



College of
Registered Nurses
of Manitoba

Documentation Guidelines for Registered Nurses

Documentation and record keeping is a vital part of registered nursing practice. The quality and coordination of client care depends on the communication between different health-care providers. Documentation is a communication tool that allows RNs and other health-care providers to exchange information about a client's care. Regardless of what format you use to document, documentation and the client record are formal, legal documents that provide details about a client's health-care and progress. Differences may exist in how the client records are kept and how you document, depending on what setting or client population you work with.

When we refer to RN within this document, we are referring to all RNs including RN(NP)s.

Defining Documentation

Documentation is any written or electronically generated information about a client that describes the status, care or services provided to that client. Through documentation, you communicate observations, decisions, actions and outcomes of these actions for clients, demonstrating the nursing process.

For the purpose of this document, client may be an individual, family, group, community or population.

Why We Document

Documentation is necessary for:

- Communication between health-care providers
 - Clear, complete and accurate documentation ensures that everyone involved in a client's care, including the client, has access to the information they need to plan and evaluate client care.
 - A good test to evaluate whether your documentation is satisfactory is to ask: "If another RN or health-care provider had to step in and take over this assignment, does the client record provide sufficient information for the seamless delivery of safe, competent and ethical care?"
- Meeting legislative requirements
 - Documentation is a valuable method of demonstrating that you have applied nursing knowledge, skill and judgment within a nurse-client relationship in accordance with the *Regulated Health Professions Act*, General Regulations, *Standards of Practice* and *Code of Ethics for Registered Nurses*.
 - Standard #4 – Client record: Registered nurses are responsible and accountable for quality documentation practices to support safe, client-centred care. As an RN, you must:
 - 25) Demonstrate skill in written and/or electronic communication that promotes quality documentation and communication between team members.
 - 26) Appropriately document the nursing care provided in a record specific to each client.
 - 27) Document the nursing care provided in the client's record as the nursing care is provided or as soon as possible after care is provided.
- Quality improvement
 - Clear, complete and accurate nursing documentation facilitates quality improvement initiatives and risk management analysis for clients, staff and organizations.
 - Documentation is used to evaluate quality of services and appropriateness of care through chart audits and performance reviews.
- Research
 - Health records serve as a valuable and major source of data for new health-care knowledge. The type of research made possible through information reviewed in client records can help improve nursing practice.



- Legal proof of health care provided
 - The client record is a legal document and can be used as evidence in a court of law or in a professional conduct proceeding.
 - Courts rely on documentation as evidence of what was done or not done. Generally speaking, if it was not documented, it was not done.
 - Courts may use the client record to reconstruct events, establish time and dates, refresh an RN's memory and verify and/or resolve conflicts in testimony.
 - Failure to meet the standards set out by your regulatory body can result in disciplinary action against you. Poor documentation can also undermine or destroy your defence in a lawsuit.

Practice Snapshot

1. *A client's family member complains to hospital staff about the care his father was receiving. The family member said he arrived earlier in the morning to find an oxygen mask on his father's face without the oxygen turned on. The family member felt that his father seemed more confused and lethargic than normal. The nursing staff said the oxygen was on all night and that the client slept well. The family member placed a formal complaint with the hospital against the nursing staff caring for his father that night. The hospital risk manager investigated the complaint and found no evidence in the client record that oxygen was used through the night or evidence that any vital signs, including oxygen saturation, were completed. If oxygen was administered, and/or vital signs were completed throughout the night, there was nothing in the client record to indicate it occurred.*
2. *Sam Jones RN provides discharge instructions for a client with a Halo fixation who is leaving the hospital to go home. Sam educates the client on pain medication, self-care (including pin site care) and informs him of the signs and symptoms of infection. Sam also schedules a follow-up appointment and gives the client a discharge instruction sheet. During the follow-up appointment in the outpatient clinic, Kelly Frances RN determines the pin sites are infected. The client says he was not aware that he was supposed to clean the Halo fixation pins. Kelly reviews the electronic medical record and sees the discharge documentation does not include information related to pin site self-care teaching or a description of the skin condition at the pin site areas.*



Discussion

Sufficient documentation provides evidence that client care was provided and an appropriate assessment was done. In the first situation, the hospital or the courts cannot rely on the client record as an accurate account of what nursing care was provided or the client's health status. In the second situation, Sam Jones RN provided all the necessary discharge instructions. However, this was not documented in the electronic medical record so there is no evidence that the discharge teaching had actually occurred.

What is quality documentation?

