Registered Nurses Association
of the Northwest Territories and Nunavut

DOCUMENTATION GUIDELINES

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Documentation Guidelines for Registered Nurses and Nurse Practitioners

Introduction

Documentation is a crucial component of safe, ethical, and effective nursing practice, irrespective of the context of practice or whether the documentation is paper-based or electronic. Documentation is defined as any written or electronic recording that describes the status of a client or the client care provided (Lyeria & Barry, 2014). Documentation establishes accountability, promotes quality nursing care, facilitates communication between healthcare providers, and conveys the contribution of nursing to health care. Documentation is neither separate from care nor optional. Documentation is a vital part of nursing practice.

The intention of this document is to provide Registered Nurses (RNs) and Nurse Practitioners (NPs) with information on their professional accountability and the Registered Nurses Association of the Northwest Territories and Nunavut's (RNANT/NU) expectations for clinical documentation. In the RNANT/NU (2014b) *Standards of Practice for Registered Nurses and Nurse Practitioners*, all four standards recognize that each RN and NP is expected to document pertinent information.

All references made to registered nurses (RNs) in this document include nurse practitioners (NPs).

Standard 1 - Responsibility and Accountability - The registered nurse is responsible for practicing safely, competently, compassionately, and ethically and is accountable to the client, employer, profession and the public.

> *Standard 1.5 –The registered nurse is accountable for nursing actions, decisions and professional conduct.*

Standard 2 - Knowledge-Based Practice - The registered nurse practices using evidence informed knowledge, skill, and judgement.

> *Standard 2.2 – The registered nurse uses critical inquiry in collecting and interpreting data, in determining and communicating client status, and in planning, implementing the plan of care, and evaluating outcomes.*
>
> *Standard 2.8 – The registered nurse maintains timely and accurate documentation.*

Standard 3 - Client-Centered Service - The registered nurse contributes to and promotes measures that optimize positive health outcomes at the individual, organizational and system level.

> *Standard 3.2 –The registered nurse communicates effectively and respectfully with clients, colleagues, and others.*

Standard 4 - Public Trust - The registered nurse upholds the public's trust in the profession.

Standard 4.3 – The registered nurse protects clients' privacy and confidentiality.

RNs must also be familiar with and follow their agency's documentation policies, standards and protocols.

RNs must also be familiar with and follow their agency's documentation policies, standards, and protocols. Although different documentation formats and technology may be used throughout the Northwest Territories (NT) and Nunavut (NU), 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 working in an independent practice. Samples and brief descriptions of different formats for documentation are included in Appendix A.

Privacy and Confidentiality

However client information is communicated (e.g., written documents or electronic transfer), RNs must adhere to the principles of privacy and confidentiality (RNANT/NU, 2014a). Examples of expected practices and value statements about privacy and confidentiality are outlined in other resources such as the *Standards of Practice for Registered Nurses and Nurse Practitioners* (RNANT/NU, 2014b), *Competencies in the Context of Entry-Level Registered Nurse Practice* (RNANT/NU, 2014a), Canadian Nurses Association (CNA, 2008) *Code of Ethics for Registered Nurses*, Accreditation Canada, agency policies, and relevant territorial legislation (see Appendix B).

Sharing of Information within the 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 *Health Information Act* (2014). 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.

Quality Documentation: Defined

Quality Documentation is described below in answer to *Why, Who, How, What, and When* questions.

Why Should Nurses Document?

Communication and 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.

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 (College of Registered Nurses of Nova Scotia [CRNNS], 2012). Information from the health record can be 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 and registered nurses are more readily able to evaluate progress towards outcomes, trend challenges, identify and manage risks and ultimately, maximize client safety.

Funding and Resource Management

Auditing of health records helps to identify the type, amount, efficiency and effectiveness of services required and provided. 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, 2012). Documentation can be used by administrators to support funding and resource management decisions.

Establishes 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 the Northwest Territories and Nunavut all RNs are required to document evidence of safe, competent and ethical care in accordance with the *Standards of Practice for Registered Nurses and Nurse Practitioners* (RNANT/NU, 2014b), the *Code of Ethics for Registered Nurses* (CNA, 2008), and applicable clinical standards and relevant agency policies. Documentation must reflect the RN's professional judgement, assessment, decisions, actions, and evaluation. Additionally, documentation must honour the ethical concepts of practice such as promoting respect, confidentiality, and informed decision-making.

