The College of Nurses of Ontario presents the Documentation Learning Module
Chapter 3: Accountability.
Accountability means being responsible for your actions and the consequences of your actions.

Documentation demonstrates a nurse’s accountability and determines responsibility. It answers the question: Who did what and when?
Standard statement

Accountability

Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

The standard statement for accountability in the *Documentation, Revised 2008* practice document states: **Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.** This chapter explains how you can meet the expectations of the accountability standard statement.
Nurses are accountable for recording information in a timely manner.

You should document information during care or as soon as possible after the care is provided. This enhances the accuracy of each entry and the overall credibility of the record.

Sometimes a practice setting or location may pose barriers that prevent the nurse from being able to document during or directly after an event. For example, a nurse assisting a client with skills development in the community may not be able to document the care until she is back in the office.

It is an expectation that nurses document as soon as reasonably possible, given the situation and the environment.

Regardless of the barrier or delays you may face, it is important that you never document care before it is given. For example, you should not complete a flow sheet about care you are going to provide until after the care has been provided, no matter how predictable you think the outcome is likely to be.
When you document, include the date and time of the documentation, as well as the date and time care was provided. Documentation should be in chronological order. Refer to your workplace policy regarding how to document a late entry.
Documentation should be completed by the individual who provided the care or observed the event. For example, you shouldn’t document care provided by a personal support worker.

An exception is made in an emergency situation. For example, during a cardiac arrest, one nurse may be designated as the recorder to document the care provided by a number of other health care professionals. When acting as a designated recorder, identify the other health care professionals involved in relation to the care they provide. For example, the documentation should specify activities such as “Dr. Sotto inserted chest tube…”
When correcting an error, a nurse is required to ensure that the original content of the documentation is maintained. The correction and the content that was changed should be identified, and the entry must be signed.

For example, if you record an incorrect date, it should remain visible as documented, even after you add the correct date to the record.

Also, you cannot delete, alter or modify in any way another individual's documentation.
All nurses are expected to be aware of legislation that may impact on documentation practices in their setting. Examples include the Mental Health Act, the Long-Term Care Homes Act, the Occupational Health and Safety Act and the Health Protection and Promotion Act. Current legislation is available on e-laws, a database of Ontario legislation and regulations.
You have now completed Chapter 3 of the Documentation learning module. There are additional chapters in this module. Chapter 1 is an overview of documentation; Chapter 2 explains communication and documentation; Chapter 4 looks at the security aspects of documentation; and Chapter 5 is a Test-Yourself chapter, where you can assess your knowledge of nursing documentation.

For more information, close this presentation, return to the Learning Centre and select the chapter of your choice.

If you have a question for a Practice Consultant, click on the link in the upper right-hand corner.