College of Registered Nurses of Manitoba

Principles of Quality Registered Nursing Documentation

Purpose:

The College of Registered Nurses of Manitoba (College) exists to serve and protect the public interest to achieve the outcome of accountable, quality and professional nursing practice. Timely, clear and comprehensive registered nursing documentation enhances communication between healthcare providers, promotes continuity of care, facilitates patient safety, and supports quality improvement initiatives within the healthcare system. To that end, the Practice Direction: Practice Expectations for Registered Nurses contains the following three statements which outline the standard for RN documentation:

- RNs must demonstrate skill in written and/or electronic communication that promotes quality documentation and communication between team members.
- RNs must document on the client's record the nursing care provided with enough information for another health-care professional to be sufficiently informed of the care provided.
- RNs must appropriately document the nursing care provided in a record specific to each client as the nursing care is provided or as soon as possible after the care is provided.

The purpose of this guidance document is to provide registrants with information and guidance to support them in meeting these practice expectations.

Note: Confidentiality and privacy are important considerations when accessing, handling, and disclosing information contained in health records. Those considerations are not addressed as part of this document. For more information about privacy and confidentiality, please review the Practice Support Document entitled *Maintaining Privacy and Confidentiality.*

Introduction

For the purpose of this guidance document, documentation refers to any written or electronically generated information about a client that describes their status, care, or services. For this document, “client” refers to any individual, family, group, community, or population receiving RN care.

Examples of documentation include (not exhaustive):

- Health Record documents
  - Progress notes
  - Patient flowsheets or assessment records
  - Medication administration records, or treatment administration records
  - Care or treatment plans
  - Order sheets
  - Consultation and referral forms
  - Consent forms
- Patient profiles and risk assessments
- Quality improvement or occurrence reporting documents (e.g. “incident reports” or “RL6 forms”)
- Narcotic administration records

According to the Canadian Nurses Protective Society (2020), documentation is necessary because:

- It provides a way for healthcare providers to communicate with eachother.
- It promotes continuity of care.
- It is required for legislative and regulatory purposes.
- It demonstrates accountability.
- It supports quality improvement.
- It supports research; and
- It acts as “legal proof of health care provided.” In regulatory and legal proceedings, documentation is relied on as evidence of what was done or not done; it is generally accepted that if something was not documented, it was not done.

Documentation can take many formats, depending on the practice setting, including but not limited to:

- Paper-based documentation
- Electronic or digital documentation
- Narrative format documentation (e.g. a “progress note”)
- Structured narrative format documentation (e.g. "Subjective-Objective-Assessment-Plan", "Data-Action-Response-Plan")
- Graphic or flowchart documentation (e.g. a physical assessment record or vital signs record)
- Photographic documentation
- Documentation of virtual care, telephone consultation, or online care

The following principles apply to Registered Nursing documentation, regardless of its format.

Principles of RN Documentation

1. RN documentation is a component of care.

Documentation is part of nursing practice. RN care is not complete until it has been well-documented. Documentation is not optional.

2. RN documentation complies with employer or facility expectations.

Most facilities and organizations have policies and procedures which govern documentation and record-keeping practices. RNs must comply with their employer’s policies, procedures, and processes, in addition to meeting their practice expectations.

3. RNs document in a record specific to each client.

In addition to the health record, practice environments may also use tools to aid teams in communicating at the transfer of care (for example, a change-of-shift report binder, a handover document, whiteboards, or tools for bed management) or for reporting errors, occurrences, or near misses. While these tools can be useful for reporting, communication, and continuity of care, they do not meet the standard of a record “specific to each client” nor do they replace the health record. RNs must document the care they provide in the health record.

4. RN documentation is legible and understandable.

RNs should avoid abbreviations, where possible, and comply with any banned abbreviations identified by their practice setting.

RNs should adhere to standard spelling and grammar conventions. Electronic patient records may have spelling/grammar editors, and other editing features which can be useful if used judiciously.

