



**DOCUMENTING
CARE:
STANDARDS FOR
REGISTERED
NURSES**

**NURSES ASSOCIATION
OF NEW BRUNSWICK**



OUR MISSION

The Nurses Association of New Brunswick is a professional organization that exists to support nurses and to protect the public 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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INTRODUCTION

The NANB has a legislated mandate to develop, establish, maintain and administer professional standards for its members. One of the most challenging realities faced by practising nurses is the documentation of client care. Writing about care is a primary activity of the discipline of nursing and, as such, documenting the care provided and the client's response is an important component of the nurse's role. It provides written evidence of the nurse's contribution to client care.

The purpose of the following standards for documenting care is to assist nurses in meeting the challenge of effective documentation by providing an overview of the purposes and expectations for documentation of care.

Although the requirements for documentation will vary depending on the client population and agency policy, the general principles of documentation can be applied in every setting and to every specialty of care including the nurse who is self-employed and/or working in an independent practice. Documentation of nursing care, regardless of the context of practice, must be consistent with the professional requirements outlined in this document.

1.0 WHY MUST YOU DOCUMENT?

The reason for establishing and maintaining client records, including nurses' notes, lies in the general commitment to high quality client care. The chart is part of the client's support system while under the care of health professionals, and it is directed primarily toward serving the interests and care of the client.

1.1 Method of Communication

The primary purpose of documentation is to communicate information to other members of the health care team enabling them to make prudent professional judgements, and to ensure the continuity of care. Documentation provides accurate, pertinent, current, comprehensive and concise information concerning the condition and care of the client. The health record makes information about clients available in a permanent form to all health care providers. It reminds nurses and others of the care they have given and the recipient's response, in order to make future care decisions.

1.2 Mechanism for Accountability

The health record demonstrates nurses' accountability and gives credit to nurses for the care they give or the service they provide. In New Brunswick, the *Standards for Nursing Practice* requires all nurses to document timely and accurate reports of relevant observations, including conclusions drawn from them, according to professional standards and agency policy. Additionally, documentation must honour the ethical concepts of good practice — confidentiality, informed decision-making and consent.

Accountability means being answerable for one's own actions. In the nursing profession, individuals are not only accountable for their immediate actions but for the thoughtful planning and reporting of those actions. Nursing records present information on care provided and are considered an accurate account of care given.

Documentation plays a key role in substantiating client status and the therapeutic interventions implemented by nurses. Good documentation reflects the professional judgement and clinical decision-making abilities of the nurse. Nursing care directly impacts client outcomes in such areas as the client's physical condition, psychological or attitudinal status, and health knowledge.

In addition, failure to keep records as required, falsifying a record, signing or issuing a document that the member knows includes a false or misleading statement, and giving information about a client without consent or legal authorization, express or implied, constitute professional misconduct under the *Nurses Act*.

1.3 Protection Against Liability

Nurses are required to make and keep records of their practice in accordance with generally accepted standards of practice of the profession. The client's record is a legal document and, as such, can be used as documentary evidence in a court of law.

The best legal protection for nurses is to make sure that their documentation adheres to the professional standards of nursing practice and follows the employer's policies and procedures. 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.

1.4 Evidence of Quality of Care

Information from the health record is often used as a quality improvement mechanism to evaluate the quality of care (for example, chart audits, performance reviews, accreditation). Clear, complete and accurate recording facilitates the evaluation of the client's progress towards desired outcomes. Recording in this manner also enables nurses to identify and address areas that need improvement.

1.5 Method of Expanding the Science of Nursing

The health record can be a valuable source of data for health research. From a nursing perspective, the health record can be used to assess nursing interventions and evaluate client outcomes, as well as identify care and documentation issues. Accurately recorded information is essential to provide accurate research data. Through nursing research, nurses are able to improve nursing practice.

