College of Registered Nurses of Manitoba

Registered Nursing Documentation Workbook (2025)

College of Registered Nurses of Manitoba

NOTE: the use of the words registrant and RN refers to registered nurse, registered nurse (authorized prescriber), registered nurse (nurse practitioner), registered nurse (graduate nurse practitioner), and graduate nurse.

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Introduction

Registrants are accountable and responsible for effectively communicating with other healthcare providers. One way of meeting this practice expectation is to demonstrate professional and effective nursing documentation.

The College of Registered Nurses of Manitoba has developed the Registered Nursing Documentation Workbook to help registrants apply the Principles of Quality Registered Nursing Documentation. Registrants are encouraged to become familiar with these principles before beginning the activities in this workbook.

The College's documentation resources draw from the registered nursing practice expectations and entry-level competencies. Both sets of documents are important because they establish the standards for registered nursing communication. By improving your documentation, you are working towards meeting the practice expectations and entry-level competencies for registered nursing.

Activities

The workbook includes four documentation activities:

1 - Case study

2 - Evaluating RN documentation 1

3 - Evaluating RN documentation 2

4 - Documentation learning needs assessment

An answer key is available at the end of the workbook for the first three activities. Some registrants may benefit from reviewing their activity responses and discussing them with a knowledgeable and trusted colleague or educator. Your colleagues can also assist you in applying organizational policy, which could further enhance your registered nursing practice.

Case Study

Instructions

- Read the case study after reviewing the Principles of Quality Registered Nursing Documentation.
- Assess the documentation quality by responding to the guided questions at the end of the case study.
- Reflect on any parallels and opportunities for documentation improvement in your practice.

Sarah Milstrone, RN, works at Silver Links Personal Care Home, a long-term care facility. After working at Silver Links for five years, she felt competent in her knowledge, skills and judgment. She was the only registered nurse (RN) on duty in the 40-bed unit, supported by Lisa, a Licensed Practical Nurse (LPN), and four healthcare aides.

While responsible for all the residents, several individuals particularly concerned her today. Two were experiencing increased confusion and needed close supervision, another resident was in palliative care with family at their bedside, and Mr. Harris had been experiencing shortness of breath and a persistent cough overnight. Earlier that morning, she had checked in on Mr. Harris — his respiratory rate was 24 breaths per minute, he had occasional clear sputum, and his temperature was 37.6°C.

Lisa approached her. “Sarah, can you take another look at Mr. Harris? He seems worse than before. I adjusted his position, which helped slightly, but I’m still worried about him.”

The two walked toward Mr. Harris’s room. As soon as Sarah stepped in, she could see a noticeable change in Mr. Harris’ condition — his skin was clammy, and his laboured breathing was more apparent. “Mr. Harris, how are you feeling?” she asked.

He smiled weakly but responded, “Not feeling great. This cough is getting worse.”

Sarah nodded. “I can see that you’re not feeling well. Let me assess you more thoroughly.” His respiratory rate was 26 breaths per minute, bilateral lower lung crackles, a temperature of 37.7°C and an oxygen saturation of 95%.

She leaned in. “Mr. Harris, your breathing seems slightly more laboured, and your chest sounds congested. I’m going to call your doctor to update her. I’ll be back shortly to let you know what she suggests.”

Sarah called Dr. Patel and detailed the changes in Mr. Harris’s condition over the past 24 hours. The physician replied, “It sounds like he might have picked up a viral infection. Keep monitoring him and let me know if he worsens.”

After documenting her assessment in his chart,

> March 20, 2025
> 1000hr – Resident states that he is not feeling well, and his cough is worsening. Resp 26, bilateral lung crackles, 37.7◦C. O2 95% room air. Breathing appears more laboured and lungs more congested than this morning at 0800hr. P – Call Dr Patel to inform her if the resident’s condition worsens. Continue to assess q 2 hours. *Sarah Milstrone*, RN

Sarah returned to Mr. Harris and administered a PRN dose of liquid acetaminophen 500mg for comfort. She ensured he was in an optimal position to ease his breathing and encouraged deep breathing and coughing before continuing her rounds.

Over the next few hours, she checked on Mr. Harris regularly. Each time she saw him, she asked how he was doing, and he responded, “I still don’t feel great.” His respiratory rate remained high, and his crackles had worsened. By mid-afternoon, she grew increasingly concerned — his breathing rate had climbed to 30 breaths per minute, his effort to breathe was visibly increased, and his oxygen saturation had dropped to 92%. She knew that if his condition continued to deteriorate, a hospital transfer might be necessary. Sarah called Dr. Patel again and was informed that the physician would come to Silver Links in an hour to assess Mr. Harris.

