2010

DOCUMENTATION STANDARDS FOR REGISTERED NURSES

Association of
Registered Nurses
of Newfoundland
and Labrador

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Introduction

Documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic. It reflects the application of nursing knowledge, skills and judgment, as well as the clients'[1] perspective. Documentation establishes accountability, promotes quality nursing care, facilitates communication between registered nurses and other healthcare providers, and conveys the contribution of nursing to health care. Documentation is not separate from care and it is not optional. It is an integral part of nursing practice.

This Interpretive Document is intended to provide RNs with information on their professional accountability and the ARNNL's expectations for clinical documentation. The ARNNL *Standards of Practice for Registered Nurses* (2013)[2], under Standard 2: Knowledge-Based Practice, Indicator 2.8 states the registered nurse "maintains timely and accurate documentation."

RNs must also be familiar with, and follow their employer's documentation policies, standards and protocols. Although different documentation formats and technology may be used throughout the province, quality nursing documentation is an expected RN practice in every area of care or service delivery and in every setting. This includes RNs who are self-employed and/or working in an independent practice. A sample of different formats for documentation is included as Appendix A.

As partners in achieving quality care, RNs and employers have a shared responsibility to create *Quality Professional Practice Environments* (QPPE) that support effective documentation. A quality professional practice environment is defined as a workplace that supports professional nursing practice, fosters professional development and promotes the delivery of quality care (ARNNL, 2006b). Information on supports and services required within a practice setting to facilitate RNs meeting their required standards for documentation is supplied in Appendix B.

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[1] In this document client refers to the range of individuals and or groups with whom RNs interact. As a recipient of nursing services it is defined as individuals, groups, communities or populations (ARNNL, 2007).
[2] Content updated to reflect the *Standards of Practice for Registered Nurses* (2013).

Definition

Nursing documentation refers to written or electronically generated client information obtained through the nursing process. Through documentation RNs communicate observations, decisions, actions and outcomes.

Privacy and Confidentiality

Regardless of the method used to communicate client information (e.g., written documents, or electronic transfer) RNs must adhere to the principles of privacy and confidentiality (ARNNL, 2007). Examples of expected practices and value statements about privacy and confidentiality are outlined in other resources such as the Canadian Nurses Association *Code of Ethics for Registered Nurses* (2008), agency policies, Accreditation Canada and relevant provincial legislation such as *Health Research Ethics Authority Act (2006), Personal Health Information Act* (2008) *and Child, Youth* and *Family Services Act* (2004*)* (see Appendix C).

Ownership

The record, i.e., the binder or software which contains the client's information, is the property of the host or health care agency (custodian) for which the client sought or participated in services. The data or information pertinent to the client is the property of the client. Therefore, in accordance with the *Personal Health Information Act* (2008), the client has the right to have access to view and/or copy their health record, and request a correction of personal health information if the client believes the information is inaccurate or incomplete. Agency policy should stipulate the processes to follow when clients want to access or make changes to their personal health information.

Sharing of Information within Circle of Care

In health care it is recognized that there is the need to balance client privacy with the need for health care providers to share information as part of the provision of care. The ability to share information within the circle of care and the concept of implied and explicit consent are outlined in the *Personal Health Information Act* (2008). Whether consent is expressed or implied, the sharing of health information even within the circle of care is to be limited to only information that needs to be shared and with whom it needs to be shared. The parameters for sharing of personal health information should be addressed in agency policy.

Disclosure without Consent in Best Interest/Life Health or Security at Risk

There are special circumstances where personal health information may be collected, used and disclosed without the client's consent (implicit or explicit) or knowledge. These situations are limited and would be in accordance with a provision in *Personal Health Information Act (2008)* legislation such as in compliance with an investigation, enforcement or law, or when the life, health or security of a person is at risk.

Quality Documentation: Defined

Quality Documentation is described below in answer to *Why*, *Who, How, What, and When* questions. While there may be some variation in the way electronic data is recorded due to software applications, the underlying principles remain the same for electronic and paper based systems. When a practice setting has two systems for documentation (paper and electronic) continuity of care must be maintained. Agency policy should identify which system to use and how to cross reference if both sources are being used or in the event of an electronic system failure. For example, the RN may need to indicate in his/her note if there is pertinent information on the same topic in another source. When the care of a client involves two different agencies such as, a personal care home and community health services from a regional health authority, it might be necessary to document client specific information in the records of both agencies. Agency policy should identify the parameters for this practice. The province is moving towards a fully integrated electronic health record. Once implemented the electronic health record (EHR) promises to increase system efficiencies.

1. WHY Should RNs Document?

1.1 Method of Communication to Support Continuity of Care

Documentation provides accurate, pertinent, current, and comprehensive information concerning the condition and care of the client or services provided. Communicating a client's health information to other members of the health care team enables all health care providers to make prudent professional judgments and promotes consistency and continuity in client care.

1.2 Promote Quality Improvement and Manage Risk

Clear, complete and accurate nursing documentation facilitates quality Improvement initiatives and risk management analysis for the client, staff and the organization (CRNNS, 2005). Information from the health record is used as a quality improvement mechanism to evaluate services or care provided and to help plan improvements (e.g., chart audits, performance reviews, and accreditation). Through information documented in client records, agencies are more readily able to evaluate progress towards outcomes, trend challenges, identify and manage risks and ultimately, maximize client safety.

