurately by all personnel within the non-hospital facility.*			

No.	Description	Reference	Risk	Change
DOC1.17.1	**M** There is policy and procedures for the medical record system. *Guidance: The policy and procedures outline the medical record format (e.g. paper, electronic (scanned paper records, direct data entry) or a combination of both), security, access and transfer and destruction of records. In addition, policy and procedures for electronic medical record systems outline the quality assurance steps taken when paper records are scanned into the electronic system, maintain the physical and technological security of the system (e.g. antivirus, spyware, automatic logout), defining user- based access levels, monitoring and auditing unauthorized access, preventing deletion of information, identifying changes and updates to the record, data sharing, secure transmission of records, backup of records, data recovery and testing and an alternate documentation method/system in the event of a system failure.*		L	
DOC1.17.2	**M** There is policy and procedures for documentation. *Guidance: The policy and procedures outline the method of documentation (e.g. focus charting, SOAP charting, narrative charting), expectations for frequency of documentation, process for corrections, addendums, amendments and "late entry" recording, and listing of acceptable abbreviations. An addendum is new documentation used to add information to an original entry in the patient's medical record. An amendment is additional documentation to clarify a pre-existing entry in the patient's medical record.*		L	
DOC1.17.3	**M** There is policy and procedures governing the collection, use and disclosure of personal information. *Guidance: The policy and procedures outline: responsibilities for the collection, use and disclosure of personal information, when expressed consent is required to disclose patient information (e.g. to an insurance provider or employer), and the process for a patient to access to their medical record. Under* PIPA*, implied consent (i.e. patient provided information for the purposes of care and treatment) is sufficient for the collection, use and disclosure of personal information for direct health-care purposes and may extend to parties who provide care to the patient as part of the patient's care team (i.e. referring physicians, lab technicians, nurses).*		L	

No.	Description		Reference	Risk	Change
DOC1.17.4	**M**	There is policy and procedures governing the use of email communication. *Guidance: The policy and procedures outline acceptable use of email between patients and care providers, consent for email correspondence, verification of email address, email etiquette, email documentation as part of the patient's medical record, and use of password protection.*		L	
DOC1.17.5	**M**	There is policy and procedures for responding to a privacy breach. *Guidance: The policy and procedures outline how to respond to a breach including contacting the privacy officer, immediately containing the breach (i.e. suspending user accounts, correcting weakness in physical security), evaluating the risks associated with the breach, implementing notification procedures, (if necessary) reporting the breach to the Office of the Information and Privacy Commissioner of BC, and preventing further privacy breaches (i.e. updating privacy and security policies, performing a security audit, employee education).*		L	

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Revision history

Date	Revisions
March 19, 2015	• NHMSFP *Medical Records and Documentation* standard approved (version 1.0)
December 30, 2017	• Bylaws change program name to NHMSFAP (no content changes) (version 1.1)
March 14, 2019	• Substantial changes to content and format (version 2.0)
June 9, 2022	• Removed criterion 1.9.10 for documentation of procedure start and stop time on the anesthetic record (version 3.0) (effective July 31, 2022)
March 24, 2023	• New College logo (no content changes) (version 4.1) (published March 24, 2023)
November 30, 2023	Gender, sex and sexual orientation health information standards and guideline revisions (version 5.0) (effective March 1, 2025) • Revised criterion 1.1.2 guidance to include patient's legal name, name used and sex assigned at birth and remove gender. • New criterion 1.6.9 name used • New criterion 1.6.10 pronouns • New criterion 1.6.11 gender identity • New criterion 1.6.12 sex assigned at birth • New criterion 1.6.19 pre-admission summative view • Section 1.6 renumbering • Reference list updated

Date	Revisions
March 21, 2024	Various revisions (version 6.0) (effective May 1, 2025) • Revised guidance to criterion 1.8.5 (content becomes a new criterion) • New criterion 1.8.6 that the medical record of any patient with a sensitivity or allergy be labelled or flagged • Revised guidance to criterion 1.8.7 that height, weight and BMI are not required for procedures in which **only topical eye drops** are administered **and** where there are no safety concerns with respect to equipment size (e.g. BP cuff), weight and/or height limits. • Guidance added to criterion 1.11.23 and criterion 1.12.10 • New section 1.13 with two new criteria regarding progress note documentation of physicians • New criterion 1.14.15 that PACU documentation includes unusual occurrences • New criterion 1.15.9 the ONS documentation includes unusual occurrences • Criterion numbering and section numbering adjusted accordingly (Sections 1.8, 1.9 (re-set to be sequential numbering), 1.14, 1.15, 1.16 and 1.17) • Reference list updated • Risk added
November 22, 2024	ISQuaEEA Logo (no content changes) (version 6.1)
December 9, 2024	VTE Revisions (version 7.0) (approved September 12, 2024) (effective within 30 days of notification). • Revised guidance 1.6.7 mentioning Thrombosis Canada as a resource. • New criterion 1.6.8 for pre-admission assessment documentation of recommended VTE prophylaxis based on the patient's VTE risk score. • Section 1.6 numbering adjusted accordingly. • New criterion 1.8.11 for admission documentation verifying VTE screening. • New criterion 1.8.12 for admission documentation verifying VTE prophylaxis.

Date	Revisions
	• New criterion 1.8.14 for pre-printed orders to facilitate VTE risk assessment, prophylaxis ordering and documentation. • Section 1.8 numbering adjusted accordingly • Revised guidance 1.8.19 to include preoperative medications ordered, VTE screening and prophylaxis. • Revised guidance 1.11.5 mentioning Thrombosis Canada as a resource. • Reference list updated.