NOVA SCOTIA COLLEGE OF NURSING

DOCUMENTATION FOR NURSES

The Nova Scotia College of Nursing (NSCN) is the regulatory body for licensed practical nurses (LPNs), registered nurses (RNs) and nurse practitioners (NPs) in Nova Scotia. Our mandate is to protect the public by promoting the provision of safe, competent, ethical and compassionate nursing services by our registrants. The term nurse in this document refers to LPNs, RNs and NPs unless otherwise stated.

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Introduction

The Nova Scotia College of Nursing is legislated to serve and protect the public interest through the regulation of individual registered nurses (RNs), nurse practitioners (NPs) and licensed practical nurses (LPNs). Only RNs, NPs and LPNs or students of a nursing program can use the term nurse; therefore, in this document, the term nurse(s) will refer to all three classes (Nursing Act, 2019).

Nursing documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic. This document describes nurses' accountability and the expectations for documentation in all practice settings, regardless of the documentation method or storage. This, as with all College documents, should be used in conjunction with *Standards of Practice*, *Code of Ethics* and all applicable practice guidelines and agency policies.

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Our practice support tools are developed using current reference material. The source of this material is available upon request.

Definition

Documentation is written or electronically generated information about a client that describes the care, including the observations, assessment, planning, intervention and evaluation or service provided to that client. Documentation is an integral part of professional nursing and safe practice. **Documentation is not optional**.

Professional Principles of Documentation

Nurses must follow agency documentation policies, standards and protocols. If no policies exist, nurses may use this document, while relying on their Standards of Practice, best practices and their professional judgment to guide their documentation. Additionally, the nurse has a professional responsibility to advocate for the creation of policies to support nursing documentation.

Essential Characteristics of Nursing Documentation	Nursing Documentation Should Contain:
Factual, objective and client centered	Descriptive and objective information based on first-hand knowledge, the nurse's assessment and the client's perception of their needs
Accurate and relevant	Clear and easy to understand information containing sufficient details about the client's care and/or variances in the client's response(s) to care
Complete (including nursing actions and client responses)	All of the components of the nursing process
Current	Information that is up-to-date and is recorded during or as soon as possible after the intervention or interaction occurred
Organized, logical and sequential	Information is in a chronological manner so that nursing decisions, nursing actions and client responses to actions are evident
Compliant with standards of practice and other legal requirements	Information reflects the delivery of safe, competent, ethical and compassionate nursing care and is consistent with standards of practice (RN Standard 2.6, LPN Standard 1.10), employer policies and provincial and/or federal legislation

Confidentiality

Health care professionals should view the security of client documentation as a serious issue. Failure to comply with legislation[1], falsifying information or providing information without the client or agency's consent may constitute professional misconduct.

Sharing confidential information is only acceptable in an effort to support the provision of quality care with health care team members who are a part of the client's circle of care. Documentation, in any format, should be maintained in areas where the information cannot be easily accessed by casual observers or those not directly involved in the care of the client.

Health records maintained in a client's home should be stored in a manner to reduce the risk of family members or others (e.g., visitors, guests) accessing confidential information. Agencies should have policies outlining who has access the health records and how clients and their family members are made aware of the importance of maintaining confidentiality.

Technology does not change a client's rights to privacy of their health information. Maintaining confidentiality (including access, storage, retrieval and transmission) of the client's health record is essential regardless of its format.

1 There may be legislation which requires mandatory report (i.e. Gunshot wounds) which require the nurse to report

Why is Documentation Important?

