




The College of Nurses of Ontario presents the *Documentation* practice standard: Meeting the Standards.

Core standards for documentation

<p>Client-focused</p>	<p>Clear, concise and comprehensive</p>	<p>Accurate</p>
<p>Relevant</p>		<p>Chronological and timely</p>
<p>Confidential</p>	<p>Permanent and retrievable</p>	<p>Record of care</p>

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The documentation method used by a practice setting should reflect client-care needs and the context of practice. Regardless of the method (narrative, charting by exception or electronic), documentation must be relevant, client-focused, comprehensive, accurate and timely. In addition, documentation must provide a clear record of the nursing care that was provided and identify who provided the care. The documentation must be permanent, retrievable and kept confidential. When a nurse's documentation meets these standards, the nurse has met the professional and legislative requirements.

Let's take a closer look at meeting the standards of practice when documenting.

Chronological and timely

- document during or immediately after care
- document the date and time of the entry and the date and time the care was provided.

Information documented during care or immediately after care has been provided is considered more reliable than information recorded at a later time. Documentation should clearly indicate when care was provided and when the documentation entry was written.

Including the date and time of the documentation entry and the time when the care was provided supports the primary purpose of documentation: communication. To present a clear picture of events and facilitate better communication among care providers, entries should be in chronological order.

Record of care

Documenting group interactions include:

- the purpose of the meeting
- the plan or approach
- the actions taken
- an evaluation of the outcomes



When documenting for groups – such as public health programs, therapy groups, coalitions and meetings related to health care initiatives – the same principles apply. The documentation should include the purpose of the meeting, the plan or approach used, the actions taken and an evaluation of the outcomes.

2006/04/30 1400 hrs At 1000 hrs

*Client shared how upset she was about her frequent admissions to the hospital.
Client cried during periods of the assessment and stated, "I hate being away
from my home. It's difficult to manage my affairs from the hospital."*

Discussed with the client the option of speaking with a social worker.

*Client agreed she would like support in managing her affairs and would
like to speak with the social worker. -----*

-----*Joan Smith, RN*

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Now, let's take a closer look at the previous documentation entry.

Nursing documentation for an individual client should include an assessment of the client's health status, implementation of the care plan and/or actions taken and evaluation of nursing strategies and client outcomes. Each nurse needs to document the care that they provided.

Client-focused documentation

- includes collaboration with other care providers
- includes incidents and incident reports relevant to the client
- contains third party information relevant to client
- relevant to the client



All documentation included in the health record must be relevant to the client. In collaborating with other health care providers regarding client care, the nurse documents the collaboration, including outcomes or agreed-upon plans of actions and the names of the people involved in the collaboration.

Facilities often require nurses to complete separate incident reports for incidents such as client falls; harm to clients, staff or visitors; and medication errors. Regardless of whether incident reports are used, nurses have a professional requirement to document incidents relevant to the clients. Incidents not relevant to the client do not belong in the client health record. For example, “The nurse fell in the client’s room” does not belong in the client chart. However, “The client fell” would be documented in the client chart. The documentation should include the nature of the incident, an assessment and the care provided.

When documenting an incident in the health record, a nurse must include the names of other care providers and third parties involved in the incident. However, to protect confidentiality, initials or codes should be used to record the identity of other clients who were involved. Nurses may obtain relevant information about a client or an incident from another person, such as information provided by the client’s family member or friend. (For example, the mother of a pediatric client may indicate that her husband is often drunk when he visits.) In these situations, nurses should use their professional judgment to determine if the information is accurate and relevant to the client. If accurate and relevant, the nurse would document the information, including the source of the information in the health record.

Clear, concise and comprehensive documentation

- facilitates the evaluation of the client's progress
- quantity of documentation is not the focus

Clear, concise and comprehensive documentation facilitates the evaluation of the client's progress toward the client's desired outcomes. Poor documentation provides incomplete or, in the worst case scenario, no written evidence of the care provided. That being said, the quantity of documentation is not the focus.

Let's look at ways to ensure that your documentation is clear, concise and comprehensive.

Subjective data

- Include statements and/or feedback from the client.

The client shared how upset she was about her frequent admissions to the hospital.

- Use quotation marks to identify the words used by the client.

"I hate being away from my home. It's difficult to manage my affairs from the hospital."

The documentation of a client assessment should include both the subjective and objective data. Subjective data includes statements and feedback from the client; for example, the client shared how upset she was about her frequent admissions to the hospital.

If nurses are documenting the clients' words, the information should be clearly identified with quotation marks. For example, the client stated, "I hate being away from my home. It's difficult to manage my affairs from the hospital" is inside quotation marks.

