Documentation

- EN to SN Courses
- Professional Development Module
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Documentation

Purpose of Documentation

- as a communication tool
- as an administrative tool
- from a legal/ethical perspective
- as a form of nursing data for research

Documentation

Principles of Quality Documentation

- Who can document?

- Documentation should be recorded from first hand knowledge

” the care provider with personal knowledge should document the client care”

(Grant & Ashman, 1997, p.137).

Documentation

- How to document?

- Document clearly and legibly
- Avoid “white space”
- Be clear, concise, unambiguous, and accurate
- Avoid the use of abbreviations whenever possible
- Correct errors appropriately
- Follow ward/unit policies

Documentation

- What to document?

- All aspects of the nursing process

- Communication between nurse/physician/ other health care provider

-Complete and accurate information on the administration of medications

-Subjective comments of clients and, when appropriate, families

-Non-compliant / risk-taking behaviour of client

Documentation

- When to document?

- At the time of an event

"Documentation of an event should **NEVER** be completed before the event takes place"

(RNA Nova Scotia, 2002, p.7)

- As client's care/condition progresses

Try to adhere to a chronological sequence

-Following an unanticipated, unexpected or abnormal incident for a client, staff or visitor

Documentation

Types of Documentation

- The Written Narrative – Most widely used

- Flow Sheets – Visual reminders – show patterns or trends

- Charting by Exception – All standards of care have been met and client responded as expected unless it was documented separately.

-Problem-Oriented Record (POR) – Charting which focuses on recording client outcomes in relation to client problems.

Documentation

Nursing Implications

Why too much paper work?

- **The patient chart serves primarily as a communication tool and as evidence of meeting professional and legal standards.**

- **Documentation can be used to determine whether or not the care provided met required standards.**

(CRNM, 2005)

Documentation

Documentation of nursing care includes:

- **The plan of care**
- **client goals**
- **client responses to the plan of care**
- **the registered nurse's clinical decision-making.**

(CRNM, 2005)

Documentation

Certain situations where one should ensure documentation:

- **Document circumstances in which the client or the nurse/facility is at increased risk**
  - **Some of these situations include:**
    - **The patient's status changes or does not improve as expected**
    - **Other members of the health care team have been notified (or re-notified) of a change or a lack of change in a client's condition**

(CRNM, 2005)

Documentation

- **The patient is being transferred between units or facilities**

- **The patient is engaging in risk-taking behaviour**

- **The patient refuses care**

- **An unanticipated, unexpected or unusual incident occurs with a patient, staff or family**

- **An error / mishap / accident occurs**

(CRNM, 2005)

Documentation

Content and style of patient records

Patient records should be:

- **Factual, consistent and accurate**

- **Written as soon as possible after an event has occurred, providing current information on the care and condition of the patient**

- **Written clearly and in such a manner that the text cannot be erased**

- **Written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly**

- **Accurately dated, timed and signed with the signature printed alongside the first entry**

- **Free of abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements**

Documentation

Patient records should be:……cont.

- **Readable on any photocopy**
- **Written, wherever possible, with the involvement of the patient, or their carer**
- **Written in terms that the patient can understand**
- **Consecutive**
- **Identify problems that have arisen and the action taken to rectify them**
- **Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared**

(Nursing and Midwifery Council, 2005 in Hutchinson & Sharples, 2006)

Documentation

Finding time to document

- **Consider the time and financial costs of inadequate documentation**
- **Avoid duplication**
- **Keep charts or flow sheets close to where care is given**
- **Review the list of activities that can be done by someone other than a registered nurse**

You can't delegate documentation

(CRNM, 2005)

Documentation

Improving Documentation

- **Review basic principles of documentation**

  - **Nursing fundamental**

  -**texts**
  -**Articles**
  -**Books**

  related to documentation skills

Documentation

Improving Documentation.....cont.

- **Participate in client reviews**

- **Re-read your notes periodically and ask yourself:**

*** Does the document provide enough information for another registered nurse?**

*** In the event of an incident five years from now, is there sufficient information in the documentation?**

*** Does the document meet the Standards of Practice?**

(CRNM, 2005)

Documentation

Summery of guidelines for records and record-keeping:

- **Record-keeping is an integral part of nursing practice**
- **Good record-keeping is a mark of the skilled and safe practitioner**
- **Records should not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements**
- **Records should be written in terms that the patient can easily understand**
- **By auditing your records, you can assess the standard of the record and identify areas for improvement and staff development**
- **You must ensure that any entry you make in a record can easily be identified**

Documentation

Summery of guidelines for records and record-keeping:....cont.

- **Patients have the right of access to records held about them**

- **Each practitioner contribution should be seen as of equal importance**

- **You have the duty to protect the confidentiality of the patient record**

- **Patients should own their healthcare records as far as it is appropriate and as long as they are happy to do so**

- **The principle of the confidentiality of information held about your patients is just as important in computer-held records as in all other records**

- **The use of records in research should be approved by your local research ethics committee**

Documentation

Summery of guidelines for records and record-keeping:....cont.

- **You must use your professional judgement to decide what is relevant and what should be recorded**

- **Records should be written clearly and in such a manner that text cannot be erased**

- **Records should be factual, consistent and accurate**

- **You need to assume that any entries you make in a patient record will be scrutinised at some point**

- **Good record keeping helps to protect the welfare of patients**

(Nursing and Midwifery Council, 2005 in Hutchinson & Sharples, 2006)

Documentation

References

Documentation: Standards of Practice Application:
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http://www.crnm.mb.ca/downloads/documentation_web.pdf

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