THE PURPOSE OF NURSING DOCUMENTATION

The basic purpose of nursing documentation is the creation of a database or a health record of a client's experience with the health care system, (Ioanna, Stiliani & Vasiliki, 2007; Beach and Oates, 2014; Prideaux, 2011). Nursing documentation demonstrates what the nurse does for/with the client (Jefferies, Johnson & Griffiths, 2010) and is one part of the broader interprofessional documentation that forms the client health record. The health record is made up of a number of interprofessional tools and documentation that provides evidence of the care, treatment or service a client receives, (Beach and Oates, 2014). Quality documentation is important in today's health context for a variety of reasons:

Purpose of Documentation	Rationale
Communication among the health care team	Quality documentation supports the exchange of pertinent client information among the interprofessional care team
Continuity of Care	All members of the health care team require accurate information about clients to ensure the development of organized comprehensive care plans. Inaccurate or incomplete documentation can lead to fragmented care, repetition of tasks and delay or omission of therapies (Perry, Potter, Stockert & Hall 2017).
Professional Accountability	Documentation is one way nursing knowledge, judgment and skills are demonstrated. Nurses are expected to follow their professional standards and Code of Ethics.
Legal	The client's record is a legal document and can be used as evidence in a court of law or professional conduct proceedings. Courts may use the health record to reconstruct events, to establish time and dates, to refresh one's memory and to substantiate and/or resolve conflicts in testimony (CNPS, 2009).
Quality Assurance	Through chart audits and performance reviews documentation is used to evaluate the quality of services and appropriateness of care.
Funding and Resource Management	The analysis of quality documentation supports the allocation of resources, workload measurement and fiscal utilization (Potter, Perry, Stockert & Hall 2017).
Research	Data obtained from health records is used in health research to assess nursing interventions, to evaluate client outcomes and to determine the efficiency and effectiveness of care.

Who Has a Role in Documentation?

FIRSTHAND KNOWLEDGE

Legislation and *Standards of Practice* require nurses to document the care they provide to demonstrate accountability for their actions and decisions. Firsthand knowledge means the professional who documents is the same individual who provided the care. In situations where two or more people provide care or services, the nurse who has the primary assignment is expected to document the assessment, interventions and client response, noting the role of other care providers, as necessary However, the second provider is expected to review the documentation and to make an additional entry if necessary.

There may be an occasion when a nurse realizes after their shift and they have left for the day that they did not document care they provided. For example, a nurse leaves for the day and realizes they had forgotten to document an issue and calls back to the unit to inform their colleagues. In these rare circumstances, another nurse, if requested can document the information, with the date, time and designation of the person from which it was received in the client record, as per agency policy.

DESIGNATED RECORDER

In emergency situations (e.g., cardiac arrest) where it may not be possible for the nurse providing care to document, it is acceptable to have a designated recorder. Agency policy should support the practice of designated recorders in these situations.

CLIENT OR FAMILY

In some settings, a client or their family members may be permitted document their observations and the care they provided in the client record. Agency policy should outline this process for the client and their family members, as well as the documentation responsibilities of nurses.

> Unregulated care providers should document care they provide. If they are unable to document their care due to agency policy, nurses should advocate for a change to this policy to ensure nurses are able to meet their professional standards

STUDENTS

Students are expected to document the care they provide in accordance with agency and academic policies. Co-signing notes written by students is not acceptable and may add a level of accountability for the nurse (SRNA, 2011). It may be necessary for the nurse who is acting as the preceptor to document their own assessment, interventions and evaluations. The need for this extra level of documentation must be based on agency policy and professional judgment.

SELF-EMPLOYED NURSES

Self-employed nurses must adopt a documentation system and develop appropriate policies, including those related to the storage, retrieval and retention of health records. NSCN has practice guidelines to support nurses who are self-employed.

Co-Signing and Countersigning Entries

Co-signing refers to a second or confirming signature of a witnessed event or activity (ARNNL, 2010). Co-signing entries made by other care providers is not a standard of practice and when poorly defined, can blur accountability (CNO, 2008). If two nurses are involved in an assessment or the delivery of care, both should document according to agency policy. For example, if two nurses are required to hang a unit of packed-cells, and both must sign the health record, the intent of a co-signature should be clearly stated in policy. In this case, agency policy could indicate that the co-signature is confirmation that the nurse (co-signee) witnessed that the correct unit was given to the correct client. Co-signing implies shared accountability therefore the person co-signing needs to witness or participate in the event (SRNA, 2011).

