On August 19, 2005 RNABC became the College of Registered Nurses of British Columbia (CRNBC). This document remains accurate and relevant. Over the next several months RNABC documents will be changed to incorporate the CRNBC name and identity.

NURSE TO NURSE
INFORMATION FOR NURSES

NURSING DOCUMENTATION

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA

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1. Introduction

The Standards for Nursing Practice in British Columbia require nurses[1] to document timely and accurate reports of relevant observations, including conclusions drawn from those observations. Documentation is an integral part of safe and appropriate nursing practice. Clear, comprehensive and accurate documentation is a record of the judgment and critical thinking used in professional practice.

The term "documentation" is used in this booklet to mean any written or electronically generated information about a client that describes the care or service provided to that client. "Client" refers to individuals, families, groups, populations or entire communities who require nursing expertise.

Documentation allows nurses and other care providers to communicate about the care provided. Documentation also promotes good nursing care and supports nurses to meet professional and legal standards.

Nurses often have questions or concerns about documentation. This booklet is intended to address these questions or concerns as well as to outline nurses' professional accountability in record keeping. The expectations for documentation outlined in this document apply to all nurses, regardless of the work setting, method of documentation or how documentation is stored.

[1] Nurse: in this document means registered nurse, licensed graduate nurse and nursing student.

2. Documentation

A. Definition

Documentation is any written or electronically generated information about a client that describes the care or service provided to that client. Health records may be paper documents or electronic documents, such as electronic medical records, faxes, e-mails, audio or video tapes and images. Through documentation, nurses communicate their observations, decisions, actions and outcomes of these actions for clients. Documentation is an accurate account of what occurred and when it occurred.

Nurses may document information pertaining to individual clients or groups of clients.

Individual Clients
When caring for an individual client (which may include the client's family), the nurse's documentation provides a clear picture of the status of the client, the actions of the nurse, and the client outcomes.

Nursing documentation clearly describes:
- an assessment of the client's health status, nursing interventions carried out, and the impact of these interventions on client outcomes;
- a care plan or health plan reflecting the needs and goals of the client;
- needed changes to the care plan;
- information reported to a physician or other health care provider and, when appropriate, that provider's response; and
- advocacy undertaken by the nurse on behalf of the client.

Groups of Clients
When providing service to groups of clients (e.g., therapy groups, public health programs), service records (or an equivalent) are used to document the service provided and overall observations pertaining to the group. Similar to documentation for individuals, documentation for groups reflects the needs assessment, plans, actions taken, and evaluation of the group outcomes.

Documentation of services provided to a group of clients describes:
- the purpose and goal of the group;
- the criteria for participation;
- intervention activities and group processes; and
- an evaluation of group outcomes.

Pertinent information about individual clients within the group is documented on individual client health records, not on the group service record. When charting on an individual client health record, names of other group members are not identified.

B. Reasons for documentation

To facilitate communication

Through documentation, nurses communicate to other nurses and care providers their assessments about the status of clients, nursing interventions that are carried out and the results of these interventions. Documentation of this information increases the likelihood that the client will receive consistent and informed care or service. Thorough, accurate documentation decreases the potential for miscommunication and errors. While documentation is most often done by nurses and care providers, there are situations where the client and family may document observations or care provided in order to communicate this information with members of the health care team.

To promote good nursing care

Documentation encourages nurses to assess client progress and determine which interventions are effective and which are ineffective, and identify and document changes to the plan of care as needed. Documentation can be a valuable source of data for making decisions about funding and resource management as well as facilitating nursing research, all of which have the potential to improve the quality of nursing practice and client care. Individual nurses can use outcome information or information from a critical incident to reflect on their practice and make needed changes based on evidence.

To meet professional and legal standards

Documentation is a valuable method for demonstrating that, within the nurse-client relationship, the nurse has applied nursing knowledge, skills and judgment according to professional standards. The nurse's documentation may be used as evidence in legal proceedings such as lawsuits, coroners' inquests, and disciplinary hearings through professional regulatory bodies. In a court of law, the client's health record serves as the legal record of the care or service provided. Nursing care and the documentation of that care will be measured according to the standard of a reasonable and prudent nurse with similar education and experience in a similar situation.