2.0 WHO MAY DOCUMENT?

All health care providers must document the care they provide. Nurses, as regulated health care professionals, have a professional responsibility to record the care provided to a client. Nursing care is not considered to be complete unless it is documented.

2.1 Documentation Should Be Recorded From First-Hand Knowledge

It is a legal and professional principle that “the care provider with personal knowledge should document the client care.”(Grant & Ashman, 1997, p. 137). The practice of documenting for other care providers may lead to errors and/or inaccuracies. While this could be directly detrimental to the provision of quality client care, it could also have an impact on the admissibility of records in court proceedings or diminish the actual credit given to a record as evidence.

An exception is an emergency such as a cardiac arrest or trauma, when it becomes necessary to document observations or care provided by others. Agency policy must clearly delineate when a designated recorder may document for others. When acting as a designated recorder for a team, the recorder identifies the persons involved and the care they provided. Documenting this type of information in the health record is important, and it has to be clear who had the first-hand knowledge of the event and who performed the activity.

2.2 Co-signing Entries

Co-signing entries made by other care providers in the health record blurs accountability. If an agency has a policy on co-signing entries then the policy must clearly indicate both the intent of a co-signature and in what circumstances co-signing is acceptable. If, as is often the case, a co-signature is evidence of someone witnessing an event, it is imperative that the person co-signing actually witness the event, and not simply rely on someone else’s word that the event took place.

Be very cautious with countersigning someone else’s documentation, for example, documentation done by auxiliary staff. Countersigning implies that the nurse either has performed the care or has seen the other caregiver administer the care. Countersigning may add a level of liability which the nurse would not otherwise carry.

Nurses are accountable for their own actions and do not need someone to check their work. If another nurse does an assessment or provides care, that action needs to be documented. If two people are involved in the care, then both need to document and sign for the care given or one person can indicate in the record that care was provided by two people who are then named.

3.0 HOW TO DOCUMENT

3.1 Document Clearly and Legibly

All entries in a client record should be written neatly in black or blue ink. Illegible notes may lead to misinterpretations by health care providers, causing potential risk to client safety or inadequate/inappropriate care.

3.2 Avoid “White Space”

Leaving “white” or empty spaces in a document presents an opportunity for others to enter data within the parameters of your signature. Drawing a single line through unused space, including before and after your signature/designation, can help prevent this risk. From a legal perspective the absence of empty space prevents the conclusion that the chronological order was tampered with after the fact.

3.3 Be Clear, Concise, Unambiguous and Accurate

Precision in documentation is imperative! Take time to review data before writing it on the chart. Always go back to the client to clarify or validate information which appears to be incomplete. Documentation is strengthened by the inclusion of details and accurate descriptions (for example, state specific quantities, actual dates, time frames and distances, and pertinent and exact client comments). Avoid vague expressions or clichés such as “slept well” or “up and about.”

Nurses maintain and gain credibility when they document conclusions that are founded. It is not acceptable for nurses to make value judgements or culturally insensitive comments. These comments might suggest or imply a dislike for a client and that, subsequently, care provided was substandard. Select neutral terminology or describe observed behaviours (for example, rather than “client was drunk” state “noted an odour of alcohol, speech was slurred”; rather than “client is demanding and aggressive” state “client has been shouting for the nurse, and using obscene language with all staff”).

3.4 Avoid the Use of Abbreviations Whenever Possible

If abbreviations are used, they should be standardized throughout an agency and formally noted in the agency’s policy/procedure manual. Nurses must use only the abbreviations approved for use in their agency.

Abbreviations must be consistent so that they mean the same thing to everyone who reads the record. This means consistent interpretation and continuity of care. The use of unauthorized abbreviations can cause error or, at the least, waste time for the person trying to find out what was meant.