Countersigning is defined as a second or confirming signature on a previously signed document, which is not witnessed (SRNA, 2011). This is not best practice and is generally not supported, but may be used as a quality control process. For example, in a 24-hour chart review, a nurse reviews a chart to determine if all the orders are accurately transcribed or all required interventions are completed. Countersigning does not imply that the second person provided the service but it does imply that the person approved or verified that the service or record was completed. Agency policy and procedure should be in place to support this practice.

Key Elements of Professional Nursing Documentation

ALL ASPECTS OF THE NURSING PROCESS

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, such as;

PROVIDING CARE TO GROUPS

When documenting for groups or communities the documentation should provide a clear picture of:

- The needs or goals of the groups
- The nurse's actions based on the needs assessment
- The outcomes and evaluations of those actions

Information about individual clients within the group may be recorded in the individual client's health record (CRNBC, 2017). Agency policy will direct where this information is recorded

> If the client is receiving services from two or more agencies or departments that have separate records (e.g. Health and Justice) it is important that the nurse follows agency policy and record the care they provided in all relevant documents.

PLAN OF CARE

Effective client-focused documentation should include a plan of care. A plan of care an individualized, comprehensive and current guide to clinical care designed to identify and meet clients' health care needs. It may or may not be developed by nurses in collaboration with other members of the health care team, including clients. For more information on the plan of care see the NSCN *Nursing Plan of Care Practice Guidelines* or *The Professional Practice Series: The Nursing Care Plan*.

ADMISSION, TRANSFER, TRANSPORT AND DISCHARGE INFORMATION

Accurate and concise documentation on admission, transfer, transport and discharge provides baseline data for planning subsequent care and follow up. Agency policy should identify expectations on recording communication between practitioners when a client's care is transferred. Nursing documentation should include 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 the client's family involvement as appropriate.

CLIENT EDUCATION

Nurses provide a wide range of client education on a daily basis. Accurate documentation of this education is essential to enable effective communication and continuity of what has been taught. 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 client and /or family
- evaluation of teaching objectives with validation of client comprehension and learning
- any follow up required

SERIOUS REPORTABLE EVENTS (SRES)

An serious reportable event (SRE) or occurrence is an event which is not consistent with the routine, expected care of a client or the standard procedures in place in a practice setting (Perry, Potter, Stockert & Hall 2017). Examples include patient falls, medication errors, needle stick injuries, or any circumstance that places clients

or staff at risk of injury. Serious reportable events which involve clients are generally recorded in two places: in the client's medical record and in a SRE report, which is separate from the chart.

> The purpose of a health record and SRE report differs. Therefore, for the sake of clarification, the nurse should avoid documenting "refer to SRE report" in a client's health record.

Documentation of a SRE in the chart should be recorded by the person who witnessed the event. The documentation should be accurate, concise, factual, unbiased and should not contain the words "error", "incident" or "accident". The nurse should first document the SRE in the health record to ensure continuity and completeness, and then complete a SRE report in accordance with agency policies.

Serious reportable event reports (also called occurrence reports or adverse event reports) are separate from the client record and are used by agencies for risk management, to track trends and to justify changes to policy, procedure and/or equipment. Information included in a SRE report is similar to the information included in a client's health record, however, the SRE report also includes additional information about the particular SRE (e.g., "a door was broken" or "this was the fourth such occurrence this week"), which is not directly related to the care of the client. Agency policy should clearly describe processes necessary to complete a SRE report.

MEDICATION ADMINISTRATION

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

- Date
- Actual time medications are administrated
- Name(s) of medications
- Route(s) of medications
- Sites of administration when appropriate
- Dosage administered
- Nurses signature/designation

Each individual health care provider (e.g., respiratory therapists, physiotherapists) should sign for the medications they administer, except in emergency situations. In emergency situations, nurses may sign for medications administered by other health care providers as long as this is supported by agency policy.

For more information about Medication Administration see the NSCN *Medication Guidelines for Registered Nurses* or *The Professional Practice Series: Medication Administration*.