C. Tools for Documentation

There are many tools used for client documentation, including worksheets and kardexes, client care plans, flowsheets and checklists, care maps, clinical pathways and monitoring strips. These tools may be written or electronic in format. Regardless of the tool used, pertinent information specific to an individual client resides within the client's health record.

Worksheets and kardexes

Nurses use worksheets to organize the care they provide, and to manage their time and multiple priorities. Kardexes are used to communicate current orders, upcoming tests or surgeries, special diets or the use of aids for independent living specific to an individual client (College of Nurses of Ontario, 2002). If a paper format is used, entries may be erasable as long as the assessment, nursing interventions carried out and the impact of these interventions on client outcomes are documented in the permanent health record. When the kardex is the only documentation of the client's care plan, it is kept as part of the permanent record.

Client care plans

Care plans are outlines of care for individual clients and make up part of the permanent health record. Care plans are written in ink (unless electronic), up-to-date and clearly identify the needs and wishes of the client.

Flow sheets and checklists

Flow sheets and checklists are used to document routine care and observations that are recorded on a regular basis (e.g., activities of daily living, vital signs, intake and output). Flow sheets and checklists are part of the permanent health record, and can be used as evidence in legal proceedings (College of Nurses of Ontario, 2002). Symbols (e.g., check marks) may be used on flow sheets or checklists as long as it is clear who performed the assessment or intervention and the meaning of each of the symbols is identified in agency policy.

Care maps and clinical pathways

Care maps and clinical pathways outline what care will be done and what outcomes are expected over a specified time frame for a "usual" client within a case type or grouping. Nurses individualize care maps and clinical pathways to meet clients' specific needs (e.g., by making changes to items that are not appropriate). If the status of clients varies from that outlined on the care map or clinical pathway at a particular time period, the variance is documented, including the reasons and action plan to address it.

Monitoring strips

Monitoring strips (e.g., cardiac, fetal or thermal monitoring; blood pressure testing) provide important assessment data and are included as part of the permanent health record.

D. Incident Reports

Agencies often have policies that require nurses to complete incident reports following unusual occurrences, such as medication errors or harm to clients, staff or visitors. Regardless of whether incident reports are used, nurses have a professional obligation to document the actual care provided to an individual in the client's health record. Incident reports are administrative risk

management tools to track trends and patterns about groups of clients over time. Incident reports are to be used for quality assurance not punitive purposes. Incident reports completed in hospital based agencies are protected from disclosure in legal proceedings in section 51 of the Evidence Act (2001). Therefore, they are retained separately from the health record and no reference to an incident report is made in the health record to protect the incident report from subpoena.

British Columbia Health Care Risk Management Society (2002) recommends the following:

- Ensure that the facts of the incident are recorded separately from opinions about the cause of the incident and from any quality assurance follow-up information. Some organizations have a two-part incident report with follow-up and recommendations separate from the rest of the report.
- Never promise a patient/family a copy of an incident report or of any report arising out of quality assurance investigation - section 51 of the Evidence Act prohibits this.

3. Directives for Documentation

Requirements for documentation and the sharing, retention and disposal of this information are drawn from several sources: (A) statutory regulations; (B) professional standards for practice; (C) agency policies and procedures; and (D) legal principles.

A. Statutory Regulations

There are no laws in British Columbia (B.C.) stating specifically how and what nurses must document. Agencies generally develop documentation policies which reflect provincial and federal government statutes and/or other relevant documents. The following statutes and documents guide policy in most B.C. agencies:

Statutes:

British Columbia Coroners Act
Child, Family and Community Service Act
Controlled Drug and Substances Act (Federal)
Electronic Transactions Act
Evidence Act
Freedom of Information and Protection of Privacy Act
Health Act
Hospital Act
Health Care (Consent) and Facilities Act
Limitation Act
Medical Practitioners Act
Mental Health Act
Nurses (Registered) Act

Other Relevant Documents:

Review of the Storage and Disposal of Health Care Records (Peck, 1995). Victoria: B.C. Ministry of Health and Ministry Responsible for Seniors.
Guidelines for the Protection of Health Information (2001). Canada's Health Informatics Association (COACH).

B. Professional Standards for Practice

A standard is a desired and achievable level of performance against which actual performance can be compared. Each of the six standards contained within the *Standards for Nursing Practice in British Columbia* incorporates one of the characteristics of the profession and provides direction to nurses about documentation.