3.5 Correct Mistaken Entries

If a mistaken entry occurs in your documentation, do not erase any content or use correction products to hide or obliterate the error. Follow the employer’s policy for correcting mistaken entries on the chart. To correct a mistaken entry, simply cross through the word(s) with a single line, and insert your initials, date and time you made the correction, and then enter the correct information. The content in question should remain readable. Some agencies will also require that you enter the word “error” or “mistaken entry” in conjunction with your initials. Failing to correct a mistaken entry appropriately (according to agency policy) may be interpreted as a falsification of a record.

3.6 Follow Agency/Unit Policies

In New Brunswick, the *Standards for Nursing Practice* requires all nurses to ensure that their practice and conduct meet legislative requirements and respect policies and standards relevant to the profession and their practice setting. Nurses have a responsibility to familiarize themselves with and follow agency policies and procedures including those on documentation.

The importance of employers’ policies in the area of documentation cannot be overstated. The NANB supports the right of agencies to establish policies and procedures for their particular situation.

Policies should address the following:

- who documents and how they identify themselves;
- what to include and exclude;
- when to document, for example, frequency;
- where to document, for example, on narrative or progress notes, on flow sheets; and
- how to document, for example, type of format used to organize health records.

4.0 WHAT TO DOCUMENT

Documentation is a valuable method for demonstrating that, within the nurse-client relationship, the nurse has applied nursing knowledge, skills and judgement according to professional standards. When documenting for individual clients, the record needs to provide a clear picture of the needs or goals of the client, the actions of the nurse, and the outcomes.

Many nurses work in settings where the focus of care or service is groups or communities rather than specific individuals. When documenting for groups or communities, the documentation must reflect the needs assessment and the actions taken based on that analysis, and the evaluation of the outcomes of those actions.

4.1 Date, Time, Signature and Designation

Notations in a health record generally begin with the date and time of an entry and conclude with the recorder's signature and designation. For each entry the nurse must include:

- the date and time of the documentation;
- the date and time of the care, if different from date and time of documentation; and
- full signature, which includes professional designation, after every entry.

Policies and procedures for documenting date, time and full signature will vary from agency to agency. For example, full signature may require one of the following: 1) first initial, surname and professional designation; 2) full first name, surname and professional designation; or 3) initials and professional designation. When using initials to identify oneself, a master list needs to be maintained on each health record to match the caregiver's initials with a signature and designation.

The designations "RN," for registered nurse; "N," for nurse; and "GN," for graduate nurse indicate to the reader that the care has been given by someone who is accountable to the Nurses Association of New Brunswick.

4.2 All Aspects of the Nursing Process

In New Brunswick, the *Standards for Nursing Practice* requires all nurses to:

- apply problem-solving processes in decision-making; and
- determine client status and responses to actual or potential health problems, plan nursing interventions, perform planned interventions, and evaluate client outcomes.

Documentation which reflects the nursing process demonstrates that the nurse has fulfilled her duty of care. It allows the nurse to be answerable for decisions made to substantiate and defend her practice.

The charting dilemma faced by all nurses is how much is enough and what needs to be documented. As a general rule, any information that is clinically significant should be included. The progression of the client's care and condition must be evident in the nurse's documentation.

Document your follow-through with the client's problems. Whenever an exceptional event is recorded, the nurse should make sure to document what happened after. What did the nurse do and what were the client outcomes? What nursing or other actions were implemented? Did the vital signs stabilize? Did the pain subside? Did the client calm down?

To determine what is essential to document, the nurse can keep in mind that a subsequent reviewer of the chart, for each episode of care, should be able to see evidence of:

- a clear, concise statement of the client status;
- the relevant assessment data used to determine the client status;
- the care (interventions including advocacy and teaching) delivered in response to the client status; and
- an evaluation of the care including the client's response to the care.

4.0 WHAT TO DOCUMENT

4.3 Discharge Information

In addition to reflecting significant events during a client's care episode, health records should also include events related to the admission and discharge periods. Health care providers are aware of the importance of assessment data as a "baseline" for subsequent care. However, specific assessment data of a client's physical/mental status at the time of discharge should also be considered as important information. Discharge documentation should note whether the client and respective family had adequate preparation prior to discharge (for example, the content and outcome of educational sessions, handouts provided, and so forth), and evidence of the client's understanding and arrangements for follow-up care. As the trend toward early discharge continues to grow, the significance of discharge assessment data will undoubtedly escalate.

