FNIHB-OR Nursing Policy and Procedure

Section:	**Professional Nursing Practice**	Policy Number:	**II - 08**
Subject:	**Documentation Standards**	Issued: Revised:	**March 31, 2015**
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 Each nurse shall be responsible for clear, accurate, comprehensive and timely health records which are in accordance with relevant FNIHB-OR policies and the College of Nurses of Ontario's (CNO) documentation standards. All entries shall be:

a. Dated (day/month/year and time)
b. Recorded in blue or black ink
c. Legible
d. Recorded in chronological order;
e. Written in SOAPIE format (Subjective, Objective, Assessment, Plan, Implementation, Evaluation); and
f. Signed by the nurse providing care/assessment/treatment (first initial, full surname, professional designation)

1.2 Nurses 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:

a. A client assessment;
b. A written plan of care with evidence of involving the individual / family in the planning of care where appropriate;
c. Evidence of teaching to the individual / family; and
d. Evidence of an evaluation of the planned care (i.e. problem resolution, reason for discontinuing or continuing care).

1.3 Each nurse shall safeguard client health information.

2. PRINCIPLES:

2.1 Health professionals are accountable for meeting professional documentation standards. Accurate and detailed documentation is a nurse's best defense in a legal proceeding (Canadian Nurses Protective Society [CNPS], 2007; CNO, 2008; CRNNS, 2005).

2.2 Documentation is necessary for:

a. Communication between health care providers
b. Legal proof or evidence of the actual health care provided or not provided
c. Meeting legislative requirements
d. Quality improvement
e. Research (CNPS, 2007).

2.3 The client's health record must be concise, comprehensive and objective. Characteristics of quality documentation include:

a. Factual
b. Accurate
c. Complete
d. Current
e. Organized

2.4 Failing to keep records as required, falsifying a record, signing or issuing a document that the nurse knows contains false statements, and/ or disclosing information about a client without consent all constitute professional misconduct.

3. DEFINITIONS:

3.1 **Nurse:** For the purpose of this policy, Nurse refers to Registered Nurses, Nurse Practitioners and Registered Practical Nurses.

3.2 **Personal Health Information:** Refers to any identifying information about clients that is in verbal, written or electronic form. Such information relates to the following:

a. Physical or mental health (including family health history)
b. Care previously provided
c. A plan of service;
d. Payments or eligibility for health care;
e. Donation of body parts or substances, or information gained from testing these body parts or substances;
f. A person's health number; or
g. The name of a client's substitute decision-maker. (PHIPA, 2004)

3.3 **Documentation** - refers to 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 (CNO, 2008).

4. PROCEDURE:

4.1 Each nurse shall document all client interactions in accordance with the CNO's *Practice Standard – Documentation.*

4.2 The following charting guidelines have been adopted from a variety of sources, including the CNO's practice standard document, and are considered to be the standards for nurses working in the FNIHB-OR.

4.3 **Detail and Frequency of Recording**

4.3.1 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 condition; and by the medical/nursing interventions administered.

4.3.2 Nurses must use their best 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 required.

4.4 **Record Chronologically**

4.4.1 Failure to record entries chronologically may result in miscommunication or misinterpretation of significant client data and potentially result in injury to the client. Failure to record events in chronological order may also cast suspicion on the accuracy of the record during legal proceedings and thus question the credibility of the health professional and the health record.

4.4.2 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.

4.4.3 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).

4.5 **Record Contemporaneously**

4.5.1 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.

4.5.2 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 4.14 of this policy.

4.6 **Record Accurately**

4.6.1 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.

4.7 **Record Concisely**

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

4.7.2 "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. In some instances, the courts have determined that the failure to record that a task was performed despite a negative finding, inferred that it was not performed.

4.8 **Record Factually**

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

4.8.2 The data should be described in quantitative terms wherever possible to reduce bias.

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

4.9.1 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.

4.10 **Sign All Entries**

4.10.1 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.

4.11 **Terminology and Abbreviations Should Be Uniform**

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

4.11.2 A list of approved abbreviations is included in Appendix A.

4.12 **Note Any Consultations**

4.12.1 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 orders must be clearly recorded.

4.13 **Refusal of Treatment / Against Medical Advice**

4.13.1 The Nurse must request that the client or client's family sign the *Refusal of Treatment / Against Medical Advice* form.

4.13.2 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.

4.14 **Correcting Errors**

4.14.1 If an error is made in the entry, do not attempt to erase, remove, or obliterate the erroneous entry.

4.14.2 A single line must be drawn through the incorrect word(s) and the nurse shall date and initial the correction. A nurse is **never to delete, alter or modify someone else's documentation**.

4.15 **Document in Ink**

4.15.1 All entries are to be made in blue or black ink only. Pencils should not be used for documentation in the client health record or on the immunization records.