Objective data

Includes:

- observed and measured data
- nursing actions and client's response
- use facts not judgments
- data to support conclusions

Objective data includes observed data such as client was crying or measured data such as blood pressure is 120/80. Objective data includes interventions, actions or procedures and the client's response. All documentation should include what was observed. Avoid "appears to" and "seems to" when describing observations.

Nurses should avoid documenting value judgments about a client or the client's behaviour, such as client uncooperative or client depressed. Instead, nurses should document supporting data and objective behaviour, such as client refuses bath, shouts and shakes fists, or client showing signs of depression: not eating, difficulty getting to sleep, lack of interest.

In the notation below, is the date and time of the documentation entry and the time that the care was provided clearly noted?

2006/04/30 1400 hrs At 1000 hrs client shared how upset she was about her frequent admissions to the hospital. Client cried during periods of the assessment and stated, "I hate being away from my home. It's difficult to manage my affairs from the hospital." Discussed with the client the option of speaking with a social worker. Client agreed she would like support in managing her affairs and would like to speak with the social worker. -----
--Joan Smith, RN

- A) Yes
- B) No

Click on the circle beside the correct answer.

Does this entry communicate the assessment data, implementation of the care plan or actions taken, or the evaluation?

Client shared how upset she was about her frequent admissions to the hospital. Client cried during periods of the assessment.

- A) assessment of the client's health status
- B) implementation of the care plan or actions taken
- C) evaluation of nursing strategies or outcomes

Click on the circle beside the correct answer.

Does this entry communicate the assessment data, implementation of the care plan or actions taken, or the evaluation?

Discussed with the client the option of speaking with a social worker.

- A) assessment of the client's health status
- B) implementation of the plan of care or action taken
- C) evaluation of nursing strategies or outcomes

Click on the circle beside the correct answer.

Does this entry communicate the assessment data, implementation of the care plan or actions taken, or the evaluation?

Client agreed she would like support in managing her affairs and would like to speak with a social worker.

- A) assessment of the client's health status
- B) implementation of the care plan or actions taken
- C) evaluation of nursing strategies or outcomes

Click on the circle beside the correct answer.

Does this entry provide subjective or objective data?

Client cried during periods of the assessment.

A) subjective

B) objective

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Click on the circle beside the correct answer.

Does this entry provide subjective or objective data?

Client stated, "I hate being away from my home. It's difficult to manage my affairs from the hospital."

- A) subjective
- B) objective

Click on the circle beside the correct answer.

Assessment, Goals and Actions

Your score	{score}
Max score	{max-score}
Number of quiz attempts	{total-attempts}

Abbreviations and meaningful statements

- Use the abbreviations and symbols approved by your facility to avoid confusion.

OD - once a day

OD - right eye

OD - overdose

- Avoid meaningless phrases.

Up and about

Good night

Some abbreviations and symbols have multiple meanings, which can lead to confusion, errors and wasted time. What does OD mean to you? Once a day, right eye or overdose?

Abbreviations and symbols can be an effective, efficient form of documentation if their meaning is understood by those who read the health record. Nurses should refer to workplace or agency policy for a list of approved abbreviations.

Also, make sure that your documentation doesn't contain meaningless phrases such as good night and up and about.

Signature and designation

- Signature or initial all entries and include your designation.

Registered Nurse	RN
Registered Practical Nurse	RPN
Register Nurse Extended Class	RN(EC)
RN in the Temporary Class	RN (Temp)
RPN in the Temporary Class	RPN (Temp)

Effective documentation clearly demonstrates a nurse's accountability. To promote communication and support accountability, all nurses must include their signature and professional designation on all entries.

RN(EC)s who are not employed in the nurse practitioner role may use RN. Nurses with Temporary registration use their designation with the word "Temp" beside it. RNs working in the RPN role may only use the RPN designation if they hold dual RN/RPN registration with the College. Dual registrants may use either title, depending on the role in which they are employed.

If initials are used in documentation, a master list that identifies the caregiver's full name, designation, full signature and initials should be maintained to clarify accountability.

Errors, changes and additions

- When making a correction, the purpose of the correction and the content that was changed should be clearly identified and signed.
- All errors must remain visible.
- Do not delete, alter or modify another provider's documentation.

All nurses may correct their own errors in the health record. When making a correction, the purpose of the correction and the content that was changed should be clearly identified, and the entry must be signed. The original information must remain visible or retrievable in the health record. Do not delete, alter or modify another care provider's documentation.

Select the documentation that best documents errors.

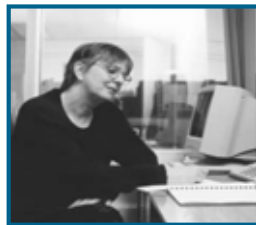
- A) Client ~~appeared to be upset~~ was upset about her frequent admissions to the hospital. She seemed to cry during periods of the assessment. L. Rogers, RPN
- B) Client ~~appeared to be upset~~ was upset about her frequent admissions to the hospital. She cried during periods of the assessment. -----L. Rogers, RPN

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Click on the circle beside the correct answer.

