Nurses Association
OF NEW BRUNSWICK

Standards for DOCUMENTATION

Mandate

Regulation for safe, competent, and ethical nursing care.

Under the *Nurses Act,* NANB is legally responsible to protect the public by regulating members of the nursing profession in New Brunswick. Regulation makes this profession, and nurses as individuals, accountable to the public for the delivery of safe, competent and ethical nursing care.

TABLE OF CONTENTS

INTRODUCTION 4
PRINCIPLES 5
PURPOSE 6
STANDARD 1: COMMUNICATION 7
STANDARD 2: ACCOUNTABILITY AND LIABILITY 8
STANDARD 3: INFORMATION SECURITY 9
GLOSSARY 10
REFERENCES 11

INTRODUCTION

Documentation by registered nurses (RNs) and nurse practitioners (collectively referred to herein as 'RNs') is fundamental to recording and evaluating nursing care and is only as complete as the information entered into the permanent **client** record. As self-regulated professionals, RNs are accountable for ensuring that their documentation (whether paper-based or electronic) is accurate and meets NANB's *Standards for Documentation, Standards of Practice for Registered Nurses,* and if a nurse practitioner, the *Standards of Practice for Primary Health Care Nurse Practitioners*.

These *Standards for Documentation* explain the regulatory and legislative requirements for nursing documentation. To help RNs understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each standard statement is followed by corresponding indicators that outline an RN's responsibility and accountability when documenting.

Words or phrases in bold print are found in the glossary. They are shown in bold format on first appearance.

PRINCIPLES OF DOCUMENTATION

The following principles apply to documentation by RNs:

- Documentation is a nursing action demonstrating that the **nursing process** has been done and identifies the care provider by name and designation (Perry, Potter, Stockert & Hall, 2017).
- It demonstrates that the RN has applied the nursing knowledge, skill and judgement required by professional and ethical standards, relevant legislation, and employer policies.
- Documentation includes any pertinent information that is received by the RN from those within the circle of care. The circle of care includes members of the **healthcare team** involved in the client's care and the client.
- Documentation reflects the client's perspective and promotes continuity of care through intra/interprofessional **communication**.
- If nursing documentation is not clear and accurate, intra/inter-professional communication and evaluation of nursing care cannot be optimal (Asmirajanti, Hamid & Hariyati, 2019).
- Co-signing implies shared accountability and indicates the person co-signing witnessed or participated in what was documented (RNANT/NU, 2015).
- It is acceptable to document for another's care provision during an emergency, when outlined in policy with clear direction regarding how and when to do so (e.g. during resuscitation by a code team).
- Quality nursing documentation is an expected RN practice in every area of care and setting, including virtual and tele-health.
- Delays in documentation may affect the continuity of care and the ability to remember details of events, therefore increasing the possibility of error (BCCNP, 2019a).
- Nursing care should be planned to include time for documentation.
- Employers should support documentation by having policies specific to documentation; by supplying appropriate paper and/or electronic tools for documentation and by prioritizing documentation as an aspect of nursing care.

PURPOSE OF DOCUMENTATION

Data from documentation has many purposes, including but not limited to the following. Nursing documentation (NSCN, 2017a & CRNM, 2017):

- serves as a communication tool within the circle of care.
- promotes continuity of care, including the creation and modification of the **care-plan**.
- demonstrates RN accountability to the client, to the employer and to the profession of nursing.
- informs quality improvement processes, including risk management.
- may be used in legal investigations and other legal proceedings.
- is a source of data in health-related research.
- is a source of information in making funding and resource management decisions.

STANDARD 1: COMMUNICATION

Registered Nurses document accurate, pertinent and comprehensive information concerning the condition of the client, the client's needs, the nursing interventions and the associated response.

INDICATORS

Registered Nurses:

1.1 document the nursing care they provide in a chronological order, including all aspects of the nursing process;

1.2 document both objective and subjective data in a clear and concise manner;

1.3 document informed consent for treatments or interventions performed;

1.4 document communication with family members/significant others, substitute decision-makers and other care providers, that may impact the client's health outcome or the plan of care (noting the date, time and content of the communication);

1.5 document any advocacy that was undertaken on the client's behalf;

1.6 ensure that relevant client care information kept in temporary documents (e.g. shift reports, care plans and communication books), is captured in the permanent health record;

1.7 provide a signature and professional designation (RN, GN, NP or GNP) with all documentation; the use of initials is acceptable when a master list of signatures/initials is incorporated into the documentation tool or health record;

1.8 adhere to employer requirements for electronic signature;

1.9 document legibly and in permanent ink when using paper documentation forms;

1.10 only use abbreviations and symbols when each has a distinct interpretation and that each is approved by the employer (ISMP Canada, 2018);

1.11 document client education, including both formal and informal;

1.12 document the nursing care provided when using virtual and telecommunication technologies (for example, providing telephone advice or when using a virtual platform to provide nursing services); and

1.13 document conclusions that are within the scope of the individual RN or NP's **scope of practice** and that can be supported by evidence or data.

