Indigenous Services Canada   Services aux Autochtones Canada

First Nations & Inuit Health Branch
Alberta Region
Nursing Policies & Guidelines

Policy Number: 1.1.1

Section: **Corporate Policies: Administration**

Subject: **Documentation and Charting**

Distribution: **All Nursing Facilities**

Issued: April 30, 2018 **Revised:** -	**Policy Number: 1.1.1**
Approved by: **Shawn Grono, Director of Nursing**	**Effective Date:** May 2018 Through April 2020

1. Policy:

1.1. Each nurse and contracted worker shall be responsible for clear, accurate, comprehensive and timely health records that are in accordance with relevant FNIHB-AB policies and the College and Association of Registered Nurses of Alberta (CARNA) documentation standards. All entries shall be:

1.1.1. Dated (day/month/year and timed using 24 hour clock);
1.1.2. Recorded in blue or black ink;
1.1.3. Legible;
1.1.4. Recorded in chronological order;
1.1.5. Written in **SOAP** format [Subjective, Objective, Assessment, Plan-including implementation] (see **Appendix A)** and,
1.1.6. Signed by the nurse providing care/assessment/treatment (first initial, full surname, and professional designation); (semi-colon)
1.1.7. If information needs to be added out of chronological order enter a Late Entry (See section 4.14.2 Correcting Errors.)

1.2. Nurses and contracted workers work in a variety of clinical settings and within varying scopes of practice. The detail required of nursing documentation in each setting is dictated by the duties and requirements of that practice setting. At minimum, the following information shall be included in the client's health record:

1.2.1. A client assessment-either a focused or a full assessment depending on the purpose of the visit using the SOAP method;
1.2.2. A written plan of care with evidence of involving the individual / family in the planning of care where appropriate; and,
1.2.3. Evidence of teaching provided to the individual / family;
1.2.4. Each nurse shall respect patient confidentiality as per the Freedom of Information and Protection of Privacy ACT (FOIP) and the Health Information Act (HIA).

2. Principles:

2.1. Health professionals are accountable for meeting professional documentation standards. (*Canadian Nurses Protective Society* [CNPS], 2007; CARNA, 2013).

2.2. Documentation is necessary for:
- 2.2.1. Providing safe, compassionate, competent and ethical care;
- 2.2.2. Communication between health care providers;
- 2.2.3. Legal proof or evidence of the actual health care provided or not provided;
- 2.2.4. Meeting professional and legal standards and requirements;
- 2.2.5. Quality improvement; and,
- 2.2.6. Research (CNPS, 2007).

2.3. The client's health record must be concise, comprehensive and objective. Characteristics of quality documentation include:
- 2.3.1. Factual
- 2.3.2. Accurate
- 2.3.3. Complete
- 2.3.4. Current
- 2.3.5. Organized

2.4. The following constitute professional misconduct.
- 2.4.1. Failure to keep records as mandated by FNIHB/CARNA/CLPNA/Alberta Paramedic Association,
- 2.4.2. Falsifying a record,
- 2.4.3. Deleting or altering a true and correct entry,
- 2.4.4. Destroying, damaging, or mutilating the record,
- 2.4.5. Signing or issuing a document that the nurse knows contains false statements, and/ or
- 2.4.6. Disclosing information about a client without consent.

3. Definitions:

3.1. Nurse: Refers to Registered Nurses, Nurse Practitioners and Licensed Practical Nurses.

3.2. Contracted Worker: Refers to a worker whose service is contracted by FNIHB. An example is the paramedic.

3.3. Personal Health Information: Refers to any identifying information about clients that is in verbal, written or electronic form. Such information relates to the following:
- 3.3.1. Physical or mental health (including family health history);
- 3.3.2. Care previously provided;
- 3.3.3. A plan of service;
- 3.3.4. Payments or eligibility for health care;
- 3.3.5. Donation of body parts or substances, or information gained from testing these body parts or substances;
- 3.3.6. A person's health number (PHN); or,
- 3.3.7. The name of a client's substitute decision-maker, eg: legal guardian.

3.4. Documentation - refers to electronic and paper charts, charting, recording, nurses' notes, and progress notes. Documentation (paper, electronic, audio or visual) is used to monitor a client's progress, communicate with the health care team, and reflect the nursing care provided to a client (CARNA, 2010; CARNA, 2013.)

4. Procedure:

Each nurse and contracted worker shall document all client interactions in accordance with the CARNA's (2013) and CLPNA's (2013b) *Practice Standards – Documentation*.

a. When charting a nursing consultation in a patient's chart, please follow the structure found in the *Primary Care Consult Template* (for Primary Care nurses only). (**See Appendix B**).
b. Telephone calls/follow ups to be recorded as follows in *Progress Notes*:
    i. Time and date
    ii. Write *Telephone Call* or *Telephone Follow Up*
    iii. Brief description of call.
    iv. Describe outcomes and follow up etc.

