Nursing Documentation: Frequently Asked Questions

Documentation demonstrates that the nursing process has been done (assessment, nursing diagnosis, planning, implementation and client evaluation), and identifies the care provider by name and designation (Perry, Potter, Stockert & Hall, 2017). Registered nurses (RNs) and nurse practitioners (NPs) in all practice settings are required to document. These frequently asked questions (FAQs) are a resource to be used in conjunction with the *Standards for Documentation* and the Nurses Association of New Brunswick standards for RNs and NPs.

What are the legal implications of documenting care?

When used as evidence, the client's chart is considered a complete record of the client's care. Nursing documentation may be used to "reconstruct events, establish times and dates, refresh the memories of witnesses and to resolve conflicts in testimony" (CNPS, 2007). The documentation can also be used to establish that the actions "were reasonable and prudent", or conversely that they "failed to meet the standard of a reasonable prudent nurse" (CNPS, 2007). Therefore, if you have not charted what you have done, then the court may infer that the act was not performed, hence the saying: *If it's not charted, it's not done.*

Who owns the health record and how does New Brunswick privacy legislation apply to my practice?

The health record (i.e. the file, binder or software which contains the client's information), is the property of the practitioner and/or the health care agency (custodian) from which the client sought services. The data or information pertaining to the client is the property of the client. Therefore, in accordance with the *Personal Health Information Privacy and Access Act,* 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. For more information regarding the Government of New Brunswick's expectations for custodians, please review *Questions and answers for custodians about the Personal Health Information Privacy and Access Act (PHIPAA)*.

What do I need to know about storage of client records, from a legal perspective?

A *custodian* refers to an individual or organization that collects, maintains or uses personal health information for the purpose of providing or assisting in the provision of health care or treatment (GNB, 2009). A custodian must ensure that the client health records are secure regardless of whether paper or electronic.

Paper documents are to be stored in a secured area and employers are expected to have policy in place regarding this process. For electronic health records, password protection on computers is a minimum safeguard, as is placing electronic portable devices, technological storage files and paper documents in a locked cabinet. Retention of health records is dependent on employer policy and legislation, but most institutions store health records 7-10 years (CRNM, 2017).

What additional considerations apply to electronic documentation, including receiving orders and sharing test results?

Electronic documentation is considered to have a higher risk of a privacy breach, otherwise the principles of documentation remain the same. There is risk of private information being sent to the wrong phone number or the wrong e-mail address, and mobile devices retain data unless permanently deleted.

Therefore, policies and procedures need to outline what is expected of RNs and NPs regarding electronic documentation and the use of electronic devices. For example, specific technologies require each user to utilize a unique password to log onto and log off a system (CNPS, 2009). This is especially true for transfer of information or the storage of any client information on a portable device. Encryption, which is an encoding process making the information intelligible until a passcode is entered, is recommended. Essentially, if the electronic communication and/or the data being stored involves personal health information, it should be encrypted (CNPS, 2017 & Conaty-Buck, 2017).

Text or e-mail communication between healthcare providers should not be used for provider convenience, but when it is in the best interest of the client. Text can be lost or subject to interpretation that leads to inappropriate or incomplete communication, including inappropriate orders (NSCN, 2017).

Additional considerations for electronic health records include:

- Follow employer policy when modifying an incorrect entry or an incorrect signature. The content in question must be clearly visible or retrievable to enable understanding of the 'mistake and correction'. Include the date and time when correcting the entry (CARNA, 2018 & NSCN, 2017).
- Use a unique-to-you identifier or electronic signature and do not share with anyone (CARNA, 2018).
- Report any concerns you have regarding suspicious messages or abnormal functioning of the electronic devices being used for client care (Conaty-Buck, 2017).
- Communicating diagnostic test results and receiving orders by text message or e-mail is discouraged to the risk of unintentional privacy breach. There should be an employer policy to support this practice, if it is allowed (NSCN, 2017).
- Any e-mails or text messages containing personal health information such as diagnostic test results, photographs or prescribed orders, are to be included in the permanent health record (CRNM, 2017).

How do I document tele-practice or nursing care provided virtually?

Nursing services must be documented in tele-practice or when using a virtual platform to provide care. Tele-practice and virtual nursing are subject to the same documentation requirements as nursing in all other settings and should include (NSCN, 2017):

- consent for treatment;
- the date and time of the incoming call, including voice mail messages from clients that contain pertinent information;

- the name and contact information of the caller, or some other unique identifier if anonymity is important;
- the reason for the call, including health history, any assessment findings, signs and symptoms described;
- any nursing interventions including information given; referrals made, agreement of follow-up care; and
- any other pertinent information for continuity of care.

What is considered 'timely' documentation?

Timely documentation refers to an acceptable time-frame from when a nursing action occurs to when it is captured in the client's permanent health record. Timely documentation enables the information to be used for the continuation of care and as evidence in the decision-making process (Ahn, Choi & Kim, 2016).

Amidst a fast-paced environment, it may be tempting to post-pone documentation until the end of a shift. Delays in documentation may negatively impact the RN or NP's ability to remember details about events or diminish the recall of the nursing assessment and interventions (BCCNP, 2019). Being busy may make documentation more difficult but it does not excuse the RN or NP from documenting clearly and in a timely manner.

