



DOCUMENTATION GUIDELINES FOR REGISTERED NURSES



College of Registered Nurses
of Nova Scotia

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INTRODUCTION

Documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic. This document is intended to provide registered nurses with guidelines for professional accountability in record keeping and to describe the expectations for nursing documentation in all practice settings, regardless of the method or storage of that documentation. Another document published by the College of Registered Nurses of Nova Scotia (the College), entitled *Guidelines for Telenursing Practice* (2000), provides additional information on documentation related to nursing services provided via electronic means (e.g., telephone-based client consultations).

Nursing documentation provides an account of the judgment and critical thinking used in the nursing process (i.e., assessment, diagnosis, planning, intervention and evaluation). Accurate, timely documentation reflects care provided; meets professional, legislative and agency standards; promotes enhanced nursing care; and facilitates communication between nurses and other healthcare providers. According to Potter & Perry (2001), nursing documentation must be both comprehensive and flexible enough to obtain critical data, maintain quality and continuity of care, track client¹ outcomes, and reflect current standards.

Documentation also reflects the application of nursing knowledge, skills and judgment, establishes accountability, and conveys the unique contribution of nursing to health care. In fact, the current goal of the International Classification of Nursing Practice (ICNP) project is to have nursing practice evident when health records are coded.

Overall, the accurate and appropriate recording of nursing care holds benefits for everyone – the client, in terms of outcomes, and all those involved in providing quality health care. The current trend toward interdisciplinary documentation is intended to eliminate duplication, enhance efficient use of time, and enrich client outcomes through team collaboration.

Registered nurses in Nova Scotia are legally and ethically required to practise nursing in accordance with the *Registered Nurses Act* (2001) and *Regulations* (2001), the College's *Standards for Nursing Practice* (2004), and the *Code of Ethics for Registered Nurses* (CNA, 2002). According to the Standards, a nurse² is expected to record and maintain documentation that is clear, timely, accurate, reflective of observations, permanent, legible and chronological. Current and accessible documentation systems, processes and policies can support nurses in meeting their professional practice standards, as well as legal documentation standards.

Nurses also need to be familiar with, and follow, agencies' documentation policies, standards and protocols. It is recommended that these *Documentation Guidelines for Registered Nurses* serve as a basis for the development of agencies' policies on nursing documentation (see Agency/District Policies & Procedures, p.12).

¹Client(s): the recipient(s) of nursing services: e.g., individuals (family members/guardians/substitute caregivers), families, groups (communities groups), populations or entire communities (adapted from CNA, NNCP, 1997, p.42).

²Nurse: refers to a registered nurse, nurse practitioner, graduate nurse, or a nursing student.

SECTION 1: PURPOSES AND PROFESSIONAL PRINCIPLES

Documentation refers to written or electronically generated information about a client, describing the care or services provided to that client (e.g., charting, recording, nurses' notes, or progress notes). In other words, documentation is an accurate account of events that have occurred and when they occurred (RNABC, 2003). Clinical documents are defined as legally authenticated (i.e., attested or signed) and persistent entries in a client's health record. Nurses may document information pertaining to individual clients or groups of clients.

Individual Clients

Nursing documentation for individual clients provides a clear picture of the status of a client, the actions of the client's nurse, the client's health outcomes, and information about or from the client's family. A client's family may also document care for an individual client (e.g., home care, family documentation of a newborn's feeding patterns).

Nursing documentation for an individual client, whether electronic or paper-based, should clearly describe:

- an assessment of the client's health status
- a care plan or health plan reflecting the needs and goals of the client
- nursing interventions carried out
- the impact of these interventions on client outcomes
- any proposed or needed changes to the care plan
- information reported to a physician or other health-care provider and, when applicable, that provider's response
- advocacy undertaken by the nurse on behalf of the client (RNABC, 2003, p.2).

Groups of Clients

A health record (or equivalent) is used to document the service(s) and overall observations provided to groups of clients (e.g., therapy groups, public health programs for groups). Documentation for groups should also reflect a needs assessment of a specific group, as well as care plans, actions taken, and evaluations of group outcomes.

Regardless of whether documentation is electronic or paper-based, nursing documentation of services provided to a group of clients should clearly describe the:

- purpose and goal of the group
- criteria for participation
- activities (interventions) and group processes

- evaluation of group and/or individual outcomes.

Specific information about an individual client within a group should be documented on individual health records and not on the group service record. When an individual health record is used, the names of group members should not be identified (RNABC, 2003, p.2).

A **health record** is a compilation of pertinent facts on a client's health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care (e.g., hospital admission, series of home visits). All healthcare professionals providing care create the pertinent facts documented in a client's health record. Health records may be paper documents (i.e., hard copy) or electronic documents such as electronic medical records, faxes, e-mails, audio or videotapes, or images.

Health records may also be referred to as "client records" or "client health records".

Purposes of Documentation

Clear, complete and accurate health records serve many purposes for clients, families, registered nurses, and other care providers. In particular, documentation of nursing care can play an integral role in interdisciplinary communications, quality assurance, and legal/ethical reviews. In addition, the Canadian Council of Health Services Accreditation sets standards for client documentation which must be met by facilities as part of their accreditation process.

Communications and Continuity of Care

The permanence of health records makes them a primary interdisciplinary communication tool, particularly in relation to providing necessary information to ensure consistency and continuity in clients' care. For instance, nurses' documentation in health records is one means of communicating assessment data and other pertinent information on a client's status, as well as nursing interventions planned and implemented, to all health-care providers involved in the care of the client.

Clear, complete and accurate documentation in a health record ensures that all those involved in a client's care

have access to reliable, pertinent, and up-to-date client information upon which to plan and evaluate their interventions. Documenting care encourages nurses to assess clients' progress, determine the effectiveness of interventions, and identify any required changes in their care plans. In some instances, healthcare providers also receive relevant information when clients and/or family members document their observations and/or care given.

Documentation can also be used for future reference (e.g., client readmissions, as a source of data for research, legal or disciplinary reviews).

Quality Improvement/Assurance and Risk Management

In their quest to ensure the provision of the highest possible quality of care, many agencies are instituting quality improvement/assurance and risk management programs. Risk management is a system used to identify, assess, and reduce, where appropriate, risks to clients, visitors, staff, and organizational assets. Risk management programs are designed to promote safety by reducing the incidence of preventable accidents and injuries through risk identification, risk analysis (to determine how future problems can be avoided), risk control/treatment, and risk financing. (American Society for Healthcare Risk Management, 2000).

Risk management entails good documentation, and client health records may be used for audits, ethical and disciplinary reviews, accreditation surveys, legislated inspections and board reviews, and ongoing risk management analysis (see Incident/Occurrence Reports, p.22).

Nursing documentation is used as a risk management and quality assurance tool, not only for the employer but also for the individual nurse (Potter & Perry, 2001, p.441). Through information documented and compiled in clients' health records, agencies are more readily able to evaluate clients' progress toward desired outcomes, identify client care issues, and recommend changes and/or improvements to care practices. Quality improvement processes incorporating the review of health records also often entail the evaluation of professional practice.

Professional Accountability

Registered nurses are expected to follow the *Standards for Nursing Practice* and *Code of Ethics for Registered Nurses* when documenting information related to the health status of clients, related situations/circumstances, and care provided.

Documentation is a valuable method of demonstrating that nursing knowledge, judgment and skills have been applied within a nurse-client relationship in accordance with the *Standards for Nursing Practice* (see Standard 1: Accountability, and Standard 3: Application of Knowledge, Skills and Judgment) and the *Code of Ethics*. Proper nursing documentation not only reflects care provided, it honours the ethical concepts of good practice and demonstrates accountability (e.g., confidentiality, research, informed decision-making, informed consent).

Legal Records

The importance of health records as legal documents cannot be overemphasized. Legal standards for documentation have evolved over time and continue to evolve. Many of the principles of documentation are based on Canadian common law court decisions. In a court of law, a health record serves as the legal record of care or service provided, and documentation is often used as evidence in legal proceedings. Nursing care and the documentation of that care is measured according to the standard of a reasonable and prudent nurse with similar education and experience in a similar situation (RNABC, 2003). Consequently, thorough and accurate documentation is one of the best defences against legal claims ... and the best defence if a lawsuit actually ensues.

Health records may be entered as evidence at trials to support a case. They are often used in court because they provide detailed and comprehensive information. For example, they provide a chronological record of events that can be used to reconstruct events, establish times and dates, and resolve conflicts in testimony (Canadian Nurses Protective Society, 1996). Health records, among other purposes, can be used to:

- “refresh memory” when testamentary evidence is required
- determine if orders were carried out
- determine if care provided was appropriate and timely
- determine if standards of care were met and if they were in accordance with the standards of the time
- reinforce testimony and uphold the credibility of a nurse and/or an institution
- help determine the extent of an injury
- show whether a client was compliant
- determine whether reactions to medications/substances were communicated.

If inaccurate or incorrect information is documented and then relied upon by expert witnesses, the resulting conclusion will be incorrect (Personal communication from presentation by E. Phillips, CNPS, Ottawa, January 28, 2005).

Funding and Resource Management

Documentation is one source of data that can be used by administration in making funding and resource management decisions. Health records are considered to be proof of care provided, and third-party insurers sometimes use documented client outcomes for the approval of insurance claims. Workload measurements and/or client classification systems, derived as a consequence of client documentation, are used by some agencies to help determine the allocation of staff and/or funding.

Research

Health records serve as a valuable and major source of data for nursing and health related research (e.g., statistical trending helps to prevent or minimize specific developments such as an increase in infection rates). Data obtained from health records are also used in health research to assess nursing interventions, evaluate client outcomes, and determine the efficiency and effectiveness of care. The type of research made possible through the information in health records can enable nurses to further improve nursing practice. Precise, clear and complete documentation is essential to ensure accurate research data.

Professional Principles of Documentation

Nursing documentation must provide an accurate and honest account of what and when events occurred, as well as identify who provided the care. Good documentation has five important characteristics. It should be: 1) factual; 2) accurate; 3) complete; 4) current (timely); and 5) organized (Potter & Perry, 2001, p.504).