4.4 Communications Between Nurse/Physician/Other Health Care Providers

Record significant communications, including telephone calls, with physicians and/or other health care providers. Note the date and time of contact, the information provided to or by the health care provider, responses from the health care provider, and any orders/interventions resulting from the call. Additionally, the nurse must record what actions were taken to ensure that the client received safe and timely care. If a nurse has repeatedly called a provider without success, there should be recorded evidence that other channels have been pursued to obtain needed medical or other clinical management.

4.5 Subjective Comments of Clients and, When Appropriate, Families

Provide a summary of significant conversations with a client or family. This will communicate information to other members of the health care team. Objective data that support a client's words are also significant and should be included. For example, client states, "I am pain-free today," or "Noted that client walked the length of the hall twice this morning unassisted." If the client or family seem unusually upset or angry over an incident, document this and communicate this information to the appropriate personnel in your agency. These situations, depending on agency policy, may also warrant the completion of an incident report.

4.6 Risk-Taking Behaviours of Client

During institutional or follow-up care, some of the more frequent occurrences of risk-taking behaviours of clients may be related to clients who are living with changes in their quality of life. The following are examples of how some people live risk: eating foods not included in a dietary restriction; ambulating when bed rest is advised; missing follow-up appointments; leaving against medical advice; refusing or abusing medications; and tampering with medical equipment.

These situations should be documented as they provide information related to a client's condition and the expected progress.

5.0 WHEN TO DOCUMENT

To decide how often to document, consider:

- the complexity of the client's health issues,
- the degree of risk associated with the client's condition, and
- the degree of risk associated with the treatment or care.

As a rule of thumb, the greater the risk to the client or the less stable a client is, the more frequently records would need updating. Never let long periods of time go by without recording (with some client populations, the frequency of charting is set by policy, for example, long-term care, where longer intervals are accepted). The higher the risk to which the client is exposed, the greater the complexity of care, the more comprehensive, in-depth and frequent should be the nurse's documentation.

5.1 At the Time of the Event

The nurse will document as soon after the event as possible because that is when circumstances will be recollected most clearly. The credibility of health records is enhanced by documenting as soon as possible after events. Documentation of an event should never be completed "before" the event takes place.

The more specific the time frame in which activities can be identified, the more accurate the record. For particularly important events, such as urgent calls to physicians, a sudden change in the client's condition, or reporting an abnormal lab result, the chart should reflect the specific time that action occurred.

When it is not possible to record contemporaneously (at the time or immediately following care or a particular event), follow guidelines related to making late entries. The nurse is expected to exercise sound professional judgement in any one case, and build in the documentation demanded by the situation.

5.2 Chronological Order

The recording of the nurse's assessments and observations are most useful when they are arranged in the order of time that they were made. The documentation of assessment data in chronological sequence is often helpful in revealing a changing pattern in a client's health status.

5.3 Forgotten or Late Entries

When it is not possible to document at the time of an event (for example, during an emergency), a late entry should be made in the first available space. Do not attempt to "squeeze in" a late entry. The nurse will document forgotten or late entries at the next available entry space; document both the date and time of the entry, and the date and time that the care was given. Designate the entry as a late entry according to agency policy.

5.4 Following an Unanticipated, Unexpected or Abnormal Incident for a Client

An unanticipated, unexpected or abnormal incident for a client might include falls, medication errors, or other harmful situations. Record the facts of the incident including any subsequent related care in the client's record without using the words incident, error or accident. Only information relevant to the care of the client should be on the client's record. In addition, most agencies require employees to document these events on an incident report for reasons of continuous quality improvement and risk management. This data collection is separate and distinct from the client's record. Complete the incident report according to agency policy.