Examples of How Nurses Meet the RNABC Standards for Nursing Practice:

Standard 1: Responsibility and Accountability - Maintains standards of nursing practice and professional behaviour determined by RNABC and the practice setting.

Examples:
- Document all relevant data.
- Ensure that each entry clearly identifies the nurse.
- Be familiar with and use the documentation method used in the agency.
- Advocate for agency policies and procedures that are clear and consistent with RNABC documentation standards.

Standard 2: Specialized Body of Knowledge - Bases practice on nursing science and on related content from other sciences and humanities.

Example:
- Understand the purpose of and reasons for accurate and effective documentation.

Standard 3: Competent Application of Knowledge - Determines client status and responses to actual or potential health problems, plans interventions, performs planned interventions and evaluates client outcomes.

Examples:
- Document client assessments, interventions and the impact of interventions on client outcomes according to agency policies and Standards for Nursing Practice in British Columbia.
- Individualize care plans to meet the needs and wishes of individual clients.

Standard 4: Code of Ethics - Adheres to the ethical standards of the nursing profession.

Examples:
- Be familiar with agency policies related to confidential information.
- Safeguard the security of printed or electronically displayed or stored information.
- Dispose of confidential information in a manner that preserves confidentiality (e.g., shredding).
- Act as an advocate to protect and promote clients' rights to confidentiality and access to information.

Standard 5: Provision of Service to the Public - Provides nursing services and collaborates with other members of the health care team in providing health care services.

Examples:
- Use documentation to share knowledge about clients with other nurses and health care professionals.
- Regularly update kardex information and ensure that relevant client care information is captured in the permanent health record.
- Keep the care plan clear, current and useful.

Standard 6: Self-Regulation - Assumes primary responsibility for maintaining competence, fitness to practice and acquiring evidence-based knowledge and skills for professional nursing practice.

Example:
- Keep current with changes in the documentation method used.

C. Agency Policies and Procedures

Most health care agencies have documentation policies. These policies provide direction for nurses to document the nursing care provided and the process of clinical decision-making in an accurate and efficient manner. Agency policies include:
- description of the method of documentation;
- expectations for the frequency of documentation;
- processes for “late entry” recording;
- listing of acceptable abbreviations or the name of a reference text in which acceptable abbreviations are found;
- acceptance and recording of verbal and telephone orders; and
- storage, transmittal and retention of client information.

Agency policies guide nurses in managing each of these specific situations. In situations where policy changes are necessary, nurses advocate for the appropriate changes.

D. Legal Principles

Legal standards for documentation have evolved over time and continue to evolve. Many are based on Canadian common law court decisions as illustrated in the following examples:

1. Nurses' notes are recognized as documentary evidence.

Case: Ares vs. Venner, 1970
Prior to 1970, nurses' notes were not considered legal evidence admissible in court unless the nurse was called to testify to the truth of the contents. In 1970, a new law was made in the Ares vs. Venner case when, for the first time, nurses' notes were recognized as admissible evidence. Nurses' notes were viewed as a record of the nursing care provided to the client. This case set out the conditions in which nurses' notes are now admissible (Richard, 1995):

- nurses' notes must be made contemporaneously;
- nurses' notes must be made by someone having personal knowledge of the matter then being recorded; and
- nurses' notes must be made by someone under a duty of care to make the entry or record.

2. Charting by exception can provide admissible evidence.

Cases: Kolesar vs. Jeffries, 1974; Ferguson vs. Hamilton, 1983; Wendon vs. Trikha, 1993
The health record is important both for what is recorded and for what is not recorded. In the case of Kolesar vs. Jeffries (1974), the nurses' notes were introduced as evidence and the absence of entries permitted the inference that "nothing was charted because nothing was done." However, in a subsequent case, Ferguson vs. Hamilton (1983), the court rejected the submission that the absence of any nurse's entry is an indication of failure in care on the part of the nurse(s). In this case, the court concluded that the fact that there was nothing in the nurses' notes during a period of time did not necessarily mean nothing was done, provided there was evidence to the contrary and the usual practice was not to chart (Richard, 1995).