Sarah hung up, checked the time, and realized she was behind on administering scheduled medications. She made a quick entry into Mr. Harris's chart:

> March 20, 2025
> 1500hr – Respiratory status worsening. Doctor notified. *Sarah Milstrone*, RN

Dr. Patel arrived an hour later, assessed Mr. Harris, and wrote new orders. As Sarah entered the nursing station, "Oh, good — you're here," she said. "What's your impression?"

Dr. Patel responded, "I think he's developing a respiratory infection on top of his flu symptoms. I've prescribed 250mg Amoxicillin PO every 8 hours and ordered oxygen therapy at 3L/min to keep him comfortable. Please check his oxygen saturation every two hours. If it drops below 92% or if his condition worsens, send him to the ER immediately."

As the doctor left, Sarah reviewed the orders and promptly faxed the antibiotic prescription to the pharmacy. She also updated Mr. Harris's documentation:

> March 20, 2025
> 1600hr – Physician assessed. Orders received and implemented. *Sarah Milstrone*, RN

Guided Case Study Questions

Question 1: Does Sarah's documentation effectively demonstrate the care she provided?

Question 2: In what ways did Sarah's documentation demonstrate the use of the nursing process? In which ways did it not?

Question 3: Based on the documentation, would another healthcare professional be sufficiently informed of Mr. Harris's condition? What should be added, revised or

removed such that Sarah's colleagues could safely and effectively take over the care of Mr. Harris?

Question 4: How effectively did Sarah document her collaboration with Dr. Patel?

Question 5: What feedback would you provide Sarah if she approached you for recommendations on improving her documentation?

Evaluating RN Documentation 1

Instructions

- Read the documentation entry.
- Note what aspects of the documentation align with the Principles of Quality Registered Nursing Documentation and which do not.
- Answer the questions that follow the registrant's documentation entry.
- Reflect on any parallels and opportunities for documentation improvement in your practice.

Patient Name: Mrs. Gladys Cooke

Date: March 11, 2025

Time: 1530 hr

The writer was informed by healthcare aide June that the patient's sacral ulcer is worsening. Upon assessment, the sacral ulcer has increased from the previous assessment, now measuring 3 cm in diameter. The wound bed appears infected with purulent drainage. The surrounding tissue is erythematous, edematous, and warm to touch. The patient complains of pain in the lower back and buttocks.

Vitals are 38.2 C, tachy, RR = 20, BP 90/67 and O2 sats of 94% r/air. She reports "feeling chilly" and asks for the room temperature to be turned up. The writer explained to the patient that the room temperature was already quite warm and would not be comfortable for the other patients in the shared room. The patient was provided with another warm blanket.

The patient's LOC is the baseline: pleasantly confused.

The patient's sacral wound was cleansed with NS, and a hydrocolloid dressing was applied. Turning instructions were provided to HCA June and written on the patient's whiteboard.

The rotating medicine service medical student was informed of the patient's worsening sacral ulcer. Blood work was ordered (to be taken during the day shift

tomorrow). The dressing is to be changed in two days, and a culture and sensitivity swab of the wound bed should be taken if drainage is present. Physiotherapy is to be consulted by the medical student. Continue monitoring the client's vital signs and contact the medical student again if they worsen. IV kept TKO. Ronald Jenner, RN

Guided Documentation Evaluation Questions

Question 1: In what ways did Ronald's documentation demonstrate the use of critical thinking? In which way does it not?

Question 2: Was Ronald's documentation descriptive and objective? In what ways was it not?

Question 3: Does Ronald's use of abbreviations align with your organization's documentation policy?

Question 4: If you were an external reviewer investigating a report of patient harm to Mrs. Gladys Cooke, what conclusions would you reach, and what feedback would you provide to Ronald about his documentation?

Evaluating RN Documentation 2

Instructions

- Read each entry made within the client's record.
- Identify the primary issue(s) with each entry and describe how to best improve it.
- Reflect on any parallels and opportunities for documentation improvement in your registered nursing practice.

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1. "The client is stable."

2. "Mrs. Jones is complaining of 5/10 pain in her right knee, again."

3. "5U of regular insulin SC was administered at 1500hrs."

4. "John Miller, physiotherapist, identified that the client's elbow range of motion increased by 10 degrees since last week and that their exercises will be increased to QID."

5. "Dr Wingsmith was texted called yesterday evening to inform him of the client's increasingly violent behaviour."

