



Nurses Association
OF NEW BRUNSWICK

Standards for DOCUMENTATION



MISSION

The Nurses Association of New Brunswick is a professional organization that exists to protect the public and to support nurses by promoting and maintaining standards for nursing education and practice, and by promoting healthy public policy

The Nurses Association of New Brunswick endorses the principles of self-regulation that is, promoting good practice preventing poor practice and intervening when practice is unacceptable.

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INTRODUCTION

Registered Nurses ¹(RNs) are required to make and keep records of their practice. As self-regulated professionals, RNs are accountable for ensuring that their documentation (whether using a paper-based or electronic system) is accurate and meets NANB's *Standards for Documentation, Standards of Practice for Registered Nurses*, and the *Standards of Practice for Primary Health Care Nurse Practitioners*. Documentation establishes accountability, promotes quality nursing care, facilitates communication among RNs and other healthcare providers, and conveys the contribution of nursing to health care.

These standards explain the regulatory and legislative requirements for nursing documentation. To help RNs understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each statement is followed by corresponding indicators that outline an RN's responsibility and accountability when documenting. 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 and setting, including RNs who are self-employed.

To further support RNs in applying the standards, important supplementary information has been included in three appendixes. Appendix A includes frequently asked questions regarding documentation. Appendix B provides strategies for nursing professionals to support quality documentation practices in their work settings. Appendix C includes a list of provincial and federal legislation governing nursing documentation.

¹ In this document, the term registered nurse includes registered nurses and nurse practitioners



PRINCIPLES

Nursing documentation:

- reflects the client's perspective, identifies the caregiver and records nursing care provided including client's health outcome;
- promotes continuity of care through intra/interprofessional communication;
- demonstrates the RN's commitment to providing safe, competent and ethical care;
- demonstrates that the RN has applied the nursing knowledge, skill and judgement required by professional and ethical standards, relevant legislation, and employer's policies.

Whether documenting for individual clients, groups or communities, documentation should provide a clear picture of: the needs or goals of the client or group; the RN's actions based on the needs assessment; and the outcomes and evaluation of those actions.

PURPOSE

Data from documentation has many purposes:

- to identify the care and services a client requires or care that was provided;
- to inform quality improvement processes;
- to review client outcome information, to reflect on the RN's own practice and identify knowledge gaps that can form the basis of learning plans;
- to be a valuable source for data collecting in health related research;
- to be used as a source of information in making funding and resource management decisions; and
- to use in legal investigations and other legal proceedings.

STANDARD 1: COMMUNICATION

Registered Nurses document accurate, pertinent and comprehensive information concerning the condition of the client, the client's needs, the nursing interventions and the client health

INDICATORS

Registered Nurses:

- 1.1 document the nursing care they provide in a chronological order, including all aspects of the nursing process: assessment, planning, intervention and evaluation;
- 1.2 document both objective and subjective data;
- 1.3 document significant communication with family members/significant others, substitute decision-makers and other care providers (noting the date and time of communication);
- 1.4 document any advocacy that was undertaken on the client's behalf;
- 1.5 ensure that relevant client care information kept in temporary hard copy documents (e.g. kardex, shift reports, communication books) is captured in the permanent health record;
- 1.6 provide a full signature and professional designation (RN, GN, NP or GNP), with all documentation; the use of initials is acceptable when a master list of full signatures/initials is incorporated into the documentation tool or clinical record;
- 1.7 adhere to all employer requirements for electronic signature;
- 1.8 document legibly and in permanent ink when using paper documentation forms;
- 1.9 use abbreviations and symbols sparingly, by ensuring that each has a distinct interpretation and that each is approved by the organization or practice setting;
- 1.10 document advice, care or services provided to an individual within a group, communities or populations (for example, group education sessions);
- 1.11 document the nursing care provided when using information and telecommunication technologies (for example, providing telephone advice); and
- 1.12 document informed consent for treatments or interventions performed.



STANDARD 2: ACCOUNTABILITY AND LIABILITY

Registered Nurses document according to professional and ethical standards, relevant legislation and employer's policies.