Maintaining accuracy

- Avoid duplication in the health record.
- The person who saw the event or performed the action should document it.



The risk of error in the health record increases with the more times the same information is written. If nurses or other health care providers have to check several places to review recorded data or determine if the information was recorded, the likelihood of an error increases. The key is to avoid duplication; therefore, all nurses need to clearly understand the expectations and implement consistent documentation practices.

The person who saw the event or performed the action, documents. An exception is in situations in which there is a designated recorder, such as during a cardiac arrest. Legislation and generally accepted standards of practice require nurses to document the care they give to demonstrate accountability for their actions and decisions. For this reason, the College recommends that unregulated care providers record the care they provide.

Nurses document conclusions that can be supported with data. Documentation of value judgments about a client or a client's behaviour should be avoided; for example, client uncooperative or client depressed. Instead, nurses should document the observed behaviour, such as client showing signs of depression: not eating, difficulty getting to sleep, staying in room.

Scenario

Susan works at a facility where RNs and RPNs work collaboratively to provide care. Susan, an RPN, and Rosa, an RN, often work the same shift and share the care of clients, but are unsure of who should document in the clients' health records.

Consider the following scenario.

Who should document the care provided?

- A) Documentation in the clients' health records should be done by Rosa, the RN, regardless of who provided the care.
- B) Susan should document the care that she provided, and Rosa should document the care that she provided.

Click on the circle beside the most appropriate response.

Documenting Errors and Maintaining Accuracy

Your score	{score}
Max score	{max-score}
Number of quiz attempts	{total-attempts}

Test Your Knowledge



Test your knowledge of the core standards of documentation.

2005/12/05 Client called. Stated I have waited all day for an ambulance to pick me up and take me to a test. It appears that the test or ambulance was never scheduled. Case manager instructed client to stop waiting. Unsure why the client needed an ambulance, his wife could have taken him. Occupational therapy visit scheduled for next week. -----Mary Brown, RN

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Review this documentation and in the space provided on the screen, or on a piece of paper, write down five aspects that are incorrect or could be improved. Then, proceed to the next slide and compare your answers.

What is wrong with this documentation?

- The entry does not include the date and time of the event, and time that the entry was made.
- The information is not client-focused or relevant.
 - **The entry does not indicate what the test was for.**
- It provides non-nursing advice.
 - **Instructed client to stop waiting.**
- Judgments are made
 - **Client complaining, wife could have taken him.**
- The action is unrelated to the assessment.
 - **Occupational therapy visit is unrelated to the test?**

Review your own documentation. Does your documentation include the following indicators?

- A) the date and time when the care was provided
- B) the date and time of the entry
- C) meaningful statements and no judgments
- D) both observed and subjective data
- E) an assessment, plan of care and evaluation
- F) your signature and professional designation
- G) avoids vague wording such as appears to

Review your own documentation

Your score	{score}
Max score	{max-score}
Number of quiz attempts	{total-attempts}

Key points to remember

Documentation must:

- be clear, concise and comprehensive;
- client-focused;
- relevant; and
- present a clear picture of the nurse's assessment, actions and outcomes.

This chapter reviewed the core standards for documentation, including ensuring that documentation is clear, concise and comprehensive, client-focused and relevant. In addition, this chapter discussed how to ensure that documentation presents an accurate picture of the nurse's assessment, actions and outcomes.

Key points to remember

- Abbreviations and symbols can add efficiency in documentation.
- Nurses may correct their own errors in a health record.
- When making a correction, the purpose and content should be clearly indicated. The original information must remain visible, and the entry must be signed.

Other important points covered in this chapter include abbreviations and symbols, which can be an effective form of documentation if their meaning is understood by the health care providers who may read the record. This chapter also provided an overview on how to document specific issues related to documentation, such as errors and changes and forgotten or late entries. Nurses may correct their own errors in a health record. When making a correction, the purpose and content should be clearly understood. The original information must remain visible, and the entry must be signed.

Documentation standards

Purpose of Documentation

Meeting the Standards

Electronic Health Records

Other Considerations

Charting by exception

Accessing health records

Documenting telephone nursing care



There are three additional chapters on documentation, including The Purpose of Documentation and Electronic Health Records. The chapter Other Considerations focuses on charting by exception, accessing and retaining health records, and documenting telephone care. To view these chapters, close this presentation and return to the Learning Centre.

To ask a College practice consultant a question, click on "Contact" in the upper right-hand corner of your screen.