Legal Reasons

The client's record is a legal document and can be used as evidence in a court of law or in a professional conduct proceeding. 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, when, how and why) about the planning for, provision of, and client's response to care or services including follow up. Documentation provides evidence that safe and competent care was delivered, the care/service met acceptable standards and procedures, was reasonable and prudent, provided in a timely manner, and consistent with organizational policies. Altering or failure to keep records as required could result in legal and professional ramifications. Quality documentation

Quality documentation is a RN's best defense in legal proceedings (Canadian Nurses Protective Society [CNPS], 2007b).

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Who Should Document?

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 was the RN who provided the care.

In situations when two or more individuals provide care the RN who has the primary assignment is expected to document the assessments, interventions, and client response, noting as necessary the role of other care providers. 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).

Co-signing and Countersigning Entries

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 cosigning is required. RNs are accountable for their own actions and do not routinely need someone to cosign their practice.

Co-signing implies shared accountability. It is imperative that the person co-signing actually witnessed or participated in the event.

There are some examples where co-signing 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. However, the second nurse is expected to review the documentation, making an additional entry if necessary and, in accordance with agency policy, co-sign the record. Co-signing implies shared accountability. 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 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 (i.e., night checks). Countersigning does not imply the second RN provided the care, it does imply the second RN approved or verified the intervention was completed.

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Co-signing and countersigning for other reasons, such as entries written by nursing students or licensed practice nurses (LPNs), is not acceptable and may add a level of accountability which the RN would not otherwise incur.

Third Party Documentation

Third party documentation is not generally supported. Documenting for others may lead to errors and 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 record the specific care they implemented. Best practice is 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, operating room or delivery room. Co-signing documentation may be appropriate in this situation.

Auxiliary Staff

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 s*ome* 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.

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.

Nursing Students

Nursing students are learners and not employees. All nursing students are expected to document the care they provide. Co-signing notes written by students is not encouraged. However, it may be necessary for the primary RN or preceptor to record her/his 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 primary RN should document.

How Should Nurses Document?

Clear, Concise, Unbiased and Accurate

Objectivity vs. Subjectivity

Objectivity means expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam-Webster, 2014a). Objective data is observed (e.g., crying, swelling, bleeding) or measured (e.g., temperature, blood pressure) and includes interventions, actions, or procedures as well as a client's response. Documentation should include objective statements related to the nursing process. At times it may be necessary to include subjective statements in the documentation to enhance the understanding of the client's care. Subjective data may include statements or feedback from a client as well as from family members or a friend. When documenting 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."

The use of words such as *appears, seems,* or *apparently* is not acceptable when used without supporting factual information because they suggest that a nurse did not know the facts and demonstrates uncertainty.

Avoid Generalizations

Avoid generalizations and vague phrases or expressions such as "status unchanged", "assessment unremarkable", "had a good day", "slept well", "up and about". Such vague statements are conclusions without supported facts. Be specific and use complete, precise descriptions of care. The use of words such as *appears*, *seems*, or *apparently* is not acceptable when used without supporting factual information because they suggest that a nurse did not know the facts and demonstrates uncertainty. For example, "appears to be sleeping" could be documented "client laying supine in bed with eyes closed, RR 18." This note may be appropriate as the only means of verification would be to wake the client and ask if s/he was actually asleep.

Avoid Bias and Labels

Do not document value judgments or unfounded conclusions; document only conclusions that can be supported by data. 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 interpreted to mean that the care provided was substandard (Association of Registered Nurses of Newfoundland and Labrador [ARNNL], 2010). Select neutral terminology or describe observed behaviors. For example rather than stating the "client drunk" it is correct to state, "noted an odor of alcohol and speech was slurred". Instead of documenting "client is aggressive", "client shouting and using obscene language" is more appropriate. Write each entry knowing the client has a right to read their own chart, keeping in mind you should only document what can be verified.

Legibility and Spelling

Writing legibly and using correct spelling when documenting illustrates a level of competency and attention to detail. Misspelled words and illegible entries can result in misinterpretation of information which could result in client harm (Lyeria & Barry, 2014), or have legal implications. Spelling errors can result in serious treatment errors. For example, certain medications, such as *digitoxin* and *digoxin* or *morphine* and *hydromorphone*, are similar and must be transcribed carefully to ensure the client receives the right medication.

All entries in a paper-based system should be written legibly, using black ink, or in accordance with agency policy.

