



# Documentation Standards for Regulated Members

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Quality **DOCUMENTATION**<sup>1</sup> and reporting are necessary to enhance efficient, individualized **CLIENT** care (Potter, Perry, Ross-Kerr, & Wood, 2009). Regardless of the format used to document, the client care record is a formal, legal document that details a client's health care and progress. Differences in how client care records are kept exist across the multiple settings in which regulated members practice, and each client population has its own unique characteristics and expectations.

The term documentation as used in this document refers to any written or electronically generated information about a client that describes client status or the care or services provided to that client (Potter, Perry, Ross-Kerr, & Wood, 2009).

The purpose of this document is to provide the professional regulatory requirements for **NURSES** that will assist them in producing clear, accurate and comprehensive accounts of client care within any practice setting.

All nurses providing nursing care must adhere to the documentation standards. Documentation is not separate from care and it is not optional. It is an integral part of the nurse's practice, and an important tool that nurses use to ensure high-quality client care.

These standards are based on CARNA's *Practice Standards for Regulated Members* (2013), which outline the expectations for safe, competent and ethical practice for registered nurses in Alberta. Standards of Practice describe the required behaviour of every nurse and are used to evaluate individual performance (Appendix 1). In CARNA's *Practice Standards for Regulated Members* indicator 2.5 states "the nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice". Thus, the quality of documentation is often construed as a reflection of the **STANDARD** of professional practice.

In Alberta, nurses are required to adhere to the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (2008) and the CARNA *Practice Standards for Regulated Members* (2013). Nurses have a responsibility to apply nursing knowledge and skill in providing safe, competent, ethical care. A nurse's professional practice with respect to documentation must reflect safe, competent and ethical nursing care.

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<sup>1</sup> Words or phrases in **BOLD CAPITALS** upon first mention are defined in the glossary.

Regardless of the practice setting, client confidentiality must be established and upheld. When the client care record is maintained in a client's home, there is the potential for family members and/or others (e.g., visitors, guests) to access confidential information. If client care records are being accessed in the community practice setting via computer or other electronic devices, the protection of the confidentiality of the client care record, health information, and the security of such devices must be a top priority. It is important that agencies/facilities have policies in place outlining who is authorized to access the client care records and how clients and/or family members will be made aware of the importance of maintaining confidentiality. All worksheets or informal notes containing personal health information must be destroyed once the information has been incorporated in the client care record.

Nurses practicing in Alberta must continue to be aware of and follow all relevant privacy legislation; and are required to adhere to CARNA's *Privacy and Management of Health Information: Standards for CARNA's Regulated Members* (2011a). To support nurses in applying the standards, Appendix 2 of this document contains additional references to legislation related to documentation.

## Assumptions Related to Standards

The *Documentation Standards for Regulated Members*:

- apply at all times to all nurses regardless of client care setting
- provide expectations of members of the profession
- enable sound decision making
- support effective communication between care team members

### Criteria:

- illustrates how standards can be met
- are not written in order of importance

## Standard 1

Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

### Criteria:

The nurse must:

- 1.1** Record a complete account of nursing assessment of the client's needs, including:
  - a.** identified issues and concerns
  - b.** assessment findings
  - c.** diagnosis
  - d.** plan of care
  - e.** intervention(s) provided
  - f.** evaluation of the client care outcomes
- 1.2** Document the following aspects of care:
  - a.** relevant objective information related to client care
  - b.** the time when assessments and interventions were completed
  - c.** follow-up of client assessments, observations or interventions that have been completed
  - d.** the administration of medications after administration
  - e.** formal and informal educational/teaching activity provided to the client and family
  - f.** any adverse event or **ADVERSE OUTCOME**
- 1.3** Ensure all entries made in the client care record (whether in person or by phone, by means of dictation/transcription) are authenticated and dated (CHIA, 2008).
- 1.4** Record:

- a. legibly, in English, using clear and established terminology
  - b. accurately, completely and objectively
  - c. only information relating to own encounter with the client
  - d. chronologically, the client **ENCOUNTER** with the health system
  - e. **CONTEMPORANEOUSLY**
  - f. late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy
  - g. in permanent ink on paper records
  - h. using only own password/personal access code on electronic entries
  - i. the date and time that nursing care was provided
  - j. communication with other care providers, including name and outcomes of discussion
  - k. communication with clients following discharge from care according to employer policy
- 1.5** Use only abbreviations that are approved through employer policy.
- 1.6** Adhere to the Privacy and Management of *Health Information: Standards for CARNA's Regulated Members* (2011a).
- 1.7** Access client health information only for purposes that are consistent with professional responsibilities.
- 1.8** Comply with the applicable privacy legislation and follow employer policies regarding the collection, use (including access to), disclosure, retention and security of health information.
- 1.9** Obtain informed consent from the client to use and disclose information to others outside the circle of care, in accordance with relevant legislation.
- 1.10** Take reasonable steps to maintain the security and confidentiality of health information that is transferred or disclosed.