Documentation Learning Needs Self-Assessment

Instructions

- Read each statement about documentation practice.
- Reflect on whether you consistently demonstrate the statement regarding documentation and select the frequency with which you meet it.
- Determine whether the documentation statement is an area of practice you would like to improve by selecting from the drop-down. You may want to obtain different perspectives and opinions from trusted colleagues, managers or educators.
- Identify activities you can implement to assist in developing a desired documentation learning need. Consider framing it from the perspective of a SMART goal (Specific, Measurable, Attainable, Relevant and Time-Bound).

Self-Reflection Questions

1. Does your documentation communicate information effectively to other healthcare providers? In the event of legal proceedings, would your documentation provide sufficient evidence of care that is understandable several years from now?
2. Does your documentation align with the CRNM Principles of Quality Registered Nursing Documentation? Are there circumstances that make it challenging to adhere to the principles?

As an RN, RN(AP) or RN(NP)...	How Consistently am I Demonstrating the Following in my Nursing Practice?	I want to Improve my Practice in the Area	Activities to Improve Documentation Practice
My documentation is legible	Select	Select	
My documentation is understandable	Select	Select	
Client information is clearly identified on each record I document on	Select	Select	
Each entry is signed either with a signature and appropriate designation, or each entry is initiated, and a signature sheet is present in the chart that indicates their name, signature and designation	Select	Select	
If changes have been made in the record, it is signed or initialled, and the original entry remains readable	Select	Select	
Each professional contact with a client is dated, and the time is noted	Select	Select	

As an RN, RN(AP) or RN(NP) I document ...	How Consistently am I Demonstrating the Following in my Nursing Practice?	I want to Improve my Practice in the Area	Activities to Improve Documentation Practice
When informed consent was obtained from the client or substitute decision-maker	Select	Select	
Informed consent when a change in treatment is noted	Select	Select	
When a consent for the release of information is requested	Select	Select	
The sources and methods used to gather information	Select	Select	
The assessment of the client's emotional status	Select	Select	
The client's cognitive status	Select	Select	
The client's emotional status	Select	Select	
The client's environmental needs	Select	Select	
The client's social needs	Select	Select	
The rationale for opinions and recommendations in relation to the request for service	Select	Select	
Objective assessment data	Select	Select	
Subjective assessment data	Select	Select	
Relevant medical and health history	Select	Select	
The client's pain status	Select	Select	
Plans of care relevant to assessment findings	Select	Select	
Goals of care relevant to assessment findings	Select	Select	
The interpretation of findings/diagnosis	Select	Select	
Consultation and collaboration	Select	Select	
Evidence of client involvement	Select	Select	
The referral to others and/or other sources to access available resources	Select	Select	
Actions taken (e.g. consultation and/or transfer of care) when the client's condition or safety has changed	Select	Select	
Changes in client condition, if any	Select	Select	
Changes in the plan of care, if any	Select	Select	
Care/options with the client	Select	Select	
Client preparation for a diagnostic procedure or treatment	Select	Select	
The results of the diagnostic preparation	Select	Select	

As an RN, RN(AP) or RN(NP) I document ...	How Consistently am I Demonstrating the Following in my Nursing Practice?	I want to Improve my Practice in the Area	Activities to Improve Documentation Practice
Post-diagnostic care	Select	Select	
Discharge plans	Select	Select	
The client's involvement in discharge planning	Select	Select	
Client referrals to community resources	Select	Select	
Pain medication administration and its effectiveness	Select	Select	
The client's response to drug therapy	Select	Select	
Medications I have administered in the Medication Administration Record (MAR)	Select	Select	
Reference to lab values and their relevance	Select	Select	
Reference to diagnostic testing and its relevance	Select	Select	
As an RN(AP) or RN(NP), I document...	**How Consistently am I Demonstrating the Following in my Nursing Practice?**	**I want to Improve my Practice in the Area**	**Activities to Improve Documentation Practice**
The date prescriptions were issued	Select	Select	
The name and address of the person for whom the drug is prescribed	Select	Select	
The weight of the client, if a child, or the age of the client, if it has a bearing on the dosage of the prescribed drug	Select	Select	
The name, strength and quantity of the prescribed drug	Select	Select	
The directions for use, including the frequency, route of administration, duration of drug therapy, and special instructions	Select	Select	
The directions for the number of allowable refills and the interval between refills, where applicable	Select	Select	
If a prescription includes more than one drug, any drug that may be refilled must be clearly identified with the number of allowable refills for each drug	Select	Select	
The prescriber's name, address, telephone number and fax number	Select	Select	
The prescriber's hand signature/ prescriptions produced by computer are hand-signed or with an electronic signature that is hand-initialled	Select	Select	