Symbols such as “emojis” or “emoticons” (for example ☺) will be misunderstood and must not be used in professional documentation.

5. RN documentation is descriptive and objective.

RN documentation should contain descriptive and objective information about what an RN sees, hears, feels, and smells. An objective description is the result of direct observation and measurement.

The following chart provides examples of vague and subjective documentation and suggestions for improving it.

Vague and Subjective	Descriptive and Objective
The client is disruptive and agitated.	The client has been yelling insults at other patients and pacing in the hallway for the last 90 minutes.
The client appears to be in pain.	The client grimaces when his left leg is repositioned in bed and rates his pain as 9/10.
The client is non-compliant.	The client stated he did not want to take his olanzapine because it makes him feel “sleepy.”
The client is a fall risk.	The client stumbles when walking 5 meters from his bed to his bathroom.
The client is confused.	The client was disoriented to time and place.
The client is depressed.	The client had a flat affect, made limited eye contact, and was tearful throughout our discussion. When asked about his mood, he stated he was “very sad.”
The wound is infected.	The peri-wound tissue is red and warm to the touch. The wound has a malodourous green discharge. The client states it has become more painful in the last 24 hours.
The client has poor insight and is a safety risk.	The client was found outside smoking while using a portable oxygen tank.
The client appears to be hemorrhaging.	The client has saturated two peri-pads with blood in the last hour.
The client is having difficulty breathing.	The client’s nares are flaring, and he is using accessory muscles when breathing.

6. RN documentation demonstrates respect, compassion, and empathy for clients and their families.

RNs are required to maintain therapeutic relationships and an RN’s documentation should be a reflection of those relationships. For more information about therapeutic relationships, see the practice support document *Professional Boundaries for Therapeutic Relationships*. In situations when an RN’s compassion, empathy, and therapeutic boundaries are questioned, an RN’s documentation can be used to characterize the nature of the therapeutic relationship.

RNs should remember that, at any point, a patient or their family can request to review the health record. Reading judgmental comments or documentation that communicates a lack of respect or compassion for patients and their families will cause a breakdown in the therapeutic relationship and harm to the patient.

7. RN narrative documentation is presented in chronological, sequential, or logical order.

RNs are accountable for both the content and organization of their documentation. Usually, documentation is presented in chronological order, however, in some cases, RNs may organize their documentation in other ways. Examples of this include:

- Organizing the record of a physical assessment by body system.
- Using an approved structured documentation format (e.g. "Data-Action-Response-Plan", or “Subjective-Objective-Assessment-Plan").

8. RNs document at the time care was provided or as soon as possible afterward.

According to the Canadian Nurse Protective Society (2019), it is generally accepted by courts that late entries are seen to be less accurate than documentation that is made contemporaneously. RNs should endeavor to document while they are providing care or as soon as possible afterward. RNs who wait to document risk forgetting relevant details, inadvertently documenting in the incorrect patient’s health record, or neglecting to document at all.

A Note on Late Entries:
While it is preferable that documentation take place immediately after the care was provided, there are some urgent and emergent circumstances when delay is required. When a late entry is made, it must be identified on the record as a late entry and comply with any practice setting requirements. Late entries should be an infrequent occurrence.

A Note on “Pre-Documentation”
“Pre-documenting” assessments or the care you intend to provide is dishonest and not an acceptable practice.

9. RN documentation is concise but provides enough information for another health-care professional to be sufficiently informed of the care provided.

The health record is a record of care provided, but it also serves as a communication tool. RNs need to consider what their colleagues need to know, in order to take over care, and include sufficient detail.

A Note on Documenting by Exception:
Documenting by exception, or variance documenting, focusses on documenting only unusual or unexpected findings. It is a shorthand method for documenting normal findings and routine care based on a clearly defined and articulated standard and predetermined criteria for nursing assessments and interventions. The clearly defined standards provide the framework for routine care for all patients. In order for documentation by exception to be permissible, the team must establish and document baseline assessments and a plan of care. This type of documenting is often done on flow sheets, care maps or clinical pathways that are evidence informed and 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.

