




The College of Nurses of Ontario presents the *Documentation* practice standard: Other Considerations.

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 documentation method (narrative, charting by exception, flow charts), it must be relevant and client-focused, comprehensive, accurate and timely. As well, it must provide a clear record of the nursing care 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 documentation practice standard by focusing on different documentation methods, documenting nursing care provided by telephone, and the retention of records.

Documentation forms and tools

- The type of forms used should be consistent with the needs of the client populations and the context of the practice.
- Documentation methods may be combined to record care effectively.
- Nurses are accountable for documenting assessments, interventions and client responses.
- Maintain competency in the documentation system.

All nurses are expected to document the care they provide by using the forms and/or tools provided at their practice setting. The type of documentation forms should be consistent with the needs of client populations and the agency's context of practice. Some facilities or agencies may combine elements of different documentation methods and formats to document care effectively. Regardless of the method or methods used, nurses are accountable for documenting their client assessments, the interventions they carried out and the client's responses. Nurses are expected to maintain competency in and knowledge of the documentation system being used.

Charting by exception

- Document only when the assessment findings vary from the norm.
- Norms and standards must be set by the facility or agency.
- Flow sheets are frequently used to document ongoing care.
- Everyone must use the same approach.

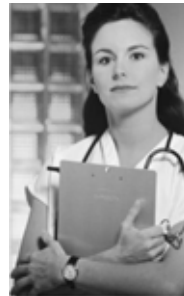
There are various formats or methods that nurses use to document. Charting by exception is a shorthand documentation method, not an absence of documentation. Charting by exception challenges the long-held legal belief, If it was not charted, it was not done. It replaces this thinking with, It was a normal or expected response unless documented otherwise.

Facilities that use charting by exception ensure that assessment norms and standards of care are explicit. It is not appropriate to use documenting by exception unless normal assessment parameters or standards have been set.

When charting by exception, flow sheets are frequently used to document ongoing care, such as personal care and vitals signs. Remember that the risk of error in the health record increases with the number of times the same information is written. The key is to avoid duplication; therefore, all nurses need to clearly understand the expectations and implement consistent practices related to documentation. In addition, everyone must use the same approach to documenting unusual events. If some nurses use a narrative approach while others document only exceptions, communication may break down.

Care plans

- Keep care plans clear, current and useful.
- Individualize care plans to meet the needs and preferences of individual clients.



Another form of nursing documentation are care plans that outline care for individual clients. Care plans need to be part of the permanent health record, kept up-to-date and clearly identify the needs and preferences of the client. When the care plan is not evident in the documentation, the nurse should ensure that a separate plan of care is retained.

Monitoring strips

- Advocate to retain strips as part of the permanent record.
- On monitoring strips, document the client's name and/or identification code, the date and the time.



All relevant assessment data needs to be retained in the health record. This includes monitoring strips, such as cardiac, fetal, thermal and blood pressure testing strips. The monitoring strips should include the client's name and/or identification code as well as the date and time.

Communication books and shift reports

- Use communication books or shift reports only as a tool to alert the health care team of critical information in the health records.
- Ensure that all pertinent information is included in the permanent health record.
- These records may be requested during legal proceedings.

Communication books and shift reports are used to alert the health care team to critical information. They can be used to direct others to the health record, where the pertinent information is recorded in detail. Nurses who use these tools must ensure that all pertinent information documented in these tools is also documented in the health record.

It is important that nurses protect the confidentiality of client information in communication books and shift reports. These records may be requested during legal proceedings.

Telephone nursing care

- All care provided over the telephone must be documented.
- The documentation may be handwritten or entered into a computer.
- The best place to document care is in the client's chart.

Click here to read the [Documentation practice standard](#).

Click here to read the [Telepractice practice guideline](#).



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Nurses in some practice settings provide nursing care via the telephone. All nurses who provide care and information to clients by phone are required to document their interactions. Documentation may be handwritten or entered into a computer, and should be stored according to the relevant legislation and regulations. The best place for information about client care is in the client's health record. When the nurse does not have access to a client's health record, a consistent method of collecting and recording the information, such as a telephone log, can be used.

For more information on documenting telephone interactions, read page 10 of the *Documentation* practice standard.

For more information on providing care, and giving or receiving information using telecommunication technology, including the telephone, read the *Telepractice* practice guideline.

Protecting confidentiality

- The confidentiality of information must be safeguarded and shared only on an as-needed basis.
- Nurses have a legislative and professional obligation to protect client information.