5.5 Omissions

Sometimes, at a later date, personnel from the health records department of an agency may request that nurses document omissions. If the nurse can accurately recall the care given, entries may be made, as with all forgotten entries. If care cannot be accurately recalled, individuals must not feel pressured to comply with these requests. The manager needs to be consulted. Nurses must refrain from completing health records when they do not recall or know the information.

6.0 TYPES OF DOCUMENTATION

Different types of documentation have been developed to meet the differing and diverse needs of care settings. The type and/or system of documentation should be consistent with the

- needs of the client population,
- an agency's context of practice, and
- professional documentation standards.

There is no one best style of documentation that is guaranteed to be perfect for all contexts of practice. Regardless of the style selected, the bottom line is that documentation should be accurate, pertinent, current, concise and comprehensive.

6.1 Documentation Formats

Documenting interventions and outcomes is the crucial link between planning and evaluating care. This documentation, depending on agency policy, may be written on a progress note, nurses note or clinical note, and, is part of the client health record. This information can be expressed in various formats.

A number of charting formats are in use. The following is a brief overview of three types of charting formats: Narrative charting, SOAP format and Focus charting®.

6.1.1 Narrative charting

Narrative charting is the most traditional approach whereby interventions and client responses are written in a paragraph format and in chronological order. Depending on the agency, all disciplines may document in the same progress note. Routine care and treatments are often documented on flowsheets leaving the significant findings and specific client problems for the narrative notes. The nursing process is often used as the organizing framework.

6.1.2 SOAP format

The SOAP format focuses on specific client problems. The client's current problems are identified and listed on the nursing care plan. Recording is organized under the following headings: S=subjective data, O=objective data, A=assessment and P=plan.

6.1.3 Focus charting®

Focus charting is a system that requires nurses to document according to one or more identified foci that reflect the client's concerns or health needs. These foci form the basis of the care plan and are determined during assessment. Recording is organized under the following headings: D=data, A=action, R=response.

6.2 Flow Sheets

Many agencies have added flow sheets as part of the health record. Flow sheets can be helpful in accurately and concisely documenting routine and frequently needed information (for example, activities of daily living, vital signs). Flow sheets are part of the permanent record and are legally recognized.

6.3 Charting by Exception

Charting by exception is a complete charting system for nurses to document, in narrative form, only those particulars or observations about the client that fall outside expected limits or established standards of care.

Charting by exception changes the philosophy of "if it wasn't charted, it wasn't done" to "all observations fall within expected limits or all care standards have been met unless the care giver has documented otherwise."

6.0 TYPES OF DOCUMENTATION

Nursing care is provided according to a detailed care plan and standard protocols. These protocols outline the normal or expected client responses and nursing interventions in a given situation. There must be written protocols and standards for each client care situation. Care provided according to established protocols and findings from assessments or observations that fall within established ranges are recorded on flow sheets.

Interventions or findings that fall outside expected ranges are detailed on a narrative record using a charting format consistent with agency policy.

Two essential pre-conditions to the introduction of charting by exception are: 1) all components of the charting by exception system must be in place and 2) an organizational policy must support this method of recording care.

6.4 Electronic Documentation

The standards for documentation remain the same whether nurses are documenting on paper or by electronic means (for example, by computer). Electronic documentation must be accurate, timely and reflect the care that was given and by whom. Nurses need to know how to correct mistaken entries on the system without deleting information already entered. All entries must comply with agency policy, and include accurate dates and times, and appropriate electronic signatures that demonstrate accountability of the recorder.

Nurses are accountable for safeguarding confidentiality of client information in an electronic record just as they would with a paper system. This includes:

- maintaining the confidentiality of passwords and/or other access information,
- logging off when not using the system or when leaving the terminal, and
- taking necessary precautions to protect confidential information displayed on monitors.

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