RNs should ensure they understand what documentation system is used in their practice setting, before practicing.

Documentation by exception carries unique and significant risks. It requires a thorough, current, and accurate assessment of the patient's baseline health status.

While documenting by exception is discouraged in most practice settings, some organizations still choose to implement it. Before a documenting by exception system is adopted, supervisors and managers overseeing RN practice should:

1. Ensure that policies, standards, procedures, and clinical pathways are clearly articulated.

2. Ensure adequate staff training has been completed so the interprofessional team understands what the baseline is, and what is/is not documented.

3. Consider consultation with a College Quality Practice Consultant to discuss how the proposed documentation system allows RNs to meet their practice expectations.

10. RN documentation should demonstrate critical thinking and use of the nursing process.

The Practice Direction: Practice Expectations for RNs requires that RNs apply, as a framework, the nursing process, which is the systematic approach to the practice that encompasses all steps taken by RNs in planning for the needs of your client, including assessment, diagnosis or determination, planning, implementation, and evaluation.

A complete review of an RN's documentation of any encounter should demonstrate that the RN has applied the nursing process when caring for their patient. Furthermore, the RN's documentation should clearly communicate what course of action they took and why.

Of note, actions like health promotion teaching, discharge planning instructions, and psychosocial support are nursing interventions that should be reflected in an RN's documentation of the care they provide.

A Note on documenting care provided virtually:
Providing assessment or advice without in-person contact makes tele-practice a complex and high-risk interaction. Because of this, extra care must be taken in gathering and documenting information. It's also important to document any telephone or video conferences related to client care that the RN has with other health-care professionals.

11. RN documentation includes client-related communications with other team members.

Many practice environments are utilizing an interprofessional health record. Such health records include entries from RNs as well as other members of the healthcare team. The idea is that when each member of a healthcare team documents in the health record, it eliminates duplication, saves time, and helps improve client outcomes. Collaborative documentation enables healthcare professionals to share documentation tools (such as clinical pathways or "Integrated Progress Notes"). RNs should ensure their documentation accurately reflects their unique contribution to nursing care.

When an RN signs their signature, it implies they have provided and are accountable for the care that is documented. When RNs collaborate with their colleagues and develop or modify the plan of care based on that collaboration, the team 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.

12. RN documentation reflects the care that they provide.

RNs must not document the assessments and care provided by other people nor change the documentation that other people have made.

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 another individual or group of individuals. Except for a few specific situations, third-party documentation is generally unacceptable. As per the Canadian Nurses Protective Society (2020), because of evidentiary rules and the potential for cross-examination in court, the RN or other healthcare provider who has first-hand knowledge of the event or actions taken must be the person who documents it.

A Note on Third Party Documentation in Emergency Situations:
In some emergency circumstances (for example when a "code blue" team provides resuscitation to a patient), it may be necessary to assign one team member to document all resuscitation efforts taken by the team. In this case,

- the person documenting on behalf of the team should be present when the care is provided and should note that they were responsible for documentation.
- the person documenting should follow any policies, procedures, or documentation guides used in their practice environment.
- the names and designations of everyone involved and what actions they took should be recorded.
- All team members should review the documentation as soon as possible, to ensure that documentation is accurate and complete.
- All team members should apply their signature indicating that the information documented adequately reflects their contribution to the team's actions.

A Note on Third Party Documentation on Behalf of Unregulated Care Providers:
In some practice settings, unregulated care providers may be authorized to document in the health record. In that case, the unregulated care provider should be directed to document the assessments and care they provided.

In practice settings where unregulated care providers are not permitted to document in the health record, the RN may be responsible to document observations and information that the unregulated care providers have reported to them. In this case, the RN should include:

- the name and designation of the person who reported the information.
- the information that was reported.
- any follow-up assessment or care that was delegated or provided by the RN

A Note on Co-signatures:
Some practice environment processes will require that an RN "cosign" a health record (for example, when administering blood products or high alert medications). Unless the intent of the co-signature is otherwise articulated in policy or procedure, cosigning a document indicates that both RNs are accountable for the assessment and care that had been documented.

