FAQ: Documentation

Proper documentation demonstrates that the nursing process has been done (assessment, nursing diagnosis, planning, implementation, and client evaluation), and identifies the care provider by name and designation (Perry, Potter, Stockert & Hall, 2017). Nurses* in all practice settings are required to complete documentation of care. These frequently asked questions (FAQs) are a resource to be used in conjunction with the Standards for Documentation and the NANB Standards for RNs and NPs.

1. What are the legal implications of documenting care?

When used as legal evidence, the client's chart is considered a complete record of the client's care. Nursing documentation may be used to "reconstruct events, establish times and dates, refresh the memories of witnesses and to resolve conflicts in testimony" (Canadian Nurses Protective Society [CNPS], 2020, para. 6). The documentation can also be used to establish that the actions "were reasonable and prudent", or conversely that they "failed to meet the standard of care of a reasonable prudent nurse" (CNPS, 2020, para. 7). Therefore, if you have not documented what you have done, then the court may infer that the act was not performed, hence the axiom: "*If it's not charted, it's not done".*

2. Who owns the health record and how does New Brunswick privacy legislation apply to my practice?

The health record (i.e., the file, binder, or software containing the client's information), is the property of the practitioner and/or the healthcare agency (custodian) from which the client sought services. The data or information pertaining to the client is the property of the client. Therefore, in accordance with the *Personal Health Information Privacy and Access Act*, 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 to be inaccurate or incomplete. For more information regarding the Government of New Brunswick's (GNB) expectations for custodians, please review Questions and answers for custodians about the Personal Health Information Privacy and Access Act (PHIPAA).

3. What do I need to know about the storage of client records from a legal perspective?

A custodian refers to an individual or organization that collects, maintains, or uses personal health information for the purpose of providing or assisting in the provision of healthcare or treatment (GNB, 2009). A custodian must ensure that the client health records are secure regardless of whether they are paper or electronic format. Paper documents are to be stored in a secured area and employers are expected to have policy in place regarding this process. For electronic health records, password protection on computers is a minimum safeguard, as is placing electronic portable devices, technological storage files, and paper documents in a locked cabinet. Retention of health records is dependent on employer policy and legislation, but most institutions store health records for 7 to10 years (College of Registered Nurses of Manitoba [CRNM], 2017).

**For the purposes of this document, the term "nurse" refers to graduate nurses, nurses on the temporary register, registered nurses, and nurse practitioners.*

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4. What additional considerations apply to electronic documentation, including receiving orders and sharing test results?

The principles of documentation remain the same; however, electronic documentation is considered a higher risk for privacy breaches. There is a risk of private information being sent to the wrong phone number or the wrong email address, and mobile devices retain data unless permanently deleted.

Therefore, policies and procedures need to outline what is expected of nurses regarding electronic documentation and the use of electronic devices. For example, specific technologies require each user to utilize a unique password to log onto and log off a system (CNPS, 2009).

This is especially true for the transfer and/or storage of any client information on a portable device. Encryption, an encoding process that makes information unintelligible until a passcode is entered, is recommended. Essentially, if the electronic communication and/or data being stored involves personal health information, it should be encrypted (Conaty-Buck, 2017; CNPS, 2017).

Text or email communication between healthcare providers should not be used for provider convenience, but when it is in the best interest of the client. Text can be lost or subject to interpretation that may lead to inappropriate or incomplete communication, including inappropriate orders (Nova Scotia College of Nursing [NSCN], 2017).

Additional considerations for electronic health records include the following:

- Nurses remain accountable to the standards for documentation, regardless of whether the documentation is completed in paper or electronic format.
- Digital signatures must comply with legal and regulatory requirements, ethical standards, as well as organizational policies and procedures.
- Nurses need to follow employer policy related to technical procedures such as logging on and off an electronic health record.
- Use a unique-to-you identifier or electronic signature and do not share with anyone (College and Association of Registered Nurses of Alberta [CARNA], 2018).
- Follow employer policy when modifying an incorrect entry or an incorrect signature. The content in question must be clearly visible or retrievable to enable understanding of the ‘mistake and correction’. Include the date and time when correcting the entry (CARNA, 2018; NSCN, 2017).
- Report any concerns you have regarding suspicious messages or abnormal functioning of the electronic devices being used for client care (Conaty-Buck, 2017).
- Communicating diagnostic test results and receiving orders by text message or e-mail is discouraged due to the risk of unintentional privacy breach. There should be an employer policy to support this practice, if it is allowed (NSCN, 2017).
- Any e-mails or text messages containing personal health information such as diagnostic test results, photographs, or prescribed orders, are to be included in the permanent health record (CRNM, 2017).