1.3 Mechanism for Professional Accountability

Accountability means being answerable for one's own actions. The health record demonstrates RNs' accountability and gives credit to RNs for the care they give or the service they provide. In Newfoundland and Labrador all RNs are required to document evidence of safe, competent and ethical care in accordance with the *Standards for Nursing Practice* (ARNNL, 2007), the *Code of Ethics for Registered Nurses* (CNA, 2008), and applicable clinical standards and relevant agency policies. Documentation must reflect the RN's professional judgment, assessment, decisions, actions, and evaluation. Additionally, documentation must honor the ethical concepts of good practice such as promoting respect, confidentiality, and informed decision-making.

1.4 Protection Against Liability

The client's record is a legal document and, as such, can be used as documentary evidence in a court of law. Documentation should be able to provide a chronological record of the many events involving client care and services and may be used to refresh one's memory, if required to give evidence in court. Courts will use clinical documents to reconstruct events, establish times and dates, and to substantiate and/or resolve conflict in testimony. Documentation provides specific information (who, what, how and why) about the planning for, provision of, and client's response to care or services. It provides evidence that safe and competent care was delivered, that the care/service met acceptable standards and procedures, was reasonable and prudent, was provided in a timely manner and, was consistent with organizational policies. Altering or failure to keep records as required could result in legal and professional ramifications. Quality documentation is a RN's best defense in legal proceedings (CNPS, 2007).

1.5 Method of Expanding the Science of Nursing

The health record can be a valuable source of data for nursing and health research. Nursing documentation can be used to identify the impact of nursing interventions and evaluate client outcomes, as well as to identify any gaps or concerns. Accurately recorded information is essential to obtain quality research data. Research derived from quality documentation can generate information on evidence-based practice which in turn can improve the profession (NANB, 2002).

1.6 Funding and Resource Management

Documentation can be used by administrators to support funding and resource management decisions. Health records can identify the type and amount of client care required, services provided, and the efficiency and effectiveness of those services. It also can be used by third party insurers for the approval of client insurance claims. Workload measurement and/or client classification systems, derived as a consequence of nursing documentation, can be used to help determine the allocation of staff, skill mix, and/or funding (CRNNS, 2005).

2. WHO Should Document?

2.1 First Hand Knowledge

Legal and professional principles dictate that the provider with personal or first hand knowledge (i.e., you did it or you saw it) should document the information. First hand knowledge in this context means that the professional who is doing the recording is the one who provided the service. For example, the recorder led an interdisciplinary team conference or family meeting, or the recorder was the RN who provided the care.

In situations when two or more people provide care or services, the RN who has the primary assignment is expected to document the assessment, intervention and client response, noting as necessary the role of other care providers. However, the second nurse is expected to review the documentation, making an additional entry if necessary and, in accordance with agency policy cosign the record (see section 2.3). In some cases it may be more appropriate for both people to document his/her role in the care, for example to reflect different assessments or roles, or to meet agency policies that require more than one care provider (e.g., two nurse assist for high risk delivery).

If the client is receiving services from two different agencies or departments that have separate records, for example health and justice, or community health and a private agency such as a personal care home, it is important that the RN record the care that he/she provided in all the relevant document(s). Expectations regarding who is supposed to document where, must be clearly articulated in agency policy to promote consistency. For example, the RN may be required to record the administration of a medication in both the client's personal care home record and the client's agency record. If this is not possible then discussion should occur between the involved agencies to determine how both parties can share information to ensure continuity of care while balancing confidentiality and client safety.

2.2 Third Party Documentation

Third party documentation is not generally supported, as documenting for others may lead to errors and/or inaccuracies which could be detrimental to the provision of quality client care. It could also have an impact on the admissibility of records in court proceedings or diminish the actual credit given to a record as evidence. There may be times when it is not possible to do first hand recording so the information must be recorded by a 'third party'. If information is recorded as reported from another source the RN must use quotation marks and identify the source. It may also be necessary to record why third party charting occurred. Agency policy should clearly delineate when a third party may document for others. The following are some circumstances where documenting for others could be considered.

Designated Recorder

It is commonly accepted practice to assign a designated recorder for emergency situations where there may be limited time to have all involved parties record the specific care they implemented. It is best practice to include in the chart a list of all who were present for validation, as necessary. Designated recorders may also be considered in select circumstances where it is not practical for client safety reasons for the care provider to contemporaneously record the event as it occurs. For example, there may be a recorder identified for routine procedural events in specialty areas such as the endoscopy unit, the operating room or the delivery room. Cosigning documentation may be appropriate in this situation.

Auxiliary or External Personnel

Health providers who provide direct care, such as unregulated care providers or personnel employed from external organizations, can only document the care they provide if this is a supported practice within the agency. If an agency's policy specifies that auxiliary/external personnel are *not* to record information, RNs must document the reports given to them by the auxiliary or external personnel, including the reporter's name and status.

Client or Family

In some settings it is an accepted practice that a client and/or family member document observations and components of care. Some examples include, newborn intake and output, palliative client's travelling diary, self administration of medications, recording of wound drainage or trending vital signs. Agencies should outline the responsibilities of RNs if they are required to transcribe, summarize or file the information into the agency record.