In the case of Wendon vs. Trikha (1993), the court concluded that omissions in documentation will be interpreted against a nurse unless other credible evidence of nursing care demonstrates that care was given. It means that if charting by exception is an agency policy, and if evidence can be given that care was provided and noted according to this method, then this evidence will be admissible and will provide proof of what was done (Richard, 1995). To meet legal documentation standards, a system of charting by exception must include such supports such as agency documentation policies, assessment norms, standards of care, individualized care plans and flow sheets.

4. Documentation Methods

Most methods of documentation fall into one of two categories: documentation by inclusion and documentation by exception (Coleman, 1997). Documentation by inclusion is done on an ongoing, regular basis and makes note of all asessment findings, nursing interventions and client outcomes. Documentation by exception, on the other hand, makes note of negative findings and is completed when assessment findings, nursing interventions or client outcomes vary from the established assessment norms or standards of care existing within a particular agency. Charting by exception replaces the long held belief of "if it was not charted, then it was not done" with a new premise, "all standards have been met with a normal or expected response unless documented otherwise."

Documentation by exception is only appropriate when assessment norms or standards of care are explicitly written and available within the agency. Documentation by exception is never acceptable for medication administration.

The documentation method selected within an agency or practice setting needs to reflect client care needs and the context of practice. Some agencies may combine elements of different documentation methods and formats. If an agency decides to change its method or format of documentation and/or expectations, it is important that this be done within a context of appropriate planning and includes the involvement and education of nurses.

Regardless of the method used, nurses are responsible and accountable for documenting client assessments, interventions carried out, and the impact of the interventions on client outcomes. Clients who are very ill, considered high risk, or have complex health problems generally require more comprehensive, in-depth and frequent documentation.

Three common documentation methods - focus charting, SOAP/SOAPIER and narrative documentation are described in the following sections. Any of these methods may be used to document on an inclusion or exception basis.

A. Focus Charting

With this method of documentation, the nurse identifies a "focus" based on client concerns or behaviours determined during the assessment. For example, a focus could reflect:

- A current client concern or behaviour, such as decreased urinary output.
- A change in a client's condition or behavior, such as disorientation to time, place and person.
- A significant event in the client's treatment, such as return from surgery.

In focus charting, the assessment of client status, the interventions carried out and the impact of the interventions on client outcomes are organized under the headings of data, action and response.

Data: Subjective and/or objective information that supports the stated focus or describes the client status at the time of a significant event or intervention.
Action: Completed or planned nursing interventions based on the nurse's assessment of the client's status.
Response: Description of the impact of the interventions on client outcomes.

Flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations such as personal care, vital signs, intake and output, etc. Information recorded on flow sheets or checklists does not need to be repeated in the progress notes.

B. Soap/Soapie(r) Charting

SOAP/SOAPIER charting is a problem-oriented approach to documentation whereby the nurse identifies and lists client problems; documentation then follows according to the identified problems.

Documentation is generally organized according to the following headings:
S = subjective data (e.g., how does the client feel?)
O = objective data (e.g., results of the physical exam, relevant vital signs)
A = assessment (e.g., what is the client's status?)
P = plan (e.g., does the plan stay the same? is a change needed?)
I = intervention (e.g., what occurred? what did the nurse do?)
E = evaluation (e.g., what is the client outcome following the intervention?)
R = revision (e.g., what changes are needed to the care plan?)

Similar to focus charting, flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations.

C. Narrative Charting

Narrative charting is a method in which nursing interventions and the impact of these interventions on client outcomes are recorded in chronological order covering a specific time frame. Data is recorded in the progress notes, often without an organizing framework. Narrative charting may stand alone or it may be complemented by other tools, such as flow sheets and checklists.

5. Use of Technology

Technology may be used to support client documentation in a number of ways. If technology is used, the principles underlying documentation, access, storage, retrieval and transmittal of information remain the same as for a traditional, paper-based system. These new ways of recording, delivering and receiving client information, however, pose significant challenges for nurses, particularly with respect to confidentiality and security of client information. It is important that nurses be supported by agencies in resolving these issues through clear policies and guidelines and ongoing education.

A. Electronic Documentation

A client's electronic health record is a collection of the personal health information of a single individual, entered or accepted by health care providers, and stored electronically, under strict security.