All entries in a paper-based system should be written legibly, using black ink, or in accordance with agency policy. The use of black ink is best for optical scanning technology, which is used in many clinical areas across the Northwest Territories and Nunavut. Never use pencil, gel pens, or colored highlighters as they are not permanent, can be erased or changed, and do not photocopy or scan readily for storage purposes. Also, do not use coloured paper as information recorded may not be legible when scanned or photocopied. Try 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.

Blank (White) Space

There should be no blank or white space in paper-based documents as this presents an opportunity for others to add information unbeknownst to the original author. Agency policy should support nursing documentation that does not allow white space to occur. An accepted practice is to draw a single line completely through the white space, including before and after your signature (Lyeria & Barry, 2014). Fill in all blocks or spaces on flow sheets with the agency policy approved symbol/comment (check mark, initials, n/a or X mark). The use of ditto (") marks to indicate repetition of information is unsafe and inappropriate and leaves excess white space (ARNNL, 2010).

Abbreviation, Symbols and Acronyms

The use of abbreviations, symbols or acronyms can be an efficient form of 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. Use only those abbreviations, symbols and acronyms that are on a current agency-approved policy. Many agencies today are referring to the list of unsafe abbreviations developed by the Institute of Safe Medication Practice (2013) in their policy on abbreviation, symbols and acronyms.

Mistaken Entry/Errors and Changes/Additions

Inaccuracies in documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to agency policy. The content in question must remain clearly visible or retrievable so the purpose and content of the correction is clearly understood. If an error occurs in paper-based documentation, do not make entries between lines, do not remove anything (e.g., monitor strips, lab reports, requisitions, checklists), and do not erase or use correction products, stickers or felt pens to hide or obliterate an error. Also under no circumstance should chart pages or entries be re-copied because of a documentation error.

Agency policy should guide nurses to the accepted means of correcting errors. A generally accepted practice to correct an error in a paper-based system is to cross through the word(s) with a single line, above the line write "mistaken entry" and insert your initials, along with the date and time the correction was made and enter the correct information. The following is an example of how to correct an error:

> *19 Nov/14 0920 hrs - Chest auscultated for decreased air entry to bases with fine crackles to ~~RtIL~~ LUL. SpO_2 92% on O_2 3L via nasal prongs. Productive cough with small amount of yellow sputum expectorated. No shortness of breath or pain. Encouraged deep breathing and coughing and use of incentive spirometry, patient demonstrated accurate use of spirometer. J. Doe, RN*
>
> *mistaken entry JD 19 Nov/14 0920 hrs*

To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove pages. A client alternate decision maker, or another care provider, may request changes or additions to documentation. When the nurse who completed the original documentation is informed of such a request s/he should refer to agency policy.

Client Care Provided Through Electronic Means

Currently across the Northwest Territories and Nunavut, health authorities have moved to or are moving towards an electronic means of providing many aspects of care. From entering requests for tests and consultations, to reporting of diagnostics testing, to the documentation of care provided, electronic documentation is part of the everyday care of clients. Electronic documentation of care can include, but is not limited to, faxes, email, telehealth, and electronic health records (EHRs).

As in paper-based documentation systems, the reliability and trustworthiness of an electronic system is essential and the principles of good documentation must be maintained. "Electronic documentation carries a higher risk of breach of confidentiality" (CNPS, 2007, p.2). While the basic principles of documentation used in paper-based systems would also apply in electronic-based systems (computers, telephones, voice recording machines, videos), these new methods of recording, delivering, and receiving client data are posing new and constant challenges for agencies and nurses, both in terms of confidentiality, security, and ensuring continuing education for healthcare providers.

Agencies must have clear policies and guidelines to address these challenges and other issues related to technologies in documentation. RNs must advocate for agency policies/guidelines that reflect and support quality, evidence-based practice. Agency policies related to electronic documentation should clearly indicate how to:

- correct documentation errors and/or make 'late entries'
- prevent the deletion of information
- identify changes and updates in a health record
- protect the confidentiality of client information
- maintain the security of a system (regularly changing passwords, issuing access cards, virus protection, encryption, well maintained firewalls)
- track unauthorized access to client information
- use a mixture of electronic and paper-based methods, as appropriate (policy should ensure continuity of care is maintained)
- back-up client information
- document in the event of a system failure
- obtain access to a specific group or area of information
- safeguard tips for privacy and confidentiality (see Appendix B)

All entries made and/or stored electronically are considered a permanent part of a health record and may not be deleted (e.g., e-mail and fax messages, including fax cover sheets; telehealth encounters). Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

Faxing

Facsimile (fax) transmission of client information between healthcare providers is convenient and efficient. In spite of this there is significant risk to the confidentiality and security of information transmitted via fax due to the possibility of transmitting to unintended recipients. Agency policy should guide nurses in the acceptance and transmission of faxes for the purposes of client care.