Students

Students are learners and not employees. All students are expected to document the care they provide. Cosigning notes written by students is not encouraged (see section 2.3). However, it may be necessary for the co-assigned RN or preceptor to record their own assessments, interventions and evaluations. The need for this extra level of documentation must be based within agency policy and upon professional judgment. For example, if a client developed an acute or complex problem the co-assigned RN should document.

2.3 Cosigning and Countersigning Entries

Cosigning refers to a second or confirming signature on a witnessed event or activity. Agency policy on cosigning must clearly indicate both the intent of a co signature and in what circumstances cosigning is required. RNs are accountable for their own actions and do not routinely need someone to cosign their practice.

There are some examples where cosigning is prudent practice, such as, recording a critical incident witnessed by a second care provider, verbal consent or telephone orders, verification of a medication dosage, discarding of a narcotic, or client identification for a blood transfusion. Cosigning implies shared accountability. It is imperative that the person cosigning actually witnessed or participated in the event.

Countersigning is defined as a second or confirming signature on a previously signed document, a blind signature which is not witnessed. This is generally not a supported or needed practice in nursing care but may be effectively utilized as a quality control process. For example, a RN reviews a chart to determine if all the orders are accurately transcribed or all required interventions are completed, such as discharge preparation. Countersigning does not imply that the second person provided the service; it does imply that the person approved or verified that the service or record was completed.

Cosigning or countersigning for other reasons such as entries written by RNs in orientation, student nurses or LPNs is not acceptable and may add a level of accountability which the RN would not otherwise incur (NANB, 2002).

3. HOW Should RNs Document?

3.1 Legibility and Spelling

All entries in a paper-based system should be written legibly using black or blue ink, or in accordance with agency policy. The use of black ink is considered best for optical scanning technology. It is advisable not to change pens while writing an entry of an event as this may give the impression that the entry was not completed in its entirety at one time. Never use pencil, gel or felt pens, or coloured highlighters, as they are not permanent, can be erased or changed, and do not copy or scan clearly.

Correct spelling demonstrates competence and attention to detail. Misspelled words and/or illegible entries can result in misinterpretation of information and could lead to a client adverse event (e.g., the letter "o" has been confused with "u", medication errors have occurred involving drugs with similar spellings).

3.2 Blank (White) Space

There should be no blank or 'white' space in documents as this space presents an opportunity for others to add information unbeknownst to the original author. To avoid this risk, draw a single line completely through the blank space, including before and after your signature/designation. When transcribing an order it is suggested to block out or trace a partial square to identify that a part of the record has been noted. Fill in all blocks or spaces on flow sheets with the approved symbol/comment, (e.g., check mark, initials, not applicable, or x mark). The use of ditto (") marks to indicate repetition of information is unsafe and inappropriate. As well, ditto marks leave excess white space.

3.3 Abbreviations, Symbols, and Acronyms

The use of abbreviations, symbols or acronyms can improve efficiencies in documentation if their meaning is well understood by everyone. Abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors, cause confusion, and waste time. Some common terms that are incorrectly abbreviated include: C/O - complaints of, pt - patient, CP - chest pain and, d/c - discharge. The Institute of Safe Medication Practices has identified a list of *do not use* medication related abbreviations that are known to be error prone (ISMP, 2006). Agencies must articulate the accepted abbreviations, symbols and acronyms for use in their organization. When there is no agency-approved list, abbreviations may be used in a single health record entry when the meaning is spelled out immediately after the abbreviation's first appearance in that entry, (e.g., deep breathing and coughing DB & C) or if a legend exists on each page (e.g., Slept "P" as "poorly", "R" as "restless", and "S" as "sound") (CRNNS, 2005).

3.4 Mistaken Entry/Errors

Inaccuracies in documentation can result in inappropriate care decisions. Errors must be corrected according to agency policy in an open and honest manner. The content in question must remain clearly visible and retrievable so that the purpose and content of the correction is clearly understood. White out or other correction type devices are not to be used. If two systems of recording are utilized, such as, an electronic chart and a paper chart, then both records must be corrected. If the electronic and paper records are retained in separate places, the agency should identify processes to ensure relevant communication regarding the correction occurs between the two systems.

To correct an error in a paper-based system, cross through the word(s) with a single line, and insert your initials, along with the date and time the correction was made. Then enter the correct information. For computer based documentation permission/access to make corrections to the record may be required. Check your agency policy for the accepted process for correcting errors. For example, some require the words 'Charting or Documentation Error' or 'Mistaken Entry' to be included with your initials, while others may require that the correction be noted with the use of a symbol such as an asterisk.

Do not make entries between lines, remove items (e.g., monitor strips, lab reports, requisitions, and checklists), erase or use correction products, hide or obliterate an error. Entries must not be recopied because of a documentation error. If for any reason paper-based documentation becomes illegible (e.g., water spills), maintain the illegible paper and follow agency policy on how to address the situation. Modifying or altering documentation, or failing to correct errors appropriately, as identified in agency policy or as above, may be interpreted as falsification of a record and can be considered professional misconduct in accordance with the *Registered Nurses Act* (2008).

4. WHAT Should RNs Document?

4.1 Clear, Concise, Unbiased and Accurate

Precision in documentation is imperative. Objectivity means expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam-Webster, 2005). Objective data means information that is observed (e.g., crying, swelling, bleeding) or measured (e.g., temperature, blood pressure, weight), and includes interventions, actions or procedures as well as the client's re-sponse. If there is uncertainty about a specific observation or assessment, document the reason for the uncertainty.