INDICATORS

Registered Nurses:

- 2.1 complete documentation in timely manner - during, or as soon as possible after, the care or event;
- 2.2 document the date and time that care was provided and when it was recorded;
- 2.3 document in chronological order;
- 2.4 indicate when an entry is late;
- 2.5 document at the next available entry space when using paper documentation forms and do not leave empty lines for another person to add documentation. If there are empty lines at the end of an entry, the RN should draw a line from the end of the entry to the signature. When using an electronic system, the nurse should refrain from leaving a space in a free-flow text box;
- 2.6 correct mistaken entries while ensuring that the original information remains visible/retrievable;
- 2.7 never delete, alter or modify anyone else's documentation;
- 2.8 document any unanticipated, unexpected or abnormal event for a client, according to employer policy, recording the facts of the incident and any subsequent related care provided;
- 2.9 document when information for a specific time frame has been lost or cannot be recalled;
- 2.10 indicate clearly when an entry is replacing lost information;
- 2.11 document their own observations and actions; in certain situations (e.g code blue, OR) it is acceptable to use a designated recorder to capture the actions of the team providing care;



- 2.12 refrain from co-signing entries unless agency policy clearly dictates the reason for the co-signature (e.g. independent double check of medication preparation, agreement on calculated dosage);
- 2.13 identify the individual with whom client information is shared with, including name and professional designation and what client information is provided (for example, reporting to a physician or another RN); and
- 2.14 advocate for clear employer documentation policies and procedures that are consistent with the NANB standards.

STANDARD 3: INFORMATION SECURITY

Registered Nurses safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with professional and ethical standards, relevant legislation, and employer's

INDICATORS

Registered Nurses:

- 3.1 maintain confidentiality of client health information, including passwords or information required to access the client health record;
- 3.2 understand and adhere to policies, standards and legislation related to confidentiality, privacy and security;
- 3.3 refrain from accessing health-care records (including their own) for purposes inconsistent with their professional obligations;
- 3.4 maintain the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, using initials when quoting a client's roommate);
- 3.5 facilitate the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health record, as defined by legislation and employer policy;
- 3.6 obtain informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care, in accordance with relevant legislation;
- 3.7 use a secure method to transmit client health information (for example, a secure fax or email system);
- 3.8 retain health records for the period the organization's policy and/or legislation stipulates; and
- 3.9 ensure the secure and confidential destruction of temporary documents.

APPENDIX A: FREQUENTLY ASKED QUESTIONS

Who should document nursing care?

Documentation can be completed by a variety of care providers depending on the circumstances. However, for reasons of legality and accountability the provider with personal or firsthand knowledge should document the information. This generally means that the provider who is documenting is the one who provided the care. An exception is made in situations where a designated recorder is used during an emergency response (e.g. code blue).

What are the legal implications of documenting care?

When used as evidence, the court expects that the client's chart will be a complete record of the client's care from the time of admission until discharge. Nursing documentation is an integral component of the record and according to The Canadian Nurses Protective Society (CNPS, 2007) it can be used at trial "to reconstruct events, establish times and dates, refresh the memories of witnesses and to resolve conflicts in testimony".

When an RN's practice is in question, their documentation can be used to establish that their actions "were reasonable and prudent", or conversely that they "failed to meet the standard of a reasonable prudent nurse". For this reason, CNPS points out that "if you have an obligation to perform a specific nursing act on a client, such as taking vital signs, and you fail to chart that you have done so, the court may infer that the act was not performed".

How frequently should I document?

The frequency of nursing documentation is dependent on numerous variables, including:

- agency policy;
- the acuity and complexity of the client's health problems;
- the degree to which the client's condition and / or planned treatments puts him/her at risk

While agency policies on documentation should be followed to maintain a reasonable and prudent standard of documentation, nursing documentation should be more comprehensive, in-depth and frequent if a client is very ill, their status is unpredictable or they are exposed to high risk.

Who owns the health record?

The record, i.e., the file, binder or software which contains the client's information, is the property of the practitioner/health care agency (custodian) from which the client sought services. The data or information pertinent to the client is the property of the client. Therefore, in accordance with the *Personal Health Information Privacy and Access Act (2009)*, 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 process to follow when clients want to access or make changes to their personal health information (ARNNL, 2010).

What should I document?

Nursing documentation should be a thorough reflection of the nursing process. Documentation should serve as a record of the critical inquiry and judgement used to describe events, interventions and discussion with clients. Complete, accurate and thorough nursing documentation provides evidence that the regulated member has met the requirements expected in the role in a particular practice setting (SRNA, 2013).

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;
- relevant assessment data;
- all ongoing monitoring and communications;
- the care/service provided (all interventions, including advocacy, counselling, consultation and teaching);
- an evaluation of outcomes, including the client's response and plans for follow-up;
- discharge planning (CRNNS, 2012)

As a self-employed RN do I have to meet the same standards for documentation?

Self-employed RNs must adopt a documentation system that meets the standards outlined in this document. As “custodians” of health records they must also ensure they comply with the federal and provincial legislation on personal health information. They should also develop appropriate policies related to the storage, retrieval and retention of health records. Further information can be found in the NANB document entitled *Guidelines for Self-Employed Practice*.

