Documentation

Overview

Nursing documentation is an important component of nursing practice.

Documentation can be:

- paper
- electronic
- audio
- visual

Review the *Documentation, Revised 2008* practice standard at **www.cno.org/pubs**

Purpose

To enhance the application of the College's *Documentation, Revised 2008* practice standard using real practice examples.

Learning Objectives

- Identify College resources that help you with documentation practices

- Apply the principles of the document to practice scenarios

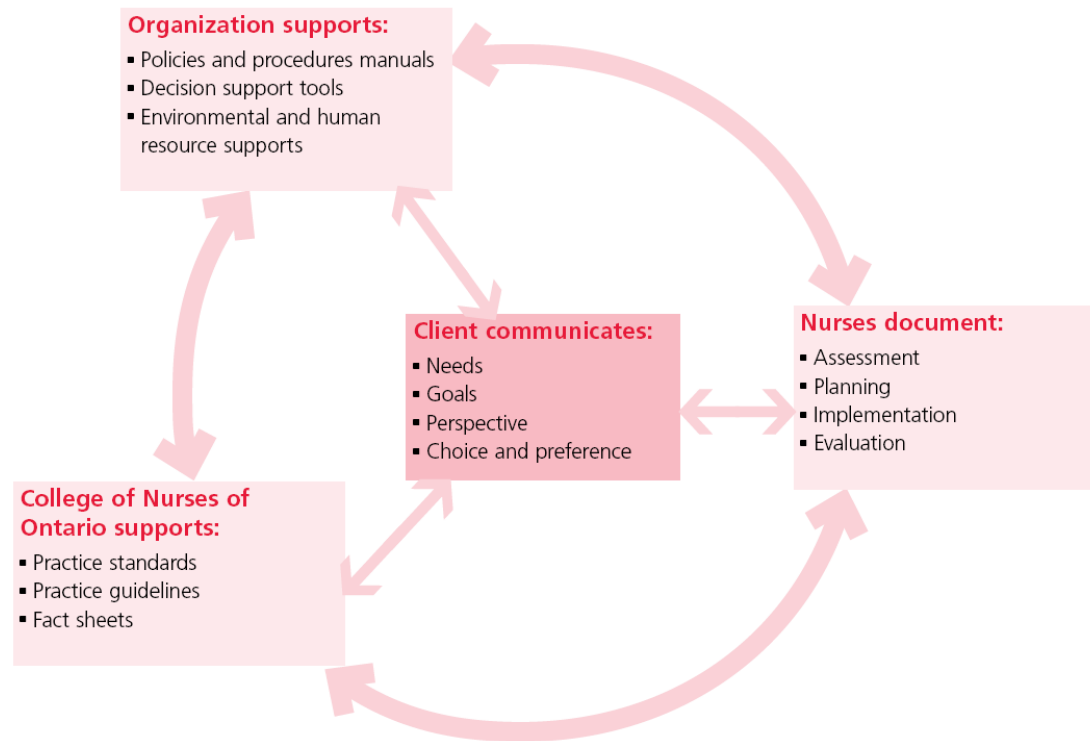- Identify how to access legislation that affects nursing documentation

Introduction to the Practice Standard

The *Documentation, Revised 2008* practice standard explains the regulatory and legislative requirements for nursing documentation.

The content is divided into three standard statements that describe broad practice principles:

- Communication
- Accountability
- Security

Documentation Interrelationships

Organization supports:
- Policies and procedures manuals
- Decision support tools
- Environmental and human resource supports

Client communicates:
- Needs
- Goals
- Perspective
- Choice and preference

Nurses document:
- Assessment
- Planning
- Implementation
- Evaluation

College of Nurses of Ontario supports:
- Practice standards
- Practice guidelines
- Fact sheets

Results of above inter-relationships
Complete documentation that demonstrates:
- Communication
- Accountability
- Legislative requirements

Why Document?

- Reflect the client's perspective
- Communicate to all health care providers
- Demonstrate safe and ethical care
- Demonstrate application of knowledge, skill and judgment
- Meet legislative requirements

Purpose of Data From Documentation

- Determine the care required or provided
- Evaluate professional practice for quality improvement
- Assess nursing interventions and evaluate outcomes
- Facilitate practice reflection

Documentation Requirements

- Ensure the documentation is accurate, timely and meets the College's practice standard

Professional Misconduct

- Failing to keep records
- Falsifying a record
- Signing or issuing a false or misleading statement
- Giving information about a client without consent

Relevant Legislation

Nursing Act, 1991

Regulated Health Professions Act, 1991

Personal Health Information Protection Act, 2004

Health Care Consent Act, 1996

Public Hospitals Act, 1990

Long-Term Care Homes Act, 2007

Review Ontario legislation at **www.e-laws.gov.on.ca**

Standard Statement for Communication

Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client's needs, the nurse's interventions and the client's outcomes.

Communication Examples 1

- Signing name and initials
- Co-signing

Communication Examples 2

- Minimizing duplication
- Charting by exception
- Check boxes

Communication Examples 3

- Abbreviations
  - www.ismp-canada.org

- Documenting the name of another care provider

- Documentation that is not related to client care

Standard Statement for Accountability

Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

Accountability Examples 1

- Late entries
- Documenting own care
- Unregulated Care Providers documenting
- Missing documentation

Accountability Examples 2

- Making corrections
- Covering for breaks
- Electronic documentation considerations

Standard Statement for 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 the standard(s) and legislation.

Security Examples

- Temporary documentation
- Access to information (by the nurse)
- Disclosure outside the circle of care
- Disclosure to clients

Security Examples

- Lockbox provision
- Electronic considerations
- Record retention

RPN: Entry-to-Practice Competencies

- Maintains clear, concise, accurate and timely records of client care.

- Demonstrates professional conduct by:
  - documenting incidents and action taken

- Uses computer skills in a professional manner to do the following:
  - document client care

RN: Entry-to-Practice Competencies

Understands the significance of nursing informatics and other information and communications technologies (ICTs) used in health care.

Uses existing health and nursing information systems to manage nursing and health care data during client care.

Reports and documents client care and its ongoing evaluation in a clear, concise, accurate and timely manner.

NP Entry-to-Practice Competencies

- Documents clinical data, assessment findings, diagnoses, plans of care, therapeutic interventions, client responses and clinical rationale in a timely and accurate manner.

- Adheres to federal and provincial or territorial legislation, policies and standards related to privacy, documentation and information management. (This applies to verbal, written or electronic records.)

Supporting Documentation Practices

Provide:

- support for staff involvement

- access to equipment

- policies that reflect the practice standard

- adequate time to document

- acknowledgement of nursing excellence in documentation

Continue Learning

Review the College's *Documentation, Revised 2008* practice standard.

Watch the Documentation learning module.

All resources are available at **www.cno.org**

Feedback

Use the *Evaluate this webcast* link to give us your feedback on this webcast.