The education provided to the client regarding the prescribed medication	Select	Select	
The client's response to the medication	Select	Select	
As an RN(AP) or RN(NP), ...	**How Consistently am I Demonstrating the Following in my Nursing Practice?**	**I want to Improve my Practice in the Area**	**Activities to Improve Documentation Practice**
I maintain a record of all prescriptions written, including refills	Select	Select	
I document the rationale for ordering a test	Select	Select	
I document my communication with other health professionals	Select	Select	
I document that I have obtained informed written consent before performing a procedure	Select	Select	

Exercise Answer Guide

Documentation Case Study

1. Sarah's documentation does not completely demonstrate the care she provided. Examples of missed opportunities to document care include a second assessment of Mr. Harris, her conversation with Dr. Patel, and how she implemented Dr. Patel's orders.

2. Sarah's documentation does not consistently or clearly illustrate her use of the nursing process.

- **Assessment:** Sarah documents her first assessment; however, some elements are missing, such as his clammy skin and whether his sputum is still clear. The second assessment note states, 'respiratory status is worsening.' This does not adequately inform another clinician of how she reached that determination.
- **Determination/Diagnosis:** Sarah identifies respiratory concerns but does not make nursing diagnoses based on her assessment.
- **Planning/Evaluation:** Sarah does not reference a care plan or document her reassessments. For example, at 1000 hr, she planned to assess Mr. Harris every two hours. There is no entry for 1200 hr. At 1500 hr, she states that his condition is worsening without providing any details.
- **Intervention:** The repositioning of Mr. Harris and the administration of Acetaminophen is not documented. While she indicates that the physician's orders were "implemented," she does not provide sufficient detail so that someone could follow up.

3. There are several opportunities for improvement in Sarah's documentation, as it would be challenging for another care provider to take care of Mr. Harris in a safe and effective manner. As Mr. Harris's condition deteriorated, so did Sarah's documentation of her assessments and interventions. A colleague reading the chart would not be sufficiently informed of what happened between 1000 hr and 1500 hr. For example, what medication or oxygen was administered? Did the acetaminophen help? What are Mr. Harris's vitals – are they worsening or improving? What is the care plan – reassessment, repositioning, contacting family?

4. Sarah's documentation of her collaboration would benefit from the following additions:

- What information did she provide to Dr. Patel about Mr. Harris?
- What was the care plan she and Dr. Patel agreed to?

5. Refer to the above.

Evaluating RN Documentation 1

1. Ronald demonstrates critical thinking by recognizing the need to escalate a worsening pressure injury and implementing interventions to improve client outcomes. However, he does not show critical thinking in his documentation by not communicating concerns regarding potential sepsis (purulent drainage, high patient temperature, and patient confusion that may be mistaken for baseline), assessing and seeking resolution of the client's pain, and acknowledging the urgency of the situation by ensuring there are concrete plans for follow-up.

2. **Descriptive:**

    - Description of the ulcer e.g. 3 cm, vital signs.
    - Description of the type of dressing "hydrocolloid."
    - Description of the general care plan.

    Not descriptive:

- What type of pain is the patient experiencing and how severe is it?
- Pleasantly confused, what does it look like?
- Turning instructions, what are they?
- What is the name of the rotating medical student, and how will follow-up occur?
- Intervention details, e.g. was a culture and sensitivity swab taken when he assessed the sacral ulcer and saw purulent drainage?

3. r/air = room air, tachy = tachycardia

4. Utilize descriptive and objective language instead of using subjective phrases such as pleasantly confused, which could also be perceived as insensitive and

unprofessional. Names and designations are important to facilitate follow-up by other members of the healthcare team. Critical thinking should be reflected in documentation, meaning the information collected through assessment is analyzed and synthesized to establish a diagnosis/determination and care plan.

Evaluating RN Documentation 2

1. **Stable**

Principle 5 – RN documentation is descriptive and objective.

"Stable" used in this context is vague and can be misinterpreted.

2. **Complaining. Again**

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

Using "complaining" and "again" connotes a possible negative client-nurse relationship and a lack of empathy or compassion for the client's pain.

3. **U**

Principle 4 – RN documentation is legible and understandable.

Registrants should avoid abbreviations, where possible, and comply with any banned abbreviations identified by their practice setting. "U" should be spelled out in full – 'units.'

4. **Documenting the physiotherapist's assessment**

Principle 12 – RN documentation reflects the care that they provide.

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

5. **Scratched out error**

Principle 14 – RN documentation demonstrates accountability.

When a documentation error is made, registrants should follow their practice setting's process for correcting it. 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.