The College of Nurses of Ontario presents the Documentation Learning Module Chapter 2: Communication.
The most important purpose of documentation is to communicate a client's health information. Documentation provides accurate, relevant, timely, and comprehensive information concerning the needs of the client, and the care and services provided by the nurse. Communicating a client’s health information to other members of the interprofessional team enables consistency and continuity in client care.
The standard statement for communication in the Documentation, Revised 2008 practice document states that: Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client’s needs, the nurse’s interventions and the client’s outcomes.

This chapter explains how you can meet the expectations of the communication standard statement related to documentation.
Documentation captures essential communication that has occurred within the interprofessional team. Nursing documentation communicates to the team your assessment, planning, implementation and evaluation of the care provided, and the client’s response to the care.

It also serves to communicate the client’s preferences and expressed needs. It is important that, when possible, you include the client’s perception of the care provided when you document.
Documentation should include both subjective and objective data. Subjective data includes statements and feedback from a client. For example, a client may describe his pain to you by saying, “I feel a strong shooting pain while standing, but it goes away when I'm sitting.”

When documenting subjective data, provide accurate examples of what the client said using quotation marks to identify her or his comments.
Objective data is data that can be observed, such as “client was crying,” or measured, such as the blood pressure is 120/80. Objectivity means documenting facts without distortion of personal feelings, prejudice or interpretations.

For example, you may document the objective fact that a client’s temperature is 38 degrees and the subjective information that the client reports: “I am feeling warm and dizzy.”
Another aspect of communication is to include a clearly identifiable signature, including designation, on all documentation.

Use of your initials is acceptable if there is a master list that provides your full signature, designation and initials.

Your designation will be either RN, RPN or NP.

Other degrees or certificates may be included with your signature depending on your workplace’s policy, but they are not required by the College.
Nurses have an obligation to ensure that their documentation is captured in the permanent health care record. If you are using temporary hard copy documents, such as Kardex, shift reports or communication books, you must ensure that relevant information is transferred to the permanent record in either electronic or hard copy format as soon as possible.
When information about a client’s health is obtained from a third party, for example, family members, nurses have to use their clinical judgment to decide if the information is relevant to the client’s current status and likely to have an impact on the client’s care.

You need to be aware of legislative requirements and organizational policies to help you decide what documentation is required. If you are unsure of what is relevant to document, discuss it with members of the team.
You have now completed Chapter 2 of the Documentation learning module. There are additional chapters in this module. Chapter 1 is an overview of documentation; Chapter 3 explains a nurse’s accountability regarding 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, 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.