Email

The use of electronic mail (email) transmission in healthcare is becoming more widespread because of its speed, reliability, convenience and

Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

low cost. However, like faxes, there is significant risk to the security and confidentiality of e-mail messaging. Messages can inadvertently be read by an unintended recipient and while the message can be erased from the local computer, they are never deleted from the central server and could be retrieved by unauthorized personnel. It is not recommended as a method for transmitting clients' health information.

In instances where an email message is considered to be the preferred option to meet client needs, there must be a reasonable belief that the transmission is secure (e.g., use of encryption software, user verification, secure point-to-point connections). Agencies should also develop specific policies for transmitting client information via e-mail to cover items such as the use of specific forms for email purposes, the procedure to obtain consent to use email, and the use of initials, names, and agency numbers.

What Should Nurses Document?

All Aspects of the Nursing Process

Documentation which reflects the nursing process demonstrates that an RN has fulfilled her/his duty of care, while demonstrating the unique contribution of nursing to the care of clients. Nurses should record data collected through all aspects of the nursing process. As a general rule, any information that is clinically significant should be documented.

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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)
- an evaluation of outcomes, including the client's response and plans for follow-up discharge planning.

Failure to document evaluation is a common deficiency in charting. **It is imperative to demonstrate the effectiveness of care/services**. For example, did the vital signs stabilize? Did the pain subside? If not, what was the action?

Plan of Care

Effective client-focused documentation should also include a plan of care. A plan of care is a written outline of care for individual clients and is part of the permanent record. The plan of care must be clear to everyone reading the chart. Effective plans of care must be up-to-date

and useful to meet the needs and wishes of individual clients. If a standardized plan of care format (care maps, clinical pathways) is not used, the nurse should ensure that her/his notes identify a plan of care for each assigned client.

Admission, Transfer, Transport and Discharge Information

Accurate and concise documentation on admission, transfer, transport and discharge provides baseline data for subsequent care and follow up. Agency policy should identify expectations on recording communication between practitioners when client's care is transferred. Nursing documentation should reflect information on the client's status at discharge, any instructions provided (verbal and written), arrangements for follow-up care and evidence of the client's understanding, and family involvement as appropriate.

Client Education

RNs provide a wide range of client education on a daily basis. Accurate documentation of this education is essential to enable communication and continuity of what has been taught. Lack of documentation about client education diminishes this important aspect of care. The following aspects of client education should be documented in the health record:

- both formal (planned) and informal (unplanned) teaching
- materials used to educate
- method of teaching (written, visual, verbal, auditory and instructional aids)
- involvement of patient and/or family
- evaluation of teaching objectives with validation of client comprehension and learning
- any follow up required.

Risk Taking Behaviours

RNs are held accountable to the *Code of Ethics for Registered Nurses* (CNA, 2008). The RN has an ethical responsibility to respect a client's informed choice, including choices related to lifestyle and treatment, which may be risky to their overall health (ARNNL, 2010). The RN must document the objective data related to the risk taking behaviours and should be cautious as to not place a value judgment on the behaviours. The nurse should also document her/his response to the risk taking behaviour and any education they provide related to the potential consequences of the behaviour. Documenting the client as "noncompliant" is not acceptable; the RN should document objective data that describes this behaviour. If the risk taking behaviour results in a situation in which mandatory reporting must occur, such as child abuse, the RN is required to follow the legislation and document appropriately.

Examples of risk taking behaviors include (ARNNL, 2010):

- threatening self-harm
- ambulating when bed rest is advised
- missing follow-up appointments
- leaving against medical advice
- refusing or abusing medications or illicit drugs
- tampering with medical equipment

Incident Reports

An incident is an event which is not consistent with the routine operations of the unit or of client care (Lyeria & Barry, 2014). Examples of incidents include: patient falls, medication errors, needle stick injuries, or any circumstances that places clients or staff at risk of injury. 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 in 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" in the documentation.