As with traditional or paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care (College of Nurses of Ontario, 2002). Entries are made by the provider providing the care and not by other staff. Entries made and stored in an electronic health record are considered a permanent part of the record and may not be deleted. If corrections are required to the entry after the entry has been stored, agency policies provide direction as to how this should occur.

Most agencies using electronic documentation have policies to support its use, including policies for:

- correcting documentation errors or making "late entries";
- preventing the deletion of information;
- identifying changes and updates to the record;
- protecting the confidentiality of client information;
- maintaining the security of the system (passwords, virus protection, encryption, firewalls);
- tracking unauthorized access to client information;
- processes for documenting in agencies using a mix of electronic and paper methods;
- backing-up client information; and
- means of documentation in the event of a system failure.

Guidelines for nurses using electronic health records are as follows:

- never reveal or allow anyone else access to your personal identification number or password as these are, in fact, electronic signatures;
- inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else;
- change passwords at frequent and irregular intervals (as per agency policy);
- choose passwords that are not easily deciphered;
- log off when not using the system or when leaving the terminal;
- maintain confidentiality of all information, including all print copies of information;
- shred any discarded print information containing client identification;
- locate printers in secured areas away from public access;
- retrieve printed information immediately;
- protect client information displayed on monitors (e.g., use of screen saver, location of monitor, use of privacy screens);
- use only systems with secured access to record client information; and
- **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.**

B. Fax Transmission

Facsimile (fax) transmission is a convenient and efficient method for communicating information between health care providers. Protection of client confidentiality is the most significant risk in fax transmission and special precautions are required when using this form of technology.

Guidelines for protecting client confidentiality when using fax technology to transmit client information are as follows:

- locate fax machines in secured areas away from public access;
- check that the fax numbers and/or fax "distribution lists" stored in the machine of the sender are correct prior to dialing;
- carefully check activity reports to confirm successful transmission;
- include cover sheet warnings indicating the information being transmitted is confidential; also request verification that, in the event of a misdirected fax, it will be confidentially and immediately destroyed without being read;
- make a reasonable effort to ensure that the fax will be retrieved immediately by the intended recipient, or will be stored in a secure area until collected;
- shred any discarded faxed information containing client identification; and
- advocate for secure and confidential fax transmittal systems and protocols.

Client information received or sent by fax is a form of client documentation and is stored electronically or printed in hard copy and placed in the client's health record. As the fax is an exact copy of original documentation, additional notations may be made on the faxed copy as long as these meet the agency standards for documentation and are appropriately dated and signed. Faxes are part of the client's permanent record and, if relevant, can be subject to disclosure in legal proceedings. Faxed information is written with this in mind.

If a physician's order is received by fax, nurses use whatever means necessary to confirm the authenticity of the order.

C. Electronic Mail

The use of e-mail by health care organizations and health care professionals is becoming more widespread as a result of its speed, reliability, convenience and low cost. Unfortunately the factors that make the use of e-mail so advantageous also pose significant confidentiality, security and legal risks.

E-mail can be likened to sending a postcard. It is not sealed, and may be read by anyone. Because the security and confidentiality of e-mail cannot be guaranteed, it is not recommended as a method for transmission of health information. Messages can easily be misdirected to or intercepted by an unintended recipient. The information can then be read, forwarded and/or printed. Although messages on a local computer can be deleted, they are never deleted from the central server routing the message and can, in fact, be retrieved.

Having considered these risks and alternative ways to transmit health information, e-mail may be the preferred option to meet client needs in some cases. Guidelines for protecting client confidentiality when using e-mail to transmit client information are as follows:

- obtain written consent from the client when transferring health information by e-mail;
- check that the e-mail address of the intended recipient(s) is correct prior to sending;
- transmit e-mail using special security software (e.g., encryption, user verification or secure point-to-point connections);
- ensure transmission and receipt of e-mail is to a unique e-mail address;
- never reveal or allow anyone else access to your password for e-mail;
- include a confidentiality warning indicating that the information being sent is confidential and that the message is only to be read by the intended recipient and must not be copied or forwarded to anyone else;
- never forward an e-mail received about a client without the client's written consent;
- maintain confidentiality of all information, including that reproduced in hard copy;
- locate printers in secured areas away from public access;
- retrieve printed information immediately; and
- advocate for secure and confidential e-mail systems and protocols.