Core principles of nursing documentation apply to every type of documentation in every practice setting. Regardless of the documentation method, nursing documentation should present a clear picture of a client's needs, a nurse's actions, and the client's response(s). The principles, when followed closely, will enhance the likelihood that the practice of a registered nurse is within acceptable nursing standards and demonstrates nursing accountability.

The following principles outline the *minimum* expectations regarding nursing documentation and apply to all documentation systems and methods used, including manual (e.g., written, paper-based) and electronic (e.g., video, computer, voice recording) health record systems. The principles also apply to the care provided to individual clients, a client's family, and/or groups, communities and populations (e.g., public health programs, meetings related to healthcare initiatives, therapy groups). Individual employers and/or legislation may require more specific documentation for particular circumstances or events.

Who should document?

First-hand knowledge only

Legislation and generally accepted standards of practice of the profession require nurses to document the care they provide; demonstrating accountability for their actions and decisions. The legal and professional principle is that “the care provider with personal knowledge should document the client care” (Grant & Ashman, 1997, p.137).

Whether using a paper-based or electronic system, entries should only be made by direct care providers (i.e., the person who saw an event or performed an action). An exception is made in emergency situations (e.g., during a cardiac arrest or newborn resuscitation) when one registered nurse is usually designated as the recorder, to document the care provided by a number of other healthcare professionals. When acting as a designated recorder, other healthcare professionals involved should be identified in relation to documentation of the care they provided.

Auxiliary Staff

Agencies need to ensure that all care providers demonstrate necessary competence with regard to documentation. The practice of documenting for other care providers (e.g., unlicensed assistive personnel or other auxiliary staff) may lead to errors and/or inaccuracies, which could be detrimental to providing quality care.

Agencies need to ensure that all care providers demonstrate necessary competence with regard to documentation. To ensure accuracy of information, auxiliary staff should document the care they provide and observations they make. In some agencies, personal care workers (PCWs) and continuing care assistants (CCAs) are permitted to document care in the permanent health record (electronically and paper-based). In other agencies, however, PCWs may have access only to notes not

contained on the permanent client health record. Agency policies need to indicate who may document in client health records and what practice is to be followed.

If an agency's policy specifies that auxiliary staff are not to record information, registered nurses should document the reports given to them by auxiliary personnel, including the individual's name and status. If possible, auxiliary staff should read and initial (if using a paper-based system) documentation related to care they provided.

Co-Signatures

Although nurses demonstrate their accountability by signing their health record entries, two signatures can sometimes lead to difficulties in determining who was responsible for the care provided. In instances where two nurses provide care but only one completes the documentation, registered nurses should be discouraged from co-signing the entries made by the other nurse. In fact, they should be discouraged from co-signing the entries made by any other care providers in the health record unless a facility or agency policy clearly indicates and defines the intent of a co-signature.

Co-signing entries made by other care providers is not a standard of practice and, when poorly defined, can blur accountability (CNO, 2003, p.10). If two nurses are involved in an assessment or the delivery of care, both nurses should document, according to agency policy. Agency policies should clearly describe how documentation should be completed when two nurses are required to be involved in an aspect of care. For example, if two registered nurses are required to hang a unit of packed-cells, and both must sign the health record, the intent of a co-signature should be clearly stated in policy. In this case, agency policy would likely indicate that the co-signature is confirmation that the nurse (co-signee) witnessed that the correct unit was given to the correct client.

However, in most instances when two nurses are involved in the care of one patient only one nurse needs to document (e.g., two-person assist in ambulating a client). In these situations, the nurse should document the action, noting the assistance of another care provider, as well as the client's response.

In certain circumstances, such as a critical incident witnessed by a second care provider (e.g., a fall), the witness should be identified in the health record.

Client, Family or Sitter

In some settings it is standard practice that a client, family and/or sitter document observations and care (e.g., mother documenting when a newborn was fed; family and/or client documenting specific information related to homecare services, such as foods consumed). Documentation of this information is significant and agencies should outline what should be documented and by whom, as well as the responsibilities of nurses with respect to the documentation.

For example, documentation should clearly identify who had first-hand knowledge of an event, a description of the event/activity, and who performed the event/activity.

What should be documented?

Relevant and client-focused information

As documentation of client care plays an integral role in communications among healthcare providers and can significantly influence the planning of clients' care, it is important that all entries reflect a complete record of nursing care provided and all relevant issues related to clients and their care. More specifically, nurses should record data collected through all aspects of the nursing process (e.g., critical assessment data, nursing interventions, evaluation of outcomes). For example, record:

- environmental factors (e.g., safety, equipment, allergies), self-care, and client education
- significant events during a client care episode
- client outcomes, including a client's response to treatments, teaching or preventive care
- discharge assessment data. Discharge documentation should note whether a client and his/her family had adequate preparation prior to discharge (e.g., content and outcome of education sessions).
- more comprehensive, in-depth and frequent notations for clients who are seriously ill, considered high-risk, or have complex health problems
- all relevant assessment data, including monitoring strips (e.g., cardiac, fetal, thermal or blood pressure), photographs, etc. **NOTE:** Monitoring strips and other irregular sized documents must be clearly marked with the client's name and identification number, and always retained with the health record.
- information related to any client transport. Agency policy should clearly outline the necessary documentation required for and during client transports from one agency to another (e.g., by air, ambulance, taxi) or from one department or site to another within the same agency.

The inclusion of details and accurate descriptions (e.g., specific or exact quantities, time frames and distances, pertinent and exact client comments) enhances client documentation and ensures that a record is accurate. Clear, concise data using precise language is easy to understand and enhances quality client care through the transfer of essential information.

Effective client-focused documentation should also include a plan of care. Care plans must be clear, current and useful to meet the needs and wishes of individual clients. If a care plan is not evident in the documentation, a separate formal plan of care should be retained with the permanent health record (see also Individual & Group Clients, p.3, and Care Maps, Clinical or Critical Pathways, and Variance Analyses, p.22).

Documenting all relevant data about a client or an incident is also essential for risk management. Relevant data should be documented on the health records of one or more patients involved in an incident (e.g., “Another client pushed Jane Doe.”) However, the names of other clients (e.g., the one who did the pushing) should not be recorded in health records other than their own (e.g., not in the health record of the client that was pushed). These names could be documented on an incident/occurrence report.

Documentation of client or family concerns related to an incident should be done according to agency policy and may require an incident report (see Incident/Occurrence Reports, p.22).

When a physician or other healthcare professional is called in relation to a specific incident, note the time of the call, as well as the intended recipient, in the progress (nurses’) notes. A notation should also be made when a physician or other healthcare provider returns a nurse’s call, along with relevant details of the ensuing discussion. If a call from a nurse about a specific incident is not returned, the nurse should also include this information in her/his documentation.

Objective/Subjective Data

There is often a question as to whether only objective information should be recorded in a client’s health record. Documentation should not be retaliatory or provide critical comments about either a client or other healthcare providers, but may include both subjective and objective data.

Objectivity means expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam-Webster Online, 2005). Objective data is observed (e.g., crying, swelling, bleeding) or measured (e.g., temperature, blood pressure), and includes interventions, actions or procedures as well as a client’s response.

Subjectivity is characteristic of or belonging to reality as perceived rather than as independent of mind (Merriam-Webster Online, 2005). Subjective data may include statements or feedback from a client as well as from family members or a friend.

- Quotation marks or other marks should be used to delineate subjective data (e.g., quoting actual statements), along with identification of the individual who made a particular statement.
- The use of inferences without supporting factual data is not acceptable because it can be misunderstood (Potter & Perry, 2001, p.504). Avoid bias by not documenting value judgments or unfounded conclusions; document only conclusions that can be supported with data.
- In relation to client interactions, provide accurate examples of what is observed (e.g., aggressive behaviour) and use quotes to reflect what is heard (e.g., obscene language).
- The use of words such as *appears*, *seems*, or *apparently* is not acceptable because they suggest that a nurse did not know the facts and demonstrates uncertainty (Potter & Perry, 2001, p.504).
- Provide a summary of significant conversations with clients and/or family members.
- Avoid generalizations and vague phrases or expressions such as ‘status unchanged,’ ‘assessment done,’ ‘had a good day,’ ‘slept well,’ ‘up and about.’ Such vague statements are conclusions without supported facts. Be specific and use complete, precise descriptions of care (e.g., ‘Slept quietly from 0100-0600 and stated that he felt well rested’). Certain verbal expressions of clients should also be recorded (e.g., Client states “I am pain-free today.”).
- If there is uncertainty about a specific observation or assessment, document the reason for the uncertainty.

Date, Time, Signature and Designation

Documenting the date and time that care is provided or that events occur supports the main purpose of documentation – to communicate relevant facts regarding a client’s care. Noting the signature and designation of

the care provider in relation to each entry also promotes communications and supports accountability.

- Signatures and/or initials need to be identifiable in either a paper-based or electronic system. In a paper-based system, all entries should be signed according to agency policy (e.g., may require the first initial, surname, and professional designation of “RN”). Note: When more than one designation is entered, university degrees should precede professional designations (e.g., BScN, RN).
- When initials are used (e.g., on flow sheets), the health record must include a mechanism to identify care providers by their initials. A master signature roster with initials should be kept as part of the original health record to facilitate retrieval purposes in the future. A separate master copy may also be kept in a location designated by agency policy.
- Electronic signatures are automatically generated when nurses log onto a computer with their confidential passwords.

Collaboration/Communication with Other Healthcare Providers

Nurses collaborate with other healthcare providers in person, by telephone, or via videoconference, online meetings or other electronic means. In these situations, record significant communications in the client’s health record, noting:

- date and time of the contact
- name(s) of the people involved in the collaboration
- information provided to or by healthcare providers
- responses from healthcare providers
- orders/interventions resulting from the collaboration
- the agreed upon plan of action
- anticipated outcomes.

For example, if a nurse seeks clarification of a doctor’s order, s/he should record: the reason for seeking clarification, the name of the healthcare provider providing the clarification, the action s/he (RN) took, and the expected outcome (see Verbal Orders, p.8, and the College’s *Guidelines for Telenursing Practice*, 2000).

Medication Administration

Although the documentation of medications may vary from agency to agency, the requirements for this type of documentation generally include:

- dates
- actual times medications are administered
- names of medications
- routes medications administered

- sites of medication administration (when appropriate)
- dosage administered
- nurse’s signature/designation.