- 1.11** Safeguard client health information by maintaining confidentiality in accordance with relevant legislation, professional standards and be familiar with any applicable employer policy.
- 1.12** Never delete or modify anyone else's documentation.
- 1.13** Identify the person(s) involved and the care they provided when acting as a designated recorder.
- 1.14** When clarifying (or altering) information after the fact in the client care record, identify the person making the alteration, the date and time; the original entry must also be included in the client care record.
- 1.15** In a paper client care record:
- a.** sign all documentation by using first initial, full legal surname and regulatory title on the client care record
  - b.** ensure there are no empty lines or spaces in the documentation
  - c.** correct own documentation by striking out the documentation error, adding the correct information, the date and time of the new entry, and initialing the amendment so that the author can be clearly identified
- 1.16** In an electronic client care record:
- a.** use only personal password (or access card) to access, or enter information into a client care record that is within an electronic documentation system
  - b.** take reasonable steps to maintain the security of user password(s) or access card and use safeguards such as logging off when finished using electronic documentation system
  - c.** correct own documentation, enter the correct information, the date and time of the new entry, so that the author can be clearly identified



# Background: Purpose and Implications of Documentation

## Communicating and Providing Continuity of Care

The client care record is, first and foremost, a clinical document. It should include information to identify:

- the client
- the care provider
- the date and time of the encounter
- prevention of illness care
- the identified issues being addressed
- the plan of care
- care provided
- the clinical reasoning for the choice of care
- the client's response and/or outcome of the interventions
- future plans

Effective written communication skills are essential in order to precisely document each of these components of nursing practice. When done well, nursing documentation is a valuable tool to support effective communication between providers and continuity of care within and across settings.

Clients are leaving acute care settings earlier and increasing numbers of clients are presenting in the community with higher acuity. Documentation in the community has different implications than in other care settings in that:

- the majority of the care is often performed by the client and family
- the nurse's role is not only in the provision of direct care and interventions but also that of educating and assisting the client and family to achieve greater independence

A good test to evaluate whether a client's care record is a satisfactory clinical document is to answer the following question: "If another practitioner had to step in to care for the client because the assigned nurse was not available, does the client care record provide sufficient information for the seamless delivery of safe, competent and ethical care to the client?"

## Accountability

Nurses are responsible for their own nursing practice, and documentation is a part of that responsibility. Documentation should serve as a record of the critical inquiry and judgment used to describe events, interventions, or discussions with clients. Comprehensive and accurate documentation provides a record of astute nursing insights, reflects the quality of nursing care, and provides a client care record of the professional and personal support that nurses provide every day to clients and their families. Complete, accurate and thorough nursing documentation provides evidence that the regulated member has met the requirements expected in the role in a particular practice setting. The nurse is creating a permanent client care record every time documentation is done.

## Legal Implications of Documentation

The client care record is an important legal document. It provides information that shows care has been provided, and it can be used to resolve questions or concerns about accountability and the provision of care. Documentation provides a chronological record of the many events involving a client from admission to a health care service until discharge and may be used to refresh the nurse's memory if the nurse is required to give evidence in court. It is very common for the courts to use clinical documents to reconstruct events, establish times and dates, and resolve conflict in testimony.

A lawyer representing a nurse will rely heavily on available documentation to establish that the care provided by the nurse was reasonable and prudent in the circumstances. Conversely, the patient's lawyer may use the same documentation to try and show that the nurse failed to meet the standard of care of a reasonable and prudent nurse (CNPS, 2007).

Quality documentation provides specific information (who, what, when, where, how and why) about the actual care the nurse provided and a record of the client's response to that care. It assists others in confirming that the nurse's care was competent and safe, met acceptable standards and procedures, was provided in a timely manner, and was consistent with organizational policies. When determining what specific kind of information should be included within a client care record, applicable legislation or regulation and facility policy should be consulted.

## Quality Improvement and Risk Management

The health information contained in the client care record is often a tool used within quality improvement processes to evaluate services provided and outcomes achieved. Accreditation Canada (formerly Canadian Council of Health Services Accreditation) sets standards for client documentation, which must be met by health service organizations as part of their accreditation process (CCHSA, 2001). Comprehensive, accurate documentation provides a sound basis for appropriate measurement of the quality of care and facilitates the evaluation of the client's progress toward preferred outcomes.

A risk-management program is a system to identify, assess and reduce risks to clients, visitors, staff and organizational assets. Good risk-management practice requires clear documentation, as client-care records are used for audits and ongoing risk management analysis (CRNNS, 2005). "The nurses' notes are risk-management and quality assurance tools for the employer and the individual nurse" (Potter et al., 2009). Quality documentation is ultimately good risk management for the client receiving care, for the staff providing the care, and for the organization.