VERBAL ORDERS AND TELEPHONE ORDERS

Authorized prescribers are expected to write orders whenever possible. Verbal orders should only be accepted in emergent or urgent situations where the prescriber cannot document their medication orders. Telephone orders should be limited to situations when the prescriber is not present. The prescriber may be accountable to review and co-sign their verbal or telephone orders as soon as reasonably possible or within the timeframe indicated in an agency's policy.

For more information about verbal and telephone orders see the NSCN *Medication Guidelines for Registered Nurses* or *The Professional Practice Series: Medication Administration*.

TEXT AND EMAIL ORDERS

Increasing numbers of health care professionals are using mobile devices to communicate prescriber orders by text message or email. This type of communication is discouraged due to the risk of violation of confidential health information and incomplete communication of client status.

Unauthorized disclosure of client's personal health information (PHI) is a risk because mobile devices can store and retain data on the device itself. Also, mobile devices are vulnerable to loss and theft because of their small

size and portability (CNPS, 2013). Encryption and the use of strong passwords are the most effective way to safeguard a client's PHI. Without encryption, any emails, voicemails, pictures or text could be inappropriately accessed or disclosed if the mobile device is lost, stolen or inadvertently viewed by another person.

Vital information related to the context of the client assessment may be lost when using text or email to communicate. Text can be subject to interpretation and lead to inappropriate, incomplete or insufficient prescriber orders.

Text or email should not be used for provider convenience; however, if text or email communication is the only way health professionals can communicate in the best interest of the client, agencies must have policies to support this practice. Policies, protocols and systems should enable health care practitioners to use secured wireless devices to interact with each other and to access client records.

COLLABORATION WITH OTHER HEALTH CARE PROFESSIONALS

Interdisciplinary communication and documentation supports interdisciplinary practice and can eliminate duplication, enhance efficient use of time and enrich client outcomes. Collaborative documentation enables health care professionals of all disciplines to share the same documentation tools. Examples of such tools are clinical pathways and integrated interdisciplinary client progress notes.

Nurses need to ensure their documentation within an interdisciplinary tool accurately reflects the unique contribution of nursing to the care of clients.

When nurses collaborate with members of the interdisciplinary team to develop and/or modify the plan of care, they should document the following:

- date and time of the contact
- name(s) of the people involved in the collaboration
- information provided to or by health care providers
- responses from health care providers
- orders/interventions resulting from the collaboration
- the agreed upon plan of action
- anticipated outcomes

For example, if a nurse seeks clarification from a physiotherapist related to mobilization of a client the nurse should record the reason for seeking clarification, the name of the health care provider responsible for the clarification, the action they took and the expected outcome.

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.

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

OBJECTIVITY VS SUBJECTIVITY

Objective information deals with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam- Webster Online, 2017). 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.

Subjective data is modified or affected by personal views, experience, or background (Merriam- Webster Online, 2017). Subjective data may include information provided by a client as well as from the client's family members or a friend.

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 information should provide accurate examples of what was said using quotes appropriately along with identification of the individual who made the statement. For example, client states, "I am pain-free today" or "I understood the information provided".

AVOID GENERALIZATIONS

Avoid generalizations and vague phrases or expressions such as "status unchanged", "assessment done", "had a good day", "slept well" or "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" are not acceptable when used without supporting factual information because they lack certainty.

AVOID BIAS AND LABELS

Only document conclusions that can be supported by data and avoid value judgments or unfounded conclusions. Select neutral terminology or describe observed behaviors. For example, rather than stating that the "client was drunk" it would be correct to state, "noted an odor of alcohol and speech was slurred". Instead of noting, "client is aggressive" it would be correct to state, "client has been shouting and using obscene language".

RISK TAKING BEHAVIOURS

Nurses have an ethical responsibility to respect a client's informed choice, even if these choices may be risky to their overall health. The nurse must document the objective data related to the risk taking behaviours and avoid placing a value judgment on the behaviors. The nurse should also document information they provide to the client about the risk taking behaviour and any potential consequences of the behavior. It is not acceptable to document the client as "non-compliant". Instead, the nurse should document the objective data that describes this behavior.

If the risk taking behavior results in a situation in which mandatory reporting must occur, the nurse is required to follow the legislation and document appropriately.