Quality documentation means that the elements of the nursing process are evident in our documentation. If the quality indicators below are achieved within your documentation, it provides evidence that you are working toward meeting the *Standards of Practice*.

What should you include in your documentation?

Quality Documentation Indicators

- Reflects the application of the nursing process including:
 - Assessment, interpretation of findings (analysis) and diagnosis
 - Including subjective (client perspective) and objective (your assessment/analysis) data
- Plan of care which takes in to account the clients' 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 emphasizing critical thinking and clinical judgment skills (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

Quality documentation includes any communication with family or other significant supports, health education or psychosocial support provided and the process used to get informed consent along with identifying the signed consent forms. Quality documentation consists of discharge planning and discharge information. This should include the client's condition at discharge, any teaching or education for self-care and any follow up appointments or referrals. Including telephone health advice provided to clients is also an important aspect of quality documentation.

Quality documentation includes:

- the process used to get informed consent and any signed consent forms
- discharge planning and discharge information (to discharge, any referrals required to facilitate discharge, the client's condition at discharge, any teaching or education for self-care and any follow-up appointments)
- communication with family or other significant supports
- telephone health advice provided
- health education and psychosocial support provided

In addition to ensuring clear, concise and accurate documentation, there are some fundamental rules of documentation.

- Use permanent ink and ensure your writing is legible – this may require you to print. This is an issue of patient safety as illegible writing can be misinterpreted and may not bring value to client care.
- Never leave blank lines as it may allow someone to add incorrect information to empty spaces.
- Events should be recorded chronologically (or sequentially and logically).



- Record date and time with each professional contact (to support clear communications is it best to write the date in full by month-day-year (e.g. October 9, 2016 at 2010 hrs. NOT: 10/09/12 at 8:10) or as outlined in your organizational policy.
- Document in a timely manner, meaning as close to real time as possible in order to ensure accuracy of details and timely communication to the team.
- Do not chart in advance of the event or care provided. Pre-charted information is not credible or accountable.
- Include your signature and designation on each entry in both hand written and electronic formats (e.g. GN, RN, GNP, RN(EP) or RN(NP)). Education credentials are optional.
- Use professional language and terminology.
- Avoid using abbreviations. Abbreviations may not be understood or may be misinterpreted.
- Only include notes of the care you provided. An exception to this rule may occur in the role of designated recorder during emergency event. Please check your organizational policy.
- Do not include bias (document only conclusions that can be supported by data).

Documentation should paint the entire picture of the client and the care provided from the time the client entered the health-care system until his or her discharge. Vague or opinionated documentation can interfere with continuity of care and misrepresent your assessment findings. Here are examples of notes from a client's record. In the left column, the notes are vague and do not promote clear and concise communication.

Unclear Documentation	Clear Documentation
Disruptive and agitated behaviour	Client is yelling and pacing in hallway
Client appears in pain	Client grimaces when moved from back-to-side
Client is non-compliant	Client said he does not want to take his medication as it makes him feel nauseous
Client is a fall risk	Client stumbles when walking and shuffles feet
Client appears confused	Client is disorientated to time and place
Client is depressed	Client had a flat affect, limited eye contact and cried frequently during conversation
Wound is infected	Skin around the wound is red, warm to touch with purulent discharge, client complains of increased pain over the past two days
Client has poor insight and is a safety risk	Client found outside smoking with portal oxygen tank in use
Client appears to be hemorrhaging	Client has saturated two peri-pads in one hour
Difficulties breathing	Nasal flaring noted and lips blueish tinge

DOCUMENTATION

Meeting the Standards

Standard # 1 – Client-Centered Practice:

Registered nurses are professionals, responsible and accountable in their practice to deliver client-centered care to the public. As an RN, you must:

- 3) Apply the nursing process, which is the systematic approach to the practice that encompasses all steps taken by an RN in planning for the needs of a client, including assessment, diagnosis or determination, planning, implementation and evaluation.

Standard #2 – Professional Practice:

Registered nurses are responsible and accountable for nursing practice that is informed by evidence and demonstrates competence. As an RN, you must:

- 12) Demonstrate use of current evidence from nursing science, other disciplines and other pertinent sources to improve and enrich your competence in nursing practice.
- 13) You must acknowledge your limitations in skill, knowledge and judgment and must ensure that you practice registered nursing within those limitations.

Practice Snapshot

Avery Wilson RN is assessing the need for PRN pain medication with a client. She assesses the situation and the client's care needs in order to determine if it's appropriate to provide the PRN medication. Avery documents in an IPN the onset, type, severity, location and radiation of pain and any restrictions of activities of daily living (ADLs) the client is experiencing.

