NOVA SCOTIA COLLEGE OF NURSING

DOCUMENTATION PRACTICE GUIDELINE

The Nova Scotia College of Nursing (NSCN) is the regulatory body for licensed practical nurses (LPNs), registered nurses (RNs), registered psychiatric nurses (RPNs) and nurse practitioners (NPs) in Nova Scotia. Our mandate is to protect the public by promoting the provision of safe, competent, ethical and compassionate nursing services by our registrants. The term nurse in this document refers to LPNs, RNs, RPNs and NPs unless otherwise stated.

Contents

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Our practice support tools are developed using current reference material. The source of this material is available upon request.

Introduction and Definition

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 guideline is for nurses in all practice settings to assist in understanding the expectation to adhere to the principles of nursing documentation, and their accountabilities, regardless of the documentation method or storage.

Nurses have the professional responsibility to advocate for the creation of employer processes and authorizing mechanisms to support nursing documentation.

Like all regulatory tools, use this guideline in conjunction with:

1. The NSCN standards of practice and code of ethics for LPNs, RNs, RPNs and NPs;
2. All applicable NSCN practice guidelines; and
3. Employer policies or authorizing mechanisms.

NSCN does not determine the methods in which nurses document but expects these principles to apply to all formats, whether paper-based or electronic charting.

If no employer policy or authorizing mechanisms exist, nurses should use this guideline, while relying on their Standards of Practice, best practices, and their professional judgment to guide their documentation.

Principles of Nursing Documentation

PRINCIPLE 1 - ALL NURSES MUST DOCUMENT AS A COMPONENT OF CARE

1.1 *Standards of Practice* require nurses to document the care they provide to demonstrate accountability for their actions and decisions. Care is not complete until documentation is complete. Each nursing designation's standards of practice indicate that nurses must document as part of nursing practice. Nurses meet their standards of practice by documenting, however specifics, such as how nurses document, are determined by employer processes and policies.

	LPN	RN	RPN	NP
Standard	Professional Accountability and Responsibility	Knowledge Based Practice	Competent, Evidence Informed Practice	Responsibility and Accountability
Indicator	Document and report according to established legislation, regulations, laws, and employer policies	Appropriately documenting (written and/or electronic) timely and comprehensive assessments, decisions about client status, plans of care, interventions and outcomes.	Applies documentation principles to ensure effective written/ electronic communication.	Document client care as required by federal and provincial legislation, regulations and organizational policies

1.2 Nurses only document the care they provide, not the care provided by others. In situations where two or more people provide care or services, the nurse who has the primary assignment is expected to document the assessment, intervention and client response, noting the role of other care providers as necessary. The second provider is expected to review the documentation and make an additional entry if necessary.

In emergency situations (e.g cardiac arrest) where it may not be possible for the nurse providing care to document, it is acceptable to have a designated recorder.

1.3 Client care must be documented in the health record. 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). Unofficial communication tools or nurses' worksheets/ notes and other tools used by nurses and members of the health care team do not replace the need to document in the client's health record.

Unregulated care providers should document the care they provide.

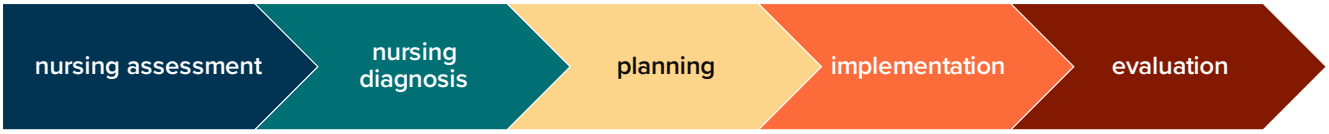
1.4 The client health care record is a legal document and may be used as evidence in a court of law or professional conduct proceedings. These records may be used in legal proceedings to reconstruct events, to establish time and dates to refresh memory and to substantiate and/or resolve conflict (CNPS, 2020)

Self-employed nurses are expected to have policies and/or processes in place related to documentation and the collection, storage, dissemination and disposal of client health information. Please refer to Self-employment Practice Guideline for additional guidance.

1.5 Nurses in non-clinical positions, such as education or management, are required to document, however the documentation will look different depending on the context of practice. In these cases, the recipient of the nurse's services would be considered their client. As a manager, the client may be their team or individuals on that team. In these settings, the nursing documentation may be in the form of remediation plans, performance appraisal, meeting notes and other professional correspondence.

1.6 Documentation in the client record should start with the plan of care, which is a comprehensive and current guide to care designed to identify and meet client health care needs. Depending on the context, it may be developed with or without the collaboration of other members of the health care team. For more information, refer to our Nursing Care Plan Practice Guideline.

1.7 Documentation must be completed for all aspects of the nursing process, including assessment, diagnosis/ determination, planning, implementation and evaluation. This documentation should reflect and articulate the nurse's critical thinking, demonstrating the course of action they took and why.



1.8 Co-signing can blur the lines of accountability. If two nurses are involved in an assessment or the delivery of care, both should document according to employer policy or authorizing mechanism. For example, if two 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 by the employer. In this case, employer policy or other authorizing mechanism could indicate that the co-signature is confirmation that the nurse (co-signee) witnessed that the correct unit was given to the correct client.

Countersigning is a quality assurance mechanism and should be defined in an employer policy or other authorizing mechanism.

1.9 Nursing students are expected to document the care they provide in accordance with employer and nursing program's policies. It may be necessary for the nurse who is acting as the preceptor to document their own assessment, interventions and evaluations. We do not recommend nurses cosign student documentation. The need for this extra level of documentation should be based on employer policy or other authorizing mechanism and professional judgment.

