College of Registered Nurses of Manitoba

Documentation Checklist

Use the following checklist to make sure you're meeting documentation requirements.

My documentation:

- ☐ **Reflects the application of the nursing process.**
  - ☐ Assessment, interpretation of findings (analysis) and diagnosis.
    - Includes subjective data (client perspective).
    - Includes objective data (my assessment/analysis).
  - ☐ Plan of care which takes into account the client's needs, circumstances, preferences, values, abilities and culture, and supports the client in self-management of care.
  - ☐ Implementation of intervention.
  - ☐ Evaluation and modification of the care plan.
  - ☐ Critical inquiry (e.g. identifying cause and effect relationships, and distinguishing between relevant and irrelevant data).
  - ☐ Consultations and referrals including provider's full name, designation and organization.
- ☐ **Includes the process used to get informed consent and any signed consent forms.**
- ☐ **Includes the discharge planning and discharge information** (e.g. potential barriers to discharge, referrals required to facilitate discharge, client's condition at discharge, teaching or education for self-care and any follow-up appointments).
- ☐ **Is client-centred**
- ☐ **Includes communication with the client's family or other significant supports.**
- ☐ **Includes telephone health advice provided.**
- ☐ **Includes health education and psychosocial support provided.**
- ☐ **Uses permanent ink and is written legibly.**
- ☐ **Does not have blank lines.**
- ☐ **Records events in the order they occurred.**
- ☐ **Records the date and time of each professional interaction or contact** (i.e. the date is written in full by month-day-year (e.g. October 9, 2016 at 2010 hrs instead of 10/09/12 at 8:10) or as outlined in my organizational policy).
- ☐ **Documents as close to real time as possible in order to ensure accuracy of details and timely communication to the team.**
- ☐ **Does not include pre-charted information** (i.e. my documentation was recorded at the time care was provided so that it is credible and accountable).
- ☐ **Includes my signature and designation in both handwritten and electronic versions (e.g. GN, RN, GNP, RN(EP) or RN(NP)).** My education credentials are optional.
- ☐ **Uses professional language and terminology.**
- ☐ **Avoids abbreviations as they may not be understood and can be misinterpreted.**
- ☐ **Only includes notes of the care I provided** (an exception to this rule may occur in the role of designated recorder during an emergency event and I am aware of my organizational policy regarding this).
- ☐ **Does not include bias** (I only documented conclusions that can be supported by data).