Before giving the medication, Avery also checks the client record to determine when the medication was last given to decide if the client received adequate pain control with the current medication type and dose. After giving the medication, she documents that the medication was administered and its effectiveness so that the next person who reads the client record is aware this occurred.

In this situation, what documentation supports evidence of the RN's critical thinking? How do Avery's actions meet the practice expectations for RNs?

Discussion

Avery's documentation shows critical thinking has occurred by her noting the assessment findings and reason for administering the PRN medication. The note provides all relevant facts and demonstrates evidence of the nursing process, including evaluation. Client-centered care is evident because Avery focused on what the pain meant to that individual and provided care accordingly. Avery's documentation in this situation meets the *Standards of Practice*.

Consider this same situation when a lack of documentation has occurred.

The client received the PRN medication. However, Avery forgot to document the administration in the records. After Avery has finished her shift and left for the day, the oncoming RN reviews the record and believes the client has not received pain medications during the previous shift.

Avery provides PRN medication to the client on a regular basis but the reason for the administration and its effectiveness of the medication has not been noted in the client record. The RN(NP) responsible for prescribing the medication is unsure of its effectiveness and is questioning the need to reorder the medication.

What are the potential implications of these two situations?

Discussion

The documentation in these two scenarios does not paint a clear picture of the client status or RN care provided. Ensuring this information is documented supports safe medication administration, quality client care and effective communication between health-care providers.

Timely Documentation

Documentation should be a regular and frequent part of your registered nursing practice. It is highly important that you document soon after you provide care to support accurate recall of information and to communicate effectively with other members of the health-care team. For accuracy, the courts have stressed the importance of recording at the time of an event or as close to it as is prudently possible. Unnecessary delay between the occurrence of the event and the recording may result in a court refusing to admit the record as proof of the truth of the event and questioning the credibility of the information or witness.

Practice Snapshot

Patrick Leek RN is escorting one of his clients to a procedure room on another unit. While away from the unit, another one of his assigned clients complains of chest pain is diaphoretic and his vital signs are abnormal. Patrick has not documented any assessment of this client previously. The nurses on the unit are unsure of the client's previous condition and rely on the client to fill in the gaps.

Discussion

Access to timely documentation supports continuity of care and communication between members of the health-care team. If Patrick had documented soon after his assessment, the health-care team could rely on the notes to determine the client's baseline status and when the client's health status started to deteriorate.

Documenting in Higher-Risk Situations

It is especially important to document more often during times when a client is at increased risk of harm, is unstable or there is a higher degree of complexity involved in the care provided.

Examples of situations where frequent documentation may be required include when a client is newly admitted or being transferred between facilities or units or discharged to self-care, or when the client's status changes or doesn't improve as expected. For example, when a wound does not improve as expected, what did you do about it?

You may document more frequently when an unanticipated, unexpected or unusual event occurs with a client or family member. For example, when a patient falls or a when a family is concerned about the care being provided or when a client is engaging in risk-taking behaviour (e.g. eating food identified as a dietary restriction, threatening self-harm, ambulating when bed rest is advised, leaving against medical advice, or if a client is refusing or abusing medications or illicit drugs). Other times you would document more frequently is when an error, mishap or accident has occurred or when the client refuses care or withdraws consent.

Meeting the Standards

Standard #4 – Client Records: Registered nurses are responsible and accountable for quality documentation practices to support safe, client-centred care. As an RN, you must:

27) Document the nursing care provided in the client's record as the nursing care is provided or as soon as possible after the care is provided.



Practice Snapshot

1. *A resident of a long-term care facility falls when transferring from his bed to the wheelchair. The resident hits her head on the side rails and scrapes her back. Diane Trembley RN conducts a complete assessment and monitors the resident's vital and neurological signs frequently throughout her shift. Diane also notifies the physician and family member of the incident. Diane documents the occurrence and plan of care in the client record and completes an occurrence/incident/patient safety event report.*
2. *After administering medication to her client, Laura Murphy RN goes to sign the medication administration record and realizes she has given Tylenol #3, ii tablets p.o. instead of Tylenol plain, ii tabs p.o. as ordered. Laura assesses the client for adverse effects and notifies the physician. Laura RN discloses the error to the client, apologizes, provides the plan for further observation and completes an occurrence/incident/patient safety event report as per organizational policy. Laura documents in the IPN to ensure that the next health care providers understand what has happened.*

Discussion

In both of these situations, having access to the details of the incident is critical to client safety. Once again, documentation demonstrates professional accountability, helps keep the health-care team informed and lets organizations track medical errors and occurrences to support quality assurance and improve client safety.