- *Avoid generalizations* - Documentation is strengthened by the inclusion of details and accurate descriptions. Vague phrases or expressions such as *status unchanged, assessment done, had a good day, small amount, up and about*, are conclusions without supported facts. Be specific and use complete, precise descriptions of care (e.g., 'slept quietly from 0100-0600 and stated that he felt well rested'). The use of words such as *appears, seems,* or *apparently* are not generally acceptable because they demonstrate uncertain-ty and suggest that a RN did not know the facts. An exception might be when the supposed fact cannot be verified. For example, appears to be sleeping, may be appropriate as the only means of verification would be to disturb the client and ask if he/she was actually asleep.

●*Avoid bias* - Do not document value judgments or unfounded conclusions; document only conclusions that can be supported with data. For example, unless you witnessed a client falling, you should state, "found client on floor". It is not acceptable for RNs to make value judgments or culturally insensitive comments. These comments might suggest or imply a dislike for a client which could be construed to mean that the care provided was sub-standard. Select neutral terminology or describe observed behaviors. For example, rather than saying that the "client was drunk" state, "noted an odor of alcohol and speech was slurred". Instead of "client is aggressive" state, "client has been shouting, and using obscene language". Write each entry with the knowledge that the client has a right to read their own chart. Only document what can be verified. If you assess that a drainage tube is dislodged when you receive a client from another area state "noted upon arrival... " versus... "tube dislodged... in the other unit".

●*Identify subjective comments* - Subjective data may include statements or feedback from a client as well as from family members or a friend. When charting subjective information provide accurate examples of what was said using quotes appropriately along with identification of the individual who made a particular statement. For example, client states, "I am pain-free today," or "I understood the information provided".

●*Read what you submit* - Be careful with the use of default and recall features in the electronic record. When using these features for efficiency or to promote consistency, be sure to read what is presented to validate that the information is accurate for this submission.

4.2 Date, Time, Signature and Designation

Notations in a health record generally begin with the date and time of an entry and conclude with the recorder's signature and designation. Policies for documenting date, time and signature will vary from agency to agency. For example, a full signature may include either the first initial or first name along with the surname and professional designation such as, RN, NP, or GN. Personal initials can only be used if a master list to match the caregiver's initials with a signature and designation is maintained within the health record. Depending upon the format approved in the agency the full signature may be located on every page/form or a list of all relevant staff signatures are saved in a designated section of each client's chart.

In the electronic chart identification is controlled through the use of passwords and other access limitations. Therefore it is imperative to ensure security of user passwords and to use safeguards such as logging off when finished using a system (see Appendix C).

4.3 All Aspects of the Nursing Process

Documentation which reflects the nursing process demonstrates that the RN has fulfilled his/her duty of care. It supports accountability by linking assessment through to evaluation. If the client interaction occurred through telehealth, it is important to identify the modality utilized (e.g., video or telephone.) As a general rule, any Information that is clinically significant should be documented. To determine what is essential to document, for each episode of care or service the health record should contain:

- a clear, concise statement of client status (including: physical, psychological, spiritual);
- relevant assessment data (include client/family comments as appropriate);
- all ongoing monitoring and communications;
- the care/service provided (all interventions, including advocacy, counseling, consultation, and teaching); and
- evaluation of outcomes, including the client's response and plans for follow up.

Failure to document evaluation is a common deficiency in charting. It is important to demonstrate the effectiveness of care/services. The RN should document answers to the following questions as appropriate: What were the client outcomes? What additional nursing actions were implemented as a consequence of client outcomes? For example, did the vital signs stabilize? Did the pain subside? Did the client understand the information? Was the referral made? What follow-up was implemented?

A good test to evaluate whether your documentation is satisfactory is to answer the following question: If another RN had to step in and take over this assignment, does the record provide sufficient information for the seamless delivery of safe, competent and ethical care" (CARNA, 2006).

4.4 Admission, Transfer, Transport, and Discharge Information

Health records must include data related to admission, transfer, transportation and discharge. This information provides baseline data for subsequent care and follow-up. Agency policy should identify expectations on the recording of communication between practitioners or services. The client's chart should reflect what information was provided to prepare the client for any transitions. The RN should include information on the client's status at the time, instructions provided (verbal and written), arrangements for follow-up, evidence of the client's understanding and, as appropriate, family involvement.

4.5 Communications Between Health Care Providers

Record all significant client related communications with other health care providers. Note the date and time of contact, the information you provided and the response received from the other health care provider. Communication includes all types of contact between care providers including written, electronic and verbal formats and all unsuccessful attempts to contact another health care provider. If communication is unsuccessful, the nurse should also record information about alternate channels pursued in his/her effort to ensure client care needs or services were met.

Faxing is a convenient method for communicating information between health care providers in different locations. Although this is a commonly accepted practice in most settings, nurses need to ensure that information is transmitted to the correct source and verify that the facsimile was completed as intended.

Email communication between health care providers should only occur within secure networks and be limited to non identifiable client information as the confidentiality of emails cannot be guaranteed. It is important to know the agency policies on communication, including when various types of communication are acceptable and the required security safeguards.

