MANITOBA ASSOCIATION OF REGISTERED RESPIRATORY THERAPISTS

# Clinical Practice Guidelines

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1. As a standard of practice for the healthcare professional, it is the mandated responsibility of each Registered Respiratory Therapist (RRT) to document on paper and/or through electronic means any and all patient care provided by the RRT, in their association either directly with the patient or indirectly via discussion with another healthcare professional.

2. This documentation must at all times be legible, comprehensive, concise and pertinent.

3. Electronic entry of patient results and/or documentation requires that the RRT entering the data be the individual currently logged onto the system, using their personal username and password. Once the entry has been completed, the electronic chart must immediately be closed with that particular RRT logging out of the system.

4. Each entry is to contain the date and time of charting, and is to be signed or initialed by the RRT with their protected title affixed.

5. If the chart entry occurs at a later time than when the intervention with the patient transpired, the documentation must be clearly labeled as a late entry along with the actual time of occurrence.

6. Any entries into the patient/client record made by students must be co-signed by a licensed RRT.

7. It is the responsibility of each individual RRT to adhere to employer policies, procedures and guidelines as they pertain to the act of documentation, while ensuring that the appropriate MARRT standards of care are being observed.