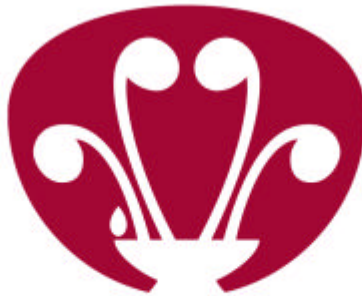


***Practice Standard:***  
**DOCUMENTATION**



**Nurses Association**  
OF NEW BRUNSWICK



#### **MANDATE**

**The Nurses Association of New Brunswick is a professional organization that exists to protect the public and to support nurses by promoting and maintaining standards for nursing education and practice, and by advocating for healthy public policy**

**The Nurses Association of New Brunswick endorses the principles of self-regulation, that is, promoting good practice, preventing poor practice and intervening when practice is unacceptable.**

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**ISBN 1 895613-60-4**



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**Practice Standard: Documentation (2/11)**

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## Acknowledgements

The Nurses Association of New Brunswick gratefully acknowledges permission granted by the College of Nurses of Ontario to quote and adapt, in whole, or in part, from the publications cited.

## Introduction

Nurses<sup>1</sup> are required to make and keep records of their professional practice. As self-regulated professionals, nurses are accountable for ensuring that their documentation is accurate and meets the NANB Practice Standard: Documentation—whether paper, electronic, or audio—is used to monitor a client’s condition, client progress and communicate with other care providers. It also reflects the nursing care that is provided to a client.

This Practice Standard explains the regulatory and legislative requirements for nursing documentation. To help nurses understand and apply the standards to their individual practise, the content is divided into three standard statements that describe broad practice principles. Each statement is followed by corresponding indicators that outline a nurse’s responsibility and accountability when documenting. They also provide guidance on applying the standard statements to a particular practice environment.

To further support nurses in applying the standards, the Document includes appendices containing important supplementary information and a list of suggested readings. Appendix A provides strategies for nursing professionals, to support quality documentation practices in their work settings. Appendix B includes a list of provincial and federal legislation governing nursing documentation.

## Principles

Nursing documentation:

- reflects the client’s perspective, identifies the caregiver and records nursing care provided including client’s health outcome;
- promotes continuity of care through interprofessional communication;
- demonstrates the nurse’s commitment to providing safe, competent and ethical care;
- demonstrates that the nurse has applied the nursing knowledge, skill and judgement required by professional and ethical standards, relevant legislation, and employer’s policies.

Whether documenting for individual clients, or for groups or communities, documentation should provide a clear picture of: the needs or goals of the client or group; the nurse’s actions based on the needs assessment; and the outcomes and evaluation of those actions.

## Purpose

Data from documentation has many purposes:

- to identify the care and services a client requires or care that was provided;
- to inform quality improvement processes;
- to review client outcome information, to reflect on the nurse’s own practise and identify knowledge gaps that can form the basis of learning plans;
- to be a valuable source for data collecting in health related research;
- to be used as a source of information in making funding and resource management decisions; and
- to use in legal investigations and other legal proceedings.

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<sup>1</sup>

For this document, the term nurse includes registered nurses and nurse practitioners

## Standard 1: Communication

***Nurses document accurate, pertinent and comprehensive information concerning the condition of the client, the client's needs, the nursing interventions and the client health outcomes.***

### INDICATORS

The nurse:

- 1.1 ensures that documentation is a complete record of nursing care provided by the individual nurse and reflects all aspects of the nursing process, in a chronological order, including: assessment, planning, intervention (independent and collaborative) and evaluation;
- 1.2 documents both objective and subjective data;
- 1.3 ensures that the nursing plan of care is clear, current, relevant and individualized to meet the client's needs and requests;
- 1.4 documents significant communication with family members/significant others, substitute decision-makers and other care providers (noting the date and time of communication);
- 1.5 documents any advocacy that was undertaken on the client's behalf. For example, when the nurse has repeatedly tried to contact a provider without success, documenting what other channels have been pursued to obtain needed clinical direction;
- 1.6 ensures that relevant client care information kept in temporary hard copy documents is captured in the permanent health record, if the electronic system is unavailable;
- 1.7 provides a full signature or initials, and professional designation (RN, GN, NP or GNP) with all documentation;
- 1.8 provides a full signature, initials and designation on a master list prior to initialing documentation and adheres to all employer requirements for electronic signature;
- 1.9 ensures that hand-written documentation is legible and completed in permanent ink;
- 1.10 uses abbreviations and symbols appropriately, by ensuring that each has a distinct interpretation and that each is approved by the organization or practice setting;
- 1.11 documents advice, care or services provided to an individual within a group, communities or populations (for example, group education sessions);
- 1.12 documents the nursing care provided when using information and telecommunication technologies (for example, providing telephone advice); and
- 1.13 documents informed consent\* when the nurse initiates a treatment or intervention.