FACTS: Factual, Accurate, Complete and Timely

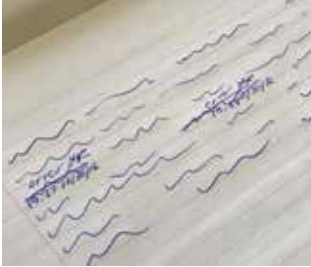
To help you remember the fundamental aspects of documentation, consider charting the FACTs. FACT is an acronym you can use to guide your documentation practice.

F = Factual	A factual record contains descriptive, objective information about what an RN sees, hears, feels and smells. An objective description is the result of direct observation and measurement.	Breath sounds clear to auscultation all lobes. Chest expansion symmetrical – no cough. Nail beds pink.
A = Accurate	Accurate is the use of exact measurements and establishes accuracy. This accuracy can be used later to determine whether a client's condition has changed.	Oral intake was 1000ml over 8 hours.
C = Complete	Charting must be complete, including appropriate and essential information.	Document: <ul style="list-style-type: none"> • changes in client status, • client's responses (especially unusual, undesired or ineffective responses) • communication with the client's family or other significant supports.
T = Timely	Timely entries are essential to the client's ongoing care in order to reflect a clear record of what has happened.	Resist the temptation to leave documentation until the end of the shift.



What if you make a mistake or forget to chart something?

How do you make a correction?



Mistakes can happen when documenting. What should you do if you realize you made an error in a client record? Fix it as soon as you can. When making a correction, follow these rules:

- always keep the original;
- draw a single line through the entry and write “error” along with your initials;
- document the corrected information;
- record the date and time the correction was entered;
- do not use white out or eliminate an entry entirely;
- do not remove pages from a paper record; and
- if you have already distributed the record, write your correction and resend the updated version in an addendum.

When using electronic health records, make sure you know how to make a correction using these principles. Forensic examination of the records can determine which entry was made before another.

How do I add a late entry?

If you forget to chart something in the client record, you should:

- identify the new entry as a “late entry”;
- ensure the date and time of your additional note is clearly indicated;
- clearly identify the event or previous note to which the new note is concerned;
- sign all new entries and include your designation; and
- never leave blank lines.

Occurrence Reports/Incident Reports/Patient Safety Events

Mistakes do happen; we are just as accountable to our mistakes as we are to our practice. Organizational policies will guide your actions when errors do occur. Organizations track errors and gather information through occurrence reports/incident reports/patient safety events. These methods support quality improvement and improved client outcomes.

Incidents are generally documented in two places: in the client’s record and in an occurrence report/incident report/patient safety event that is separate from the client record. Documentation in the client record is used to ensure continuity of client care and should be accurate, concise, factual, unbiased and recorded by the person who witnessed the event. Occurrence reports/incident reports/patient safety events are separate from the client record and are used by organizations for risk management, to track trends in systems and client care and to justify changes to policy, procedure and/or equipment for improvement to client care.

Common Documentation Systems

Client data can be recorded using a number of documentation systems. The documentation systems used today reflect specific needs and preferences of the many health-care organizations. There are many different methods of documentation including but not limited to:

- narrative charting, source-oriented charting, problem-oriented charting (SOAP/SOAPIE),
- problem-intervention-evaluation charting (PIE),
- focus charting (DARP-Data, action, response, plan),
- critical pathways, and
- charting by exception.

Charting by exception is a method of documentation that can put the RN, client care and client outcomes at risk if not completed correctly.

What is charting by exception?

Charting by exception, or variance charting, focusses on documenting only unusual or unexpected findings, or those outside the established norm. It is a shorthand method for documenting normal findings and routine care based on clearly defined standards and predetermined criteria for nursing assessments and interventions. These clearly defined standards provide the framework for routine care for all clients.

This type of charting is often done on flow sheets, care maps or clinical pathways that are based on pre-established guidelines, protocols and procedures. Additional documentation is needed when the client's condition deviates from the standard or what is expected. In other words, narrative documentation on IPNs includes care or observations that are outside the established expectations or norms.

Before a charting by exception system can be used, employers need to ensure that policies, standards, procedures, clinical pathways and staff training has been done to support this practice.

Charting by exception documentation and IPNs are meant to work together to show the entire picture of the care provided. The challenge is to understand when an IPN is required. If your flow sheet, care map or clinical pathway does not give a clear picture of what happened to that client or what care was provided, write it out in an IPN.