5. RELATED POLICES AND PROCEDURES:

FNIHB-OR Policy: Telephone Triage and Advice
College of Nurses of Ontario. *Practice Standard: Documentation*
College of Nurses of Ontario. *Practice Standard: Ethics*
Oath of Office and Secrecy.

6. REFERENCES:

Canadian Council on Health Services Accreditation (2007). *Patient / Client Safety Goals and Required Organizational Practices. (Patient Safety Area 2: Communication).* Ottawa, ON.

Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses.* Ottawa: On

Canadian Nurses Association (2001). Privacy of Personal Health Information Position Statement. Ottawa, ON.

Canadian Nurses Protective Society. (2007). *Quality Documentation: Your Best Defense. Info Law: A Legal Information Sheet for Nurses.* Canadian Nurses Protective Society: Ottawa, ON.

College of Nurses of Ontario (2009). Practice Standard: Confidentiality and Privacy – Personal health information.

College of Nurses of Ontario. (2008). *Practice Standard: Documentation*. College of Nurses of Ontario: Toronto, ON.

Personal Health Information Protection Act.

Approved by:		**Effective Date:**
		March 31, 2015
Director of Nursing, Ontario Region	**Date:**	
Regional Executive, Ontario Region	**Date:**	

APPENDIX A: Abbreviations for Use with FNIHB

Abbreviation	Means	Abbreviation	Means
A	Assessment	**BCG**	Bacillus Calmette-Guerin
AA	Alcoholics Anonymous	**BG**	Blood glucose
AAA	Abdominal aortic aneurysm	**BID**	bid twice daily
AAT	Activity as tolerated	**Bilat**	Bilateral
abd	Abdomen	**Bili**	Bilirubin
Abn	Abnormal	**BM**	Bowel movement
ABG	Arterial blood gas	**BMI**	Body mass index
ac	Before meals	**BP**	Blood pressure
ACL	Anterior cruciate ligament	**BPH**	Benign prostatic hypertrophy
ACTH	Adrenocorticotropin hormone	**BR**	Bathroom
ACLS	Advanced cardiac life support	**BUN**	Blood urea nitrogen
ADD	Attention deficit disorder	**BX**	Biopsy
ADHD	Attention deficit hyperactivity disorder	**C**	Centigrade (Celsius)
ADL	Activities of daily living	**C+S**	Culture + sensitivity
A/E	Air entry	**Cap**	Capsule
Afib	Atrial fibrillation	**CC**	Chief complaint (not cubic centimeter)
AFB	Acid Fast Bacillus	**Ca**	Calcium
AFO	Ankle foot orthosis	**CA**	Cancer, carcinoma
AIDS	Acquired immune deficiency syndrome	**CABG**	Coronary artery bypass graft
Alb	Albumin	**CABG**	Coronary Artery Bypass Graft
Alk Phos	Alkaline phosphatase	**CAD**	Coronary artery disease
ALT	Alanine aminotransferase	**CAGE**	Alcohol screening test
ALS	Amyotrophic lateral sclerosis	**cal**	Calorie
A.M.	Morning	**CT**	Computerized tomography
A.M.A.	Against medical advice	**CBC**	Complete blood count
AMI	Acute Myocardial Infarction	**CBT**	Cognitive behaviour therapy
ANA	Antinuclear antibodies	**CDC**	Center for disease control
Amnio	Amniocentesis	**CHF**	Congestive heart failure
Amp	Ampoule	**CHR**	Community Health Representative
Amt	Amount	**Cl**	Chloride
ASA	Aspirin	**CK**	Creatine kinase
ANA	Antinuclear antibodies	**cm**	Centimeter
ARDS	Acute Respiratory Distress Syndrome	**CMOH**	Chief medical officer of health
ARM	Artificial Rupture of Membranes	**CNO**	College of Nurses of Ontario
AROM	Active Range of Motion	**c/o**	Complaining of
ASAP	As soon as possible	**CMV**	Cytomegalovirus
ASD	Atrial Septal Defect	**CN**	Cranial nerve
A/P	Anterior posterior	**CNS**	Central nervous system
AST	Aspartate aminotransferase	**CO2**	Carbon dioxide
AWOL	Absent without leave	**COPD**	Chronic obstructive pulmonary disease
BBB	Bundle branch block	**C-PAP**	Continuous positive airway pressure
B-blocker	Beta-blocker	**FAE**	Fetal Alcohol Effect(s)