From the nurse's perspective, it is important to realize that e-mail messages are a form of client documentation and are stored electronically or printed in hard copy and placed in the client's health record. E-mails are part of the client's permanent record and, if relevant, can be subject to disclosure in legal proceedings. E-mail messages are written with this in mind.

Similar to physicians' orders received by fax, if physicians' orders are received by e-mail, nurses use whatever means necessary to confirm the authenticity of the orders.

D. Telenursing

Giving telephone advice is not a new role for nurses. What is new is the growing number of people who want access to telephone "help lines" to assist their decision-making about how and when to use health care services. Agencies such as health units, hospitals and clinics increasingly use telephone advice as an efficient, responsive and cost-effective way to help people care for themselves or access health care services.

Nurses who provide telephone care are required to document the telephone interaction. Documentation may occur in a written form (e.g., log book or client record form) or via computer. Standardized protocols that guide the information obtained from the caller and the advice given are useful in both providing and documenting telephone nursing care. When such protocols exist, little additional documentation may be required.

Minimum documentation includes the following:

- date and time of the incoming call (including voice mail messages);
- date and time of returning the call;
- name, telephone number and age of the caller, if relevant (when anonymity is important, this information may be excluded); and
- reason for the call, assessment of the client's needs, signs and symptoms described, specific protocol or decision tree used to manage the call (where applicable), advice or information given, any referrals made, agreement on next steps for the client and the required follow-up.

Telenursing is subject to the same principles of client confidentiality as all other types of nursing care.

6. Guidelines for Nursing Documentation

Familiarize yourself with agency policies on documentation and follow them, including policies on documenting verbal and telephone orders. Use professional judgment in applying these policies. In situations in which policy changes are necessary, advocate for the appropriate changes.

Follow these common guidelines for documentation:

1. **Write legibly in ink (paper-based system).**
   If the system is paper-based, write legibly in ink. Illegible entries and/or misspelled words can result in misinterpretation of information and possible client harm. Pencil is never to be used as it is not permanent and can be erased or changed. When using electronic documentation, the entries are made by the provider providing the care and not by other staff.

2. **Sign all entries.**
   Signatures or initials need to be identifiable, whether a paper-based or electronic system. In a paper-based system, sign all entries with first initial, last name and title (RN, LGN, SN). If using initials, the record must have a system to identify the care provider. Electronic signatures are generated automatically when a nurse logs into the computer system using a password.

3. **Document on agency forms.**
   Document on appropriate agency forms and clearly identify the client on both sides of every form.

4. **Correct errors.**
   Refer to the agency policy for the accepted means of correcting errors. In a paper-based system, the usual practice is to draw a single line through the error and make a notation "charting error" and initial. The correct entry is then recorded. Do not use whiteout, erasures or entries between lines. Do not leave blank lines between entries. If a blank line is inadvertently left, draw a line through the blank line so that no further entry can be made.

5. **Document in chronological order with the correct time and date for each entry.**
   If making a late entry, document "late entry" with the date and time of the entry and the time that the observation was made or the care was given. If extensive time has elapsed, a "note to file" should be included in the record.

6. **Document concurrently or as close as possible to the time care was given.**
Document as close as possible to the time care was performed to reflect ongoing client assessments, changes to care plans, nursing interventions carried out and the impact of those interventions on client outcomes. In high-risk situations, this becomes even more important. Delayed recording increases the potential for omission, error and inaccuracy due to memory lapse. Pooling observations to record at the end of the nurse's shift is not recommended.

7. **Write concisely and factually.**
Document concisely and factually, using precise language. Do not offer your opinions. If the client slept from 0300 to 0500 hours, document this. Using such phrases as "slept poorly" does not describe what actually occurred. It is not necessary to repeat information that is stated elsewhere in the health record, such as on a flow sheet. Only issues related to client care are recorded in the health record. Professional practice issues are not documented in the health record (e.g., if Digoxin is given 2 hours late, chart the time the Digoxin was given; do not chart "Mary forgot to give Mr. C. his Digoxin, therefore I am giving it two hours late").

8. **Avoid bias.**
Describe observations and behaviour of the client rather than "label" a client. An entry such as "manipulative" does not describe the behavior. Inaccuracies can result in inappropriate care decisions and client injury. If the accuracy of a nurse's charting is questioned in a court of law, questions might be raised about the credibility of both the documentation and the nurse.