Meeting the Standards

Standard #3 – Collaborative Care: Registered nurses are responsible and accountable for collaborating with the client and other team members and for demonstrating nursing leadership to promote the delivery of safe client-centered care.

20) You must document on the client's record the nursing care provided with enough information for another registered nurse or health-care professional to be sufficiently informed of the care provided.



Practice Snapshot

Mr. Jones is an independent resident in a long-term care facility. Jane Lam RN has written the same entry in Mr. Jones' chart for the last four months. Each month, her entry states: "Resident doing well at this time". One day, Jane finds Mr. Jones crying alone in his room. Jane talks to him for a few minutes and determines that it is the anniversary of his late wife's death. Mr. Jones seems to calm down and Jane makes no mention of the interaction in his client record. One week later, it is again charted in an IPN that "Resident doing well at this time" along with a few recorded vital signs. A few days later, Mr. Jones leaves the facility without notifying anyone and does not return. Jane calls the police and a search for Mr. Jones begins. Mr. Jones is found several miles away attempting to board a bus and says to the police "No one at that place cares about anything. I just want to die".

Discussion

Proper charting by exception requires that each resident has a well-documented health baseline and a detailed plan of care. This will help give a clear picture of the client's entire health status and promote clear communication between health-care team members. Additional IPN charting must be done for any change or deviation from the baseline or norm, no matter how minor. Writing "resident doing well at this time" is not sufficient documentation. If Mr. Jones' distress over the anniversary of his wife's passing had been identified and documented as an exception, he may have received the support he required and it may have prevented this occurrence from happening.

Use of Technology and Documentation

Electronic Records

How does documentation differ from electronic records?

The basic principles of quality documentation still apply when using electronic health records. However, electronic health records carry higher risks around privacy and confidentiality as they are easier to retrieve than paper copies.

Health-care professionals are not permitted to access records of clients who are not under their care or access their own personal health information. If you would like to access your own information, you would have to follow the same process as any other client.

It is important to check your organization's policies on protecting confidentiality when using electronic health records. A few special considerations include:

- do not login for someone else,
- create a strong password and change it frequently,
- do not share your password with anyone,
- log off when you are finished using the system,

- make every effort to protect your monitor/screen from being seen while you are working,
- if your electronic signature is automatic, confirm that your full name is correctly spelled and your professional designation is included (e.g. Jane Smith RN), and
- sometimes electronic systems have automatic features such as signatures, auto spelling and drop down menus. Attention should be paid to accuracy, spelling and grammar to ensure that quality is not compromised. Taking action to address technological issues that impact quality documentation is important.

What if you make an error in electronic documentation?

- Correct error promptly
- Record the date and time the correction was entered
- Know your facility's policy on making corrections (e.g. should not delete errors, make a separate entry to indicate error)
- Do not change/edit another staff member's entries

What if you forget to add something in electronic documentation?

- Document the date and time of your entry
- Within the body of your note indicate the time of the occurrence to which you are referring

It is important to note that forgetting to chart and late entries should not be a regular occurrence. A pattern of late or no entries can affect the credibility of your client records.

Practice Snapshot

Justin Smith RN is self-employed and uses his own computer to document client interactions. The computer system crashes and Justin loses all of his client files. How should Justin manage this situation? What actions would have prevented this from happening?



Discussion

Self-employed RNs who store data on their personal devices should ensure they have a secure confidential back-up system. Since none of his client information could be saved after this event, Justin should attempt to recreate his client's files to the best of his ability and notify all clients of the incident. He should then establish a routine and secure back-up system to use going forward (e.g. back-up all files on a secure commercial cloud or external drive).

Telepractice

How do I document telepractice?

Nursing telepractice encompasses all types of nursing care and services delivered across distance. For example:

- telephone triage or video conferencing with a client or another professional from an urban to remote area,
- telephone consultation for insurance companies and public health agencies, or
- responding to a client's question over the telephone.

Telephone and video conferencing documentation

When you accept a telephone call or video conference with a client you are establishing a duty of care or a therapeutic relationship with the caller. Providing advice without in-person contact makes telepractice a high-risk interaction. Because of this, extra care must be taken in gathering information and documentation is crucial. It's also important to document any telephone or video conferences related to client care that you have with other health-care professionals.

Practice Snapshot

Kim Martin RN works in a northern nursing station and receives a call from a post-partum mother who has recently returned to her community after the birth of her son. The mother complains of engorged and slightly reddened breasts and a mild fever. Kim conducts a phone assessment, provides short-term advice and recommends the mother should be seen by the RN(NP) who will be working at the clinic the next day. The mother books an appointment with the RN(NP) for the following day.

