PRACTICE STANDARD

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Documentation, Revised 2008

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COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

VISION
Leading in regulatory excellence

MISSION
Regulating nursing in the public interest

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Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their roles, job description or areas of practice.

— College of Nurses of Ontario

Introduction

Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client[1] health record. Documentation — whether paper, electronic, audio or visual — is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client.

This practice standard explains the regulatory and legislative requirements for nursing documentation. To help nurses[2] understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each statement is followed by corresponding indicators that outline a nurse's accountability when documenting and provide guidance on applying the standard statements to a particular practice environment.

To further support nurses in applying the standards, the document also includes appendices containing important supplementary information and a list of suggested readings. Appendix A provides strategies for nursing professionals — including nurses, researchers, educators and nurse employers — to support quality documentation practices in their work settings. Appendix B includes a sampling of provincial and federal legislation governing nursing documentation, and Appendix C references general resources on electronic documentation.

Why Document?

Nursing documentation:

- reflects the client's perspective, identifies the caregiver and promotes continuity of care by allowing other partners in care to access the information;
- communicates to all health care providers the plan of care,[3] the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions;
- is an integral component of interprofessional documentation within the client record;
- demonstrates the nurse's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history; and
- demonstrates that the nurse has applied within the therapeutic nurse-client relationship[4] the nursing knowledge, skill and judgment required by professional standards regulations.

Whether documenting for individual clients, or for groups or communities, the documentation should provide a clear picture of:

- the needs or goals of the client or group;
- the nurse's actions based on the needs assessment; and
- the outcomes and evaluation of those actions.

Data from documentation has many purposes:

- It can be used to evaluate professional practice as part of quality improvement processes.
- It can be used to determine the care and services a

[1] In this document, a client may be an individual, family, group or community.

[2] In this document, nurse refers to Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[3] In this document, the term plan of care may refer to treatment plan, care plan, care map, service plan, case management, mental health assessment plan, resident assessment forms, or other terms organizations use.

[4] For more information, refer to the College's *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard at **www.cno.org/publications**.

client required or that were provided.
- Nurses can review outcome information to reflect on their practice and identify knowledge gaps that can form the basis of learning plans.
- In nursing research, documentation is used to assess nursing interventions and evaluate client outcomes, identify care and documentation issues and advance evidence-based practice.