1.10 Nurses should document when providing care to groups. When documenting they should consider:

- The needs or goals of the groups
- The nurse's actions based on the needs assessment
- The outcomes and evaluations of those actions

Information about individual clients within the group may be recorded in the individual client's health record. Employer policy or other authorizing mechanism will direct where this information is recorded.

PRINCIPLE 2 - DOCUMENTATION SUPPORTS SAFE CARE

2.1 Quality documentation supports the exchange of pertinent client information among the interprofessional care team. All members of the health care team require accurate information about clients to ensure the development of organized comprehensive care plans.

2.2 Quality documentation minimizes the risk of errors, delays in treatment and fragmented care, thus contributing to quality client care.

Nurses are accountable to complete serious reportable event records, in accordance with employer policy or other authorizing mechanisms, in addition to documenting in the client's health record.

Indicators of quality documentation include:

- Documentation should be clear and complete. It should be legible and organized, with correct spelling.
- Nurses should not leave blank white space in their documentation.
- Only approved acronyms and abbreviations should be used.
- The nurse's signature, date and time should be included when documenting in the health record.
- To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove chart pages.
- Errors and changes to inaccurate documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to employer policy or other authorizing mechanism in both electronic and paper-based systems

PRINCIPLE 3 COLLABORATION WITH MEMBERS OF THE HEALTH CARE TEAM SHOULD BE DOCUMENTED.

3.1 When nurses collaborate with members of the interdisciplinary team to develop and/or modify the plan of care, this collaboration should be documented. For example, if a nurse seeks clarification from a physiotherapist related to mobilization of a client the nurse should record the reason for seeking clarification, the name of the health care provider responsible for the clarification, the action they took and the expected outcome.

PRINCIPLE 4 DOCUMENTATION SHOULD OCCUR AT THE TIME CARE WAS PROVIDED OR AS SOON AS POSSIBLE IN CHRONOLOGICAL AND SEQUENTIAL ORDER.

4.1 Documentation should occur as soon as possible after an event has occurred.

> Documentation should never occur before an event has taken place.

When it is not possible to document at the time of or immediately following an event, or if extensive time has lapsed, a late entry is required. When documenting late entries seek advice from the employer or follow employer policy and authorizing mechanisms.

4.2 Care should be documented chronologically. Chronological order is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications regarding the care provided, the assessment data, and outcomes or evaluations of that care (including client responses).

4.3 As complexity and acuity increases, documentation should become more frequent.

	LOW	MEDIUM	HIGH
ACUITY →			
COMPLEXITY →			
VARIABILITY →			
FREQUENCY OF DOCUMENTATION →			

PRINCIPLE 5 DOCUMENTATION SHOULD DEMONSTRATE RESPECT FOR THE CLIENT

5.1 Nursing documentation should be factual, unbiased, nonjudgmental, objective and avoid generalizations and labels. For example: nurses should not document a client's behavior as "non-compliant", rather they should document the objective data that describes the behaviour.

5.2 Nurses have a professional responsibility to respect a client's informed choice even when the choice does not align with the nurse's belief or what may be considered best practice. The nurse should document any information related to client teaching about their choice and any potential consequences of the choice. Refer to the Harm Reduction Q&A for more information on integrating a harm reduction approach into nursing care.

PRINCIPLE 6 DOCUMENTATION SHOULD PROTECT CLIENT PRIVACY AND CONFIDENTIALITY

6.1 Nurses have ethical and legal responsibilities to maintain the confidentiality and privacy of a client's personal health information, including the health record.

6.2 Documentation, in any format, should be maintained in areas where the information cannot be easily accessed by casual observers or those not directly involved in the care of the client.

Health records maintained in a client's home should be stored in a manner to reduce the risk of people who are not in the client's circle of care (e.g. visitors, guests) accessing confidential information.

Employers should have policies outlining who has access to the health records and how clients and their family members are made aware of the importance of maintaining confidentiality.

> In some settings, a client or their family members may document their observations and the care they provided in the client record. Employer policy or other authorizing mechanism should outline this process for the client and their family members, as well as the documentation responsibilities of nurses.

6.3 Technology does not change a client's rights to privacy of their health information. Maintaining confidentiality (including access, storage, retrieval and transmission) of the client's health record is essential regardless of its format, whether it is paper-based or electronic (including email, text, e-record). Nurses should ensure that they use only employer-approved methods of communication including mobile devices, fax machines, etc. and ensure they follow employer policy or other authorizing mechanism and procedures related to these devices.

As artificial intelligence is more frequently being used, nurses must be aware of their accountabilities. Nurses must continue to follow these guidelines, maintain client privacy, confidentiality and follow employer policies when using AI. This includes reviewing any AI generated documentation for accuracy and completeness before being saved in the client record. Please refer to the Artificial Intelligence practice support tool.

Key Points

- Nurses should recognize that the documentation of their nursing decisions and actions is critical in caring for clients
- Quality documentation is an important element of nursing practice, essential to support safe care and patient outcomes.
- Documentation is a key component of meeting nursing Standards of Practice.
- Nurses' documentation practices should also follow employer policy or other authorizing mechanisms.

Links to Other NSCN Related Resources

- Standards of Practice
- Code of Ethics
- Medication Guidelines for Nurses
- Confidentiality and Privacy of Personal Health Information Practice Guideline
- Artifical Intelligence Practice Guideline
- Harm Reduction Approach in Substance Use Q&A
- Protected Titles and Designations Position Statement