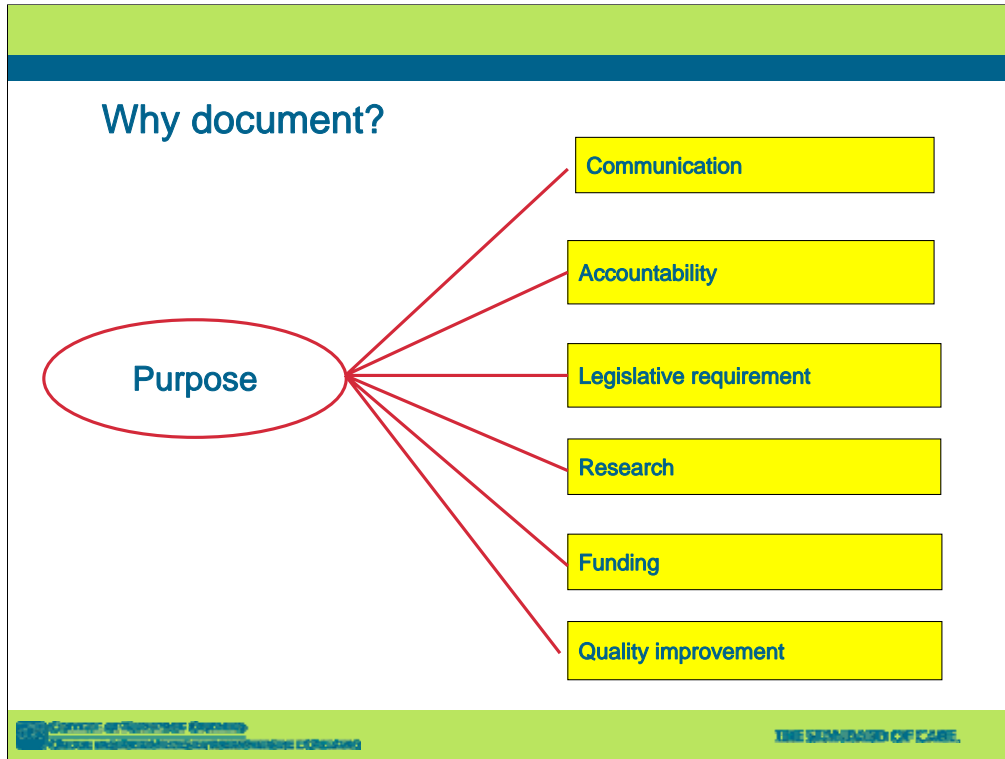




The College of Nurses of Ontario presents the *Documentation* practice standard:  
The Purpose of Documentation



Documentation can refer to both the act of creating records and the actual records themselves.

Documentation is used to communicate client health information, demonstrate accountability and meet legislative requirements. In addition, documentation can play an integral role in research, allocation of funds and quality improvement.

## Communication

Documentation fosters communication by:

- reflecting the client's perspective;
- ensuring continuity of care; and
- describing the care provided and its effect.



One of the most-important purposes of documentation is communication. Documentation reflects the clients' perspective of their health and well-being.

Effective documentation allows nurses and other health care providers to communicate about the care, and the client's response to the care.

## Accountability

Documentation demonstrates accountability by:

- identifying the care provider;
- determining responsibility; and
- contributing to legal proceedings.



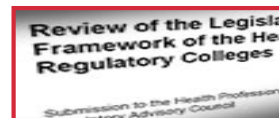
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University of North Carolina at Chapel Hill

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Accountability answers the question, Who did what and when? Documentation demonstrates a nurse's accountability and determines responsibility. It also resolves questions or concerns about the provision of care. A nurse's documentation may be used in a legal proceeding, such as a lawsuit, coroner's inquest or a discipline hearing at the College.

## Legislative requirements

- The *Nursing Act* requires all nurses to make and keep records of their practice.
- Documentation must meet the standards outlined in the *Documentation* practice standard.
- Nurses in independent practice have additional requirements.



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

The *Nursing Act, 1991*, states that all nurses are required to make and keep records of their professional practice. The records must meet the standards defined in the College's *Documentation* practice standard. Failure to follow the standard constitutes professional misconduct.

Other legislation, such as the *Public Hospitals Act*, may identify specific content that must be maintained. Nurses need to consult legislation related to their area of practice and employment setting.

Nurses in independent practice have additional requirements for the storage and retrieval of documentation. For more information, access the Information and Privacy Commissioner of Ontario's website.

## Research

Health records can be used to:

- promote evidence-based practice; and
- assess nursing interventions and evaluate client outcomes.



Health records can be a valuable source of data for health research. They can be used to promote evidenced-based nursing practice, assess nursing interventions and evaluate client outcomes. As well, health records can identify care and documentation issues.

## Funding and resource management

Health records can:

- identify care needs; and
- derive workload systems.



In addition, data from health records can identify the type and amount of client needs, the care and services provided, and the efficiency and effectiveness of that care. These factors can be useful when determining funding and resource allocation.

## Quality improvement

Health records can be used to:

- evaluate professional practice;
- evaluate care and outcomes; and
- help nurses identify and address practice areas that they need to improve in.



Information in the health record can also be used to evaluate professional practice during quality-improvement processes, such as performance reviews, chart audits, accreditation, legislated inspections and board reviews. Clear, complete and accurate documentation facilitates the evaluation of the clients' progress toward their health goals.

Individual nurses can use the outcome information or information from a critical incident to reflect on their practice and make needed changes.

**Match the purpose of documentation with a descriptor.**

<b>Purpose</b>	<b>Action</b>
<ul style="list-style-type: none"><li>■ f 1. Communication</li></ul>	<ul style="list-style-type: none"><li>■ a ) evaluate professional practice</li></ul>
<ul style="list-style-type: none"><li>■ e2. Accountability</li></ul>	<ul style="list-style-type: none"><li>■ b ) identify resource allocation needs</li></ul>
<ul style="list-style-type: none"><li>■ d3. Legislative Requirement</li></ul>	<ul style="list-style-type: none"><li>■ c ) promotes evidence based practice</li></ul>
<ul style="list-style-type: none"><li>■ c4. Research</li></ul>	<ul style="list-style-type: none"><li>■ d ) nurses must make and maintain records</li></ul>
<ul style="list-style-type: none"><li>■ b5. Funding</li></ul>	<ul style="list-style-type: none"><li>■ e ) determines responsibility</li></ul>
<ul style="list-style-type: none"><li>■ a6. Quality Improvement</li></ul>	<ul style="list-style-type: none"><li>■ f ) reflects client's perspective</li></ul>


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Click on a Purpose and drag it to its appropriate Action.

## Purpose of Documentation

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

## Core standards for documentation

Client-focused	Comprehensive	Accurate
Relevant		Chronological and timely
Confidential	Permanent and retrievable	Record of care

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Documentation must be relevant, client-focused, comprehensive, accurate and timely. As well, documentation 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.

## Documentation standard

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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To learn more about meeting the documentation core standards, review the learning module chapter Meeting the Standards.

Other documentation chapters include Electronic Health Records; and Other Considerations, which focuses on charting by exception, accessing and retaining health records and documenting 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.