4.6 Client Care Provided Through Electronic Means

Providing nursing care or service delivery through electronic means (i.e. telehealth) is considered to be practicing nursing and thus the interactions must be documented (ARNNL, 2002). Electronic care or services includes but is not limited to video/audio conferencing, telephone calls, faxes, emails, or transmittal of data such as diagnostic results or digital photographs. Agency policy should identify how client information obtained through electronic care/services is to be transmitted, recorded and shared between care providers.

When providing care via electronic means when the client cannot be observed, (e.g., telephone) the RN has to rely exclusively on his/her verbal communication skills and the client's self assessment of the situation. As a result documentation may need to be more extensive. For example:
- it may be prudent to document in detail all the client's subjective comments and related environmental factors;
- it may be necessary to note the date and time of the episode, commenting if there is a time gap between receipt and response to communication, for example, email or telephone voice message and follow-up personal contact;
- it is recommended to reference any standard, policy, protocol, or care plan followed;
- it is important to document all referrals or suggested next steps for follow-up, for example, instructions to call back if the situation changes.

4.7 Client Education

Registered nurses provide a broad range of client education. Comprehensive documentation of client education supports effective planning and reflects the importance of this component of care or service. The RN needs to consider the following when documenting client education:
- document formal (planned education) as well as informal (unplanned) teaching activity;
- written entries about client education should include:
  - a brief description of the material utilized;
  - the method(s) used for teaching (e.g., written, visual, verbal, auditory, and instructional aides used);
  - as applicable, the involvement of and the interaction between client and family in the teaching/learning process;
  - the identification of any outstanding issues or common themes that require follow-up;

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- evaluation of the teaching objectives with validation of client comprehension and learning. For example, "Teaching was provided related to infection. Client accurately described the signs and symptoms of infection and reported accurately that if any of these develop, he would call his nurse";
- identify follow-up education requirements, handouts and web links provided (CARNA, 2006).

To help promote consistency and to encourage thorough client education it may be beneficial for RNs to advocate for or develop a common template or form to document education activities.

4.8 Risk-Taking Behaviors

Some clients, by choice, participate in risk taking behaviors. The following are examples of risk taking behaviors: eating foods identified as a dietary restriction; threatening self harm, ambulating when bed rest is advised; missing follow-up appointments; leaving against medical advice; refusing or abusing medications and/ or illicit drugs; and tampering with medical equipment. Clients may also decline to receive information about their health condition or make choices about which interventions they may or may not accept.

These situations reflect the capable individual's right of choice and should be respected as such - *Nurses are to respect the informed decision-making of capable persons, including the choice of lifestyles and treatment not conducive to good health (*CNA, 2008). However it is vital that the RN document the information provided, to whom and the outcomes of the discussion in an unbiased and objective manner (see section 4.1). Some settings may stipulate that a record of the incident is documented on a separate agency specific form or electronic file for quality assurance purposes. If the risk taking behavior constitutes a breach of legislation, that requires mandatory reporting such as, child abuse, the RN is required to follow the stipulations in the relevant legislation and document accordingly. It is important in all questionable situations, or if the person is not deemed to be capable, that the nurse is familiar with relevant legislation and agency policies and consults with his/her manager or others as required.

4.9 Unanticipated, Unexpected or Abnormal Incident

An unanticipated, unexpected or abnormal incident for a client might include falls, medication errors, delays in service or other undesired situations. Record the facts of the situation including any related care in the client's record without using the words incident, error or accident. Only information relevant to the care of the client should be on the client's record. In addition, most agencies require employees to document these events on an incident/occurrence report or in a specific electronic file for reasons of continuous quality improvement and risk management. This data collection is separate and distinct from the client's record. Nurses must familiarize themselves with their agency's policies on recording incidents.

5. WHEN Should RNs Document?

5.1 Timely, Frequently and Chronologically

Documentation should be done as soon as possible after care is provided to enhance the accuracy of each entry and the overall credibility of the health record. Documentation should **never** be completed before the care/service is provided.

Frequent documentation supports accuracy, particularly when precise assessment is required as a result of changing client conditions or to limit reliance on memory when caring for multiple clients. Charting should be more comprehensive, in-depth and frequent if a patient is very ill or exposed to high risk (CNPS, 2007). The frequency and amount of detail required is generally dictated by a number of factors, including:
- agency policies and procedures;
- complexity of a client's health problems;
- degree to which a client's condition puts him/her at risk;
- degree of risk involved in a treatment or component of care;
- changes in care plan; and
- client transition, e.g., admission/discharge, transfer or transport.

Documenting events in the chronological order in which they took place is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications; enabling health care providers to understand what care was provided, based on assessment data, and any outcomes or evaluations of that care, including client responses.

5.2 Late or Lost Entries

Record information as soon as possible after the event occurs. When it is not possible to document at the time of or within a reasonable period following an event, a late entry is required. Late entries should be defined in agency policy. Late entries in a health record should be made on a voluntary basis and only when a RN can accurately recall the care provided or the event. Late entries for paper-based health records must be clearly identified and dated with reference to the actual time of documentation as well as the time when the care/event occurred.

In the event of a lost entry (mislaid paper or a computer glitch), the RN may be asked to reconstruct the entry. The new note must clearly indicate the information recorded is a replacement for a lost entry. If the care/event cannot be recalled, the new entry should state that the information for the specific time of the event has been lost (CRNNS, 2005).