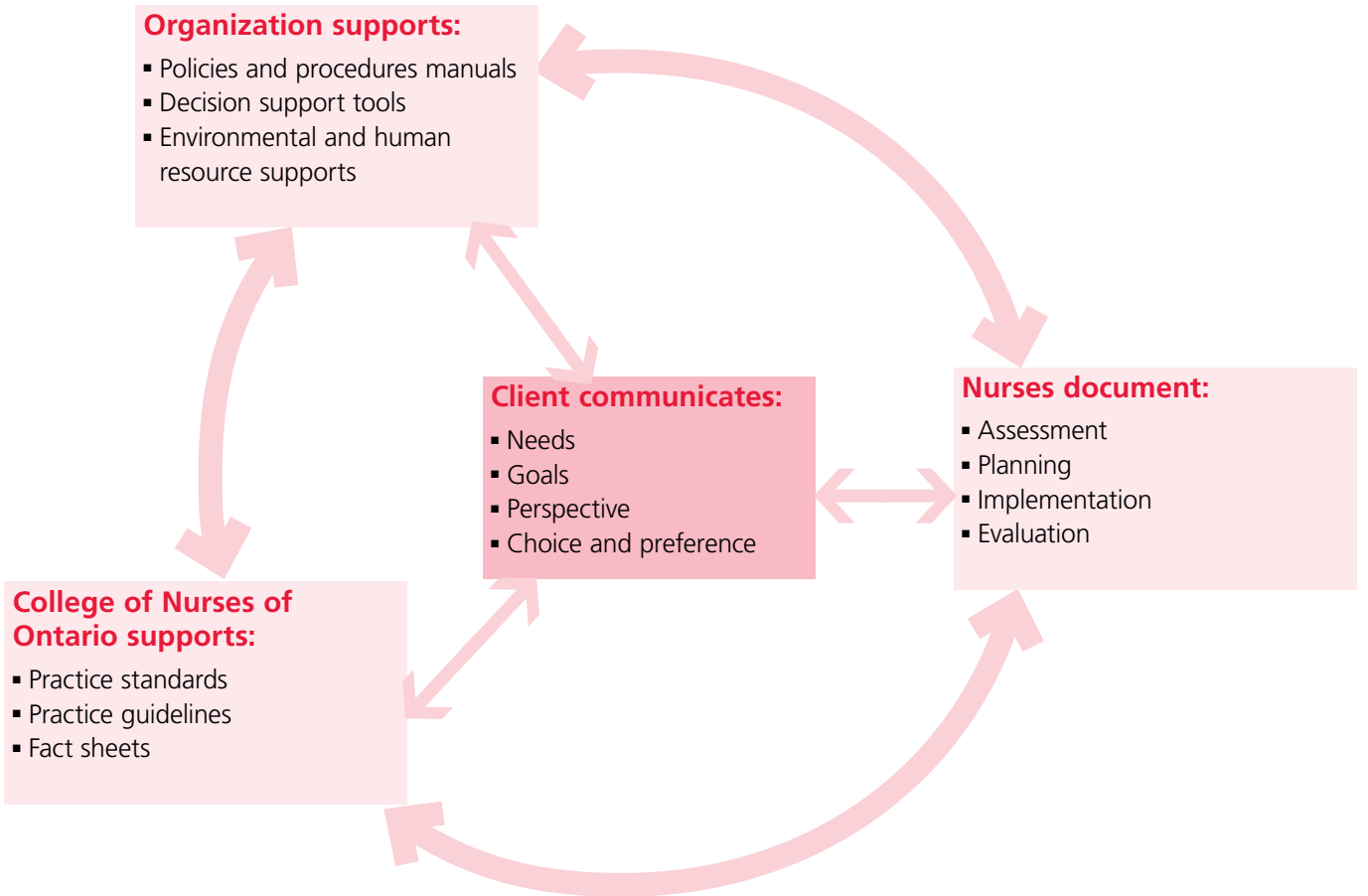
Nurses are required to make and keep records of their professional practice. As regulated health care professionals, nurses are accountable for ensuring that their documentation is accurate and meets the College's practice standards. Failing to keep records as required, falsifying a record, signing or issuing a document that the member knows includes a false or misleading statement, and giving information about a client without consent, all constitute professional misconduct under the *Nursing Act, 1991*. Nursing documentation may be accessed in College investigations and other legal proceedings.

The diagram on page 5 illustrates the inter-relationships supporting nurses in the provision of safe, effective and ethical care.

The Inter-relationships that support clients through documentation

This diagram illustrates how the nursing profession, the organizational environment and the self-regulatory framework within which nurses practise work together to support the client to obtain and/or maintain optimal functioning.

- The College's fact sheets, practice standards and guidelines support nurses in the provision of safe, ethical and effective care.
- Nursing organizations support nurses with policies, procedures and decision support tools.
- As self-regulated professionals, they are accountable to the practice standards that the College sets.



Results of above inter-relationships

Complete documentation that demonstrates:

- Communication
- Accountability
- Legislative requirements

Standard Statements and Indicators

Documentation, Revised 2008 includes three standard statements and corresponding indicators that describe a nurse's accountabilities when documenting.

- The standard statements describe broad principles that guide nursing practice.
- The indicators can help nurses apply the standard statements to their particular practice environment.

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.