4.1 Detail and Frequency of Recording

4.1.1 The amount of detail to be documented and the frequency of making those entries are determined by the complexity and acuity of the client's health problem; the degree of risk presented by the client and/or his/her condition; and by the medical/nursing interventions administered.

4.1.2 Nurses and contracted workers must use their clinical judgment when deciding the amount of detail and the frequency of his/her chart entries; however, the general rule is - the more acutely ill the client, the greater the detail and frequency of documentation required.

4.1.3 In communities that have an Electronic Medical Record (EMR), for example CHIP, CARE, and paper-based charting system, always check both systems, recognizing that the EMR should be the most current, as per practice standards. Check Netcare where possible and validate against Health Care Records.

4.2 Record Chronologically

4.2.1 Failure to record entries chronologically may result in miscommunication or misinterpretation of significant client data and potentially result in injury to the client.

4.2.2 Entries are made on every line of the record. If any line or portion of a line is not used for that entry, a single line shall be drawn through each gap to eliminate the possibility of an entry being made out of chronological order.

4.2.3 If a "late entry" is made out of chronological order, it should be clearly marked as such. The nurse shall write "late entry" with the actual date and time the note is written. The nurse shall also write in parenthesis (the date and time that the actual event occurred).

4.3 Timely Documentation

4.3.1 Events should be recorded as soon as reasonably possible after it occurs, particularly when the client's condition is more acute, emergent and/or complex.

4.3.2 Documenting the event as soon as possible improves the quality and accuracy of the record and thus admissibility of the health record during court proceedings. Entries must be made within 24 hours of the event occurring. In the event that a documentation error is made or an error of omission occurs, the nurse shall make the correction as soon as he/she becomes aware of the error and in accordance with 4.13 of this policy.

4.4 Record Accurately

4.4.1 An accurate entry not only refers to the absence of errors, but also refers to entries which are clearly stated and without ambiguity. Inaccurate records may result in miscommunication or misinterpretation and thus potentially result in injury to the client.

4.5 Record Concisely

4.5.1 Only essential information should be recorded to enable information to be retrieved quickly from the record when needed and avoid sifting through extraneous or irrelevant material.

4.5.2 "Negative" or "absent findings" are not necessarily irrelevant or extraneous. Including these types of findings in the documentation should be considered relevant when they assist with the process of confirming or refuting the differential diagnoses.

4.6 Record Factually

4.6.1 Recording is based on accurately perceived data objectively obtained from a variety of sources, such as observation, inspection, percussion, palpation and auscultation. Verbal cues or statements made by a client may also be recorded into the entry; however, avoid assumptions or inferences about client statements.

4.6.2 The data should be described in quantitative terms wherever possible to reduce bias. Use patient quotes whenever possible.

4.7 Entries to be Made by the Individual Having Personal Knowledge of the Event(s)

4.7.1 All entries should be made by the health professional who performed the action or observed the event (except when there is a designated recorder) to reduce the risk of errors and to maintain the credibility of the health record in the case of legal proceedings.

4.8 Sign All Entries

4.8.1 Signatures and initials should be easily identifiable. Whenever initials are used, the corresponding full signature must also be indicated on the record, to assist in identifying the person making the entry. All signatures are to include the nurse's professional designation. Each chart will have a signature sheet located at the front of the chart noting all who have made entries into the chart (printed first name, last name and signature with professional designation).

4.9 Terminology and Abbreviations

4.9.1 Uniform terminology and abbreviations should be used by **all** health care professionals working in FNIHB-AB. This consistency helps to eliminate misinterpretation of recorded data and potential risk of injury to the client.

4.9.2 A list of approved abbreviations located in **Appendix C**.

4.10 Consultations

4.10.1 All nurse-initiated consultations with other health care team members should be noted in the client's health record, showing timely reporting of any abnormal findings, medical direction given, and action taken. These entries must include the actual date and time of the consultation and any verbal Physician/Nurse Practitioner orders must be clearly and thoroughly recorded.

4.11 Refusal of Treatment / Against Medical Advice

4.11.1 In the event that a client or client's family member refuses treatment, the nurse must request that the client or client's family sign the *Statement of Refusal of Services* form, **Appendix D**.

4.11.2 The nurse must document the circumstances of the refusal; the information provided to the client/family about the potential consequences of refusing treatment; any additional client teaching, treatment or medication provided; and, the reasons to seek medical attention in the future.

4.12 Correcting Errors

4.12.1 If an error is made in the entry, do not attempt to erase, remove or destroy the entry. A single line must be drawn through the incorrect word(s) and the nurse shall write 'error' and initial the correction. A nurse is **never to delete, alter or modify someone else's documentation**.

5. References:

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