Conclusion

Quality documentation is an integral part of professional nursing practice. When RNs meet the standards and expectations outlined in this document, they are demonstrating professional responsibility and accountability.

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Appendix A

Documentation Tools and Formats

Different documentation systems and tools have been developed to meet the diverse needs of care settings. There is no one *best* system that will be perfect for all contexts of practice. In fact, in many areas of nursing practice, elements of several systems or methods of documentation are often combined. Regardless of the method of documentation used, it is essential that all RNs are familiar with and follow agency guidelines for the proper utilization/completion of 'charting' in the area they practice. Whenever a system changes, it is important that a plan be devised for implementation, and that the plan include the involvement and education of registered nurses. The following examples were modified from information obtained from other sources (CNO, 2008; CRNBC, 2008; CRNNS, 2005; NANB, 2002).

Documentation Tools

There are many tools used for client documentation, including; worksheets and kardexes, client care plans, flowsheets and checklists, care maps, clinical pathways, and monitoring strips. These tools may be in written or electronic format. Relevant nursing care stemming from health information documented in any of these tools must also be reflected in the client's record (e.g., care initiated in response to an elevated temperature noted on a vital sign form is recorded in progress note).

Care Plans

Care plans are written outlines of care for individual clients and are part of the permanent record. Effective care plans are up-to-date and include the client's needs and goals. If a standardized care plan format is not used, the nurse should ensure that his/her notes identify a plan of care for each assigned client.

Flow Sheets

Flow sheets and checklists are used to document abbreviated client information. They are:
- frequently recorded information associated with care (e.g., daily living activities, vital signs, intake & output);
- often used in conjunction with other documentation tools;
- visual reminders and are helpful in showing patterns or trends in data and promoting continuity of care or services;
- part of the permanent health record, and can be used as evidence in legal proceedings;
- acceptable practice if it is clear who performed the assessment or intervention and the meaning of each of the symbols is identified in agency policy; and
- cues to ensure necessary components of a procedure have been done and are documented (e.g., consent obtained, IV initiated, gauge number of catheter, presence of blood in hub, proper sharp disposal, IV running, IV connected, bag hung, etc.).

Care Maps, Clinical or Critical Pathways

Care maps and clinical or critical pathways are forms of charting by exception that outline care that will be done as well as outcome expected over a specified time frame for a 'usual' client within a case type or grouping. Care maps:
- identify expected outcomes for each day of care for a specific kind of client (e.g., labour/delivery, orthopedic surgery);
- require individualization to meet clients' specific needs (e.g., making changes to items that are not appropriate); and
- mandate how variances are to be recorded.

Worksheets and Kardexes

Worksheets and kardexes are tools used to communicate client information between providers for the purpose of organizing care, and managing time and multiple priorities. They are paper-based or electronic formats used to convey such things as current orders, upcoming tests or surgeries, special diets or the use of aids for independent living specific to an individual client. Agency policy should identify if information on these sources may be erased and or need to be retained as a permanent record. If they are not retained it is important to follow agency policy on discarding to ensure client confidentiality.

Shift Reports

Shift reports are used to alert the health care team to important information. They:

- generally occur through verbal, or tape recorded but can be written;
- can be used in conjunction with kardexes or worksheets;
- should be addressed in agency policy including the process for maintaining/destroying shift reports and/or erasing/destroying audiotapes; and
- should be linked to the health record where the pertinent information is recorded in detail.

Documentation Formats

A number of charting formats are available. The following is a brief overview of some of these formats.

Narrative Charting

Narrative Charting is the most traditional approach whereby interventions and client responses are written in a paragraph format and recorded in chronological order. The nursing process is often used as the organizing framework.

Historically, different disciplines record in their own section or electronic page of the record. However, Accreditation Canada has identified that this practice limits the ability for interprofessional communication and thus identified that all disciplines should document in the same part of the record. One of the challenges noted with one common document is the need to balance privacy and provision of care by providers who are within the circle of care.

Narrative notes may stand alone or be used in combination with other documentation tools (e.g., flow sheets). Information noted in one section of a health record may not need to be repeated in another area (e.g., data noted on a flow sheet does not need to be repeated in narrative notes). However, it may be helpful to make a notation in narrative that further information related to a specific event/intervention has been recorded in another section (e.g., 'refer to flow sheet').

SOAP Charting

The SOAP format focuses on specific client problems. The client's current problems are identified and listed on the nursing care plan. There is an optional addition to the SOAP format – Soap I.E.R. that focuses on outcomes and evaluation. Recording is organized under the following headings:

S = subjective data (verbalizations of client/ e.g., how the client feels);
O = objective data (measured or observed/ e.g., relevant vital signs);
A = assessment (nursing diagnosis based on data);
P = plan (what caregiver plans to do);
I = intervention (care, procedures provided);
E = evaluation (how plan worked, whether changes are needed); and
R = revision (changes, if necessary, to plan of care, based on evaluation).

Focus charting®

Focus charting is a system that requires RNs to document according to one or more identified foci that reflect the client's concerns or health needs (e.g., symptom, behavior or event). These foci form the basis of the care plan and are determined during assessment. Recording is organized under the following headings **DAR or DARP**.