[Click here to view the Confidentiality and Privacy – Personal Health Information](#)

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When clients entrust personal information to a health care professional or facility, it is essential that the confidentiality of that information be safeguarded and shared only as necessary in serving the interests of the client. Nurses have a legislative and professional obligation to protect their clients' personal information.

For more information on the *Personal Health Information Protection Act*, read the *Confidentiality and Privacy - Personal Health Information* practice standard.

Access to health records by clients and their representatives

- Facilitate the rights of clients and/or substitute decision-makers to access, inspect and obtain a copy of health records.
- Advocate for policies that facilitate client access to information.
- Ensure that those seeking access have the required authority.

Clients are entitled to access, inspect and copy the information in their health record – whether the record is maintained in a paper, electronic or any other format. Nurses should advocate for policies that facilitate client access to information.

The only time that a nurse would not permit client access to his or her records is when there is a compelling reason for denying access; for example, when access would cause harm to the client or a third party.

Nurses have a legislative and professional obligation to protect client confidentiality. A nurse must be satisfied that those seeking access to a client's health record have the legal authority to see the record. If you're unsure of a person's authority to access a record, consult with your employer.

Access to health records by others

- Advise clients of the composition of the health care team and that the team will have access to their confidential information.
- Obtain consent from the client and/or substitute decision-maker to collect, use and disclose information with others outside of the health care team.

Click here to access the [Information and Privacy Commissioner website](#)

To meet client care needs, nurses share client information with the health care team. Nurses should ensure that clients understand that confidential information will be shared with team members. Nurses may also disclose confidential information to a third party when they have received consent from the client or the person with the authority to act on the client's behalf.

There are situations in which nurses have a legal obligation to disclose client information without prior consent from the client. For example, nurses are required to report child abuse, comply with search warrants during criminal and coroner investigations, and cooperate with investigations carried out under the *Regulated Health Professions Act*.

For more information on sharing person health information, contact the Information and Privacy Commissioner of Ontario.

Permanent and retrievable

- Retain health records for 10 years.
- For clients under 18 years of age, retain records for 10 years after the client's 18th birthday.
- Destroy records after the retention period.
- When there are multiple providers, use one health record.

Nurses have a legislative responsibility beyond documenting in the client's health record. Legislation requires that most practice settings retain health records for a minimum of 10 years after the client was last assessed or treated. The health records of clients under age 18 at the time of last assessment or treatment must be retained for a minimum of 10 years from the day the client turns 18. Nurses who store and retain records, such as those in independent practice, are required to permanently destroy the records after the retention period.

Legislation may require that certain practice settings retain the records for a longer period. All nurses need to be aware of the legislation affecting retention periods. When more than one agency is involved in providing care, for example in the community, the College recommends that all care providers document in one health record. The decision of who and how the record will be retained should be made before care is provided.

Key points to remember

- The documentation method should reflect client care needs and the context of practice.
- Regardless of the documentation method, the health record must present a clear picture of the nurse's assessment, actions and outcomes.
- The risk of error increases with the number of times the same information is written.

This chapter briefly discussed various methods that can be used for documenting care. Nurses must ensure that they know and use the documentation method in their facility and ensure that it presents an accurate picture of their assessment, actions and outcomes.

The risk of error increases with the number of times the same information is written in the health record. The key is to avoid duplication.

Key points to remember

- Telephone interactions with clients must be documented.
- Monitoring strips and care plans are part of the permanent client record.
- Clients have a right to access records.
- Records must be retained for 10 years.

Nurses providing care or giving information over the telephone are required to document their interactions, either in the client chart (if available) or in a telephone log book.

Monitoring strips and care plans need to be part of the permanent health record. Care plans must be kept up-to-date and clearly identify the clients' needs and preferences.

Clients are entitled to access, inspect and copy the information contained in their health record. Some exceptions apply.

And finally, records must remain confidential and be retained for a period of 10 years. If the client is under 18 years of age, the records must be retained for 10 years following the client's 18th birthday.

Documentation standards

Purpose of Documentation

Meeting the Standards

Electronic Health Records

Other Considerations

Charting by exception

Accessing health records

Documenting telephone nursing care



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Additional chapters on documentation include The Purpose of Documentation, Electronic Health Records and Meeting the Standards, a learning module that demonstrates how you can meet the requirements of the *Documentation* practice standard. To view these chapters, close this presentation and return to the Learning Centre.

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