STANDARD 2: ACCOUNTABILITY AND LIABILITY

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

INDICATORS

Registered Nurses:

2.1 complete documentation in a **timely** manner - during, or as soon as possible after, the care or event;

2.2 document more frequently when a client is at increased risk of harm, is unstable, or there is a higher degree of complexity involved in the nursing care (CRNM, 2017);

2.3 document the date and time that care was provided;

2.4 document in chronological order;

2.5 indicate when an entry is late, including the date and time of the care that was provided along with the date and time of the entry into the health record;

2.6 correct mistaken entries while ensuring that the original information remains visible/retrievable;

2.7 never delete, alter or modify anyone else's documentation;

2.8 document any unanticipated, unexpected or abnormal client incidents according to employer policy, recording the facts of the incident and any subsequent related care provided;

2.9 document when information for a specific time frame has been lost or cannot be recalled, indicating clearly when an entry is replacing lost information;

2.10 only co-sign when there is supporting employer policy (e.g. independent double check of medication preparation, agreement on calculated dosage);

2.11 identify the individual with whom client information is shared, including name and professional designation and what client information was provided (for example, reporting to a physician, a licenced practical nurse, or another RN); and

2.12 **advocate** for clear employer documentation policies and procedures that are consistent with NANB standards.

STANDARD 3: INFORMATION SECURITY

Registered 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

Registered Nurses:

3.1 maintain **confidentiality** of client health information (including passwords required to access client health information);

3.2 understand and adhere to legislation, standards, and policies related to confidentiality, **privacy** and security of client health information;

3.3 access client health information for purposes consistent with professional obligations, only;

3.4 facilitate the rights of the client or substitute decision-maker to access, inspect, and obtain a copy of the health record, as defined by *Personal Health Information Privacy and Access Act* and employer policy;

3.5 obtain informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care;

3.6 use secure methods to transmit client health information (for example, a secure fax line or encryption of messages being shared electronically);

3.7 retain health records as defined by employer policy and/or legislation stipulates; and

3.8 ensure the secure and confidential destruction of temporary documents and permanent records that have passed their retention period, according to employer policy.

Glossary

Advocate: Actively supporting, protecting and safeguarding clients' rights and interest. It is an integral component of nursing and contributes to the foundation of trust inherent in nurse-client relationships (CRNNS, 2017b).

Care plan: An individualized and comprehensive plan guiding the nursing care for a client. The purpose is to enhance communication between care providers so care is provided consistently and client goals are achieved (NSCN, 2019).

Client: Individuals, families, groups, populations or entire communities who require nursing expertise. The term "client" reflects the range of individuals and/or groups with whom nurses may be interacting. In some settings, other terms may be used such as patient or resident. In education, the client may also be a student; in administration, the client may also be an employee; and in research, the client is usually a subject or participant (NANB, 2018).

Communication: The transmission of verbal and/or non-verbal messages between a sender and a receiver for the purpose of exchanging or disseminating meaningful, accurate, clear, concise, complete and timely information (includes the transmission using technology) (NSCN, 2017b).

Confidentiality: The ethical obligation to keep someone's personal and private information secret or private (CNA, 2017).

Healthcare team: Providers from different disciplines, often including both regulated health professionals and unregulated workers, working together to provide care for and with individuals, families, groups, populations or communities. The team includes the client (CNA, 2017).

Nursing Process: A systematic problem solving approach toward providing individualized nursing care that includes; assessment, nursing diagnosis, planning, implementation and client evaluation (Perry, Potter, Stockert & Hall, 2017).

Privacy: (1) Physical privacy is the right or interest in controlling or limiting the access of others to oneself; (2) informational privacy is the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared. A person has a reasonable expectation of privacy in the health-care system so that health-care providers who need their information will share it only with those who require specific information (CNA, 2017).

Scope of practice: The activities that registered nurses are educated and authorized to perform, as set out in legislation and described by standards, limits, and conditions set by regulators (BCCNP, 2019b).

Timely: Ensuring that a response or action occurs within a timeframe required to achieve safe, effective and positive client outcomes (NSCN, 2017b).

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