APPENDIX A: Abbreviations for Use with FNIHB

Abbreviation	Means	Abbreviation	Means
CPR	Cardiopulmonary resuscitation	**FAS**	Fetal Alcohol Syndrome
CRP	c-reactive protein	**FASD**	Fetal Alcohol Spectrum Disorder
Cr	Creatinine	**FBG**	Fasting Blood Glucose
CR	Controlled release	**FFP**	Fresh Frozen Plasma
cr	Cream	**FHR**	Fetal Heart Rate
CPK	Creatine phosphokinase	**FHx**	Family history
CSF	Cerebrospinal fluid	**FSH**	Follicle stimulating hormone
C-spine	Cervical spine	**ft.**	Feet
CV	Cardiovascular	**f/u**	Follow-up
CVA	Cerebrovascular accident	**GC**	Gonococcus, gonorrhea
Cx	Cervix	**GERD**	Gastroesophageal reflux disease
CXR	Chest x-ray	**GGT**	Gamma glutamyl transferase
D&C	Dilation and curettage	**G.I.**	Gastrointestinal
D/C; dc; d/c	Discontinue ONLY (not discharge)	**GSW**	Gun shot wound
DDAVP	Desmopressin	**gtt**	Drop
DM	Diabetes mellitus	**G.U.**	Genito-urinary
DNR	Do not resuscitate	**g**	Gram
DOB	Date of birth	**HA**	Headache
drsg	Dressing	**HbcAB**	Hepatitis B core antibody
Ds, DS	Double strength	**HBsAb**	Hepatitis B surface antibody
DSM	Diagnostic & statistical manual of mental disorders	**HbsAg**	Hepatitis B surface antigen
DT	Diphtheria, tetanus toxoid	**Hct**	Hematocrit
DVT	Deep vein thrombosis	**HDL**	High density lipoprotein
Dx	Diagnosis	**HEENT**	Head, eye, ear, nose & throat
EA	Each	**Hep A, B, C**	Hepatitis A, B, C
EC	Enteric coated	**Hgb**	Hemoglobin
EEG	Electroencephalogram	**HbA1C**	Hemoglobin A1C
EENT	Eye-ear-nose-throat	**HIV**	Human immunodeficiency virus
e.g.	For example	**HOB**	Head of bed
EKG, ECG	Electrocardiogram	**H/O**	History of
EMG	Electromyography	**HPI**	History of present illness
ENT	Ear, nose, throat	**HPV**	Human papillomavirus
EOM	Extra Ocular Movement	**HRT**	Hormone replacement therapy
ER	Emergency Room	**H2O**	Water
ERCP	Endoscopic retro cholangiopancreatogram	**H & P**	History & physical
EPS	Extra pyramidal symptoms	**hr**	Hour
ES	Extra strength	**H.S.**	Hour of sleep; at bedtime
ESR	Erythrocyte sedimentation rate	**ht.**	Height
ETOH	Alcohol	**HTN**	Hypertension
F	Fahrenheit	**HV**	Home visit
FBS	Fasting blood sugar	**Hx**	History
FDA	Food and drug administration	**I&D**	Incision and drainage
Fe	Iron	**IBS**	Irritable bowel syndrome

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Abbreviation	Means	Abbreviation	Means
i.e.	That is	**MCP**	Metacarpal phalangeal joint
Inh	Inhalation	**MCV**	Mean corpuscular volume
Inj	Injectable	**MD**	Medical doctor
IM	Intramuscular	**MDI**	Meter dose inhaler
Info	Information	**meds**	Medications
INR	International normalized ratio	**meq**	Milliequivalents
IOP	Intraocular pressure	**Mg**	Magnesium
I & O	Input & output	**mg**	Milligram
irreg.	irregular	**MI**	Myocardial infarction
IUD	Intrauterine device	**misc.**	Miscellaneous
IV	Intravenous	**ml**	Milliliter
IVP	Intravenous pyelogram	**mm**	Millimeter
JVD	Jugular venous distention	**mmol**	Millimole
JVP	Jugular venous pulse/pulsation	**MMSE**	Mini-mental status exam
KCl	Potassium chloride	**mod**	Moderate
k	Potassium	**movt**	Movement
kg	Kilogram	**MRI**	Magnetic resonance imaging
KUB	Kidney, ureter, bladder	**MS**	Multiple sclerosis
L	Liter	**MSE**	Mental status exam
LBBB	Left bundle branch block	**MVA**	Motor vehicle accident
lab	Laboratory	**MVP**	Mitral valve prolapse
lb.	Pound	**NaCl**	Sodium chloride
LDH	Lactate dehydrogenase	**N/A**	Not applicable
LDL	Low density lipoprotein	**Na**	Sodium
LFT	Liver function test	**NAD**	No abnormality detected
LLL	Left lower lobe	**NAHCO3**	Sodium bicarbonate
LLQ	Left lower quadrant	**NAS**	No added salt
LML	Left middle lobe	**neb**	Nebules
LMP	Last menstrual period	**neg**	Negative
LP	Lumbar puncture	**neuro**	Neurological
L-spine	Lumbar spine	**NG**	Nasogastric
LS-spine	Lumbosacral spine	**NGT**	Nasogastric tube
LUL	Left upper lobe	**NKA**	No known allergies
LUQ	Left upper quadrant	**NKDA**	No known drug allergies
LV	Left ventricle	**NKFA**	No known food allergies
LVH	Left ventricular hypertrophy	**NPO**	Nothing by mouth
lytes	Electrolytes	**NP**	Nurse practitioner
Liq	Liquid	**NS**	Normal saline
RPN	Registered practical nurse	**NSAIDS**	Non-steroidal anti-inflammatory drugs
m	Meter	**NSR**	Normal sinus rhythm
MAOI	Monoamine-oxidase inhibitor	**NWB**	Non-weight bearing
max	Maximum	**N/V**	Nausea & vomiting
mcg	Microgram	**O**	Objective
MCH	Mean corpuscular hemoglobin	**O2**	Oxygen
MCHC	Mean corpuscular hemoglobin concentration	**O2sat**	Oxygen saturation

