Practice Standard

Documentation

College of Nurses
of Ontario
Ordre des infirmières
et infirmiers de l'Ontario

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CNO practice standards outline accountabilities for nurses and inform the public, including clients and organizations, what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice. Nurses are expected to practice in compliance with relevant legislation, the Code of Conduct, all other standards of practice of the profession and applicable employer and organizational policies. Not complying with legislation or failing to meet the standards of practice may be considered ***professional misconduct.***

Introduction

Documentation is an essential component of safe nursing practice. It involves recording key information that provides evidence of a **client's** health status, needs or goals, **communication** with the **health care team**, the decision-making process and care provided, including outcomes and evaluations. This process supports both the delivery and continuity of care.

Documentation can take many forms, which include but are not limited to paper-based records, electronic systems, electronically generated notes and audio or visual recordings. It may include clinical assessments, the rationale behind care decisions and any changes in the client's condition.

Whether documenting for individual clients, groups or communities, documentation supports collaborative practice. It ensures all members of the health care team have access to clear, complete and accurate information, which is essential for making informed decisions and delivering coordinated care. Documentation that meets this standard ensures accountability, enhances client safety and supports legal and professional accountabilities.

As technology continues to evolve, nurses are required to meet documentation requirements regardless of the format or platform used.

Bolded terms are defined in the glossary at the end of the document.

Why document?

Nursing documentation reflects:

- the nursing process and **nursing care** provided to demonstrate commitment to safe nursing practice
- the client's needs and goals
- the nurse's application of knowledge, skill and judgment in providing safe and effective care
- the communication across the broader health care team throughout the continuum of care

Clear, complete and accurate documentation is essential for safe client care, as it ensures critical information is effectively communicated to support informed decision-making and the continuity of care.

Documentation may be used as evidence in legal proceedings, as it provides an account of the client's current health status, the nurse's assessment, decision-making and the actions taken based on collaboration with the client and/or **substitute decision-makers** and the health care team. Not documenting relevant care, events or interactions may lead to the conclusion that the care, events or interactions did not occur.

Documentation has many other uses, including but not limited to:

- evaluating professional practice for quality improvement
- determining appropriate care and services for clients
- supporting reflective practice
- supporting nursing research

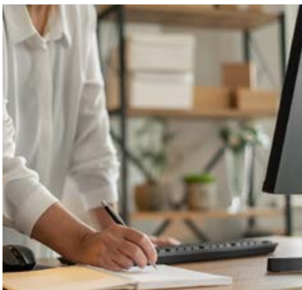
To meet the expectations for this practice standard, nurses must consider the following principles:

Communication

Effective communication through documentation promotes safe and quality care.

Documentation requirements

Consistent, appropriate and accurate documentation practices meet legal and professional accountabilities and support safe care.



Information security

Nurses ensure that any written or electronically documented information about a client is secure.

Each principle includes a set of nursing accountabilities, which are described in this practice standard.

Communication

Effective communication is a foundational documentation accountability that promotes safe and quality nursing care. Nurses must apply their knowledge, skill and judgment when documenting, ensuring their documentation is a clear, complete and accurate representation of the client's health status including the nursing care provided and any significant interactions.

Accountabilities

To maintain effective communication, nurses:

- document in a clear, complete and accurate manner
- document the nursing care provided and their decision-making involved in the care. This can include:
  - the nursing process (for example, assessment, diagnosis[1], planning, intervention and evaluation)
  - **subjective** and **objective information**
  - plan of care

[1] Nurses recognize and work within the limits of their legal scope of practice and their knowledge, skill and judgment.

- document the medication they administered to the client, as set out in CNO's *Medication* practice standard
- apply their knowledge, skill and judgment to include relevant information in their documentation
- document relevant communication with the client, family members, substitute decision-makers or any person involved in the client's care, such as interpreters or religious or spiritual care providers
- document relevant communication with other health care team members, including name, any designated title (of the other health care team members), the mode of communication (such as in-person, telephone, email, video or other digital platforms) and the outcome of the discussion
- use documentation methods approved by their employer/organization—such as templates, flow sheets or narrative notes—to ensure a clear and comprehensive representation of the client's health status, adding relevant details as needed to capture clinical information, decision-making and care provided
- review their documentation for accuracy, including when generated through the use of technology, such as **artificial intelligence,** as outlined in CNO's *Artificial Intelligence* guidance and in accordance with employer/organizational policies
- ensure their documentation is free from discrimination and respects how a client self-identifies, as outlined in the *Ontario Human Rights Code*
- document services provided to a group of clients in accordance with employer/organizational policies. If advice, care or services are provided to an individual within a group, the nurse documents this information within the individual client's **record** (if applicable).

Documentation requirements

Consistent, appropriate, and accurate documentation practices are essential for safe, reliable care. They support accessibility, ensure continuity, and uphold legal as well as professional accountabilities.