5. How do I document telenursing or virtual nursing care?

Nursing services must be documented in tele-practice or when using a virtual platform to provide care. Telenursing and virtual care services are subject to the same documentation requirements as nursing in all other settings and should include (NSCN, 2017):

- consent for treatment;
- the date and time of the incoming call, including voice mail messages from clients that contain pertinent information;
- the name and contact information of the caller or some other unique identifier if anonymity is important;
- the reason for the call, including health history; any assessment findings; signs and symptoms described;
- any nursing interventions, including information given; referrals made; agreement of follow-up care; and,
- any other pertinent information for continuity of care.

6. What is considered 'timely' documentation?

Timely documentation refers to an acceptable time-frame from when a nursing action occurs to when it is captured in the client's permanent health record. Timely documentation enables the information to be used for the continuation of care and as evidence in the decision-making process (Ahn et al., 2016).

Amidst a fast-paced environment, it may be tempting to post-pone documentation until the end of a shift. Delays in documentation may negatively impact the nurse's ability to remember details about events, or diminish the recall of the nursing assessment and interventions (British Columbia College of Nursing Professionals [BCCNP], 2019). Being busy may make documentation more difficult but it does not excuse the RN or NP from documenting clearly and in a timely manner.

The frequency of documentation is dictated but not limited to the following factors: employer policy; complexity of client care needs; the risk of negative outcome for the client; and the level of nursing care required. Typically, the sicker the client the greater the nursing care required, and therefore the greater need for frequent documentation (NSCN, 2017). Unplanned events (e.g., client refusing care, withdrawal from consent to care, or a negative incident with the client) also require more frequent documentation because the situation has resulted in a phase of instability or unpredictability (CRNM, 2017).

From a liability perspective, the court will examine the frequency of entries in the health record and how soon the RN or NP documented after care was provided, and the judge (or jury) will assess any delay in the documentation as part of the overall evidence (CNPS, 2019). Therefore, documentation entries made only at the end of a shift may not hold the same weight as frequent entries made throughout the shift.

7. How do I document subjective data, objectively?

Subjective data can be included into the health record to enhance the understanding of the client's care. The subjective information should provide accurate examples of what was said, by whom, and at what time. For example, subjective data included in the health record may be from a friend or family member, if it contains information that will impact the plan of care or provide clarity to the client's care plan.

When documenting, avoid generalized statements such as 'slept well'; labels such as 'non-compliant'; and bias. Only document subjective conclusions that can be verified (NSCN, 2017). For example, instead of writing "client was aggressive," an objective statement would be "client was pacing, speaking in loud tones, and using obscene language."

8. When is it appropriate to use abbreviations when documenting?

When communicating medication information, the use of certain abbreviations, symbols, and dose designations has been identified as a significant contributing factor to serious and potentially fatal medication incidents (Institute for Safe Medication Practices Canada [ISMPC], 2025). Many organizations have developed policies to discourage the use of abbreviations in general and/or restrict their use to an approved, standardized list. The ISMPC has updated the list and recommends that health care organisations and pharmacies adopt the list or adapt it to reflect their local context (ISMPC, 2025). For more information on other related recommendations, refer to the *ISMP Safety Bulletin Do Not Use: Dangerous Abbreviations, Symbols, and Dose Designations 2025 Update*.

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

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

There are some examples where co-signing is prudent practice, such as: verification of a medication dosage, discarding of a narcotic, or client identification for a blood transfusion. Cosigning implies shared accountability; therefore, it is imperative that the person co-signing actually witnessed or participated in the event. Co-signing entries written by another healthcare provider (such as student nurses and unregulated care providers) is not acceptable and adds a level of accountability which the RN would not otherwise incur (RNANT/NU, 2015).

Any second or confirming signature on a previously signed document (countersigning) should only be completed in accordance with employer policy. Countersigning is generally not supported or needed in nursing practice but may be effectively used as a quality control process. An example of countersigning is when 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 (NSCN, 2017).

10. When providing client education, what should I document?

After teaching clients, accurate documentation is essential to enable communication and the continuity of teaching by others. The following aspects should be included in the health record regarding both planned (formal) and informal teaching (Registered Nurses Association of the Northwest Territories and Nunavut [RNANT/NU], 2015):

- the date and time of the teaching;
- the materials used to educate (teaching sheets and/or instructional aids);
- the method of teaching (written or verbal);

- who was taught (client and/or family);
- an evaluation of teaching objectives with validation of client comprehension; and
- any follow-up required.

