CRNNL | College of Registered Nurses of Newfoundland & Labrador

College of Licensed Practical Nurses of Newfoundland and Labrador
LPNs - A Practical Approach to Quality Care

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# Documentation Principles

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This document replaces *Documentation Standards for Registered* Nurses (2010)

This collaborative document is prepared by the College of Registered Nurses of Newfoundland and Labrador (CRNNL) and the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL). In Newfoundland and Labrador, the CRNNL is the regulatory body for Registered Nurses and Nurse Practitioners and the CLPNNL is the regulatory body for Licensed Practical Nurses. The mandate of a regulatory body is to protect the public through regulation of the profession in accordance with the respective legislation: the *Registered Nurses Act, 2008*, or the *Licensed Practical Nurses Act, 2005*. In this document, the term nurse includes nurse practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs).

# Purpose

The purpose of this practice guideline is to identify the principles that form the basis of documentation by nurses. These principles apply to documentation in all practice settings including care provided virtually.[1]

Specific requirements related to where, when, what and how nurses document will be dictated by several factors, reflecting the diversity of nursing practice and practice environments. These factors include (but are not limited to) the complexity of client care, employer policies,[2] the practice environment, documentation methods or formats, and technologies.

The requirement for documentation is embedded in the *Standards of Practice for RNs and NPs, the Standards of Practice for LPNs in Canada*, and the codes of ethics. This practice guideline is to be used in conjunction with professional standards of practice, ethical codes, relevant legislation, and evidence-informed best practices.

# Introduction

Documentation is a nursing action that produces a written and/or electronic account of pertinent client data, nursing clinical decisions and interventions, and the client's responses in a health record (Potter, Perry, Stockert & Hall, 2017). Documentation reflects the application of nursing knowledge, skills, and judgment, and the client's perspective. Documentation establishes accountability, promotes quality nursing care, facilitates communication between healthcare providers, informs the plan of care, and conveys the contribution of nursing to health care. Documentation may also be required for legislative compliance.

# Principles

## Documentation is a component of care.

Documentation is an integral part of nursing practice and occurs following the provision of care. Care is not complete until documentation is complete.

[1] Refer to your Regulatory Body's document on Virtual Nursing Practice.

[2] Employer policies should support nurses in upholding their professional obligations. If nurses are concerned that policies do not support their professional obligations, they must address this with their employer. In the absence of policy, nurses advocate for policy development. Nurses in self-employment establish documentation policies. Refer to your Regulatory Body's documents related to self-employment.

## Documentation supports the safe provision of care.

Documentation must be concise, objective, legible, chronological, and must provide sufficient information for the seamless delivery of safe and competent care. Documentation enables health care professionals to identify the care that was provided and by whom, any changing patterns in client health status, and the outcomes or evaluations of that care.

## Documentation includes all aspects of the nursing process.

The nursing process provides a systematic and sequential guide to planning and providing care. The plan of care identifies a client's health care status (assessment) and actual or potential health problems (nursing diagnosis), establishes a plan to intervene in meeting the identified needs (planning), identifies nursing actions (implementation), and allows for determination of the effectiveness of the plan (evaluation) in meeting the identified needs.

## Documentation includes client-related communications with other health care professionals.

Client-related communication can include written, electronic,[3] and verbal communications. Documenting communications provides clarity regarding the plan of care and identifies the avenues that were pursued to ensure client care needs or services were met, including response(s) received and unsuccessful attempts.

## Nurses are responsible and accountable for documenting the care they provided.

Care provided by other care providers is documented by those individuals. Designated recorders may be identified in select circumstances (e.g., code blue, operating room) when the care provider is unable to document the event as it occurs. Documentation includes information reported to the nurse by others and reflects what was reported, and by whom.

## Documentation occurs at the time the care was provided or as soon as possible afterward.

Documentation is not completed before care is provided. Documentation occurs as close as possible to the time of the provision of care to enhance the accuracy and the overall credibility of health records. In situations where documentation is not timely,[4] a late entry is required.

## Complexity and risk influence the frequency of documentation.

The frequency of documentation is influenced by the complexity of a client's health status, the degree of risk involved in a treatment or component of care, changes to the plan of care, when clients move from one place to another (e.g., admission/discharge, transfer, or transport), or from one care provider to another. Employer policies may identify a required frequency of documentation as well as the format[5] used in the practice area.

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[3] Follow employer policies for authorized practice (e.g., e-mails and mobile device use) and in relation to safeguards and security.

[4] Timely means ensuring that a response or action occurs within a timeframe required to achieve safe, effective, and positive client outcomes.

### Nurses safeguard client privacy and confidentiality in all forms of documentation.

Nurses take measures to safeguard the privacy, security, and confidentiality of a client's personal health information and health record, including in accordance with applicable legislation.

### Documentation demonstrates respect for client's choice(s).

Nurses have an ethical responsibility to respect a client's informed choice, even if these choices may pose a risk to a client's overall health. Respectful documentation is devoid of value judgments about a client's choices and behaviors.

## Conclusion

Documentation is an integral part of professional nursing practice. Adherence to the principles for documentation is a requirement in meeting professional responsibilities and accountabilities.

[5] Employers may identify the methods or formats of documentation used in a practice environment. Methods and formats (e.g., SOAP, DAR, Charting by Exception) utilized by the nurse must be in accordance with all identified principles.

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