Incident reports (also called risk pro unusual/occurrence reports) are separate from the patient 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 equipment. Information included in an occurrence/incident report is similar to the information included in a client's health record, however, the incident/occurrence report would also include additional information with respect to the particular incident ("a door was broken," or "this was the third incident this week"). Information recorded is not directly related to the care of the client. Agency policy should clearly describe processes necessary to complete an incident/occurrence report.

Date, Time, Signature and Designation

Documentation in the health record begins with date and time and ends with the recorder's signature and designation. Signatures and initials need to be identifiable and follow specific agency policy. Personal initials can only be used if a master list matching the caregiver's initials with a signature and designation is maintained in the health record.

Medication Administration

Agencies should have specific policies and procedures related to documentation of medication administration. The general requirements for this type of documentation include:

- Date
- Actual time medications are administrated
- Names of medications
- Routes of medications
- Sites of administration when appropriate
- Dosage administered
- Nurses signature/designation.

Each healthcare provider (respiratory therapists, physiotherapists) should sign for the medications they administer, except in emergency situations. In emergency situations, registered nurses may sign for medications administered by other healthcare providers as long as this is supported by agency policy (see Co-signing, p.7).

The nurse should avoid using the words "error", "incident" or "accident" in the documentation.

As part of the nursing process it is important that pre-administration assessment data and post-administration evaluation data should be documented as warranted by the classification of medication or a client's physical/mental condition.

Verbal Orders and Telephone Orders

The expectation is that authorized prescribers will write medication orders whenever possible. RNs can accept verbal medication orders from authorized prescribers (either face-to-face or by telephone) when it is in the best interest of a client and there are no reasonable alternatives. Situations in which verbal orders would be considered acceptable include:

- urgent or emergency situations when it is impractical for a prescriber to interrupt client care and write the medication order
- when a prescriber is not present and direction is urgently required by a RN to provide appropriate client care.

Authorized prescribers should review and countersign verbal orders as soon as reasonably possible or within the timeframe indicated in an agency's policy. To ensure that a verbal or telephone medication order is complete, RNs should check for the following:

- client's name
- medication name
- dosage form (e.g., tablet, inhalant)
- route of administration
- exact strength of concentration
- dose (in unit of measurement)
- frequency of administration
- quantity and duration
- purpose or indication for the medication (i.e., appropriate for client's treatment plan)
- prescriber's name and designation.

When prescribers transmit medication orders via the telephone they generally do not have the benefit of conducting direct assessments of clients' conditions and, therefore, base their decisions solely on a RN's assessment of the clients receiving the medications.

Comprehensive documentation of RNs' assessments can reduce the likelihood of errors, however, errors can still occur as a result of poor communications or inaccurate transcriptions. Since negative client outcomes can result from these types of errors, telephone orders, and verbal orders are discouraged.

Agency policy must support the method in which date and time is documented. For example, is a 24-hour or 12-hour clock used and what consistent written format

RNs can accept verbal medication orders from authorized prescribers (either face-to-face or by telephone) when it is in the best interest of a client and there are no reasonable alternatives.

does the date follow? A consistent timepiece should be used to record time (e.g., cardiac monitor). If you are unable to use this timepiece your documentation should reflect what you are using to record time.

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.

When should Nurses document?