Is Kim required to document her telephone conversation with the mother since the mother will be seen by the RN(NP) tomorrow and her encounter was only via the telephone? Where should Kim document this information?

Discussion

Yes, Kim should document the encounter with this client. Her documentation should include an assessment and interpretation of assessment including:

- diagnosis (if applicable),
- any advice provided to the client and the plan of care (including self-management), and
- any follow-up and referral to the RN(NP).

Kim should confirm the nursing station policies to determine if a new client chart should be opened or if there's an existing record she should use. With either option, Kim should ensure the RN(NP) is aware of the new notation and can access the record to ensure continuity of care. This may require a formal referral note.

Email documentation

Health-care organizations and health-care professionals use email extensively because of its accessibility, speed, reliability and convenience. However, the same characteristics that make email use advantageous are also the source of risks, including miscommunication and potential privacy breaches. Being aware of the risks inherent in the use of email can help you manage those risks and decrease your potential liability.



If email is an acceptable form of communication in your practice environment, you will need to:

- let clients and other health-care providers know when the use of email is appropriate (as guided by your employer's policy), how long it will likely be until you respond and what to do in the event that symptoms worsen or there is a delay in responding,
- place copies of any emails in the client's record,
- ensure you have used a professional tone,
- proofread every message before you send and make sure you have entered the correct recipient's email address, and
- follow your employer's guidelines and policies regarding email communications.

Interprofessional Collaboration and Documentation

Interprofessional documentation occurs when more than one type of health-care professional documents in the same record (e.g. hospital record or records maintained in a family practice clinic).

The vision for interprofessional practice is collaboration and shared decision-making between a team of health-care providers and a client. When each member of a health-care team documents in the client record, it eliminates duplication, saves time and helps improve client outcomes. Collaborative documentation enables health-care professionals from different disciplines to share the same documentation tools such as clinical pathways or Interprofessional notes (IPNs).

As RNs, we need to ensure our documentation within an interdisciplinary tool accurately reflects our unique contribution of nursing care. We should not simply sign off on the flow sheet or care map if we haven't contributed to a client's care. Signing off on a chart implies you have provided care that is documented and you will be held accountable for the care that was provided.

When we collaborate with our interdisciplinary team members and develop and/or modify the plan of care based on our collaboration, we should document the following:

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

Consider an example where an RN seeks clarification from a physiotherapist regarding a client's mobilization. In this scenario, the RN should document the reason for seeking clarification, the name of the physiotherapist, the action he or she took as the RN and the client's expected outcome.

All of the same principles of documentation apply when you're documenting within an interprofessional team clinical record.



Interprofessional documentation also includes:

- space available for documentation of all interprofessional assessments performed;
- diagnoses based on the expertise of all health care providers;
- plan of care that includes all of the interprofessional disciplines that the client needs;
- care provided by each of the care providers; and
- evaluation of outcomes of client care by all of the care providers.

Is Third Party Charting Acceptable?

Third-party documentation occurs when one piece of documentation is recorded for the care provided by the interprofessional care team. For example, documentation is recorded by one person for all the actions taken by a group of professional during an emergency response (cardiac resuscitation).

Generally speaking, third party documentation is not acceptable. As per the Canadian Nurses Protective Society, because of evidentiary rules and the potential for cross-examination in court, the RN or other health-care provider who has first-hand knowledge of an event must be the person who documents it.

When one person documents on behalf of a group of professionals, entries should be made by a person directly involved in the event. The names and professional designations of the professional involved in the situation or service provision should also be documented. It is important that you ensure that documentation is accurate and complete prior to applying your signature. When your signature is attached to the note you are attesting the information accurately communicates your actions. The note should also clearly identify you are only attesting to the documentation pertaining to your actions or professional opinion.

Practice Environments Supports

RNs have a responsibility to document client care; however, support to achieve quality documentation is also a requirement for our work environments.

A practice environment that supports quality documentation is one that provides:

- an orientation to the documentation system for all new employees;
- access to the client record, making it easy to document when care is provided;
- a quiet and private space for the intellectual work of documentation. Sometimes the bedside is the most appropriate place to chart, for example in the ICU as the patient is in front of you. Other times this is not the best place as there are too many distractions;
- an understanding that colleagues can cover for each other while one person documents by saying things such as “I will keep an eye on your clients while you chart and then we can switch”; and
- respect for the time and space needed for documentation.

Do you sometimes get pulled away from documentation because it’s not seen as important as other components of care? Consider other barriers that may impact the quality of your documentation.