Indicators

A nurse meets the standard by:

a) ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;
b) documenting both objective and subjective[5] data;
c) ensuring that the plan of care is clear, current, relevant and individualized to meet the client's needs and wishes;
d) minimizing duplication of information in the health record;
e) documenting significant communication with family members/significant others,[6] substitute decision-makers and other care providers;
f) ensuring that relevant client care information kept in temporary hard copy documents (such as kardex, shift reports or communication books) is captured in the permanent health record. For example, if the electronic system is unavailable, the nurse must ensure that information captured in temporary documents is entered in the electronic system when it becomes available again;
g) providing a full signature or initials, and professional designation (RPN, RPN[Temp], RN, RN[Temp] or NP) with all documentation;
h) providing full signature, initials and designation on a master list when initialling documentation;
i) ensuring that hand-written documentation is legible and completed in permanent ink;
j) using abbreviations and symbols appropriately by ensuring that each has a distinct interpretation and appears in a list with full explanations approved by the organization or practice setting;
k) documenting advice, care or services provided to an individual within a group, groups, communities or populations (for example, group education sessions);
l) documenting the nursing care provided when using information and telecommunication technologies[7] (for example, providing telephone advice);
m) documenting informed consent[8] when the nurse initiates[9] a treatment or intervention authorized in legislation; and
n) advocating for clear documentation policies and procedures that are consistent with the College's practice standards.

[5] Documentation should reflect a nurse's observations and should not include unfounded conclusions, value judgments or labelling.

[6] Significant other may include, but is not limited to, the person the client identifies as being the most important in his or her life. Examples include spouse, partner, parent, child, sibling or friend.

[7] For more information, refer to the College's *Telepractice* practice guideline at **www.cno.org/publications**.

[8] For more information, refer to the College's *Consent* practice guideline at **www.cno.org/publications**.

[9] For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at **www.cno.org/publications**.

Accountability

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

Indicators

A nurse meets the standard by:

a) documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;
b) documenting the date and time that care was provided and when it was recorded;
c) documenting in chronological order;
d) indicating when an entry is late as defined by organizational policies;
e) documenting at the next available entry space, and not leaving empty lines for another person to add documentation (when using paper documentation forms). If there are empty lines, the nurse should draw a line from the end of the entry to the signature. When using an electronic system, the nurse should refrain from leaving a space in a free-flow text box;
f) correcting errors while ensuring that the original information remains visible/retrievable;
g) never deleting, altering or modifying anyone else's documentation;
h) enabling a client to add his or her information to the health record when there is a disagreement regarding care;[10]
i) documenting when information for a specific time frame has been lost or cannot be recalled;
j) indicating clearly when an entry is replacing lost information;
k) ensuring that documentation is completed by the individual who performed the action or observed the event, except when there is a designated recorder, who must sign and indicate the circumstances (for example, a code situation, or instances when an electronic system has technical difficulties and someone else enters the information when the system becomes available again);
l) clearly identifying the individual performing the assessment and/or intervention when documenting; and
m) advocating at the nurse's facility for clear documentation policies and procedures that are consistent with the College's standards.

[10] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

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.

Indicators

A nurse meets the standard by:

a) ensuring that relevant client care information is captured in a permanent record;
b) maintaining confidentiality of client health information,[11] including passwords or information required to access the client health record;
c) understanding and adhering to policies, standards and legislation related to confidentiality;
d) accessing only information for which the nurse has a professional need to provide care;
e) maintaining the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, using initials when quoting a client's roommate);
f) facilitating the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health record, unless there is a compelling reason not to do so (for example, if disclosure could result in a risk of serious harm to the treatment or recovery of an individual);[12]
g) obtaining informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care;[13]
h) using a secure method such as a secure line for fax or e-mail to transmit client health information (for example, making sure the fax machine is not available to the public);
i) retaining health records for the period the organization's policy and legislation stipulates when required by the nurse's role (for example, in independent practice);
j) ensuring the secure and confidential destruction of temporary documents that are no longer in use; and
k) advocating for clear documentation policies and procedures that are consistent with the College's standards.

[11] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[12] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[13] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

Appendix A: Supporting Documentation Practices

All nurses — including employers who are nurses, researchers and educators — must demonstrate the knowledge, skill, judgment and attitude required of regulated health professionals. They must also reflect on their role in improving their practice settings, and advocate for quality nursing care practices.