\*The *CNA Code of Ethics for Registered Nurses (2008)* defines 'informed consent' as: "the process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research."

## Standard 2: Accountability and Liability

***Nurses document according to professional and ethical standards, relevant legislation and employer's policies.***

### INDICATORS

The nurse:

- 2.1 documents and completes documentation during, or as soon as possible after, the care or event;
- 2.2 documents the date and time that care was provided and when it was recorded;
- 2.3 documents in chronological order;
- 2.4 indicates when an entry is late as defined by organizational policies;
- 2.5 documents at the next available entry space, not leaving empty lines for another person to add documentation (when using paper documentation forms). If there are empty lines, the nurse should draw a line from the end of the entry to the signature. When using an electronic system, the nurse should refrain from leaving a space in a free-flow text box;
- 2.6 corrects mistaken entries while ensuring that the original information remains visible/retrievable, as defined by organizational policies;
- 2.7 never deletes, alters or modifies anyone else's documentation;
- 2.8 documents any unanticipated, unexpected or abnormal event for a client, according to employer policy, recording the facts of the incident and any subsequent related care provided;
- 2.9 documents when information for a specific time frame has been lost or cannot be recalled;
- 2.10 indicates clearly when an entry is replacing lost information;
- 2.11 ensures that documentation is completed by the individual who performed the action or observed the event, except when there is a designated recorder, who must sign and indicate the circumstances (for example, a code situation);
- 2.12 identifies the individual performing the assessment and/or intervention when documenting;
- 2.13 follows agency policy on co-signing entries;
- 2.14 identifies the individual with whom client information is shared with, including name and professional designation and what client information is provided (for example, reporting to a physician or another nurse); and
- 2.15 advocates for clear employer documentation policies and procedures that are consistent with the NANB standards.



## Standard 3: Security

***Nurses safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with professional and ethical standards, relevant legislation, and employer's policies.***

### INDICATORS

The nurse:

- 3.1 ensures that relevant client care information is captured in the client health record, as defined by employer policy;
- 3.2 maintains confidentiality of client health information, including passwords or information required to access the client health record;
- 3.3 understands and adheres to policies, standards and legislation related to confidentiality, privacy and security;
- 3.4 accesses only information for which the nurse has a professional need to provide care;
- 3.5 maintains the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, using initials when quoting a client's roommate);
- 3.6 facilitates the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health record, as defined by employer policy;
- 3.7 obtains informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care, in accordance with relevant legislation;
- 3.8 uses a secure method to transmit client health information (for example, using a secure line for fax or e-mail);
- 3.9 retains health records for the period the organization's policy and legislation stipulates when required as part of the nurse's responsibilities; and
- 3.10 ensures the secure and confidential destruction of temporary documents that are no longer in use.



## APPENDIX A: Supporting Documentation Practices

Nurses in all practice settings, must demonstrate the knowledge, skill, judgement and attitude required of self-regulated health professionals. They must also demonstrate knowledge on their role in improving their practice environment, and advocate for quality nursing care. Nurses may consider the following conditions when advocating for a work environment that supports documentation practices:

- facilitating nursing staff involvement in choosing, implementing and evaluating the documentation system as well as the policies and procedures and risk management systems related to documentation;
- providing access to appropriate, reliable and available documentation equipment, and to Information Technology (IT) support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring policies are available and reflect the documentation standards to guide practise;
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;
- ensuring that effective mechanisms and resources are in place to help nurses apply the organization's documentation policies;
- supporting nurses' development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- advocating for best practises in documentation;
- developing performance management processes that provide opportunities to improve documentation;
- providing adequate time to document appropriately and review prior documentation; and
- identifying and acknowledging nursing excellence in documentation.



## APPENDIX B: Nursing Documentation Legislation References

There are federal and provincial legislation that may impact nursing documentation. The following list of current legislation at time of publication is included here for consultation purposes only.