NOTE: Except in emergency situations, each healthcare provider should sign for the medications they administer (e.g., physiotherapists, respiratory technologists, physicians). In emergency situations, registered nurses may sign for medications administered by other healthcare providers (see Co-Signatures, p.6). In agencies where disciplines other than nursing administer medications, agency policies should be inclusive of all involved disciplines.

Pre-administration assessment data and post-administration evaluation data should be documented according to agency policy or, as warranted, by the classification of medication or a client’s physical/mental condition (e.g., a client expresses concern about having a medication administered, or a client has an unusual reaction).

Verbal Orders

Giving and receiving verbal orders is considered a high-risk activity and should be carried out only in situations in which it is deemed to be in a client’s best interest. However, any miscommunication or lack of communication could lead to negative implications for the client.

Nurses and physicians have shared accountability in relation to verbal orders as a physician’s decision to provide a verbal order is, generally, based solely on a nurse’s assessment of a client. Conversely, a nurse’s acceptance of a verbal order is generally done knowing that the physician has not directly assessed a client’s condition.

- **Telephone orders** should be co-signed by the physician involved at the first available opportunity or within the time frame indicated in the agency policy or licensing requirements (e.g., *Homes for Special Care Act*).

Errors in recording telephone orders can occur, and there is always the question of who made the error: the physician in the ordering or the nurse in recording. Despite these concerns, there are times when telephone orders may be the next best option for the client. In these cases, nurses should be aware of agency policy with regards to accepting and documenting telephone orders (see *Guidelines for Telenursing Practice*, 2000). Orders left on answering machines are never acceptable.

Guidelines for Taking/Recording Telephone Orders

- Write down the time and date on the physicians' order sheet.
- Write down the order exactly as given by the physician.
- Read the order back to the physician to ensure it is accurately recorded.
- Record the physician's name on the order sheet; state "telephone order"; print your name and sign the entry, along with your designation (e.g., "RN").
- On-site verbal orders also have the potential for error and should be avoided except in urgent or emergency situations (e.g., cardiac arrest). Again, nurses need to be aware of agency policy related to accepting and documenting on-site verbal orders.

NOTE: In Nova Scotia, pharmacists can accept and record verbal orders to dispense medications from physicians. Agency policies should clearly direct nurses in these situations. For example, nurses in some agencies may carry out these orders based solely on directions noted on the labels of the dispensed medications. However, in other agencies nurses will only be authorized to carry out these orders when the pharmacist has either transcribed instructions directly to a client's chart or transmitted them by fax.

How should information be documented?

Clearly, comprehensively, completely, accurately and honestly

Legibility and Spelling

All entries in a paper-based system should be written legibly using black ink, or in accordance with agency policy. The use of black ink is best for optical scanning technology.

Try not to change pens while writing an entry of an event as this may give the impression that the entry was not completed in its entirety at one time. If you must change pens, document the reason why.

Never use pencil, gel pens, or coloured highlighters, as they are not permanent, can be erased or changed, and do not photocopy (microfilm) readily for storage purposes. Also, do not use coloured paper as information recorded may not be legible when scanned or photocopied.

Use accepted terminology and correct spelling (see Abbreviations, Symbols and Acronyms, p.10). Correct spelling demonstrates competence and attention to detail, while misspelled words and/or illegible entries can result in misinterpretation of information and possible client harm (e.g., the letter "o" is often confused with "u").

Spelling errors can also cause serious treatment errors (e.g., medication errors in cases where names of medications have similar spellings).

If, for any reason, paper-based documentation becomes illegible (e.g., from water or coffee spills), maintain the illegible paper and follow the guidelines for Late, Delayed or Lost Entries, p.11.

Forms, Flow Sheets, Checklists and Progress Notes

Using appropriate agency/facility forms for documentation (according to policy) will enhance the consistency of documentation among healthcare providers. Agency policies should specify what constitutes a complete, permanent health record (i.e., what are essential components), and recommend that all documentation forms be regularly reviewed and revised to ensure their relevance and effectiveness.

Clear and accurate client identification is critical in health records. Clients' identification must be clearly noted on all documentation forms whether they are paper-based or electronic (e.g., flow sheets, checklists, progress notes, medication records). In paper-based health records, client identification must appear on each sheet of paper used. Promptly recording client identification is especially important for items that could easily be misplaced (e.g., monitor strips).

Flow sheets, which are considered part of permanent health records, are often used to document frequently performed care/actions (e.g., routine care such as daily living activities, monitoring of vital signs, intake and output). As these sheets generally allow only enough space for initials, mechanisms must be in place to allow accurate identification of caregivers (e.g., a master list matching initials with caregivers). Accountability is also an issue when check marks are used on flow sheets. In this situation a mechanism must also be in place to ensure the identification of those who provided care and/or performed an assessment (see Date, Time, Signature & Designation, p.7, and Flow Sheets, p.22).

In paper-based documentation systems, progress notes (nurses' narrative notes) are used to communicate

nursing assessments and interventions, as well as the impact (evaluation) of these interventions on client outcomes. In addition, progress notes should include:

- client assessments prior to and following administration of PRN medications
- information reported to a physician or other healthcare provider and, when appropriate, the provider's response
- client teaching
- discharge planning, including instructions given to clients and/or families, and planned community follow-up
- pertinent data collected in the course of providing care, including data collected through technological devices (e.g., strips produced during cardiac or fetal monitoring)
- advocacy undertaken by a nurse on behalf of a client (see Principles of Documentation, p.5; *Standards for Nursing Practice*, 3:3).

Electronic documentation systems generally require less narrative notes as pertinent information is documented in a number of specifically designed computer screens (see Electronic Documentation, p.16).

Blank (White) Space

There should be no blank or 'white' space in paper-based documents as this space presents an opportunity for others to add information unbeknownst to the original author. To avoid this risk, draw a single line completely through the blank space, including before and after your signature/designation.

Mistaken Entry/Errors

Inaccuracies in documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to agency policy. Correct errors openly and honestly. The content in question must remain clearly visible or retrievable so that the purpose and content of the correction is clearly understood.

If an error occurs in paper-based documentation, do not make entries between lines, do not remove anything (e.g., monitor strips, lab reports, requisitions, checklists), and do not erase or use correction products or felt pens to hide or obliterate an error. Also, under no circumstance should chart pages or entries be recopied because of a documentation error. If information is difficult to read, add pertinent information in a 'note to chart' or 'note to file'.

Correcting, modifying or altering someone else's documentation is illegal and considered to be professional misconduct.

To correct an error in a paper-based system, cross through the word(s) with a single line, and insert your initials, along with the date and time the correction was made. Then enter the correct information. Some agencies require that the correction be noted with the use of an arrow or an asterisk. Check your agency/facility policy for the accepted means of correcting errors (e.g., some require the words 'Charting or Documentation Error' or 'Mistaken Entry' to be included with your initials).

Failing to correct an error appropriately (according to agency policy) may be interpreted as falsification of a record. Falsifying records is considered professional misconduct according to the definition under Section 2(ag)(viii) of the *Registered Nurses Act* (2001,c.10, s.1).

(also see Electronic Documentation, p.16)

Changes or Additions

To protect the integrity of a health record, changes or additions need to be carefully documented. *Never remove pages.*

A client, alternate decision maker, or another care provider may request changes or additions to documentation if they believe the health record is incorrect, incomplete or inappropriate. When the nurse who completed the original documentation is informed of such a request, s/he should refer to the agency/facility's policy.

(also see Electronic Documentation, p.17)

Abbreviations, Symbols and Acronyms

The use of abbreviations, symbols or acronyms can be an efficient form of documentation if their meaning is well understood by everyone. Abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors, cause confusion, and waste time. A useful reference for policy development in this area is the list of unsafe abbreviations developed by the Institute of Safe Medication Practice (www.ismp.org/Error-prone.pdf).

Use only those abbreviations, symbols and acronyms that are on a current agency-approved list (agency policies are approved within a specified timeframe, generally every three years) or an agency approved reference text.

When there is no agency-approved list nor an approved reference text, widely understood abbreviations may be used in a single health record entry when the meaning is spelled out immediately after the abbreviation's first appearance in that entry (e.g., a legend on a flow sheet depicting "P" as "poorly", "R" as "restless", and "S" as "sound").

When should information be documented?

Timely, frequently, chronologically

Documentation should be done as soon as possible after an event has occurred (e.g., care provided, medication administered, client fall) to enhance the accuracy of each entry and the overall credibility of a health record. Documentation of an occurrence should never be completed before it actually takes place.

In addition to timeliness, frequency of documentation supports accuracy, particularly when precise assessment is required as a result of client conditions (e.g., intensive care, fluctuating health status). While agency policies on documentation should be followed to maintain a reasonable and prudent standard of documentation, nursing recording should be more comprehensive, in-depth and frequent if a patient is very ill or exposed to high risk (Canadian Nurses Protective Society, 1996, p.2). The frequency and amount of detail required is, generally, dictated by a number of factors, including:

- facility/agency policies and procedures
- complexity of a client's health problems
- degree to which a patient's condition puts him/her at risk
- degree of risk involved in a treatment or component of care.

When it is not possible to document at the time of or immediately following an event, or if extensive time has elapsed and a late entry is required, document "Note to File" and follow the guidelines for Late, Delayed or Lost Entries (see p.11).

Documenting events in the chronological order in which they took place is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications; enabling healthcare providers to understand what care was provided, based on what assessment data, and then any outcomes or evaluations of that care (including client responses). Reliable documentation should clearly state when care was provided,

when an event occurred, and when the documentation of the care/event occurred. Agency policies should clearly identify the approved manner for making late entries.

Late, Delayed or Lost Entries

Late entries should be made according to agency policy (e.g., the length of time permitted for late entries). However, regardless of how late an entry is made information documented must be accurate and complete.

Late entries or corrections incorporating omitted information in a health record should be made, on a voluntary basis, only when a nurse can accurately recall the care provided or an event.

Late entries must be clearly identified (e.g., "Addendum to Care"), and should be individually dated, include reference to the actual time recorded as well as the time when the care/event occurred, and must be signed by the nurse involved.