Strategies that nurses in all roles can use to support documentation practices that meet the College's *Documentation, Revised 2008* practice standard include:

- 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 appropriate, reliable and available documentation equipment, and to IT support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring policies are available and reflect the documentation standards to guide practice (for example, having explicit assessment norms and standards of care for charting by exception);
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;
- ensuring that effective mechanisms are in place to help nurses apply the organization's documentation policies;
- supporting nurses' development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- developing performance management processes that provide opportunities to improve documentation;
- providing adequate time to document appropriately and review prior documentation;
- identifying and acknowledging nursing excellence in staff documentation;
- having an available and open management structure (for example, "management walkabouts" that focus on documentation issues or trends); and
- providing opportunities to explore or promote team building as it relates to documentation practices.

Appendix B: Nursing Documentation Legislation References

The following list contains a sampling of federal and provincial legislation that may affect nursing documentation. The legislation was in force at the time this document was published.

Federal Legislation

To obtain copies of current federal legislation, contact the Government of Canada Inquiry Centre at 1 800 O Canada (1 800 622-6232) or visit the Department of Justice website at www.laws.justice.gc.ca/en.

Access to Information Act

Personal Information Protection and Electronic Documents Act

Privacy Act

Provincial Legislation

To obtain copies of current Ontario legislation, contact Publications Ontario at 1 800 668-9938 or visit the Ontario Statutes and Regulations website at www.e-laws.gov.on.ca.

Child, Youth and Family Services Act, 2017

Coroners Act

Freedom of Information and Protection of Privacy Act

Health Care Consent Act

Health Protection and Promotion Act

Mental Health Act

Municipal Freedom of Information and Protection of Privacy Act

Nursing Act, 1991

Occupational Health and Safety Act

Personal Health Information Protection Act

Public Hospitals Act

Quality of Care Information Protection Act, 2004

Regulated Health Professions Act, 1991

Appendix C: Electronic Documentation Resources

Below are some general resources related to electronic documentation.

Canada Health Infoway *Canada Health Infoway: Establishing Electronic Health Records for Canadians* www.infoway-inforoute.ca

Canadian Institute for Health Information *CIHI - Canadian Institute for Health Information* www.cihi.ca

E-Health Ontario www.ehealthontario.ca

Health Canada *Electronic Health Record* www.hc-sc.gc.ca

Registered Nurses Association of Ontario *Nursing and E-health Initiative* www.rnao.org

Suggested Reading List

Ammenwerth, E., Mansmann, U., Iller, C., & Eichstadter, R. (2003). Factors affecting and affected by user acceptance of computer-based nursing documentation: Results of a two-year study. *Journal of the American Medical Informatics Association*, *10*(1), 69-84.

Cheevakasemsook, A., Chapman, Y., Francis, K., & Davies, C. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice*, *12*(6), 366-374.

Hebert, M. (2000). A national education strategy to develop nursing informatics competencies. *Canadian Journal of Nursing Leadership*, *13*(2), 11-14.

Kossman, S.P., & Scheidenhelm, S.L. (2008). Nurses' perceptions of the impact of electronic health records on work and patient outcomes. *CIN: Computers, Informatics, Nursing*, *26*(2), 69-77.

Langowski, C. (2005). The times they are a changing: Effects of online nursing documentation systems. *Quality Management in Health Care*, *14*(2), 121-125.

Lee, T. (2006). Nurses' perceptions of their documentation experiences in a computerized nursing care planning system. *Journal of Clinical Nursing*, *15*(11), 1376-1382.

Nagle, L.M., & Catford, P. (2008). Toward a model of successful electronic health record adoption. *Electronic Healthcare*, *7*(1), 84-91.

Oroviogoicoechea, C., Elliott, B., & Watson, R. (2008). Review: Evaluating information systems in nursing. *Journal of Clinical Nursing*, *17*(5), 567-575.

Saletnik, L.A., Niedlinger, M.K., & Wilson, M. (2008). Nursing resource considerations for implementing an electronic documentation system. *AORN Journal*, *87*(3), 585-596.

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