Self-Assessment Tool: Documentation

The *Documentation, Revised 2008* practice standard is one of the practice documents selected for the Quality Assurance (QA) Program.

Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client health record. Documentation—whether visual, electronic or audio—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 tool will help you identify your areas of strength and the areas you need to improve related to the *Documentation, Revised 2008* practice standard, and give you more information on how to apply the standard to your individual practice. The tool lists the standard statements specific to the practice standard. This is not a comprehensive summary of the *Documentation* document, which can be viewed here.

This tool can be downloaded or copied for future use.

How to use this tool

Step 1 Review the indicators listed in the tool.
If you are unsure of the behavioural indicator, read the bulleted notes to get an example of the indicator being used in practice.

Step 2 Identify your areas of strength and the areas you need to improve.
After reviewing each behavioural indicator, mark in the box beside the statement to show whether the indicator is an area of strength or an area you need to improve.

If you need more space to write your examples, print additional copies of the tool or use extra paper.

- **Area of strength:** If you choose this box, provide an example of why this is an area of strength for you and how you can apply this strength in your practice.
- **Area of improvement:** If you choose this box, provide an example of why it is an area requiring improvement and how you can improve that area in your practice.

Step 3 Use the information on the tool to develop learning goals that you can use in your Learning Plan.

Once you have identified your areas of strength and the areas you need to improve, you can create your learning goals and start developing your Learning Plan.

Use the *Developing SMART Learning Goals* guide to help you create goals that are specific, measurable, attainable, relevant and time-limited.

Create your goal statement by starting with a phrase, for example:

"I want to share my knowledge/expertise about …" (for areas of strength)

"I want to work on/learn how to …" (for areas of improvement)

Then add the applicable behavioural indicator that was noted as an area of improvement or strength. This information forms the basis for documenting activities for your learning goals.

Remember to incorporate the following four elements in your self-assessment and the development of your Learning Plan:

- advances in technology;
- changes in the practice environment;
- entry-to-practice competencies; and
- interprofessional care.

Self-Assessment Tool: Documentation

Behavioural indicators • Bullet points are examples of how the indicator can be applied in practice.	Identify whether the behavioural indicator is an area of strength, with an example, or an area you need to improve, with an example of how that area can be improved.	
	Area of strength	**Area you need to improve**
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. You meet the standard by:** • 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. • Documenting both objective and subjective data. • Ensuring that the plan of care is clear, current, relevant and individualized to meet the client's needs and wishes. • Minimizing duplication of information in the health record. • Documenting significant communication with family members/significant others, substitute decision-makers and other care providers. • 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. • Providing a full signature or initials, and professional designation (RPN, RPN[Temp], RN, RN[Temp] or NP) with all documentation. • Providing full signature, initials and designation on a master list when initialing documentation. • Ensuring that hand-written documentation is legible and completed in permanent ink.		

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	Area of strength	**Area you need to improve**
• 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. • Documenting advice, care or services provided to an individual within a group, groups, communities or populations (for example, group education sessions). • Documenting the nursing care provided when using information and telecommunication technologies (for example, providing telephone advice). • Documenting informed consent when the nurse initiates a treatment or intervention authorized in legislation. • Advocating for clear documentation policies and procedures that are consistent with the College's practice standards. • Adhering to College standards and organizational policies by not falsifying client records, including not signing or issuing a document that the member knows includes a false or misleading statement.		
Accountability **Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete. You meet the standard by:** • Documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event. • Documenting the date and time that care was provided and when it was recorded. • Documenting in chronological order. • Indicating when an entry is late as defined by organizational policies.		

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	Area of strength	**Area you need to improve**
• 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 space in a free-flow text box. • Correcting errors while ensuring that the original information remains visible/retrievable. • Never deleting, altering or modifying anyone else's documentation. • Enabling a client to add his or her information to the health record when there is a disagreement regarding care. • Documenting when information for a specific time frame has been lost or cannot be recalled. • Indicating clearly when an entry is replacing lost information. • Ensuring that documentation is completed by the individual who performed the action or observed the event, except in situations 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). • Clearly identifying the individual performing the assessment and/or intervention when documenting. • Advocating for clear documentation policies and procedures at the nurse's facility that are consistent with the College's standards.		

<table>
<tr><th rowspan="2">Behavioural indicators
• Bullet points are examples of how the indicator can be applied in practice.</th><th colspan="2">Identify whether the behavioural indicator is an area of strength, with an example, or an area you need to improve, with an example of how that area can be improved.</th></tr>
<tr><th>Area of strength</th><th>Area you need to improve</th></tr>
<tr><td>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.
You meet the standard by:
• Ensuring relevant client care information is captured in a permanent record.
• Maintaining confidentiality of client health information, including passwords or information required to access the client health record.
• Understanding and adhering to policies, standards and legislation related to confidentiality.
• Accessing only information for which the nurse has a professional need to provide care.
• 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).
• Facilitating the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health records, 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).
• Obtaining informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care.
• 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).
• 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).
• Ensuring the secure and confidential destruction of temporary documents that are no longer in use.</td><td></td><td></td></tr>
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	Area of strength	**Area you need to improve**
• Advocating for clear documentation policies and procedures that are consistent with the College's standards.		
During the Self-Assessment process, remember to incorporate the following four elements in your reflection		
	Area of strength	**Area you need to improve**
Entry-to-practice competencies: Expectations that all nurses must maintain throughout their career. The RN, RPN and NP competency statements are available at www.cno.org/qa.		
Advances in technology: The introduction of new, innovative or different skills, processes or knowledge into a nurse's practice setting. For example, learning how to use a new electronic documentation system.		
Changes in the practice environment: Changes that require additional knowledge, skill and judgment for a nurse to deliver safe, effective and ethical nursing care. For example, changes in the client population, nursing care delivery systems or legislation.		
Interprofessional care: The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.		