A delayed entry may occur when two nurses enter data on the same patient. Delayed entries must be entered on a chart on the same shift that the care was provided and/or event occurred, even if the information is not entered in chronological order (personal communication from presentation by E. Phillips, CNPS, Ottawa, January 28, 2005). Delayed entries should be made according to agency policy.

Although it is preferable to document in chronological order, documentation that is not chronological and entered at a later time on the same shift should be recorded as a delayed entry, with the time that the care was provided being clearly noted. Undue delay between the occurrence of an event and its recording may result in a court refusing to admit a record as proof of the truth of the event and questioning the credibility of information or witnesses (CNPS, 1996, p.2).

In the event of a lost entry (misaid or omitted), nurses need to refer to agency policy and may reconstruct the entry by clearly indicating the care/event as a replacement for a lost entry. If the care/event cannot be recalled, the new entry should state that the information for the specific time of the event has been lost.

(also see Electronic Documentation, p.16)

SECTION 2: LEGAL PRINCIPLES, POLICIES, AND LEGISLATION

Requirements for documentation, including sharing, retention and disposal of client information, are based on various levels of authority (e.g., statutory legislation, professional standards, agency policies and procedures, legal principles). Agency/district policies generally reflect provincial and federal government and/or other relevant documents.

In addition to the professional principles previously outlined, registered nurses need to be aware of agency-specific policies and federal/provincial legislation that relate to their documentation (e.g., the *Freedom of Information and Protection of Privacy Act* [FOIPOP], *Access to Information Act*, and *Personal Information Protection & Electronic Documents Act* [PIPEDA]). Both FOIPOP and PIPEDA apply to all private sector organizations in Canada (with the exception of Quebec) that collect, use or disclose personal information in the course of commercial activity (Fedeke & Wilson, 2004). PIPEDA came into effect on January 1, 2004, and its intent is to protect consumers by establishing rules that balance an individual's right to the privacy of personal information with the need of organizations to collect, use or disclose personal information for legitimate business purposes.

Other legislative documents that need to be taken into consideration include those pertaining to specific areas of practice or employment settings.

Agency/District Policies and Procedures

The policies and procedures of healthcare agencies should provide direction for nurses in relation to clinical decision-making and accurate and efficient documentation of nursing care provided. As registered nurses are responsible to comply with and follow agency/facility documentation policies and procedures, it is recommended that agency/facility policies and procedures incorporate the documentation principles outlined in this document. Agencies also need to ensure that all care providers demonstrate necessary competence in their documentation.

- Policies are broad statements that provide direction for non-negotiable, realistic rules. They mandate standards for acceptable behaviour, enable

informed decision-making, prescribe limits and assign responsibilities. Policies describe what “*must*” be done.

- Procedures are negotiable and give directions for the daily operations (details) that are to be conducted within the framework of a policy. Procedures relate to the “*how to's*”.

In relation to documentation, agency policies must address:

- accepted methods of documentation
- expectations on frequency of documentation
- ‘late entry’ recordings
- acceptable or unacceptable abbreviations (possibly noting a reference text in which acceptable abbreviations can be found)
- receipt and recording of verbal and telehealth orders
- storage, transmittal and retention of client information.

Professional Accountability/Knowledge Management

From a legal perspective, adherence to the documentation principles outlined in this document should ultimately affect the credibility of health records as evidence in court proceedings, and may impact the ‘weight’ given to the records (information) themselves.

“If the accuracy of a nurse’s charting is questioned in a court of law, questions might be raised about the credibility of both the documentation and the nurse” (RNABC, 2003, p.17).

Beyond documenting information to enhance the care of a client and meet all legal requirements, nurses’ accurate and timely documentation of data is also often used for administrative purposes (e.g., research, client classification, workload measurement) and in the pursuit of professional practice improvements). Documentation principles are also generally reviewed during risk-management audits.

Evidence-based changes to nursing practice occur, in large part, as a result of nurses analysing, synthesizing,

interpreting and using data from health records in decision-making. In situations where policy changes related to documentation are necessary, nurses are encouraged to advocate for a change in policies that reflect evidence-based or current best-practice information.

Confidentiality and Security

Clients have a right to protection of their privacy with respect to the access, storage, retrieval and transmittal of their records and to receive a copy of their health records for a reasonable fee. The rights of clients and obligations of public agencies are outlined in FOIPOP and often summarized in agency policies.

Regardless of whether client information is obtained in an agency, facility or independent practice, it is essential that it remain confidential and shared only when necessary to serve the interests of clients (see Ownership of and Access to Client Information, p.13).

Whether documentation is paper-based, electronic or in any other format, maintaining confidentiality of all information in a health record is essential, and relates to access, storage, retrieval and transmission of a client's information (see Electronic Documentation, p.16; Transmission of Client Health Information, p.18).

Healthcare professionals should also view security of client documentation as a serious issue. Documentation, in any format, should be maintained in areas where the information cannot be easily read by casual observers. Although nurses often share client information with the healthcare team, it is important that clients understand that sharing confidential information with team members occurs only in an effort to ensure the provision of quality care. Clients also need to know that sharing such information enables healthcare professionals, through research, to make evidence-based changes to their practice.

When health records are maintained in a client's home, there is the potential for family members and/or others (e.g., visitors, guests) to access confidential information. It is important that agencies/facilities have policies in place outlining who should be able to access the health records and how clients and/or family members will be made aware of the importance of maintaining confidentiality.

Technology does not change client's rights to privacy of

health information, and there are legal risks associated with computerized documentation because of the increased potential for unauthorized persons to gain access to client data, either from within or outside an agency (see Electronic Documentation, p.16).

If patient information is inappropriately released or accessed by unauthorized persons, a breach of the patient's rights may result in legal liability. The *Personal Information Protection & Electronic Documents Act* (PIPEDA) attempts to minimize/eliminate these risks. This act applies to all public bodies, including hospitals and health authorities' boards, and gives the public a right of access to records held by one of these public bodies. Individuals also have the right to request a correction of such information. PIPEDA also prevents the unauthorized collection, use or disclosure of personal information by a public body (see also Ownership and Access to Client Information, p.13).

For further information on PIPEDA visit http://www.privcom.gc.ca/legislation/02_06_01_01_e.asp or contact: The Privacy Commissioner of Canada, 112 Kent Street, Ottawa ON K1A 1H3. Tel 1-800-282-1376. Fax 1-613-947-6850. Website: www.privcom.gc.ca. E-mail: info@privcom.gc.ca.

Failure to comply with keeping records as required, falsifying or furnishing false information and providing information about a client without consent can constitute professional misconduct under the *Registered Nurses Act* (2001). This statement does not necessarily mean 'client consent'; access to client information can be granted by agency administration in response to other legal processes.

Ownership of and Access to Client Health Information

Who owns client health records?

The agency/facility in which a client's health record is compiled is the legal owner of the record as a piece of physical or electronic property. The information in the record, however, belongs to the client. A self-employed nurse, like an agency/facility, would also be the legal owner of a client record.

Can clients access their health record?

Through FOIPOP, clients have right of access to their health records and to receive a copy at a reasonable fee. FOIPOP allows clients to submit written requests

for access to their records or for information that might otherwise not normally be provided. Agency policies should clearly outline the documents included in a health record (e.g., student notes, x-rays), provide clear directions on who may access the health record, and how the record is to be released (e.g., whether a client can view the record in person or only in the presence of a staff member; whether photocopying of any or all parts of the chart is permissible). Agency/facility policy should also indicate who would provide assistance with interpreting the meaning of a record (e.g., lab results, terminology, abbreviations) and how staff should respond to inquiries while a record is being reviewed (Grant, 1997, p.10).

The *Standards for Nursing Practice* require that registered nurses advocate for clients and share relevant information in appropriate circumstances. In circumstances when a client that is still under the care of an agency requests to see his/her health record, the registered nurse should refer to agency/facility policy. In very limited circumstances, the right to access health records by a client may be restricted (see section 5.71(3) of the *Hospitals Act*, which states that a hospital or qualified medical practitioner may refuse to make available information from the health records or particulars of a person or client if there is reasonable grounds to believe it would not be in the best interest of the client to make that information available).

Who else can access clients' health information?

Information in any health record is considered confidential. A client's consent for disclosure of this information to staff within an agency, for purposes related to care and treatment, is implied upon admission, unless there is a specific exception established by law or agency policy. Client consent is required if the contents of a health record are to be used for research or if any client information is to be transmitted outside an agency.

The Nova Scotia *Hospitals Act*, which also applies to lawyers and law enforcement officers, sets out the general rule regarding hospital records in section 71 (1): ***“a person's or patient's records in hospital are confidential and shall not be made available to any person or agency except with consent or authorization of the patient/person.”***

However, according to this legislation (section 71[5]), hospital records can be made available to:

- a) persons on staff of a hospital for hospital or medical purposes
- b) a qualified medical practitioner designated by the client/patient
- c) persons authorized by a court order or subpoena
- d) persons or agencies otherwise authorized by law (e.g., medical examiner, under the *Fatality Investigations Act*; suspicion of child or elder abuse through the *Adult Protection Act* and *Child and Family Services Act*; communicable and notifiable diseases, under the *Health Protection Act*).
- e) the minister of health or any person or agency designated or authorized by the minister (e.g., the College), in accordance with the *Health Protection Act*.

A nurse should disclose confidential information in accordance with an agency's policy on 'Release of Information', which should address issues such as the age of consent, definition of a mature minor, when and how consultation should occur, and the nurses' role with regard to releasing information. Clients may grant access to a third party such as a lawyer, but nurses should know that a ministerial authorization, other legislative authorizations (e.g., fatality investigations), court orders, subpoenas and/or search warrants may be issued contrary to a client's wishes. However, subpoenas may not necessarily grant access to a health record, but rather to an individual. In these circumstances, the release of information is done in consultation with administration, risk management and/or legal counsel.

As previously stated, although an agency owns clients' health records, the information in them belongs to the clients. If a nurse following agency policy is not satisfied that an individual seeking access to a client's health record has the legal authority to do so, s/he should seek advice from the employer.

With respect to research, section 71(6) of the *Hospitals Act* allows for the publication of reports or statistical information relating to research or studies that do not identify individuals or sources of information.

NOTE: Communications to police about the condition of a client may be a violation of a client's right to privacy. Client records and the information contained in these records are confidential; police do not have the right to access a client's health information unless they have a subpoena or search warrant.