Accountabilities

To maintain documentation requirements, nurses:

- sign all documentation entries with a unique identifier, such as their written signature, initials and/or electronically generated identifier, and designated title (NP, RN or RPN)
- document in chronological order
- ensure all documentation entries include the date and time
- document in a timely manner, either at the time they provide care or as soon as possible after the care or event occurred. Nurses do not document before the care is provided
- ensure all documentation is legible and in permanent form
- document the mode of communication with clients, such as in-person, telephone, email, video or other digital platforms
- capture all relevant documentation in the permanent record, including any images, videos or information exchanged through the use of technology

- indicate a **late entry** and the date and time the care or action occurred
- document any event or care they provide and do not document any care that is provided by another individual, except when there is a **designated recorder**
- do not co-sign documentation entries
- do not delete their own documentation. If documentation corrections are needed, nurses ensure the original documentation remains retrievable and legible
- do not delete, alter or modify any documentation produced by others
- do not falsify a record relating to their practice, including signing or issuing a document that they know or ought to know includes a false or misleading statement
- document **informed consent** as set out in the *Health Care Consent Act, 1996* (see CNO's *Consent* guideline for additional explanation)

Information security

Documentation is a record of personal health information. Nurses secure and protect personal health information by maintaining privacy and confidentiality, which includes acting in accordance with relevant legislation, standards of practice and employer/organizational policies.

Accountabilities

To protect personal health information, nurses:

- maintain the confidentiality and privacy of their documentation, as set out in CNO's *Confidentiality & Privacy – Personal Health Information* practice standard and the *Personal Health Information Protection Act, 2004*
- use their unique access credentials, such as login credentials, when documenting electronically
- obtain informed consent from the client when using artificial intelligence technologies for the purpose of documentation, in accordance with employer/organizational policies
- maintain the security of personal health records during the transmission or disclosure of information. This includes when using technologies, such as email or secure messaging
- transport documentation only when authorized and in a secure manner
- keep their documentation secure and participate in the confidential destruction of temporary documents

Partners in safety

Standards of practice and employer/organizational policies guide nurses in determining documentation requirements, to ensure key information is communicated effectively.

Employers/organizations are important system partners and share responsibility for client safety. Employers/organizations and others in the system are responsible for establishing a work environment that supports safe and effective client care. They ensure nurses have access to the necessary training to support clear, accurate, consistent documentation practices, and access to resources that help nurses meet their professional standards of practice and legal obligations, such as establishing documentation policies and procedures. CNO does not regulate employers or organizations; however, CNO encourages policies and procedures that prioritize, support and enable client safety. Documentation policies and procedures should align with relevant legislation and CNO's standards of practice.

Nurses who are employers, including those operating an independent practice, may have additional record keeping responsibilities, as set out in legislation and CNO's *Confidentiality & Privacy – Personal Health Information* practice standard. In these circumstances, nurses are accountable for meeting both the standards of practice of the nursing profession, as well as their responsibilities as employers. Nurses who are employers also should be aware of the documentation requirements outlined in other applicable legislation, such as the *Employment Standards Act, 2000,* the *Occupational Health and Safety Act, 1990* and the *Ontario Human Rights Code*.

Glossary

Artificial intelligence: Encompasses a broad spectrum of technologies aimed at mimicking cognitive functions associated with human intelligence.

Client: An individual, family, group, community or population receiving nursing care, including, but not limited to, “patients” or “residents” (Code of Conduct, 2025).

Communication: The transmission of verbal and/or nonverbal messages between a sender and a receiver for the purpose of exchanging or disseminating information (Nova Scotia College of Nursing, 2025).

Designated recorder: In situations (for example, cardiac arrest, during a procedure or surgery) where it may not be possible for the nurse providing care to document, it is acceptable to have a designated recorder. Typically, employer/organizational policies support the practice of designated recorders in these situations (Nova Scotia College of Nursing, 2024).

Documentation: Health records that provide evidence in a variety of forms (for example, paper-based, electronic, electronically generated, audio or visual), used to reflect the client’s health status, needs or goals, communication with the health care team, the decision-making process and care provided, including the outcomes and evaluations of those decisions.

Health care team: Members of the intraprofessional and/or interprofessional team and/or community supporting client care. This also includes students, new learners and Indigenous and traditional healers (Code of Conduct, 2025).

Informed consent: As described under the *Health Care Consent Act, 1996*, a person’s consent is informed if the person receives information about a treatment that a reasonable person in the same circumstances would require to make a decision and if the person receives responses to their requests for additional information about the treatment.

The information must include the treatment’s nature, expected benefits, material risks and side effects; alternative courses of action; and likely consequences of not having the treatment (Code of Conduct, 2025).

Late entry: A documentation entry made after the usual or reasonably expected time from the care or event has passed, rather than at or near the time of the care or event. To maintain accuracy and transparency, a late entry should be clearly identified as a late entry, dated, and refer to the date and time of the related care or event.

Nursing care: Nursing care given to a client, which includes, but is not limited to, assessment, planning, delivery, monitoring, evaluation and care coordination (Code of Conduct, 2025).

Objective information: Objective information deals with facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations. Objective data is observed (for example, swelling, bleeding) or measured (for example, temperature, blood pressure) and includes interventions, actions or procedures as well as the client's outcome (Nova Scotia College of Nursing, 2024).

Professional misconduct: An act or omission that contravenes nurses' legislated obligations or the standards of practice and ethics of the profession. Professional misconduct is defined in section 51(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professionals Act, 1991*, and further described in the Professional Misconduct regulation (O. Reg. 799/93) under the *Nursing Act, 1991* (Discontinuing or Declining to Provide Care, 2024).

Record: Any record of information, however recorded, whether in printed form, on film, by electronic means or otherwise (*Freedom of Information and Protection of Privacy Act*, 2024).

Subjective information: Subjective information may include information provided by a client or any person the client wants involved in their care and is modified or affected by personal views, experience or background (Nova Scotia College of Nursing, 2024).

Substitute decision-maker: Person, identified by the *Health Care Consent Act, 1996*, who makes a treatment decision for someone who cannot make their own decision. See CNO's *Consent* guideline for more information (Code of Conduct, 2025).

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