Timely, Chronologically and Frequently

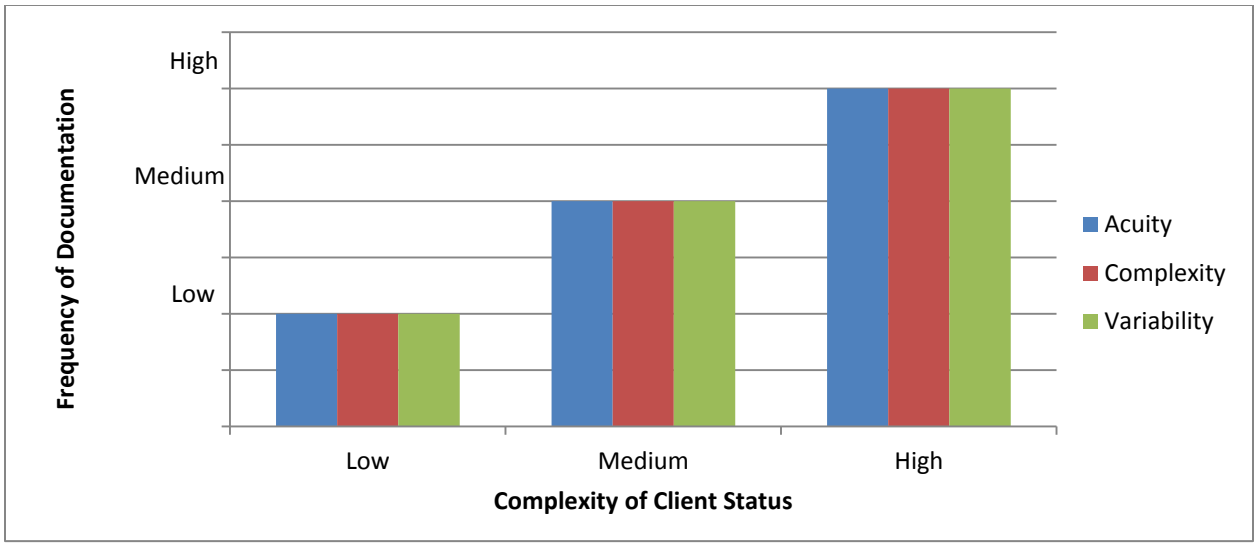
Documentation should be completed contemporaneously, at the time of the event or close to the event as sensibly possible (CNPS, 2007; Lyeria & Barry, 2014). This enhances the accuracy and reliability of the documentation. Documentation should never be completed before an event actually takes place.

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 healthcare providers to understand what care was provided, based on what assessment data, and any outcomes or evaluations of that care (including client responses).

The frequency and amount of detail required in documentation is, generally, dictated by a number of factors, including:

- facility/agency policies and procedures
- complexity of a client's health problems
- degree to which a patient's condition puts him/her at risk
- degree of risk involved in a treatment or component of care

While agency policies on documentation should be followed to maintain a reasonable and prudent standard of documentation, nursing recording should be more comprehensive, in-depth and frequent if a patient is very ill, very unpredictable, or exposed to high risk (CNPS, 2007b). The table below illustrates the frequency of documentation based on complexity.



Client status will predicate the timeliness of documentation. "When client acuity, complexity, and variability are high, documentation will be more frequent than when clients are less acute, less complex, and/or less variable" (College of Registered Nurses of British Columbia [CRNBC], 2013, p. 19).

Late or Lost Entries

As stated, documentation should occur as soon as possible after an event has occurred. When it is not possible to document at the time of or immediately following an event, or if extensive time has elapsed a late entry is required. Late entries should be defined by agency policy. Late entries or corrections incorporating omitted information in a health record should be made, on a voluntary basis, only when a nurse can accurately recall the event or care provided. Late entries must be clearly identified (e.g., "Addendum to Care") and should be individually dated. They should reference the actual time recorded as well as the time when the care/event occurred and must be signed by the nurse involved. The following is an example of how to document a late entry:

21 October 2014 1850hrs - Late entry to care provided at 1000 hours. Client's IV to left forearm not flushing. Client reports pain to IV site. Erythema noted to surrounding area. IV cannula to left forearm removed, cannula intact. Cool compress applied to site for comfort. Reinserted IV #22 gauge cannula to right forearm, flushed with 10ml normal saline. IV infusion of D51/2 NS started at 1030hrs. IV monitored throughout shift, zero complications noted. J. Doe, RN ———————————————

In the event of a lost entry, the RN may be asked to re-construct the entry. Falsifying records is considered professional misconduct according to the Northwest Territories Nursing Professions Act (2004) Section 32, subsection 2(e), and the Nunavut Nursing Act (2004) Section 2. The RN must clearly indicate the information recorded is replacing a lost entry. Lost entries should be made according to agency policy. 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.

Conclusion

Quality documentation is an integral part of professional RN practice. Quality documentation reflects the application of nursing knowledge, skills and judgment, the clients' perspective and interdisciplinary communications. These guidelines will support RNs to contribute to the development of agency policy and promote evidence-informed practice, which enables RNs to meet the *Standards of Practice for Registered Nurses and Nurse Practitioners* (RNANT/NU, 2014b) every day in client care.

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Glossary of Terms

Accountability: the obligation to acknowledge the professional, ethical, and legal aspects of one's role, and to answer for the consequences and outcomes of one's actions. Accountability resides in a role and can never be shared or delegated (CRNNS & CLPNNS, 2012).

Adverse event: an unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by healthcare management (Adverse Events in Canadian Hospitals Study Report, CIHI-CIHR, 2004).