What happens to third-party information when other information in a health record is to be released?

Nurses may obtain relevant information about a client or an incident from another person other than the client (e.g., client's family member or friend). They may also gain information about a third party that is, in fact, relevant to the client. When a client's record has another person's name in it or contains information about another person – especially if the information was given in confidence – the record may need to be “severed” before it is released. This means that some portions of the record may have to be removed and not released to the client requesting the record. For example, if a client's record included the name of a friend or that of another client, that section of the record should be removed or deleted before the health record is released.

Health Records Retention, Storage and Disposal

Policies on the retention, storage and disposal of health records and client documentation may differ from practice setting to practice setting; however, every agency should have related policies. Records that contain references to blood or blood products must be maintained in perpetuity in all settings (Minister of Health, communication, 1996/1997).

Although most registered nurses in hospital settings are not involved with the retention, storage or disposal of health records, they should be familiar with their agency/facility policies and check with health records personnel whenever necessary.

Nurses directly involved with the retention, storage and disposal of health records (e.g., occupational health nurses, those practising in long-term care facilities and private agencies) need to ensure appropriate processes are in place to enable them to follow agency policy.



SECTION 3: TECHNOLOGIES IN DOCUMENTATION

Technology has changed the manner in which health care is offered throughout the world, and increasing pressure on healthcare systems to improve access while containing costs, along with the concurrent growth in information technology and communications systems, has led many to explore opportunities to apply these technologies more and more in health documentation.

While the basic principles of documentation used in paper-based systems would also apply in the case of electronic-based systems (e.g., computers, telephones, voice recording machines, videos), these new methods of recording, delivering and receiving client data are posing new and constant challenges for agencies and nurses - both in terms of confidentiality and security (see p.18), and in ensuring continuing education for healthcare providers.

Agencies must have clear policies and guidelines to address these and other issues related to technologies in documentation, and registered nurses must advocate for agency policies/guidelines that reflect and support quality, evidence-based practice.

Electronic Documentation



The high volume of client contacts has made computerized documentation an essential tool for healthcare providers. The electronic health record is a

collection of personal health information about a single client entered or received by healthcare providers, and stored electronically under strict security. Electronic documentation tools have been developed for interdisciplinary use in an effort to minimize duplication, enhance efficient time use, and enrich client outcomes.

“Online documentation is defined as a technology that automates the capture of clinical care data. In the nursing realm, this can include assessment data, clinical findings, nursing plans of care, nursing interventions (along with results), patient progress toward goals, critical pathways, medication administration, risk assessments, discharge planning, patient education, and more”(Kirkley & Renwick, 2004, p.647).

As a first step in creating a provincial electronic health record (EHR) for every Nova Scotian, which would be accessible online from various automated systems, the Department of Health introduced the Nova Scotia Hospital Information System (NSHIS) in 2001. The NSHIS is designed to link health information within and between hospitals throughout the province, enabling healthcare professionals to share detailed, up-to-date information vital to the delivery of quality healthcare services. A specific goal of this project is to create individual electronic health records, referred to as Enterprise Medical Records (EMR), to store the clinical data of every Nova Scotian entering the healthcare system. Within the NSHIS, a list of caregiver clients and caregiver interventions (the Patient Care System or PCS), can be accessed in order to document. This documentation will then flow to the EMR.

As in paper-based documentation systems, the reliability and trustworthiness of an electronic system is essential and the principles of good documentation must be maintained (i.e., comprehensive, accurate and timely information documented; clear identification of who provided care and who completed the documentation; errors corrected according to agency policy). Also, like paper-based documentation, all entries made and/or stored electronically are considered a permanent part of a health record and may not be deleted (e.g., e-mail and fax messages, including fax cover sheets; telehealth encounters). Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

Agency policies related to electronic documentation should clearly indicate how to:

- correct documentation errors and/or make 'late entries'
- prevent the deletion of information
- identify changes and updates in a health record
- protect the confidentiality of client information
- maintain the security of a system (e.g., regularly changing passwords, issuing access cards, virus protection, encryption, well maintained firewalls)
- track unauthorized access to client information
- use a mixture of electronic and paper-based methods, as appropriate
- back-up client information
- document in the event of a system failure.

Agency policies should also make reference to the fact that the majority of staff should only have access to records of clients in their work area. Select staff may be given authority to access all client records. And in terms of research, client confidentiality can be enhanced when researchers are granted only a certain level of accessibility to data (Potter, P. & Perry, A., 2001, p.515).

Agencies that use two systems for documentation (paper-based and electronic) should have policies to ensure that continuity of care is maintained. For instance, electronic records must identify when paper-based records are also being used, and in the event that an electronic system fails there should be a contingency plan in place that directs users to the paper-based system.

Some attributes of an electronic documentation or patient care system (PCS) that support nurses in meeting their documentation standards include:

- confidentiality and security are enhanced through controlled access., passwords, encryption, firewalls, etc.
- deletion of information is prohibited
- changes and updates can be clearly identified
- information is always legible and can be retrieved regardless of where it is stored
- information can be reproduced in a usable format (e.g., printed)
- backup systems allow users to document during a system failure
- corrections can be made and clearly identified, while original entries are maintained
- electronic signatures can be verified
- temporary users (e.g., agency staff, students) can access computer records readily

- duplication of recording can be avoided
- care providers and appropriate departments (e.g., pharmacy, diagnostic imaging, diagnostic testing) can share and retrieve electronic health record/information readily
- identity of care provider entries can be tracked
- data entry occurs at the point of care
- knowledgeable system support staff are available to nursing staff (CNO, 2004, p.13).

Confidentiality and Security

Just as is the case with paper-based documentation, nurses are accountable for safeguarding confidentiality of client information when using electronic records. However, to avoid the additional risks posed by this method of documentation, nurses should follow these guidelines:

- Never reveal or allow anyone access to their personal identification number or passwords (these are, in fact, electronic signatures).
- Inform immediate managers when it is suspected that someone else is using an assigned personal identification code.
- Change passwords at frequent and irregular intervals (as per agency policy).
- Choose passwords that cannot be easily deciphered.
- Log off when not using a system or when leaving a terminal.
- Maintain confidentiality of all information, including all print copies of information.
- Shred any discarded print information containing client information.
- Locate printers in secured areas away from public access.
- Retrieve printed information promptly.
- Protect client information displayed on monitors or transmitted through other means (e.g., use screen savers and privacy screens, select location of monitors and fax machines carefully).
- Access only that information required for providing nursing care for a particular client: accessing information for other purposes is a breach of confidentiality (RNABC, 2003, p.13).

NOTE: In the event that a nurse is concerned about the reliability of a computer system, it is crucial that s/he exercise good clinical judgment and check with agency computer personnel (personal communication from presentation by E. Phillips, CNPS, Ottawa, January 28, 2005).

Transmission of Client Health Information

The potential for breaching client confidentiality does increase when client information is transmitted from one place to another. For example, when information is transmitted via mail or courier there is the potential for it to be lost, destroyed, or read by unauthorized personnel. To minimize these risks: 1) place client information in a sealed envelope, clearly identified as confidential; and 2) institute a tracking mechanism on the delivery and receipt of items (information).

However, there are additional and unique risks associated with transmitting information electronically.

Dictating Machines

Although traditionally used by physicians, nurses sometimes use dictation to generate client information. This form of technology supports the quick transfer of information to other members of the health care team and enables timely response regarding referrals, and consultations.

Electronic Mail (E-mail)

The use of electronic mail (e-mail) transmission by healthcare organizations and healthcare professionals is becoming more widespread because of its speed, reliability, convenience and low cost. However, because messages can easily be misdirected or intercepted by unintended recipients, the security and confidentiality of e-mail messaging cannot be guaranteed and is not recommended as a method for transmitting clients' health information. In addition, while messages on a local computer can be deleted, they are never deleted from the central server routing the message and can be retrieved by unauthorized personnel.

Although the basic principles of documentation apply to e-mail documentation, agencies should also develop specific policies for transmitting client information via e-mail; to cover items such as the use of specific forms for e-mail purposes, the procedure to obtain consent to use e-mail, and the use of initials, names, and hospital/agency numbers.

In instances where an e-mail message is considered to be the preferred option to meet client needs, there must be a reasonable belief that the transmission is secure (e.g., use of encryption software, user verification, secure point-to-point connections).

Confidentiality and Security of E-Mail Messages

In addition to the measures noted previously, the confidentiality and security of transmitting client information via e-mail can be further enhanced when nurses:

- verify e-mail addresses of intended recipients before sending information.
- ensure transmission of e-mail messages are to specific e-mail addresses, and request acknowledgement of receipt.
- include a confidentiality statement, indicating that the information is confidential, to be read only by intended recipients, and not to be copied or forwarded to others.
- advocate for secure and confidential e-mail systems and protocols (e.g., consent process, security software, process to authenticate physicians' names and signatures (RNABC, 2003, p.14).

Facsimile (Fax)

Facsimile (fax) transmission of client information between healthcare providers is convenient and efficient. And because a fax is an exact copy of an original document, additional notations may be made on a fax copy if they meet agency policies for documentation and are appropriately dated and signed. As with e-mail, there is significant risk to the confidentiality and security of information transmitted via fax due to the possibility of transmitting to unintended recipients.

Confidentiality and Security of Facsimile Messages

The confidentiality and security of transmitting client information via facsimile can be enhanced when nurses:

- verify fax numbers and fax distribution lists stored in machine of sender prior to dialing.
- carefully check activity reports to confirm successful transmissions.
- note, on cover sheet, that the information being transmitted is confidential, and request verification that a misdirected fax has been immediately destroyed without being read.
- make a reasonable effort to ensure that the fax will be retrieved immediately by the intended recipient, or will be stored in a secure area until collected.
- shred any discarded faxed information containing client identification.
- verify that information received is legible and complete.
- advocate for secure and confidential fax transmittal systems and protocols (RNABC, 2004, p.14; CNO, 2003, p.16).

Personal Digital Assistants (PDA)

A PDA is a hand-held computing device with the capacity to store information, similar to a personal computer. While PDAs are gaining acceptance for the purpose of personal data collection, currently they are not being used to collect client data in the NSHIS electronic Patient Care System. However, laptop computers on portable carts are being used.