Data (subjective or objective)
Action (nursing interventions)
Response (evaluation of effectiveness)
Plan (next steps)

PIE Charting

This format uses a problem-oriented approach and is based on the nursing process. The PIE system consists of a 24-hour daily assessment flow sheet. Quite often, standardized or individual care plans need to be used in conjunction with PIE charting.

Problems

Interventions

Evaluation

Charting by Exception

Charting by exception is a charting system for RNs to document only those particulars or observations about the client that fall outside expected limits or established standards of care. It assumes all observations fall within expected limits or all care standards have been met with the normal or expected response unless the care giver has documented otherwise. To be effective, all components of the charting by exception system must be effectively utilized (e.g., flow sheets, care plans and protocols).

When charting by exception it is important to remember:

- a normative baseline for a client must be established;
- all procedures performed including medication administration, vital signs; area specific required observations must be charted;
- any changes in a patient's condition must be charted; and
- if you are unsure as to whether something is an exception, chart it.

Appendix B

Quality Professional Practice Environments (QPPE) and Documentation

A quality professional practice environment is defined as a workplace that supports professional nursing practice, fosters professional development and promotes the delivery of quality care (ARNNL, 2006b). As partners in achieving quality care, RNs and employers have a shared responsibility to create practice settings that support effective documentation.

RNs report that due to workload, physical layout, availability of required materials and support in the health care environment they are challenged to find the 'time to write a good note'. Despite such challenges, ARNNL standards and agency policies identify that documentation is a critical responsibility of the RN. The following ideas are posed to help address these challenges.

How Do I Find the Time to Document?
- Consider the time and financial costs of inadequate documentation.
- Avoid duplication (such as transcribing working notes into the chart).
- Keep charts or flow sheets close to where care is given.
- Review the list of activities you do everyday that can be done by someone other than a registered nurse. Documentation cannot be delegated.
- Advocate for more efficient/streamlined documentation tools.

How Do I Improve my Documentation?
- Review the basic principles of documentation outlined in this document and other references on documentation skills and systems, e.g., agency policies and legal articles.
- Participate in client reviews and chart audits.
- Re-read your entries periodically. Ask yourself does your entry provide enough information for another registered nurse or member of the interdisciplinary team to act. In the event of an incident five years from now is there sufficient information in the documentation? Does the entry meet the standards for nursing practice?
- Advocate for current policies and education on documentation as required.

How Can I as a Manager Help my Staff Document Better?
- Provide appropriate space for registered nurses to have time to reflect and be able to write a thorough and timely entry.
- Seek input from other members of the health care team. Advocate for user-friendly charting policies and systems that demonstrate nursing accountability and professional judgment.
- Advocate for point-of-care charting, such as flow sheets & medication administration records.
- Enhance continuity of care by promoting and supporting interdisciplinary documentation.
- Include nursing staff in chart reviews/audits to increase awareness of gaps in documentation (CRNM, 2005).

How as an Organization, Can We Help Facilitate Quality Nursing Documentation
- Provide reliable documentation supplies and equipment available within clinical area.
- Provide equipment that meets ergonomic standards.
- Facilitate nursing staff involvement in choosing, implementing and evaluating the documentation systems.
- Design continual quality improvement activities related to effective documentation.
- Have current policies and procedures on effective documentation and management of client health information.
- Provide RNs with adequate time to document appropriately and review prior documentation.
- Provide staff orientation that includes the introduction of documentation systems and relevant policies and procedures.
- Have performance management processes that provide opportunities to improve documentation.
- Provide support for RNs to develop information and knowledge management competencies.
- Whenever a system changes, it is important that a plan be devised for implementation, and that the plan include the involvement and education of registered nurses (CNO, 2008).

Appendix C
Expectations Regarding Privacy and Confidentiality

Canadian Nurses Association Code of Ethics (2008):
Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.
1.   Nurses respect the right of people to have control over the collection, use, access and disclosure of their personal information (E-1).
2.   When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard (E-2).
3.   Nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with privacy laws (E-3).
4.   When nurses are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the individual, family or community (E-4).
5.   When nurses engage, in any form of communication, including verbal or electronic, involving a discussion of clinical cases, they ensure that their discussion of persons receiving care is respectful and does not identify those persons unless appropriate (E-5).
6.   Nurses advocate for persons in their care to receive access to their own health-care records through a timely and affordable process when such access is requested (E-6).
7.   Nurses respect policies that protect and preserve people's privacy, including security safeguards in information technology (E-7).
8.   Nurses do not abuse their access to information by accessing health-care records, including their own, a family member's or any other person's for purposes inconsistent with their professional obligations (E-8).
9.   Nurses do not use photo or other technology to intrude into the privacy of a person receiving care (E-9).
10.   Nurses intervene if others inappropriately access or disclose personal or health information of persons receiving care (E-10).

Personal Health Information Act

In the spring of 2008, the *Personal Health Information Act* (PHIA) was passed in the Newfoundland and Labrador House of Assembly. The Act establishes rules related to the collection, use and disclosure of personal health information. It also provides individuals with the right to access and request correction of their own health information. The Act applies to both public and private custodians of personal health information.

The *Personal Health Information* Act ensures consistent rules for all health information regard less of the format of that health information or whether it is held in the public or private system. Without this Act, personal health information in this province would be subject to different legislation depending on the setting. The federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) is currently the Act that regulates private practitioners. Public bodies, such as Regional Health Authorities are subject to the *Access to Information and Protection of Privacy Act* (ATIPPA).