LEGIBILITY AND SPELLING

Correct spelling and legibility of nursing documentation demonstrates attention to detail and nursing competence. Misspelled words or illegible entries can result in misinterpretation of information and could result in client harm. Spelling errors can result in serious treatment errors. For example, the names of certain medications, such as digitoxin and digoxin.

All entries in a paper-based system should be written legibly in accordance with agency policy related to the type and colour of writing instrument and the colour of paper used.

BLANK (WHITE) SPACE

Blank or white space in paper-based documents should be avoided as this presents an opportunity for others to add information unknown to the original author. An accepted practice is to draw a single line completely through the white space, including before and after your signature. Fill in all blocks or spaces on flow sheets with the agency approved symbol or comment.

ABBREVIATION, SYMBOLS AND ACRONYMS

The use of abbreviations, symbols or acronyms can be an efficient form of documentation if their meaning is well understood. Abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors. Use only those abbreviations, symbols and acronyms on a current agency-approved list.

Click here to review the list of error prone abbreviations developed by the Institute of Safe Medication Practice.

ERRORS AND CHANGES

Inaccurate 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 that 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. 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.

To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove chart pages. Entries should not be re-copied or removed because of a documentation error.

CLIENT CARE PROVIDED THROUGH ELECTRONIC MEANS

Today in Nova Scotia many agencies have moved towards electronic means of providing many aspects of care. Electronic documentation is now part of the everyday care of many clients. This could include entering requests for tests and consultations, reporting diagnostics testing, or documenting care provided.

> Failing to correct an error appropriately (according to agency policy) or correcting or modifying another's documentation may be interpreted as falsification of a record. Falsifying records is considered professional misconduct.

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 paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care. Entries are made by the nurse 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. Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

Agencies need to have clear policies and guidelines to address these challenges and other issues related to documentation for electronic health records. Nurses 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 (e.g., 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

USING FAX TECHNOLOGY TO TRANSMIT CLIENT INFORMATION

Facsimile (fax) transmission of client information between health care 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.

The confidentiality and security of transmitting client information via fax can be enhanced by:

Guidelines	Rationale
Locate fax machines in secured areas away from public access.	Decreases the likelihood of an unintended breach of client confidentiality.
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.	
Carefully check activity reports to confirm successful transmission.	Ensures that the fax was sent and is not sitting in the queue to be resent or accessed by someone else.
Include a cover sheet with a Confidentiality Statement that identifies the fax document as confidential and instructs unintended recipients to immediately destroy the document without reading it.	This is a safeguard that make the unintended recipient accountable for any actions they may take with information incorrectly sent to them.
Advocate for secure and confidential fax transmittal systems and policies.	This is an important leadership action that contributes to quality practice environments.

Client information received or sent by fax is a form of client documentation and should be stored electronically or printed in hard copy, appropriately labeled with the necessary client information and placed in the client's health record. Faxes are part of the client's permanent record and can be subject to disclosure in legal proceedings.

E-MAIL

The use of electronic mail (e-mail) transmission by health care agencies and health care professionals is becoming more widespread because of its speed, reliability, convenience and 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.

Guidelines	Rationale
Obtain client consent before transferring health information by e-mail as dictated by policy.	Even with safeguards, transmitting information by email has a higher risk. The client should be informed about the process and any potential risks.
Transmit e-mail using special security software (e.g., encryption, user verification or secure point-to-point connections).	Encryption safeguards against hacking and unauthorized persons from accessing client information.
Never allow anyone else access to your password for e-mail.	Sharing passwords is a risk prone activity because it allows access to client information under your name. Nurses that share their passwords or do not take reasonable steps to protect their passwords may be held accountable for any activity in their name.