PDAs can communicate with other devices and can be used for client tracking, pharmacy, education and prescribing regimens. The newer PDAs can also be used for e-mail and purposes other than collecting data. However, security is an issue and it is recommended, at this time, that PDAs not be used to transfer client information.

Telephone/Video Consultation (Telehealth)

Telehealth is defined as “the use of information and communications technology to deliver health and health-care services and information over large and small distances” (NIFTE Framework of Guidelines, 2003, p.18). Not to be confused with the College’s continuing nursing education sessions delivered via the provincial Telehealth Network, telehealth relates to the provision of clinical services (e.g., teletriage, telecare, teleconsultation) using telephone and video technology. (Additional information on telehealth and telenursing can be found in the College’s *Guidelines for Telenursing Practice*.)

As a result of the growing number of telehealth projects, programs, and services (e.g., lactation consultants, patient navigators), more attention is now being focused on the development of policies, as well as quality and outcome issues related to the delivery of telehealth services. A national framework has been developed to help with the development of telehealth policy, procedures, guidelines, and standards. This framework provides information about clinical standards and outcomes, human resources, organizational readiness and leadership, as well as technology and equipment. For more information, review the *National Initiative for Telehealth Guidelines* (2003) or visit www.cst-sct.org.

While the basic principles of documentation and guidelines for electronic documentation apply to client-nurse interactions taking place via telehealth, it is also important to note that:

- agencies’ policies and procedures should indicate who has custody of telehealth records. (Until they are in place, when more than one organization is involved in a telehealth encounter, the health record of an encounter should be kept at each site).
- the client in every telehealth encounter must be informed as to who will maintain their health record of the encounter.
- the client must clearly know who has ongoing responsibility for any required follow-up and ongoing health care.
- nurses should advocate for secure and confidential telehealth (phone, video, computer) systems, including the development of required policies and procedures.

Minimum documentation of a telehealth nurse-client interaction should include:

- date and time of the incoming call (including voice mail messages) or video interaction
- date and time when telephone call returned
- name and age of client, if relevant (when anonymity is important, this information may be excluded)
- telephone number for telephone calls
- reason for the call or consultation; assessment of the client’s needs; signs and symptoms described; specific protocol or decision tree used to manage call/consult (where applicable); advice or information given; referrals; agreement on next steps for the client; and required follow-up.

Voice Mail/Messages

Voice mail/messaging is yet another convenient and efficient method to communicate information between healthcare providers and clients (e.g., advising clients of appointments). However, as with other electronic forms of communication, there is always the risk of leaving a message for, or having a message overheard by, an unintended recipient.

Using portable or cellular phones adds another variable in terms of confidentiality and security of information because of the ability of scanners to access conversations.

Never leave confidential information on a voice-message. If a client has indicated that s/he considers it acceptable to leave a voice message, leave either the agreed upon message or a contact name and phone number for the recipient to call back when it is convenient.

SECTION 4: DOCUMENTATION SYSTEMS AND TOOLS

Different documentation systems have been developed to meet the diverse needs of care settings. There is no one *best* system that will be perfect for all contexts of practice. In fact, in many areas of nursing practice, elements of several systems or methods of documentation are often combined.

The type, model or system of documentation selected should be consistent with the needs of client populations and an agency's context of practice. Whenever a system changes, it is important that a plan be devised for implementation, and that the plan include the involvement and education of registered nurses.

Regardless of the method or system used, nurses are responsible and accountable for documenting client assessments, nursing interventions, and the impact of interventions on client outcomes. The same principles of documentation apply regardless of the method/system of documentation.

Documentation Systems

Written Narrative

- Nursing actions and client responses are recorded in chronological order and reflect care given within a particular timeframe.
- Allows space for nurses to document data not captured elsewhere in a health record (do not duplicate information unless there is a need to further describe a complex situation).
- Tends to be warranted and necessary when the complexity of care requires detailed, written explanations.
- May stand alone or be used in combination with other documentation tools (e.g., flow sheets).

NOTE: Information noted in one section of a health record does not need to be repeated in another area (e.g., data noted on a flow sheet does not need to be repeated in narrative notes). However, it may be helpful to make a notation in narrative that further information related to a specific event/intervention has been recorded in another section (e.g., 'refer to flow sheet or tick box').

Charting by Exception

- Abbreviated approach to documenting normal assessments and responses, where only unusual or out-of-the-ordinary events are documented: reducing repetition and time spent documenting.
- Based on the premise that planned nursing care is documented in care plans and only significant findings and unanticipated responses to a proposed plan (i.e., exceptions to standards or norms of care) are documented in narrative notes.
- Assumption that all standards are met with a normal or expected response unless otherwise documented.
- The three key elements of charting by exception are: unique flow sheets; documentation by reference to the standards for nursing practice; and bedside accessibility of documentation forms (Grant & A. Ashman, 1997, p.143).

NOTE: Medication administration should always be documented on designated medication administration forms and never charted by exception.

It is necessary to use a consistent approach in documenting unusual events. Agencies should have well-defined policies and pre-determined norms for nursing assessments and interventions. And, as with all documentation systems, to ensure that legal standards are met all healthcare providers should receive appropriate education and support.

Morris, Ferguson and Dykeman (1999, p.85) suggest that when using charting by exception it is important to ensure specific conditions exist. They further indicate that nurses' written observations are very helpful in showing that adequate care was given and that 'a rapidly declining condition or sudden event could not have been anticipated or prevented'.

When charting by exception it is important to remember:

- a normative baseline for a client must be established
- it is a nursing responsibility to ensure that baseline assessments continue to be accurate depictions of a client's condition or to document changes in nursing notes
- all nurses in an agency should document in a consistent manner and use the same norms

- nurses should be familiar with and adhere to agency policies, standards and protocols regarding charting by exception
- nurses should ensure that they chart any procedures they perform (including medication administration); vital signs; required observations; and any changes in a patient's condition
- if a nurse is unsure as to whether to chart by exception s/he should document in the nurses' notes
- agencies should provide adequate training and ongoing support for staff when charting by exception (A. Grant, & A. Ashman, 1997, p.144).

Problem-Oriented Documentation

- Data is organized by problem or diagnosis.
- Nurses identify and document problems, care provided, response to routine interventions, and impact of those interventions.
- A common plan of care more easily coordinated when members of the healthcare team each contribute to the list of identified problems.

SOAP/SOAPIER

- Problem-oriented approach to documentation in which nurses document information in an organized fashion:

- S** = subjective data (verbalizations of client/e.g., how the client feels)
- O** = objective data (measured or observed/ e.g., relevant vital signs)
- A** = assessment (diagnosis based on data)
- P** = plan (what caregiver plans to do)
- I** = intervention (care, procedures provided by nurse)
- E** = evaluation (how plan worked, whether changes are needed)
- R** = revision (changes, if necessary, to plan of care, based on evaluation).

Focus Charting/Documentation (DAR or DARP)

- Process-driven format that supports outcome based care; structured according to client concerns (e.g., a sign or symptom, condition, significant event) and recorded according to the nursing process.
- Structured method of documentation that allows nurses to consider interventions and patient responses, as well as patient observations.
- Nurses record outcomes in relation to specific client concerns or behaviours (rather than problems) identified during an assessment.

- Research and audit information can be retrieved readily and utilization reviewers can easily spot progress, or lack of it, within a few days.
- Progress notes are clear and easy for other nurses and disciplines to review.
- Paper-based system uses three DAR or four DARP columns (the fourth column is used in some settings).
- Using this form of charting, the assessment of the client and the care provided are organized under:
 - D** = Data
 - A** = Action (nursing intervention)
 - R** = Response (evaluation of effectiveness),
 - P** = Plan

PIE Charting

- Uses problem-oriented approach similar to SOAP or SOAPIER charting
 - P** = Problems
 - I** = Interventions
 - E** = Evaluation
- Based on the nursing process, the PIE system consists of a 24-hour, daily assessment flow sheet. Quite often, standardized or individual care plans need to be used in conjunction with PIE charting (Potter & Perry, 2003).



Documentation Tools

When used, the following communication tools would be considered part of a client's permanent health record:

Flow Sheets

- Used in both paper-based and electronic systems for frequently recorded information associated with routine care (e.g., daily living activities, vital signs, intake & output): most often used in conjunction with other documentation tools (see Flow Sheets & Checklists, p.9; Abbreviations, Symbols, & Acronyms, p.10).
- Serve as visual reminders and are helpful in showing patterns or trends in data.
- Suggested for recording simple data, treatment plans, and symptom management.
- Can enhance continuity of care by providing comparative records.
- Can be used successfully in the absence of traditional documentation to communicate data across a period of time in a particular client setting (e.g. ambulatory care) (CRNNS, 2002, p.10).
- Incomplete flow sheets can test the credibility of a nurse and play a major role in a legal review (e.g., initials should be used for entries on a flow sheet rather than using a check mark, to identify the individual who performed the action).

Tick Charts

- Used to document procedures.
- Serve as cues to ensure necessary components of a procedure have been done and are documented (e.g., IV initiated: tick chart to confirm verbal consent obtained, IV inserted, gauge number of cathlon, presence of blood in hub, proper sharp disposal, IV running, IV connected, bag hung, etc.).

Care Maps, Clinical or Critical Pathways, Variance Analyses

- Forms of charting by exception; more directive in outlining care that will be done as well as outcomes expected over a specified time frame for a 'usual' client within a case type or grouping.
- Identifies expected outcomes for each day of care for a specific kind of client (e.g.. labour/delivery, chest pain, abdominal pain).
- Often used in managed care and case management care delivery systems: individualized to meet clients' specific needs (e.g., making changes to items that are not appropriate).

- If a client's status varies from that outlined on a care map or clinical pathway, the variance is documented, including the reasons and action plan to address it (RNABC, 2003, p.4).