Agency: facility or organization through which health services are provided or offered (e.g., health authorities, hospitals, community health centres, physicians' offices, home care programs).

Authorized prescriber: a healthcare provider authorized by legislation to prescribe drugs and other health products. In the Northwest Territories and Nunavut authorized prescribers include physicians, dentists, nurse practitioners, midwives, and optometrists.

Auxiliary Staff: health providers who provide direct care, such as unregulated care providers or personnel employed from external organizations.

Client: The individual, family, group, community or population who is the recipient of nursing services and, where the context requires, includes a substitute decision-maker for the recipient of nursing services. In some clinical settings, the client may be referred to as a patient or resident (RNANT/NU Standards of Practice, 2014).

Circle of Care: the individuals and activities related to the care and treatment of a patient. It covers the health care providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or case consultation with other health care providers (Information and Privacy Commissioner of Ontario, 2005).

Collaborate: building consensus and working together on common goals, processes, and outcomes (CNA, 2008).

Competence: the quality or ability of a registered nurse to integrate and apply the knowledge, skills, judgments, and personal attributes to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs (RNANT/NU, 2014b).

Competent: having or demonstrating the necessary knowledge, skills and judgments required to practice safely and ethically in a designated role and setting (CRNNS, 2009).

Competency: the integrated knowledge, skills, judgment and attributes required of a registered nurse to practice safely and ethically in a designated role or setting. Attributes include, but are not limited to, attitudes, values, and beliefs (CNA, 2008).

Co-signing: refers to a second or confirming signature on a witnessed event or activity.

Countersign: a second or confirming signature on a previously signed document (a blind signature) which is not witnessed.

Documentation: refers to charts, charting, recording, nurses' notes, progress notes. Documentation is written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client (Lyeria & Barry, 2014).

Electronic Health Record (EHR): a record of patient health information accessible online from many separate but interoperable automated systems within an electronic network (Lyeria & Barry, 2014).

Electronic Patient Record: an electronic method of storing, manipulating and communicating medical information of all kinds including text, images, sound, video and tactile senses, which are more flexible than paper-based systems. Often referred to as a medical record, it contains a client's entire medical history and information crucial to future care.

Electronic documentation: a document existing in an electronic form to be accessed by computer technology.

Electronic message system (email): a system that transmits messages in electronic form over a communications network of computers.

Encryption: a process of disguising data information as "ciphertext," or data that will be unintelligible to an unauthorized person.

Facsimile: a system of transmitting and reproducing graphic matter (as printing or still pictures) by means of signals sent over telephone lines.

Intervention: task, procedure, treatment, function, drug or action with clearly defined limits.

Firewall: a computer or computer software that prevents unauthorized access to private data (as on a company's local area network or intranet) by outside computer users (as on the Internet).

Health record: a compilation of pertinent facts on a client's health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care (e.g., hospital admission, series of home visits). All healthcare professionals providing care create the pertinent facts documented in a client's health record. Health records may be paper documents (i.e., hard copy) or electronic documents such as electronic medical records, faxes, e-mails, audio or videotapes, or images.

Legal reviews: review of a health record when requested for legal purposes.

Password: a sequence of characters required for access to a computer system.

Practice of registered nurses: a registered nurse is entitled to apply nursing:

(a) to promote, maintain and restore health;
(b) to prevent and alleviate illness, injury and disability;
(c) to assist in prenatal care, childbirth, and postnatal care;
(d) to care for the terminally ill and the dying;
(e) in the coordination of health care services;
(f) in administration, supervision, education, consultation, teaching, policy development and research with respect to any of the matters referred to in paragraphs (a) to (e); and
(g) to dispense, compound and package drugs where the bylaws so permit (NWT Nursing Profession Act, 2004)

Practice of nurse practitioners: in addition to the functions of a practicing registered nurse a nurse practitioner is entitled to apply advanced nursing knowledge, skills and judgment:

(a) to make a diagnosis identifying a disease, disorder or condition;
(b) to communicate a diagnosis to a patient;
(c) to order and interpret screening and diagnostic tests authorized in guidelines approved by the Minister;
(d) to select, recommend, supply, prescribe and monitor the effectiveness of drugs authorized in guidelines approved by the Minister; and
(e) to perform other procedures that are authorized in guidelines approved by the Minister (NWT Nursing Profession Act, 2004).

Professional misconduct: includes such conduct or acts relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonorable or unprofessional.