9. **Use appropriate abbreviations.**
Use only abbreviations that are on the agency approved abbreviation list or in an agency approved reference text.

10. **Document only from first-hand knowledge.**
Whether using a paper-based or electronic system, document or enter into a computer only from first-hand knowledge and only for the care you provide.

    An exception is an emergency, such as a cardiac arrest, when one registered nurse will be designated as recorder and will document the care provided by other health professionals.

11. **Care provided by auxiliary staff is documented by auxiliary staff.**
If agency policy is such that auxiliary staff does not record, then document their report to you and include their names and status. If possible, have auxiliary staff read and initial (if a paper-based system) the documentation.

12. Safeguard the confidentiality of documentation.

Consider the importance of confidentiality in accessing, storing, retrieving and transmitting any part of the client record. Nurses disclose confidential information only as authorized by the client, unless there is substantial risk of serious harm to the client or other persons, or a legal obligation to disclose. Refer to the RNABC publication, *Confidentiality for Nurses* (pub. 382) for a discussion of specific situations.

7. Common Questions about Documentation

1. What information is included in the progress notes?

Progress notes (nurses' notes) are used to communicate nursing assessments, interventions carried out, and the impact of these interventions on client outcomes. In addition, progress notes are intended to include:

- client assessments prior to and following administration of PRN medications;
- information reported to a physician or other health care provider and, when appropriate, that provider's response;
- all client teaching;
- all discharge planning, including instructions given to the client and/or family and planned community follow-up;
- all pertinent data collected in the course of providing care, including data collected through technology such as monitoring devices (e.g., strips produced during cardiac or fetal monitoring); and
- advocacy undertaken by the nurse on behalf of the client.

2. What is considered "timely" documentation?

The timeliness of documentation will be dependent upon the client. 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. Graphically, this is shown as follows:

	Low	Med	High
Acuity			→
Complexity			→
Variability			→
Frequency of documentation	→	→	→

3. Who owns the health record?

The self-employed nurse or the agency in which the client's health record is compiled is the legal owner of the record as a piece of physical or electronic property. The information in the record, however, belongs to the client. Clients have a right of access to their records and to protection of their privacy with respect to the access, storage, retrieval and transmittal of the records. The rights of clients and obligations of public agencies are outlined in the Freedom of Information and Privacy Act and are often summarized in agency policies.

4. How does the Freedom of Information and Protection of Privacy Act (FOIPPA) affect documentation?

The FOIPPA provides the legislative framework for information and privacy rights. This act applies to all public bodies, including hospitals, health authority boards, RNABC and similar organizations. The legislation gives the public a right of access to records held by one of these public bodies. Individuals have a right of access to personal information about themselves (including their health records) and a right to request correction of such information. The act also prevents the unauthorized collection, use or disclosure of personal information by a public body.

5. Is the information in the client's health record confidential?

Yes. Information in the health record is considered confidential. Client consent for disclosure of this information to agency staff for purposes related to care and treatment is implied upon admission, unless there is a specific exception established by law or agency policy. Client consent is required if the contents of the health record are to be used for research or if any client information is to be transmitted outside the agency.

Nursing documentation must be produced according to agency policy when:

- clients request access to their personal records;
- RNABC, under the Nurses (Registered) Act, needs to inspect or investigate records;
- a subpoena is provided (e.g., negligence suit); or
- a statutory mandate requires the release of the information (e.g., reporting communicable diseases or child abuse).

6. Do clients have access to their health record?

Yes. The Standards for Nursing Practice in British Columbia require that nurses provide clients, in appropriate circumstances, with access to their health records or assist them to obtain access to these records. These standards are consistent with the Freedom of Information and Protection of Privacy Act whereby clients can submit written requests for access to their records or for information that might otherwise not normally be provided. Refer to agency policy as to the process to follow when clients request access to their health records.

7. What happens to third party information when information in a health record is to be released?

Nurses may obtain relevant information about a client or an incident from another person, such as the client's family member or friend. Nurses may also learn information about a third party that is relevant to the client. When a client's record has another person's name on it or contains information about another person - especially if the information was given in confidence - the record may need to be "severed" before it is released. This means that some portions of the record are removed and not released to the client requesting the record. For example, if the client's record included the name of a friend of the client or

another client, the section of the record that includes this information would need to be removed before releasing the record to the client.