When used, the following communication tools would *not* be included in a client's permanent health record:

Incident/Occurrence Reports

- Provide a description of unusual occurrences (e.g., client falls; harm to clients, staff or visitors; medication errors).
- Unlike a client health record, incident/occurrence reports are intended for purposes of risk management, to track trends and patterns about a client or groups of clients over time.
- Should contain accurate, concise, factual information by the person who witnessed the event (without opinions or judgments). Information obtained from a client or other individuals should be clearly identified.
- Recommended that nurses first document an incident in the health record to ensure continuity and completeness, and then complete an incident report in accordance with facility policies and procedures (Grant & Ashman, 1997).
- Generally retained separately from a health record because they are internal records, intended to provide agencies with data to determine the cause(s) of an incident and/or analyze trends in an attempt to implement required changes to prevent/minimize future incidents. Information included in an occurrence/incident report is similar to the information included in a client's health record, however, the incident/occurrence report would also include additional information with respect to the particular incident (e.g., "a door was broken" or "this was the fourth such incident this week").
- Information recorded is not directly related to the care of an individual client.
- Because the purposes for a health record and occurrence/incident report differ, do not document "refer to incident report" in a client's health record.
- Agency policy should clearly describe process necessary to complete an incident/occurrence report.
- Reports *may* be exempt from disclosure in court proceedings.

Worksheets and Kardexes

- Paper-based and electronic formats used to organize care, and manage time and multiple priorities.
- Information may be erased provided the permanent health record reflects nursing assessments, care provided, changes in clients' conditions, and outcomes.

EXCEPTION: If the Kardex is the ONLY documentation of a client's care, it should be part of the permanent record and have no erasures.

Communication Books, Anecdotal Records and Assignment Sheets

- Provide notice of critical information on items such as changes in care, new technologies available, staff relations/issues, or alerts health care team about critical client information.
- Personal reflections that contain client information must also be recorded in clients' health records.
- References alerting staff about specific client care should direct them to the health record where pertinent information is recorded in detail.

Shift Reports (Written/Dictated)

- Generally recorded in writing; in some agencies through the use of a dictaphone or audiotape.
- References alerting staff to specific client care direct others to the health record where the pertinent information is recorded in detail.
- Agency policy should outline process for maintaining/destroying shift reports and/or erasing/destroying audiotapes.

- **Whenever a reference to specific client care is included in a worksheet, kardex, communication book, shift report, anecdotal record or assignment sheet, client confidentiality must be a major concern. These communication tools need to be protected (i.e., not left in locations where client information could be easily viewed by unauthorized healthcare professionals or visitors).**
- **Relevant health information documented in any of these tools must also be documented in the health record.**
- **As these communication tools could be requested during legal proceedings, apply the basic principles of documentation in their composition.**

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APPENDIX A

Legal Charting Requirements

- Sign every entry.
- Write complete date and time of each entry.
- Avoid spaces.
- Read previous entries prior to documenting care given.
- Write neatly, concisely and legibly.
- Use proper spelling and grammar.
- Use authorized abbreviations; avoid using medical terms inappropriately.
- Be precise in documenting information reported to physician.
- Use graphic record to record vital signs.
- Chart promptly after delivery of care.
- Avoid block charting.
- Do not tamper with records; avoid erasures, backdating or additions to previous entries.
- Correctly identify late entries.
- Chart only the care given or supervised.
- Document exact quotes.
- Document in black ink only.
- Use 24-hour clock.
- Ensure patient's name is addressographed on each form.
- Transcribe orders with precision.
- Avoid using nursing notes to criticize other health professionals.
- Eliminate bias from written notes.
- Never leave a terminal unattended after you have logged on.
- Do not access patient information without a purpose.
- Do not share access passwords.

Adapted from DuGas, B., Esson, L. & Ronaldson, S. (1999). *Nursing Foundations: A Canadian Perspective*. Scarborough: Prentice Hall Canada, p. 480.

APPENDIX B: GLOSSARY OF TERMS

Accountability: an obligation to accept responsibility or to account for one's actions to achieve desired outcomes. Accountability resides in the role and can never be delegated away. Accountability is always about outcomes, not processes, which are simply the means through which outcomes are achieved (Porter-O'Grady and Wilson, 1995).

Adverse event: an unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by healthcare management (Adverse Events in Canadian Hospitals Study Report, CIHI-CIHR, 2004).

Advocacy: the supporting, protecting and safeguarding of clients' rights and interests. Advocacy is undertaken in the best interests of clients. Advocacy is an integral part of nursing and forms the foundation of trust inherent in the nurse-client relationship (RNABC, 2000). Within the boundaries of their roles, nurses ensure that clients have the necessary information to make decisions and choices and act according to their own wishes.

Agency: facility/institution/district.

Alternate decision-maker: includes persons appointed by clients (e.g., a family member with the power of attorney), families or courts to disclose personal client information.

Autonomy: the ability to independently implement the roles and accountability of one's position. Levels of autonomy in nursing can be considered to be:

Independent: individual carries out all aspects of nursing care, from decision-making to the management of outcomes.

Peer consultation: individual seeks advice from an experienced and competent nursing colleague or member of the health team in carrying out aspects of nursing care.

Under direction: decision for nursing care is made by other registered nurses who provide direct or indirect assistance, supervision or evaluation, as required.

Boundary: a dynamic line of separation in the nurse-client relationship between professional and therapeutic, and non-professional and personal (RNABC, Position Statement, 2000). Professional boundaries are the defining lines which separate the therapeutic behaviour of a registered nurse from any behaviour which, well intentioned or not, could reduce the benefit of nursing care to patients, clients, families and communi-

ties (Guidelines for Nurse-Client Relationships, CRNNS, 2002).

Client(s): the recipient(s) of nursing services: e.g., individuals (family members/guardians/substitute caregivers), families, groups (communities groups), populations or entire communities (adapted from CNA, NNCP, 1997, p. 42):

Individuals - single human beings throughout the lifespan, including neonates (birth to 28 days), infants (29 days-1 year), children (1-12 years), adolescents (12-18 years), adults (19-65 years) and elderly adults (65+).

Family - people united by common ancestry (biological), acquisition (marriage or contract), or choice. Also includes friends of the family.

Groups - two or more people having some unifying relationship.

Population - refers to all people in a designated area (Erwin, 2002). Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups (Health Canada). Population health considers and acts upon the broad range of factors and conditions that have a strong influence on health.

Communities - a group of people living in one place, neighborhood or district or sharing common institutions, characteristics, values, interests and daily life. Nursing practice aimed at the community as a client, involves assisting communities to identify and manage their health concerns. The focus is on the common or collective good, instead of an individual's health.

Collaborative: working together with one or more members of the health team to reach a common goal. Each individual contributes from within the limits of his or her scope of practice

Communication: an interpersonal activity involving the transmission of messages by a sender to a receiver (Arnold and Boggs, 1999). Communication involves a complex composite of verbal and nonverbal behaviours integrated for the purpose of sharing information and also includes new methods of technological communication.

Competent: the ability to integrate and apply the knowledge, skills and judgment required to practise safely and ethically in a designated role and practice setting (*Registered Nurses Regulations*, 2001).

Continuing competence: the ongoing ability of a registered nurse to integrate and apply the knowledge, skills and judgment required to practise safely in a designated role and setting.

Critical thinking: type of reasoning which formulates problems, clarifies and explains assumptions, weighs evidence, evaluates conclusions, discriminates between good and bad arguments and seeks to justify values that result in credible beliefs and actions (Bandman and Bandman, 1995). Critical thinkers in nursing practise the cognitive skills of analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge (Scheffer and Rubenfeld, 2000). Reflective and purposeful judgment are critical to the understanding of critical thinking.

Culturally competent care: provision of care within the cultural context of the client. This does not mean that the registered nurse has expert knowledge of all cultures and cultural groups; however, as part of the assessment process there is an expectation to become familiar with and respect aspects of the clients' culture that impact and influence client care. This includes understanding the client's perspectives, expectations, behaviours, and decisions, related to their health, as reflective of their values and beliefs and adapt nursing practice to meet the needs of the client.

Delegation: the transfer of a task or function to a healthcare provider who does not have the authority to perform that task or function (Phillips, Canadian Nurses Protective Society, 1997). Delegation involves the transferring of responsibility for the performance of a task or activity, but not the accountability for the outcome of the task or activity.

While specific tasks or procedures may be appropriately delegated, a registered nurse cannot delegate nursing activities that include the core of the nursing process and require the specialized knowledge, judgment, and/or skill of a registered nurse.

Delegation occurs in limited or specified situations when a task is within the scope of practice of a delegating registered nurse and outside the scope of practice and/or employment of another healthcare team member. The registered nurse is responsible for the decision to delegate, with five requirements:

1. Delegate task based on sound nursing judgment and rationale.
2. Delegate to the appropriate healthcare provider.
3. Delegate the appropriate task and confirm that the team member has the knowledge and ability to perform it.
4. Communicate the task (or part thereof) to the healthcare team member, and his/her accountability to complete it safely and ethically.

5. Communicate to the healthcare team member the requirement for feedback and appropriate documentation of the task.

Determinants of health: health is determined by complex interactions among social and economic factors, physical environment and individual behaviours, which do not exist in isolation from each other. Key determinants of health include income and social status, social support networks, education, employment working conditions, social environments, physical environment, personal health practices in coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (CNA, 2003).

Diversity: understanding that each client is unique, and respecting individual differences along the dimensions of race, ethnicity, gender, sexual orientation, social economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

Documentation: refers to charts, charting, recording, nurses' notes, progress notes. Documentation is written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client.

Electronic Health Record (EHR): health record of an individual that is accessible online from many separate, interoperable automated systems within an electronic network (Health Canada). See Enterprise Medical Record.

Electronic Patient Record: an electronic method of storing, manipulating and communicating medical information of all kinds including text, images, sound, video and tactile senses, which are more flexible than paper-based systems. Often referred to as a medical record, it contains a client's (patient) entire medical history and information crucial to future care.

Electronic documentation: a document existing in an electronic form to be accessed by computer technology.

Electronic message system (e-mail): a system that transmits messages in electronic form over a communications network of computers.

Encryption: a process of disguising data information as "ciphertext," or data that will be unintelligible to an unauthorized person.

Enterprise Medical Record (EMR): stores all clinical data entered on a client in the Nova Scotia Hospital Information System (NSHIS).

Evidence-based practice: best practice that is ideally based on science derived from systematic observation, study, qualitative and quantitative research (RNABC, 2000). When there is insufficient evidence from science, expert opinion or a combination of science and expert opinion is used. Evidence-based nursing is the combination of the best scientific evidence from nursing and other research with the special clinical perspective of nurses in performing patient care activities pertinent to the nursing profession (McPheeters, 1999).