APPENDIX A: Abbreviations for Use with FNIHB

Abbreviation	Means	Abbreviation	Means
OA	Osteoarthritis	**RBBB**	Right bundle branch block
OCD	Obsessive compulsive disorder	**RBC**	Red blood count
Oint	Ointment	**Re; re**	Regarding
O & P	Ova & parasites	**Rehab**	Rehabilitation
Ophth	Ophthalmic	**resp**	Respiratory
ORIF	Open reduction internal fixation	**RLL**	Right lower lobe
ortho	Orthopedic	**RML**	Right middle lobe
O.T.	Occupational therapy	**RLQ**	Right lower quadrant
OTC	Over the counter	**R/O**	Rule out
oz.	Ounce	**ROM**	Range of motion
PAC	Premature atrial contraction	**ROS**	Review of systems
PAP Smear	Papanicolaou Smear	**RUQ**	Right upper quadrant
PC	After meals	**R/T**	Related to
PEG	Polyethylene glycol	**RUL**	Right upper lobe
per	By; through	**RVH**	Right ventricular hypertrophy
PERRL	Pupils equal, round, reactive to light	**Rx**	Prescription, to take, to treat by
PERRLA	Pupils equal, round, reactive to light and accommodation	**Rxn**	Reaction
PET	Positron emission tomography	**S**	Subjective
PFT	Pulmonary function test	**SE**	Side effects
PID	Pelvic inflammatory disease	**sed rate**	Erythrocyte sedimentation rate
pkg	Package	**SLE**	Systemic lupus erythematosus
PKU	Phenylketonuria	**SOB**	Shortness of breath
PLS	Preloaded syringe	**spec.**	Specimen
P.M.	Afternoon	**SC**	Subcutaneous
PMH	Past medical history	**SR**	Sustained release
po	By mouth	**SSRI**	Selective serotonin reuptake inhibitor
post-op	After operation	**STAT**	Immediately
PPE	Personal protective equipment	**STI**	Sexually transmitted infection
pre-op	Before surgery	**Susp**	Suspension
PR	By rectum	**supp**	Suppository
PRN; prn	As necessary; as needed	**T**	Temperature
PSA	Prostatic specific antigen	**tab**	Tablet
PTSD	Post traumatic stress disorder	**TB**	Tuberculosis
pt.	Patient	**Tbsp**	Tablespoon
PUD	Peptic ulcer disease	**TCA**	Tricyclic antidepressant
PVC	Premature ventricular contraction	**TIA**	Trans ischemic attack
PVR	Post void residual	**TIBC**	Total iron binding capacity
PWB	Partial weight bearing	**tid**	Three times daily
qid	Four times daily	**TENS**	Transcutaneous electrical nerve stimulation
q(*)h	Every (*) hour	**TKVO**	To keep vein open
qam	Every morning	**TM**	Tympanic membrane
qhs	At every bedtime	**TMJ**	Temporomandibular joint
qs	A sufficient quantity	**TPN**	Total parenteral nutrition

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Abbreviation	Means	Abbreviation	Means
RN	Registered nurse	**TPR**	Temperature, pulse, respiration
TSH	Thyroid stimulating hormone	**Vag**	Vaginal
T-spine	Thoracic spine	**VDRL**	Venereal disease research lab test
tsp	Teaspoon	**VF**	Visual field
TURP	Transurethral resection prostate	**Vfib**	Ventricular fibrillation
Tx	Treatment, therapy	**VS**	Vital signs
Td	Tetanus, diphtheria, toxoid	**VSS**	Vital signs stable
UA, U/A	Urinalysis	**V Tach**	Ventricular tachycardia
URI	Upper respiratory infection	**WBC**	White blood count
US	Ultrasound	**w/c**	Wheelchair
UTI	Urinary tract infection	**wt.**	Weight
Δ	Change		