Guidelines	Rationale
Check that the e-mail address of the intended recipient(s) is correct prior to sending.	Decreases the likelihood of an unintended breach of client confidentiality.
Ensure transmission and receipt of e-mail is to a unique e-mail address.	
Maintain confidentiality of all information, including that reproduced in hard copy.	
Locate printers in secured areas away from public access.	
Retrieve printed information immediately.	
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.	This is a safeguard that make the unintended recipient accountable for any actions they may take with information incorrectly sent to them.
Never forward an e-mail received about a client without the client's written consent.	The client must grant permission for their information to be shared with others.
Advocate for secure and confidential e-mail systems and policies.	This is an important leadership action that contributes to the quality practice environments.

TELENURISNG

Giving telephone advice is not a new role for nurses. What is new is the growing number of people accessing 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 support self care or to provide health services. Telenursing is subject to the same principles of client confidentiality as all other types of nursing care.

Nurses that 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. Minimum documentation includes the following:

- date and time of the incoming call (including voice mail messages)
- name, telephone number and age of the caller, if relevant (when anonymity is important, this information may be excluded)
- reason for the call, assessment findings, 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

For further information on telenursing see the NSCN *Telenursing Practice Guidelines* or the *Telenursing* document.

When timing matters

TIMELY, CHRONOLOGICALLY AND FREQUENTLY

Documentation should occur as close as possible to the time of care to enhance credibility and accuracy of health care records (CARNA, 2013). Documentation should never be completed before it actually takes place.

Documenting events in the chronological order is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications, regarding the care provided, the assessment data, and 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:

- agency policies and procedures
- complexity of a client's health problems
- degree to which a client's condition puts the client 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 client is very ill, very unpredictable or exposed to high risk (Canadian Nurses Protective Society, 2007, p.2).

The following table demonstrates how as clients change the frequency of documentation should also change:

	LOW	MEDIUM	HIGH
ACUITY →			
COMPLEXITY →			
VARIABILITY →			
FREQUENCY OF DOCUMENTATION →			

LATE 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 or corrections incorporating omitted information in a health record should be made only when a nurse can accurately recall the event or care provided. Late entries must be clearly identified, individually dated and follow agency policy. 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. If extensive time has elapsed between the care and the documentation entry, seek guidance from your employer before adding notes (CRNBC, 2017)

Conclusion

Nurses should recognize that the documentation of their nursing decisions and actions is equally as valuable, professionally and legally, as the direct care provided to clients. Quality documentation is an important element of nursing practice, essential to positive client outcomes and a key component of meeting their Standards of Practice.

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Appendix - Legislation affecting Nursing Documentation

FEDERAL

Access to Information Act
http://laws-lois.justice.gc.ca/eng/acts/A-1/index.html

Controlled Drugs and Substances Act
http://laws-lois.justice.gc.ca/eng/acts/C-38.8/index.html

Personal Information Protection and Electronic Documents Act
http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html

Privacy Act
http://laws-lois.justice.gc.ca/eng/acts/P-21/index.html

For information on where to obtain copies of current federal legislation, call the Government of Canada Inquiry Centre at 1-800-O Canada or visit the Department of Justice website at http://laws.justice.gc.ca.

PROVINCIAL

Freedom of Information and Protection of Privacy Act
http://nslegislature.ca/legc/statutes/freedom%20of%20information%20and%20protection%20of%20privacy.pdf

Health Act
http://nslegislature.ca/legc/statutes/health.htm

Health Protection Act
http://nslegislature.ca/legc/statutes/health%20protection.pdf

Homes for Special Care Act
http://nslegislature.ca/legc/statutes/homespec.htm

Hospitals Act
http://nslegislature.ca/legc/statutes/hospitals.pdf

Nursing Act (2019)
https://nslegislature.ca/legc/bills/63rd_2nd/3rd_read/b121.htm

Occupational Health and Safety Act
http://www.nslegislature.ca/legc/statutes/occupational%20health%20and%20safety.pdf

Personal Health Information Act
http://www.nslegislature.ca/legc/bills/61st_2nd/3rd_read/b089.htm

Persons in Protection of Care Act
http://novascotia.ca/dhw/ppcact/

For more information or to obtain copies of current provincial legislation, visit the Government of Nova Scotia Publications website https://publications.nsgos.acol.ca/SetLocale.action?locale=en_CA.