Professional practice issue: any issue or situation that either compromises client care/service by placing a client at risk, or affects a nurse's ability to provide care/service consistent with the *Standards of Practice for Registered Nurses and Nurse Practitioners* (RNANT/NU 2014b), CNA Code of Ethics, other standards and guidelines, or agency policies or procedures.

Progress notes: documentation of client care by all health care team members.

Self-regulation: the relative autonomy by which a profession is practised within the context of public accountability to serve and protect the public interest. The rationale for self-regulation is the recognition that the profession is best able to determine what can be practised, how it is to be practiced, and who can practise, as long as the public is well served.

Scope of practice: the roles, functions and accountabilities which members of a profession are legislated, educated, and authorized to perform.

Scope of employment: the range of responsibilities defined by an employer.

Telehealth: the delivery of health related services, enabled by the innovative use of technology, such as videoconferencing, without the need for travel. Telehealth can refer to transmission of medical images for diagnosis (referred to as store and forward telehealth) or groups or individuals exchanging health services or education live via videoconference (real-time telehealth).

Unprofessional Conduct: an act or omission of a nurse constitutes unprofessional conduct if a Board of Inquiry finds that the nurse:

(a) engaged in conduct that:
  (i) demonstrates a lack of knowledge, skill or judgment in the practice of nursing,
  (ii) is detrimental to the best interests of the public,
  (iii) harms the standing of the nursing profession,
  (iv) contravenes this Act or the regulations, or
  (v) is prescribed by the bylaws as unprofessional conduct; or

(b) provided nursing services when his or her capacity to provide those services, in accordance with accepted standards, was impaired by a disability or a condition, including an addiction or an illness.

Examples of unprofessional conduct include:

(a) practice that fails to meet accepted standards;

(b) the abandonment of a patient in danger without first ensuring that the patient has obtained alternative medical or nursing services;
(c) verbal or physical abuse of a patient;
(d) irresponsible disclosure of confidential information about a patient;
(e) providing false or misleading information respecting birth, death, notice of disease, state of health, vaccination, course of treatment or any other matter relating to life or health;
(f) the impersonation of another member or health professional;
(g) obtaining registration or employment through misrepresentation or fraud
(h) the failure, or refusal, without reasonable cause, to respond to an inquiry, or to comply with a demand for the production of documents, records or other materials made by an investigator under subsection 39(1);
(i) a conviction for a criminal offence, the nature of which could affect the practice of nursing (NWT Nursing Profession Act, 2004).

Voicemail: an electronic communication system in which spoken messages are recorded or digitized for later playback to an intended recipient.

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 many areas of nursing practice elements of several systems or methods of documentation are often combined. Regardless of the method of documentation used RNs must be familiar with and follow agency guidelines for the proper utilization/completion of documentation in their practice area. Whenever a system changes, it is important that a plan be devised for implementation and that the plan include the involvement and education of RNs.

The following examples were modified from information obtained from other sources (College of Nurse of Ontario, 2008; College of Registered Nurses of British Columbia, 2008; CRNNS, 2012; Lyeria & Barry, 2014; Nurses Association of New Brunswick, 2002).

Documentation Tools

There are many tools used for client documentation, including: worksheets and kardexes, client care plans, flow sheets 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 a 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 client 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 outcomes 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. Shift reports:

- can be verbal (face-to-face), tape recorded, or 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 – SOAPIER, focusing on outcomes and evaluation. Documentation using SOAPIER 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

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.
Ethical responsibilities:

1. Nurses respect the right of people to have control over the collection, use, access and disclosure of their personal information.
2. When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard.
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.
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.
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.
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.
7. Nurses respect policies that protect and preserve people's privacy, including security safeguards in information technology.
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.
9. Nurses do not use photo or other technology to intrude into the privacy of a person receiving care.
10. Nurses intervene if others inappropriately access or disclose personal or health information of persons receiving care.

Personal Health Information Act:

In March 2014, *Bill 4 - Health Information Act* was passed by the Legislative Assembly of the Northwest Territories. This Bill establishes rules related to the collection, use, disclosure and security of personal health information and the privacy of individuals the information is about, while facilitating the effective provision of health services.

In 2003, the Legislative Assembly of Nunavut enacted the *Consolidation of Access to Information and Protection of Privacy Act.* The purpose of this Act is to make public bodies more accountable to the public and to protect personal privacy.

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 of when no longer required, (e.g., agendas, schedules, care plans, 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.