## Facilitating Evidence-Informed Practice and Clinical Decision Support

Evidence-informed practice is supported and informed by research findings, as well as by the depth and breadth of knowledge and experience of registered nurses. The client care record can be an important source of data for nursing and health research and, for this purpose, accurate and thorough documentation is essential. The documentation by the regulated member provides a rich source of information related to nursing interventions and evaluation of client outcomes.

## Glossary

**ADVERSE OUTCOME** – Refers to a deterioration of the client’s condition that is unexpected, based on the plan of care.

**CLIENT** – Refer to patients, residents, families, groups, communities, and populations.

**CONTEMPORANEOUSLY** – The completion of the client-care record notes at the time of the event or as close to it as prudently possible. Enhances the credibility and accuracy of client-care records.

**DOCUMENTATION** – Any written or electronically generated information about a client that describes client status or the care or services provided to that client.

**ENCOUNTER** – A client’s interaction with the health system and the nurse, related to a particular occurrence.

**NURSES** – All regulated members of the College and Association of Registered Nurses of Alberta (CARNA) including: registered nurses (RNs), graduate nurses (GNs), certified graduate nurses (CGNs), nurse practitioners (NPs) and graduate nurse practitioners (GNPs).

**STANDARD** – An authoritative statement that describes the required behavior of every nurse and is used to evaluate individual performance.

## References

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## Appendix 1: Other Standards Documents Published by CARNA

CARNA has other specific standards to provide direction to nurses in addition to the *Documentation Standards for Regulated Members* (2013). These include:

- *Complementary and/or Alternative Therapy and Natural Health Products: Standards for Registered Nurses* (2011)
- *Registered Nurses with a Blood-Borne Virus Infection: Standards for Reporting and Guidance for Prevention of Transmission of Infection* (2008)
- *Practice Standards for Regulated Members* (2013)
- *Privacy and Management of Health Information: Standards for CARNA's Regulated members* (2011)
- *Health Professions Act: Standards for Registered Nurses in the Performance of Restricted Activities* (2005)
- *Decision-Making Standards for Nurses in the Supervision of Health Care Aides - CARNA, CRPNA, CLPNA* (2010)
- *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care* (2005)
- *Standard for the Use of the Title "Specialist" in Registered Nurse Practice* (2006)

Current versions of all CARNA standards are available from the CARNA website at: [www.nurses.ab.ca](http://www.nurses.ab.ca)

## Appendix 2: Legislation – Nursing Documentation

The following legislation has an effect on nursing documentation and was in force at the time of printing. The list is not exhaustive.

### Federal

*Access to Information Act*

(<http://laws-lois.justice.gc.ca/eng/acts/A-1/>)

*Controlled Drugs and Substances Act*

(<http://laws-lois.justice.gc.ca/eng/acts/C-38.8/>)

*(Personal Information Protection and Electronic Documents Act*

(<http://laws-lois.justice.gc.ca/eng/acts/P-8.6/>)

*Privacy Act*

(<http://laws-lois.justice.gc.ca/eng/acts/P-21/index.html>)

### Provincial

*Health Information Act*

([http://www.qp.alberta.ca/574.cfm?page=H05.cfm&leg\\_type=Acts&isbncln=9780779724758](http://www.qp.alberta.ca/574.cfm?page=H05.cfm&leg_type=Acts&isbncln=9780779724758))

*Freedom of Information and Protection of Privacy Act*

(<http://foip.gov.ab.ca/legislation/act/index.cfm>)

*Mental Health Act*

([http://www.qp.alberta.ca/574.cfm?page=M13.cfm&leg\\_type=Acts&isbncln=0779748727](http://www.qp.alberta.ca/574.cfm?page=M13.cfm&leg_type=Acts&isbncln=0779748727))

*Occupational Health and Safety Act*

(<http://www.qp.gov.ab.ca/documents/acts/O02.cfm>)

*Health Professions Act*

*([http://www.qp.alberta.ca/574.cfm?page=h07.cfm&leg\\_type=Acts&isbncln=9780779738083](http://www.qp.alberta.ca/574.cfm?page=h07.cfm&leg_type=Acts&isbncln=9780779738083))*

*Personal Information Protection Act*

*(<http://www.pipa.gov.ab.ca/index.cfm?page=legislation/act/index.html>)*

Legislation is subject to amendment from time to time. Readers should ensure they consult the current version of federal or provincial legislation.

For information on where to obtain copies of current federal legislation, call the Government of Canada Inquiry Centre at 1-800-O Canada or visit the Department of Justice website at <http://laws.justice.gc.ca>.

For information on where to obtain copies of current provincial legislation, call the Queen's Printer at 780 427-4952 (toll free dial 310-0000 first and then the number) or visit the Queen's Printer website at [www.qp.gov.ab.ca/](http://www.qp.gov.ab.ca/).