Ask a
PRACTICE
CONSULTANT

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YOU'VE ASKED

Frequently Asked Questions About Documentation

A REVISED VERSION OF THE *Standards for Documentation* was approved by NANB's Board of Directors in June 2015. This Ask a Practice Consultant column will answer some frequently asked questions that NANB's Practice Department receives from registered nurses (RNs) regarding documentation requirements.

Who should document nursing care?

Documentation can be completed by a variety of care providers, i.e., RNs, LPNs or unregulated care providers, depending on the circumstances. However, for reasons of legality and accountability the provider with personal or firsthand knowledge should document the information. This generally means that the provider who is documenting is the one who provided the care. An exception is made in situations where a designated recorder is used during an exceptional situations (e.g., code situation OR in an operating room).

What are the legal implications of documenting care?

When used as evidence the court expects that the patient's chart will be a complete record of the patient's care from the time of admission until discharge. Nursing documentation is an integral component of the record and according to The Canadian Nurses Protective Society (CNPS, 2007) it can be used at trial "to reconstruct events, establish times and dates, refresh the memories of witnesses and to resolve conflicts in testimony".

When an RN's practice is in question, their documentation can be used to establish that their actions "were reasonable and prudent", and conversely that they "failed to meet the standard of a reasonable prudent nurse". For this reason CNPS points out that "if you have an obligation to perform a specific nursing act on a patient, such as taking vital signs, and you fail to chart that you have done so, the court may infer that the act was not performed".

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How frequently should I document?

The frequency of nursing documentation is dependent on numerous variables, including:

- agency policy;
- the acuity and complexity of the client's health problems;
- the degree to which the client's condition and/or planned treatments puts him/her at risk.

While agency policies on documentation should be followed to maintain a reasonable and prudent standard of documentation, nursing documentation should be more comprehensive, in-depth and frequent if a patient is very ill, very unpredictable or exposed to high risk.

Who owns the health record?

The record, i.e., the file, binder or software which contains the client's information, is the property of the host or health care agency (custodian) for which the client sought or participated in services. The data or information pertinent to the client is the property of the client. Therefore, in accordance with the *Personal Health Information Privacy and Access Act*[1] (2009) (http://gnb.ca/0051/acts/index-e.asp), the client has the right to have access to view and/or copy their health record, and request a correction of personal health information if the client believes the information is inaccurate or incomplete. Agency policy should stipulate the process to follow when clients want to access or make changes to their personal health information.

As an RN, what should I document?

Nursing documentation should be a thorough reflection of the nursing process. Documentation should serve as a record of the critical inquiry and judgment used to describe events, interventions or discussion with clients. Complete, accurate and thorough nursing documentation provides evidence that the regulated members have met the requirements expected in their role in a particular practice setting.

To determine what is essential to document, for each episode of care or service, the health record should contain:

- a clear, concise statement of client status;
- relevant assessment data;
- all ongoing monitoring and communications;

- the care/service provided (all interventions, including advocacy, counselling, consultation and teaching);
- an evaluation of outcomes, including the client's response and plans for follow-up; and
- discharge planning.

As a self-employed RN do I have to meet the same standards for documentation?

Self-employed RNs must adopt a documentation system that meets the document standards. As "custodians" of health records they must also insure they comply with the federal and provincial legislation on personal health information. They should also develop appropriate policies related to the storage, retrieval and retention of health records.

When is it appropriate to use abbreviations when documenting?

One of the primary uses of the clinical record is to support communication between healthcare providers working with a common client. Clinicians commonly report using abbreviations in the health record to save time and space while documenting the care they provide. However, increasing evidence suggests that this practice increases the chances for error because the abbreviations are not commonly understood or are misinterpreted. Consequently, many organizations have developed policies to discourage the use of abbreviations in general and/or restrict their use to an approved, standardized list.

The Institute of Safe Medical Practices has developed a list of "Do Not Use" abbreviations that have been shown to be particularly error prone. It can be retrieved at: www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

Should I co-sign or countersign the documentation of another RN, nursing provider or nursing student?

Co-signing refers to a second or confirming signature on a witnessed event or activity. Agency policy on co-signing must clearly indicate both the intent of a co-signature and in what circumstances co-signing is required. RNs are accountable for their own actions and do not routinely need someone to co-sign their practice.

There are some examples where co-signing is prudent practice, such as, verbal consent or telephone orders, verification of a medication dosage, discarding of a narcotic, or client identification for a blood transfusion. Co-signing implies shared accountability, therefore, it is imperative that the person co-signing actually witnessed or participated in the event.

Countersigning is defined as a second or confirming signature on a previously signed document, a blind signature – which is not witnessed. This is generally not a supported or needed practice in nursing care but may be effectively used as a quality control process, and should be completed in accordance with agency policy and procedure. For example, an RN 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; it does imply the person approved or verified that the service or record was completed.

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What standards apply when I document electronically?

Electronic documentation carries a higher risk of breach of confidentiality. Policies and procedures, as well as specific technologies, are required to protect the confidentiality of the patient's health record and system security. This is especially true for the transfer of information (CNPS, 2007). Otherwise, the standards for documentation apply when documenting electronically.

Is completing an incident report the same as documenting nursing care?

Incidents are generally recorded in two places, in the client's medical record and in an incident report, which is separate from the chart. Documentation in the chart is used to ensure continuity of client care and should be accurate, concise, factual, unbiased and recorded by the person who witnessed the event. The RN should avoid using the words "error", "incident", or "accident" in the documentation.

Incident reports are separate from the patient record and are used by organizations for risk management, to track trends in systems and client care and to justify changes to policy, procedure and/or equipment. Information included in an incident report is similar to the information included in a client's health record, however, the incident report would also include additional information with respect to the particular incident (e.g., "a door was broken" or "this was the fourth occurrence this week"). Information recorded is not directly related to the care of the client.

For more questions on documentation and nursing practice, call NANB's Practice Department to speak with a Nursing Practice Consultant at 1-800-442-4417 or email us at nanb@nanb.nb.ca. You can also visit www.nanb.nb.ca/index.php/publications/briefs-presentations to watch a recorded webinar on Documentation Standards.

The revised *Standards for Documentation*'s (2015) can be retrieved at the following web address: www.nanb.nb.ca/index.php/publications/practice.

REFERENCES

Canadian Nurses Protective Society. *Charting: The Legal Aspects*. Retrieved January 6, 2015, from www.cnps.ca/index.php?page=86

Nurses Association of New Brunswick (2015). *Standards for Documentation*. Fredericton: Author.