Record Management: Maintaining Safe and Secure Records

Introduction

Health information is personal and sensitive, and clients have a right for their health records and privacy to be protected.

The Personal Health Information Act (PHIA) is a privacy law that establishes rules for trustees of personal health information on how to collect, use, disclose, maintain or destroy personal health information. In this section we will talk about safe and secure storage, access and disclosure of personal health information.

What is the best way to store a record so it's secure? The trustee of the records can keep information confidential and private by using physical security, such as locked filing cabinets and restricted office access, and electronic security, such as computer log-out processes and secure back-up systems.

Storing Records

Storing health information is an important part of maintaining safe and secure records. Client clinical records must be kept for at least 10 years following the date of the last entry on the record. Records of minors must be kept for at least 10 years after the minor turns 18 years of age.

Security

To ensure the security of personal health information, trustees must have:

- physical safeguards such as locked filing cabinets (some practice environments, such as home care, may have policies to guide safe storage of records in the home);
- technical safeguards such as secure networks, passwords, encryption software, firewalls and antivirus; and
- policies and procedures to support the security of information.

Protecting Client Information

Increasing numbers of RNs are using mobile devices or electronic means to communicate with colleagues and clients by telephone, text message or email. Some even use these devices to photograph wounds or skin conditions. Understanding the risks involved in using mobile devices and electronic communication may prevent potential adverse personal and professional consequences.

Employers generally have policies that require us to use such safeguards to protect personal health information. Without technical safeguards such as encryption, any emails, voicemails, pictures or text messages containing a client's personal health information could be accessed or disclosed if the mobile device is lost, stolen or unintentionally viewed by a friend or family member. Unauthorized disclosure can also occur during the wireless transmission of personal data.

Personal health information

Personal health information is recorded information about an identifiable individual that relates to:

- a) the individual's health, or health-care history, including genetic information about the individual,*
- b) the provision of health care to the individual, or*
- c) payment for health care provided to the individual,*

and includes:

- d) the PHIN (personal health identification number) and any other identifying number, symbol or particular assigned to an individual, and*
- e) any identifying information about the individual that is collected in the course of, and is incidental to, the provision of health care or payment for health care*



Practice Snapshot

1. A nurse lost a USB stick that contained the personal health information of approximately 83,500 clients who had been immunized for H1N1. The USB stick was not encrypted. This incident resulted in an investigation by the privacy oversight office and a class action lawsuit.
2. A nurse working for a large teaching hospital had her laptop stolen from her car. The laptop contained records of approximately 20,000 clients. The laptop was not encrypted despite the hospital's policy on ensuring technical safeguards are in place.

These cases highlight that encryption is now the expected safeguard for data protection on mobile devices.

Mobile devices

When using mobile devices, consider doing the following to keep information secure:

- where available, use employer-issued mobile devices instead of your own;
- limit the use of your device for recording, transmitting or storing clients' personal health information unless there are clear organizational policies that allow you to do this;
- if you plan to use your own device, work with your employer's IT department to ensure your device has features that make it secure and follows your employer's "bring your own device" policies;
- use a strong password and encryption capabilities;
- limit the amount of personal health information on your device or de-identify the personal health information it contains;
- turn off or do not enable Wi-Fi and Bluetooth on any device that has access to clients' personal information without confirming the connection is secure and protected;
- transfer a client's personal health information stored on your mobile device to the client's record as soon as possible, and then use wiping software to permanently erase the information from your device;
- use the time-out feature so that your device automatically locks when not in use;
- store your mobile device in a secure location and avoid leaving it unattended so that others cannot access it; and
- confirm whether your device has the capability to remotely erase data stored on the device, in the event that it is stolen.

Email Communication

Before you send a client's personal information by email, you must let your client know the risks associated with email use and discuss the potential benefits and drawbacks over using other methods of communication. You should get the client's consent before sending information by email. You would document this informed consent in the client record. Remember that ensuring reasonable safeguards for information protection is still your responsibly, not the client's.

Trustee

Trustees are registered or designated health professionals, health-care facilities, health services agencies and public bodies that collect and maintain personal health information. If you are self-employed you are a trustee of client information. PHIA regulates the information practices of health information trustees.

PHIA imposes two broad obligations on trustees:

- the obligation to grant individuals access to their own personal health-care records
- the obligation to protect the privacy of personal health information

Before sending personal information over email, you should also ask yourself:

- Is the person I'm sending this to authorized to receive the information?
- Did I enter the email address correctly?
- Is my message clear and accurate?
- Do other people, other than the intended recipient, have access to the email address?