11. How do I document a consultation with another healthcare provider?

When consulting with a nurse colleague (i.e. clinical nurse specialist, resource nurse, nurse practitioner), or other healthcare provider who is providing advice, it would be expected that the nurse would document this consultation per indicators 1.4 and 2.11 of the standards for documentation. The nurse should note the date, time, along with the colleague's name and designation. The content of the documentation should include the information given to the colleague; the information received; the agreed upon plan of action; and anticipated outcomes and follow up plan.

12. How do I document when I have consulted for another healthcare provider?

When providing nursing consultation services to other healthcare providers, the nurse continues to have a professional responsibility to maintain records and to demonstrate professional accountability for nursing practice in the consultative role. From a practicality standpoint, the standards for documentation are broad and principle-based so that they can be applied to various settings/contexts of nursing practice and all nursing domains. As such, NANB does not provide specific guidance as to the precise process for implementing consultative documentation and recommends that employer policy supports the best process for the organization. The employer policy should provide further guidance on how this is to occur according to the setting, consultation practices, client record, and documentation tools.

13. My nursing practice does not involve direct care of clients – am I still responsible to document?

Nurses who do not provide direct client care (e.g. administrators, educators, researchers) still have a professional responsibility to maintain records and demonstrate professional accountability for their nursing practice. Records of nursing practice must be in accordance with legislation and organizational policies; however, they may differ from other forms of direct client care documentation. Examples may include:

Administrators:

- Recording performance reviews and performance management.
- Documenting trends for quality improvement initiatives.

Educators:

- Documenting learner progression and evaluation throughout their course.
- Documenting for the purpose of program evaluation.

Researchers:

- Documenting the research process carefully to ensure reporting is accurate.
- Documenting and collecting accurate qualitative and quantitative data.

NANB does not provide specific guidance as to the precise process for implementing documentation practice for nurses not directly involved in client care. NANB recommends that employer policy supports

the best process for the organization and provides further guidance on how documentation is to occur according to the setting, nursing practice, and documentation tools.

The content of this FAQ is adapted from the College of Registered Nurses of Manitoba's (CRNM) Documentation Guidelines for Registered Nurses.

14. As a self-employed RN or NP, do I have to meet the same standards for documentation?

Yes, all nurses in all domains of practice and in all work settings are required to meet their regulatory standards, including those who are self-employed. Self-employed RNs and NPs are often considered the legal custodian of the health information (i.e., the health record) and as "custodians" of health records, they must ensure they comply with the federal and provincial legislation on personal health information. Self-employed RNs and NPs are required to develop appropriate policies and practices related to the storage, retrieval, and retention of health records.

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

Incidents are generally recorded in two places, in the client's health record and in an incident report. Documentation in the health record is used to ensure continuity of client care and should be objective, concise, unbiased and be 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 in the health record and should not allude to an incident report. The RN should document in the health record first and then follow employer policy in filling out an incident report (NSCN, 2017).

16. Should I decide to evaluate my documentation practices, what are some indicators of good documentation?

Having a positive mindset towards documentation and valuing it as an aspect of your nursing role should foster improved documentation practices. It is important to plan your care to include time for documentation. Quality indicators for evaluating your documentation practices include, but are not limited to:

- Is the nursing process evident?
    - Do you document your assessments?
    - Do you modify the care plan?
    - Do you document your interventions and then the evaluation of the interventions?
    - Do you record pertinent consultations with other healthcare team members, including their name and designation?
- Are you meeting your employer policies and the NANB Standards for Documentation?
- Do you chart objectively and in a timely manner?

If you often find that you are not documenting in a timely manner, then it is prudent to advocate for time to document with your employer. Likewise, if you feel that you need to develop better documentation

practices, it is your responsibility to identify this and to seek help in learning how to document concisely and in a timely manner.

17. How can employers facilitate better documentation practices?

Research (Ahn et al., 2016) has shown that nurses need support to prioritize documentation within the overall workflow of nursing care. Documentation can be viewed as a burden or a task that interrupts client care instead of being an aspect of the nursing care. Employers need to allow sufficient time for nursing documentation and can 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 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 nurses apply the organization's documentation policies;
- supporting nurse 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.

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