When is it appropriate to use abbreviations when documenting?

One of the primary uses of the clinical record is to support communication between healthcare providers working with a common client. Clinicians commonly report using abbreviations in the health record to save time and space while documenting the care they provide. However, increasing evidence suggests that this practice increases the chances for error because the abbreviations are not commonly understood or are misinterpreted (Parvaiz, Subramanian & Kendall, 2008). Consequently many organizations have developed policies to discourage the use of abbreviations in general and/or restrict their use to an approved, standardized list.

The Institute of Safe Medical Practices has developed a list of “Do Not Use” abbreviations that have been shown to be particularly error prone. It can be retrieved at:

<https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf>

Should I co-sign or countersign the documentation of another RN, nursing provider or nursing student?

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

There are some examples where co-signing is prudent practice, such as verbal consent or telephone orders, verification of a medication dosage, discarding of a narcotic, or client identification for a blood transfusion. Co-signing implies shared accountability, therefore, it is imperative that the person co-signing 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 used as a quality control process, and should be completed in accordance with agency policy and procedure. For example, an RN reviews a chart to determine if all the orders are accurately transcribed or all required interventions are completed. Countersigning does not imply that the second person provided the service: it does imply the person verified that the service or record was completed.

Co-signing or countersigning for 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 (SRNA, 2013).

What standards apply when I document electronically?

Electronic documentation carries a higher risk of breach of confidentiality. Policies and procedures, as well as specific technologies, are required to protect the confidentiality of the client’s health record and system security. This is especially true for the transfer of information (CNPS, 2007). Otherwise, the standards set out in this document apply when documenting electronically.

Is completing an incident report the same as documenting nursing care?

Incidents are generally recorded in two places, in the client’s medical record and in an incident report, which is separate from the chart. Documentation in the chart is used to ensure continuity of client care and should be accurate, concise, factual, unbiased and recorded by the person who witnessed the event. The RN should avoid using the words “error”, “incident”, or “accident” when documenting the facts of the event.

Incident reports are separate from the client record and are used by organizations for risk management, to track trends in systems and client care and to justify changes to policy, procedure and/or equipment. Information included in an incident report is similar to the information included in a client's health record, however, the incident report would also include additional information with respect to the particular incident (e.g. "a door was broken" or "this was the fourth occurrence this week"). Information recorded is not directly related to the care of the client (CRNNS, 2012).



APPENDIX B: SUPPORTING DOCUMENTATION PRACTICES

RNs in all practice settings, must demonstrate the knowledge, skill, judgement and attitude required of self-regulated health professionals. They must also demonstrate knowledge on their role in improving their practice environment, and advocate for quality nursing care. RNs, and employers, help establish work environments that support documentation practices by:

- facilitating nursing staff involvement in choosing, implementing and evaluating the documentation system as well as the policies and procedures and risk management systems related to documentation;
- providing access to appropriate, reliable and available documentation equipment, and to Information Technology (IT) support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring electronic documentation systems support documentation standards;
- ensuring policies are available and reflect the documentation standards to guide practice;
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;
- ensuring that effective mechanisms and resources are in place to help RNs apply the organization's documentation policies;
- supporting RNs' development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- advocating for best practices in documentation;
- developing performance management processes that provide opportunities to improve documentation;
- providing adequate time to document appropriately and review prior documentation; and
- identifying and acknowledging nursing excellence in documentation.

APPENDIX C: LEGISLATION AFFECTING NURSING DOCUMENTATION

The following list contains a sampling of legislation that has an effect on nursing documentation. The list is not exhaustive and is subject to amendment from time to time. RNs should ensure that they consult the current version of federal and/or provincial legislation.

FEDERAL LEGISLATION

Current federal legislation can be accessed via the Department of Justice website at:
<http://laws-lois.justice.gc.ca/eng/>

Access to Information Act, 1985

Controlled Drug and Substances Act, 1996

Personal Information Protection and Electronic Documents Act, 2000

Privacy Act, 1985

PROVINCIAL LEGISLATION

Current provincial legislation can be accessed via the website of the Office of the Attorney General at:
http://www2.gnb.ca/content/gnb/en/departments/attorney_general/acts_regulations.html

Hospital Services Act, 1973

Hospital Act, 1992

Nursing Home Act, 1982

Personal Health Information Privacy and Access Act, 2009



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165 Regent Street
Fredericton, NB, E3B 7B4
Canada

Tel.: 506-458-8731
Toll-free: 1-800-442-4417
www.nanb.nb.ca