The frequency of documentation is dictated but not limited to the following factors: employer policy, complexity of client care needs, the risk of negative outcome for the client, and the level of nursing care required. Typically, the sicker the client, the greater the nursing care required and therefore the greater need for frequent documentation (NSCN, 2017). Unplanned events (such as a client refusing care, withdrawal from consent to care or a negative incident with the client), also require more frequent documentation because the situation has resulted in a phase of instability or unpredictability (CRNM, 2017).

From a liability perspective, the court will examine the frequency of entries in the health record and how soon the RN or NP documented after care was provided, and the judge (or jury) will assess any delay in the documentation as part of the overall evidence (CNPS, 2019). Therefore, documentation entries made only at the end of a shift may not hold the same weight as frequent entries made throughout the shift.

How do I document subjective data, objectively?

Subjective data can be included into the health record to enhance the understanding of the client's care. The subjective information should provide accurate examples of what was said, by whom, and at what time. For example, subjective data included in the health record may be from a friend or family member, if it contains information that will impact the plan of care or provide clarity to the client's care plan.

When documenting, avoid generalized statements such as 'slept well'; labels such as 'non-compliant'; and bias. Only document subjective conclusions that can be verified (NSCN, 2017). For example, instead of writing "Client was aggressive," an objective statement would be "Client was pacing, speaking in loud tones and using obscene language."

When is it appropriate to use abbreviations when documenting?

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 for Safe Medication Practices (ISMP) Canada has developed a list of "Do Not Use" abbreviations that have been shown to be particularly error-prone and recommends that abbreviations only be used when "their intended meaning is fully understood by all persons who will be deciphering the information and when there is no potential for misinterpretation" (ISMPC, 2018, p.1).

When providing client education, what should I document?

After teaching clients, accurate documentation is essential to enable communication and the continuity of teaching by others. The following aspects should be included in the health record regarding both planned (formal) and informal teaching (RNANT/NU, 2015):

- the date and time of the teaching;
- the materials used to educate (teaching sheets and/or instructional aids);
- the method of teaching (written or verbal);
- who was taught (client and/or family);
- evaluation of teaching objectives with validation of client comprehension; and
- any follow-up required.

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

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

There are some examples where co-signing is prudent practice, such as: 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. Co-signing entries written by another healthcare provider, (such as student nurses and unregulated care providers), is not acceptable and adds a level of accountability which the RN would not otherwise incur (RNANT/NU, 2015).

Any second or confirming signature on a previously signed document (countersigning) should only be completed in accordance with employer policy. Countersigning is generally not supported or needed in nursing practice but may be effectively used as a quality control process. An example of countersigning is when 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 (NSCN, 2017).

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

Yes, all RNs and NPs in all domains of practice and in all work settings are required to meet their regulatory standards, including those who are self-employed. Self-employed RNs and NPs are often considered the legal custodian of the health information (i.e., the health record) and as "custodians" of health records, they must ensure they comply with the federal and provincial legislation on personal health information. Self-employed RNs and NPs are required to develop appropriate policies and practices related to the storage, retrieval and retention of health records.

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

Incidents are generally recorded in two places, in the client's health record and in an incident report. Documentation in the health record is used to ensure continuity of client care and should be objective, concise, unbiased and be recorded by the person who witnessed the event. The RN should avoid using the words "error", "incident", or "accident" when documenting the facts of the event in the health record and should not allude to an incident report. The RN should document in the health record first and then follow employer policy in filling out an 'incident' record (NSCN, 2017).

Should I decide to evaluate my documentation practices, what are some indicators of good documentation?

Having a positive mindset towards documentation and valuing it as an aspect of your nursing role should foster improved documentation practices. It is important to plan your care to include time for documentation. Quality indicators for evaluating your documentation practices include but are not limited to:

- Is the nursing process evident?
    - Do you document your assessments?
    - Do you modify the care plan?

    - Do you document your interventions and then the evaluation of the interventions?
    - Do you record pertinent consultations with other healthcare team members, including their name and designation?
- Are you meeting your employer policies and the NANB S*tandards for Documentation*?
- Do you chart objectively and in a timely manner?

If you often find that you are not documenting in a timely manner, then it is prudent to advocate for time to document with your employer. Likewise, if you feel that you need to develop better documentation practices, it is your responsibility to identify this and to seek help in learning how to document concisely and in a timely manner.

How can employers facilitate better documentation practices?

Research (Ahn, Choi & Kim, 2016) has shown that RNs and NPs need support in prioritizing documentation into overall workflow of nursing care. Documentation can be viewed as a burden or a task that interrupts client care instead of being an aspect of the nursing care. Employers need to allow sufficient time for nursing documentation and can establish work environments that support documentation practices by:

- 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 reliable and available documentation equipment, and to Information Technology (IT) support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring electronic documentation systems support documentation standards;
- ensuring policies are available and reflect the documentation standards to guide practice;
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;

- ensuring that effective mechanisms and resources are in place to help RNs and NPs apply the organization's documentation policies;
- supporting RN and NP development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- advocating for best practices 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.

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