Facsimile: a system of transmitting and reproducing graphic matter (as printing or still pictures) by means of signals sent over telephone lines.

Firewall: a computer or computer software that prevents unauthorized access to private data (as on a company's local area network or intranet) by outside computer users (as on the Internet).

Generalist: a registered nurse prepared to practise safely and effectively along the continuum of care in situations of health and illness across the persons lifespan. (CNA, 2003).

Health record: a compilation of pertinent facts on a client's health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care (e.g., hospital admission, series of home visits). All healthcare professionals providing care create the pertinent facts documented in a client's health record. Health records may be paper documents (i.e., hard copy) or electronic documents such as electronic medical records, faxes, e-mails, audio or videotapes, or images.

Healthcare team: clients, families, health professionals, nursing students, volunteers, and any others who may be involved in the planning and delivery of care.

Legal reviews: review of a health record when requested for legal purposes.

Legal standards: see Standards.

Nurse: refers to a registered nurse, nurse practitioner, graduate nurse, or a nursing student.

Nurses' notes: a record of the nursing process: assessment, nursing diagnosis, planning, implementation and evaluation of care.

Nursing assignment: designating nursing activities to be performed by an individual, which are in her/his licensed scope of practice (National Council of State Boards of Nursing, 1997).

Nursing diagnosis: a statement that describes the client's actual or potential response to a health problem that the nurse is licensed and competent to treat (e.g., impaired skin integrity related to decreased mobility); providing the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable (Potter & Perry, 2001).

Nursing process: application of the nursing process is fundamental to the definition of nursing practice and includes assessment, diagnosis, planning, implementation and evaluation. The nursing process is a systematic approach used to gather client data, critically examine and analyze data, design expected outcomes, take appropriate action and evaluate whether the action is effective (SRNA, 2003).

Nursing standards: statements that describe the desirable and achievable level of performance expected of registered nurses in their practice, against which actual performance can be measured and serve as a guide to the professional knowledge, skills, and judgment needed to practise nursing safely. Standards established by the College of Registered Nurses of Nova Scotia are the benchmark for assessing the professional conduct of all registered nurses in Nova Scotia, regardless of specialty or practice setting. They also apply to nurse practitioners along with additional standards set specifically for their expanded practice. (Standards for Nursing Practice, CRNNS, 2004).

Orientation: process of providing information and support to new employees to orient them to the responsibilities and expectations of the organization and work setting.

Password: a sequence of characters required for access to a computer system.

Patient Care System (PCS): within the Nova Scotia Hospital Information System (NSHIS) this is where the list of caregiver clients and caregiver intervention lists are accessed in order to document care. Documentation flows to the Enterprise Medical Record (EMR).

Plan of Care (POC): is a group of problems (diagnosis), outcomes or goals), interventions, and orders assigned to a client specific to the diagnosis using the Nova Scotia Hospital Information System (NSHIS), e.g. diabetes care plan.

Preceptorship: a teaching and learning method in which the learner is assigned to an experienced nurse so the learner can experience day-to-day practice with a role model and resource person immediately available in the practice setting (Chickerella and Lutz, 1981). Preceptorship assists the learner to become socialized

to the new practice environment and assists in bridging the theory-practice gap.

Predictable: extent to which one can identify in advance a patient's response on the basis of observation, experience, or scientific reason (Merriam-Webster Online Dictionary). Predictability involves assessment of how effectively a health condition is managed, the changes likely to occur, and whether the type and timing of change can be predicted (College of Nurses of Ontario, 1997, p.6).

Primary health care: the first level of care and is usually the initial point of contact individuals and families have with the health system, usually in community health centres or physicians' offices (Health Canada, 2002) It is essential healthcare (health promotion, preventive, curative, rehabilitative, and supportive) that focuses on preventing illness and promoting health with optimal individual and community involvement. The five principles of primary health care are accessibility, public participation, health promotion, appropriate technology, and intersectoral collaboration.

Professional misconduct: includes such conduct or acts relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonorable or unprofessional which, without limiting the generality of the foregoing, may include:

- (i) failing to maintain the College of Registered Nurses of Nova Scotia *Standards for Nursing Practice*,
- (ii) failing to uphold the code of ethics adopted by the College,
- (iii) abusing a person verbally, physically, emotionally or sexually,
- (iv) misappropriating personal property, drugs or other property belonging to a client or a registrant's employer,
- (v) inappropriately influencing a client to change a will,
- (vi) wrongfully abandoning a client,
- (vii) failing to exercise discretion in respect of the disclosure of confidential information,
- (viii) falsifying records,
- (ix) inappropriately using professional nursing status for personal gain,
- (x) promoting for personal gain any drug, device, treatment, procedure, product or service that is unnecessary, ineffective or unsafe,(xi)publishing, or causing to be published, any advertisement that is false, fraudulent, deceptive or misleading,
- (xii) engaging or assisting in fraud, misrepresentation,deception or concealment of a material fact when applying for or securing registration or a

licence to practise nursing or taking an examination provided for in this Act, including using fraudulently procured credentials (*Registered Nurses Act*, 2001).

Professional practice issue: any issue or situation that either compromises client care or service, by placing a client at risk or affecting a nurse's ability to provide care/service consistent with the *Standards for Nursing Practice*, other standards and guidelines, or agency policies (Resolving Professional Practice Issues, CRNNS, 2002).

Progress notes: documentation of the progress of client's problems by all health team members. Nurses' notes are one component of the progress notes.

Quality care: in nursing practice is not something arbitrarily defined. The process is ongoing, involving all registered nurses and occurs at every level (clinical practice, education, administration and research) and is based on the *Standards for Nursing Practice* (CRNNS, 2004), the Canadian Nurses Association's *Code of Ethics* (2003), practice standards developed by and for a specialized area of nursing practice, and specific client care standards. These standards define how registered nurses are expected to perform and provide services to clients in a manner aimed toward ensuring excellent client outcomes.

Quality improvement: organizational philosophy that seeks to meet client needs by utilizing a structured process that identifies and improves all aspects of care and service on an ongoing basis (CCHSA, 1995).

Reasonable: nursing practice compared to registered nurses with similar education and experiences.

Reports: within the Nova Scotia Hospital Information System (NSHIS), a variety of reports can be printed from the report icon on the desktop.

Research utilization: reading and critically evaluating nursing research and best practice knowledge, using relevant findings in practice, evaluating results and communicating findings to others, to ultimately enhance client care in the clinical setting.

Scope of practice: the roles, functions and accountabilitys which members of a profession are educated and authorized to perform.

Search warrant: a written order by a judge that permits a law enforcement officer to search a specific place and identifies the persons (if known) and any articles intended to be seized (often specified by type, such as 'evidence of bodily harm'). The evidence sought must

be ‘relevant or rationally connected to the incident under investigation, the parties involved and their potential culpability.’

Self-regulation: the relative autonomy by which a profession is practised within the context of public accountability to serve and protect the public interest. The rationale for self-regulation is the recognition that the profession is best able to determine what can be practised, how it is to be practised, and who can practise, as long as the public is well served.

Stable situation: situations in which the client’s health status can be anticipated, the plan of care is readily established, and is managed with interventions that have predictable outcomes (CNA, 2003).

Standard of Care (SOC): a group of interventions that must be assigned to a client before any assessment is done. It is a predefined list of tasks required for proper client care regardless of the medical diagnosis or problem. With the NShIS patient care system (PCS), interventions from the SOC and the plan of care will flow to the intervention list in the PCS.

Subpoena: an order of the court for a witness to appear at a particular time and place to testify and/or produce documents in the control of the witness. A subpoena is used to obtain testimony from a witness at both depositions (testimony under oath taken outside of court) and at trial. Subpoenas are usually issued automatically by the court clerk but must be served personally on the party being summoned. Failure to appear as required by the subpoena can be punished as contempt of court if it appears the absence was intentional or without cause. Safeguards are involved with a judge and lawyer’s input as to how much information is required and relevant and when necessary, restrictions on how the information may be used, such as a publication ban.

Unstable situation: situations in which the client’s health status is fluctuating, with atypical responses, the plan of care is complex, requiring frequent assessment and modification and is managed with interventions which may have unpredictable outcomes and/or risks (CNA, 2003).

Telehealth: the delivery of health related services, enabled by the innovative use of technology, such as videoconferencing, without the need for travel. Telehealth can refer to transmission of medical images for diagnosis (referred to as store and forward telehealth) or groups or individuals exchanging health services or education live via videoconference (real-time telehealth).

Telenursing: use of electronic means by registered nurses to establish communication links with clients and/or other healthcare professionals in the delivery of professional nursing services.

Therapeutic relationship: a purposeful, goal directed relationship between nurse and client(s) that is directed at advancing the best interest and outcome of clients. The therapeutic relationship is central to all nursing practice and is grounded in an interpersonal process that occurs between the nurse and client(s) (RNAO, 2002).

Unpredictable: client health outcomes that cannot reasonably be expected to follow an anticipated path.

Voicemail: an electronic communication system in which spoken messages are recorded or digitized for later playback to an intended recipient.

APPENDIX D

Self-Employed Nurses/Independent Practice

Self-employed nurses must adopt a documentation system and develop appropriate policies, including those related to the storage, retrieval and retention of health records. What they record will depend on the type of services they provide, and while required forms can be straightforward they should address nursing assessments, plans, interventions and client outcomes.

Registered nurses in independent practice, as well as those who volunteer their services, also need to be aware that both the *Freedom of Information and Protection of Privacy Act* (FOIPOP) and *Personal Information and Protection of Electronic Documents Act* (PIPEDA) apply to them as they will collect, use or disclose personal information in the course of their professional practice (see *Transmission of Information*, pg. 18).

The College's *Guide for Self-Employed Nurses* and *Self-Employed Resource Package* provide direction on the documentation requirements for self-employed nurses and is available by contacting the College or visiting the College website at www.crnns.ca.

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College of Registered Nurses of Nova Scotia
600-1894 Barrington St., Halifax, NS B3J 2A8
Tel 902-491-9744 Fax 902-491-9510 Toll-free (NS) 1-800-565-9744
E-mail: info@crnns.ns.ca Website: www.crnns.ca