Custodian Responsibilities
Whether a health professional works for a Regional Health Authority (RHA) or a private company, the requirements for privacy are the same and upholding the precepts of the *Personal Health Information Act (2008)* are essential. In the Act, however, health professionals are listed as custodians of personal health information, but they may also be employees of custodians. For example, a nurse working for the RHA is not the custodian of the personal health information. The custodian is the RHA. If the nurse is owner of a private business such as foot care then he/she is the custodian and is not only responsible for his/her own actions under the law, but must ensure that employees, agents, other health professionals with rights to work within that business, including volunteers, are aware of their responsibilities under PHIA and sign an oath or affirmation of confidentiality. Custodians of personal health information are also required to designate a person to make decisions under the Act. As a custodian health professionals are required by the Act to establish policies and procedures that protect the privacy of personal health information and to protect the confidentiality of individuals as it relates to collection, storage, transfer, copying, modification, use, and disposition of personal health information.

Privacy and Confidentiality Safe Guard Tips for Electronic Documentation

The following safe guards are suggested to ensure the security and confidentiality of client information.

1. Never reveal or allow anyone else access to your personal identification number or password as these are, in fact, electronic signatures.

2. Log off when not using the system or when leaving the terminal.

3. Protect client information displayed on monitors (e.g., use of screen saver, location of monitor, use of privacy screens).

4. Only access client information which is required to provide nursing care for that client; accessing client information for purposes other than providing nursing care is a breach of confidentiality.

5. Ensure all materials that you print or generate that contain client personal health information are secured at all times and shredded or appropriately disposed off when no longer required, (e.g., agendas, schedules, careplans, change of shift report, personal notes, lap tops and mobile client records).

6. Be diligent when sending client information via fax or emails. Make sure all addresses are correct and verified before sending, that the content is limited to what is appropriate to share and that the transmittal was complete.
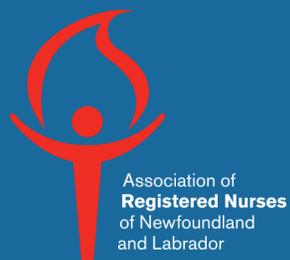
Appendix D

Exercises

The following exercises are provided as examples to use when planning nursing education sessions on the documentation standards.

1. Joseph Brown is an 80-year-old man admitted with a diagnosis of possible pneumonia. He complains of general malaise and a frequent productive cough, worse at night. Vital signs are as follows: blood pressure 150/90 mm Hg, pulse rate 92 beats per minute, respirations 22 breaths per minute, and temperature 38.5° C. During the initial assessment, he coughs violently for 40 to 45 seconds without expectorating. His lungs have wheezes and coarse crackles at both bases. He states, "It hurts in my chest when I cough." Differentiate between objective and subjective data in this case example.

2. The nurse positions Mr. Brown in a semi-Fowler's position, encourages increased fluid intake, and gives Tylenol 650 mg PO as ordered for fever. One hour later, the client is resting in bed. Vital signs are as follows: blood pressure 130/86 mm Hg; pulse 86 beats per minute; respirations 22 breaths per minute; and temperature 37.7° C. He states he has been able to sleep. His fluid intake has been 200 mL of water. Use the given information to write a nurse's progress note, using the DAR format.

3. Near the end of your shift, you have identified *fluid volume deficit* as a nursing diagnosis for Mr. Brown. Since his admission he has had fluid intake of about 600 mL, and his urine output was 300 mL of dark, concentrated urine. His temperature is back up to 38.4° C, his mucous membranes are dry, and he states he feels very weak. List what should be included in the change-of-shift report.

4. Several days later, following treatment with intravenous antibiotics, Mr. Brown is feeling much better and preparations are being made for discharge. He is to take Keflex 500 mg q6h for the next 10 days, continue to drink extra fluids, and get extra rest. He lives alone. Although he is generally co-operative, he does not like drinking water or taking pills. He is to make an appointment with his physician if he develops symptoms of recurrence. Write a discharge summary that is concise and instructive.

5. You are the community health nurse receiving Mr. Brown's referral, draft a potential care plan to guide his care.

6. You just finished a long 12 hour night and are driving home when you realized you forgot to record the output from Mrs. Jones drainage tube. You know that the physician is waiting for this information to make a decision about removing the tube. You are unable to return to the unit to record this information yourself so you call the day nurse and inform her of your omission and request that she records the drainage output in the record. How would the day nurse record this information in the client record?

7. You are a public health nurse who just returned to the office from a longer than anticipated postnatal visit. The mom, who had a Caesarean section, was having difficulties with breastfeeding, and there were many social issues. It is now Friday afternoon at 3 p.m. and the computers are down. Your IT support is stationed in another community, and you are communicating by message manager. IT has informed you the problem has not yet been identified, and may not be resolved today. The documentation policies in your agency requires documentation within 24 hours of providing a service. You also want to refer the family to another PHN in a different office for a weekend visit. How will you proceed, ensuring confidentiality is maintained and policies are addressed?

8. You are a mental health nurse counseling a client who, because of the fear of stigma, asked you not to document information on his sexual orientation. You understand his concerns but in your professional Judgment think that this information is essential to the continuity of care. How do you document your session, balancing the client's rights and your professional responsibility to document pertinent information?