### FEDERAL LEGISLATION

To obtain copies of current federal legislation, contact the Government of Canada Inquiry Centre at 1 800 O Canada (1 800 622-6232) or visit the Department of Justice website at [www.laws.justice.gc.ca/en](http://www.laws.justice.gc.ca/en)

*Access to Information Act, 1985*  
<http://laws.justice.gc.ca/en/A-1/218072.html>

*Controlled Drug and Substances Act, 1996*  
<http://laws.justice.gc.ca/en/C-38.8/229593.html>

*Personal Information Protection and Electronic Documents Act, 2000*  
<http://laws.justice.gc.ca/en/P-8.6/258031.html>

*Privacy Act, 1985*  
<http://laws.justice.gc.ca/en/P-21/255104.html>

*Health Protection and Promotion Act, 1990*  
[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90h07\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm)

### PROVINCIAL LEGISLATION

*Hospital Services Act*  
<http://www.gnb.ca/0062/acts/acts/h-09.htm>

*Hospital Act, 1992*  
<http://www.gnb.ca/0062/acts/acts/h-06-1.htm>

*Nursing Home Act, 1982*  
<http://www.gnb.ca/0062/acts/acts/n-11.htm>

*Personal Health Information Privacy and Access Act, 2009*  
<http://www.gnb.ca/0062/PDF-acts/p-07-05.pdf>



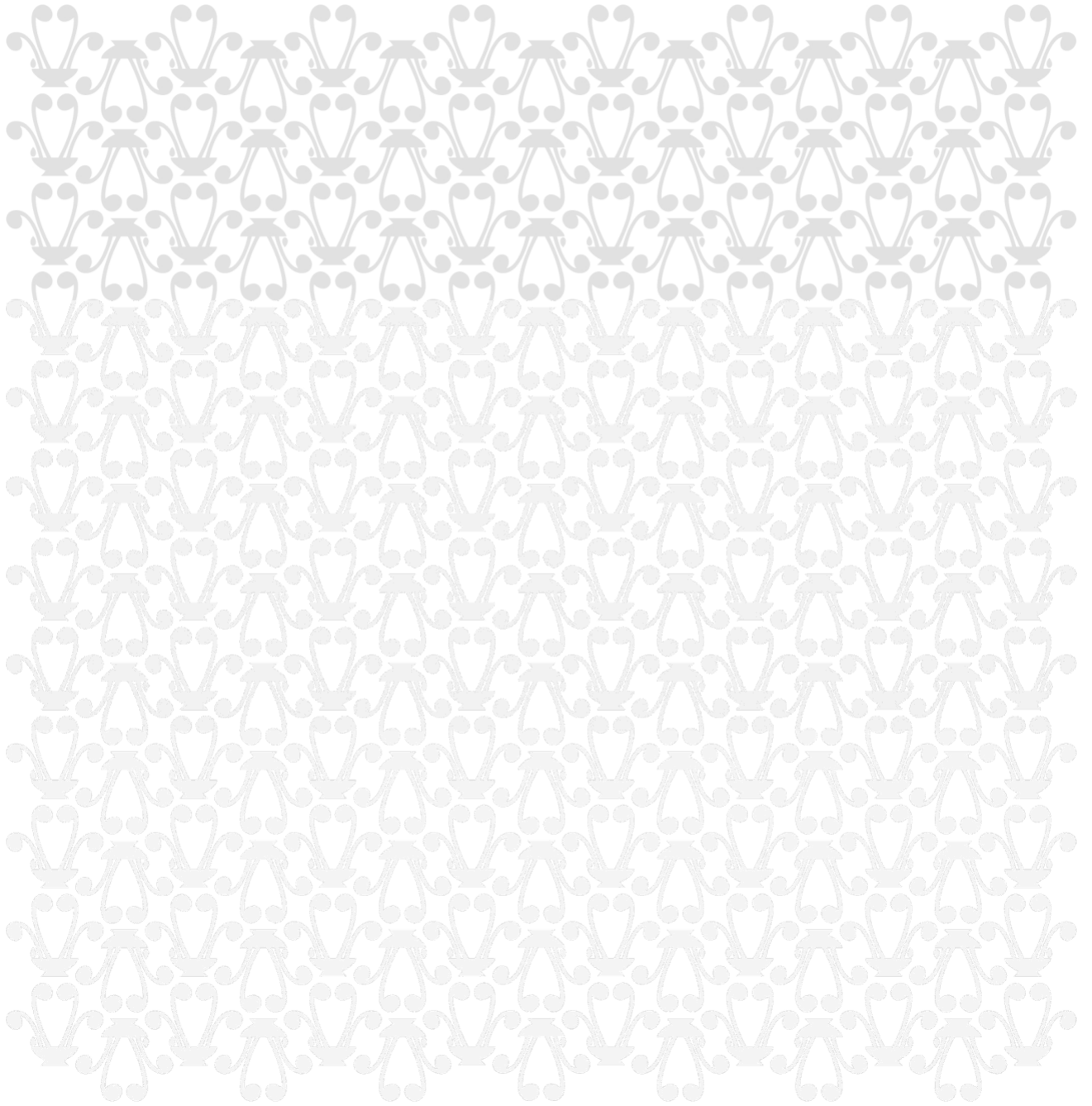
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