Transporting Confidential Information

RNs are not always working in the same place and at times you may be required to transport confidential information. You may be visiting clients at home or in the community and be transporting client records with you in either paper or electronic form. So how do you reduce the risk of unauthorized access to this information when you are outside of your facility and its secure settings?

If you are using any portable device such as a laptop, tablet or USB stick you should password protect and securely store it when you aren't using it. Encrypting any documents that include personal health information adds another level of protection. If you are transporting paper records, make sure no unauthorized people can visually or physically access them and securely store the files when not in use. Organizational policies will determine what level of protection is required for your work place setting and it is important to know and follow these expectations.

A Client's Access to Records

There are times when clients need to access their personal health information. In Manitoba, PHIA gives clients the right to access their personal health information by making a formal request in writing to the trustee of their record.

Under the law, trustees have a duty to make every reasonable effort to help and respond to a client's request openly, accurately, completely and without delay. Trustees must provide the client with as much of the information requested as possible. PHIA does set out some limitations where the trustee may refuse to provide the client with some information. If this occurs the trustee must:

- inform the client in writing;
- let the client know the reason why the information cannot be provided; and
- let the client know they have a right to go to the Manitoba Ombudsman.

Manitoba Ombudsman

Manitoba Ombudsman refers to both the individual appointed as Ombudsman and to the office as a whole. Manitoba Ombudsman can investigate a client's complaint about access to information and privacy matters, the fairness of government actions or decisions, or serious 'wrongdoings' a client believes may have occurred.

Meeting the Standards

Standard #1 – Client-Centered Practice:

Registered nurses are professionals, responsible and accountable in their practice to deliver client-centred care to the public. As an RN, you must:

- 2) Recognize the practice of registered nursing encompasses a number of domains, such as clinical practice, education, administration and research. A client may be an individual, a family, a group of people, a community or a population. Depending on your domain or domains(s) of practice, a client may be a patient, a nursing student, a research participant, another RN or health-care provider.
- 4) Recognize the principles of client-centered practice in a clinical practice setting also apply to the practice of registered nursing in other domains such as education, administration and research.

Record Keeping in Other Non-Clinical Roles

RN administrators, educators and researchers also have a professional responsibility to maintain records and document according to legislation and organizational policies.

- **RN Administrators:**
 - Documenting family meetings or phone calls in the client chart
 - Documenting trends for quality improvement initiatives
 - Documenting a performance review in an employee file
- **RN Educators:**
 - Documenting student progression and evaluation throughout their course or program (This could include feedback from clinical educators on how well a student is managing)
 - Documenting for program evaluation and accreditation
 - Documenting to inform ongoing curriculum and program delivery
- **RN Researchers:**
 - Documenting the research process carefully to ensure reporting is accurate
 - Documenting data management activities to guide current work and help inform future research
 - Documenting feedback from participants or focus groups to collect accurate qualitative and quantitative data.

Improving Your Documentation

It takes time and practice to be competent in nursing documentation. Whether you've been practising for many years or are a new grad, here are some tips on how you can improve your documentation:

- Review the [Documentation Checklist](#) on a regular and ongoing basis – as legislation, regulations and *Standards of Practice* change, these indicators may change as well. It is important to ensure you have the most up to date version of these documents to ensure you are meeting the requirements.
- Participate in chart reviews or audits – a chart audit is one of several tools available for quality improvement.
- Complete a self-audit – self-audits can be used to review your own documentation. Here are some questions to consider:
 - How does my documentation contribute to better client care?
 - Is the contribution of registered nursing evident, does it reflect nursing process?
 - Who needs to read my notes?
 - Have I met the Quality Documentation Indicators?

Conclusion

This document was designed to highlight the importance of documentation and record keeping as an integral component of nursing practice. Within this document we covered:

- the expectations and requirements for documentation and record keeping in a variety of practice settings and contexts of care;
- why and how you should maintain client records;
- your responsibility in making sure personal health information remains private and secure;
- that clients have a legal right to access their own information; and
- the documentation requirement when working in a shared or multi-disciplinary practice.

As registered nurses, we have the opportunity to be leaders in documentation practices and improve client outcomes. The Documentation Checklist can be used at any time to evaluate your own documentation practices.

Resources

- [*Standards of Practice for Registered Nurses*](#)
- [*Standards of Practice for Registered Nurses on the Extended Practice Register*](#)
- [*Documentation Checklist*](#)





College of
Registered Nurses
of Manitoba

890 Pembina Highway
Winnipeg, MB R3M 2M8

P 204-774-3477
F 204-775-6052
TF (Manitoba) 1-800-665-2027

crnm.mb.ca