8. How is client information contained in communication books and shift reports communicated?

Communication books and shift reports are used to alert the health care team to critical information. These tools are used to direct others to the health record where the pertinent information is recorded in detail. Relevant health information communicated by these tools is documented in the health record (College of Nurses of Ontario, 2002).

9. Should I document incidents where calls are made because of a concern about a specific client but are not returned?

It is important to document only facts on client health records. In cases where calls are made because of a concern about a specific client, a notation of these calls is made in the progress (nurses') notes. A notation is made after each call, regardless of whether the call was returned. If a call is returned, that is noted.

10. Under which circumstances are verbal orders appropriate?

Telephone orders

Orders accepted over the telephone are generally made without the physician's direct assessment of the client's condition. Decisions are based solely on the nurse's assessment of the client. Any miscommunication or lack of communication could lead to negative implications for the client. Errors in recording telephone orders can also occur and there is always the question of who made the error, the physician in ordering, or the nurse in recording. Despite these concerns, there are times when telephone orders may be the best option for the client - in these cases, the nurse makes himself/herself aware of the agency's policy with regard to accepting and documenting telephone orders. Orders left on answering machines are not acceptable.

Documenting Telephone Orders

- Write down the time and date on the physician's order sheet.
- Write down the order given by the physician.
- Read the order back to the physician to ensure it is accurately recorded.
- Record the physician's name on the physician's order sheet, state "telephone order," print your name, sign the entry and identify your status (e.g., RN).

On-site verbal orders

On-site verbal orders also have the potential for error and are avoided unless in an emergency situation, such as a cardiac arrest. Nurses need to be aware of the agency's policy with regard to accepting and documenting on-site verbal orders. Of nursing staff, only registered nurses take verbal orders (and telephone orders) pertaining to medications.

Orders taken verbally and recorded by pharmacists

In B.C., pharmacists can accept and record verbal orders from physicians to dispense medications. In these circumstances, nurses can carry out the orders from the label on the dispensed medication.

11. Should chart pages or entries be recopied?

Under no circumstances are chart pages or entries recopied. Errors are corrected according to agency policy. If information is difficult to read, then add information in a "note to chart" or "note to file."

12. How are "after the fact" notes developed by nurses for potential use in the future handled?

There are occasions when nurses write notes "after the fact" (e.g., one day later, one week later), most often to provide clarification following an "incident" or an unexpected client outcome. Nurses usually write these notes while the event is current in the nurse's memory, in case of an investigation or lawsuit at a later date. It is recommended that nurses do not keep these notes at home but provide them to a supervisor or risk manager within the agency for safe keeping.

13. How long do health records need to be kept?

Self-employed nurses and agencies should have policies on the retention of health records and client documentation. Current legislation needs to be considered in the development of these policies. Legislation differs, depending upon the setting. In all settings, records

which contain references to blood or blood products must be maintained in perpetuity (MOH communication, 1996/1997). In other words, these records must be kept forever.

In acute care hospitals, documents contained in the health record may be considered primary, secondary or transitory. Records are kept for the following time periods (from date of discharge):

- Primary documents (e.g., physicians' orders, nursing admission assessment, consultations, discharge summary, and notice of death): ten years
- Secondary documents (e.g., most diagnostic reports, medication records, flow sheets and nurses' notes): six years
- Transitory documents (e.g., diet report, graphic chart): one year

Depending upon agency policy, records of minors may be required to be kept longer than the time periods listed above.

In community care, public health and mental health settings, client records of adults are generally kept for ten years and minors for 25 years from the date of service.

Some exceptions apply to the timeframes listed above, requiring certain practice settings to have longer retention periods (e.g., forensic mental health). Nurses need to be aware of agency policy and legislation impacting these retention periods.

14. What records are self-employed nurses required to keep?

Self-employed nurses must have a documentation system. What is recorded will depend on the type of service offered. Forms can be simple and still address nursing assessment, plans, interventions and client outcomes. The RNABC document, *The Self-Employed Nurse* (pub. 123) provides direction on documentation requirements for self-employed nurses and is available from the RNABC Helen Randal Library.

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