13. RNs document more frequently when acuity, complexity, and risk increase.

It is especially important to document more frequently 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 more frequent documentation may be required include:

- When a client is newly admitted or being transferred between facilities or units.
- When a client is being discharged from care.
- When a client's status changes or doesn't improve as expected.
- When an error, mishap, or accident has occurred.
- When the client refuses care or withdraws consent.

Many practice settings will have expectations related to the frequency of documentation in policy and procedure. RNs should ensure they practice in compliance with those requirements.

14. RN documentation demonstrates accountability.

When an RN signs their name to a record (electronically or with a pen), it signals that they are accountable for the care that was documented. To that end, an RN's signature should include, at a minimum, the name that appears on Nurse Check, the College's online verification system, followed by their professional designation (RN, RN(NP), or RN(AP)). Additional educational and professional designations can also be added, as required.

When a documentation error is made, RNs should follow their practice setting's process for correcting the error. In paper-based documentation systems, documentation errors should be corrected by making a single line through the error and signing or initialing the error. White-out, erasing, or destruction of part or all of the record is not permitted.

When a practice error is made, RNs are also required to demonstrate accountability when documenting the error and their response to it. The practice environment will usually have processes that outline specific reporting requirements which will require RNs to document and report the incidents for quality improvement purposes. RNs should ensure they are familiar with and in compliance with occurrence reporting policies and processes in their practice setting.

15. Practice settings and employers have an important role in supporting RN documentation.

Employers can also contribute to quality RN documentation. A practice environment that supports quality documentation is one that provides:

- Clearly articulated expectations about RN documentation that are in line with these guidelines.
- An orientation to the health record, documentation system, and occurrence reporting processes.
- Easy and convenient access to the health record and all required physical and digital forms and documentation tools.
- A quiet and private space for the intellectual work of documentation.
- Support and coverage to allow RNs to document.

A Note on Self-Employed Practice
Self-employed registrants have unique requirements related to documentation and record keeping. For more information, review the Self-Employed Practice Direction, Self-Employed Practice Handbook, and reach out to a Quality Practice Consultant with any questions.

16. Documentation Principles Apply to all registrants.

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

RN Administrators:

- Should document family meetings or phone calls in the health record, when necessary.
- Should document trends for quality improvement initiatives.
- Should document performance review and performance management.

RN Educators:

- Should document learner progression and evaluation throughout their course or program.
- Should document for the purposes of program evaluation and accreditation.
- Should document to inform ongoing curriculum and program delivery.

RN Researchers:

- Should document their research process carefully to ensure reporting is accurate.
- Should document data management activities to guide current work and help inform future research.
- Should document feedback from participants or focus groups to collect accurate qualitative and quantitative data.

Resources

College of Registered Nurses of Manitoba. 2024. *Maintaining Privacy and Confidentiality.*

College of Registered Nurses of Manitoba, *Self-Employed Practice Handbook*

College of Registered Nurses of Manitoba, *Self-Employed Practice Direction*

References

Canadian Nurses Protective Society. 2019. *Ask a Lawyer: Documentation of Late Entries - Canadian Nurses Protective Society (cnps.ca)*

Canadian Nurses Protective Society. 2020. *InfoLAW: Quality Documentation: Your Best Defence - Canadian Nurses Protective Society (cnps.ca)*

College of Registered Nurses of Manitoba. *Practice Direction: Practice Expectations for RNs*

Acknowledgements

Portions of this document were adapted from the following documents:

College of Registered Nurses of Newfoundland and Labrador. 2021. *Documentation Principles*

College of Registered Nurses of Saskatchewan. *Documentation Guideline*

Nova Scotia College of Nursing. 2022. *Documentation for Nurses*