

Documentation

- EN to SN Courses
- Professional Development Module
- Vincent Saliba
- November 2006





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**

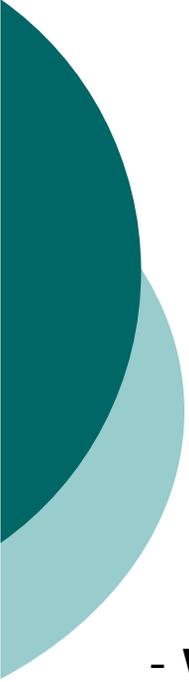
(CRNM, 2005)



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)

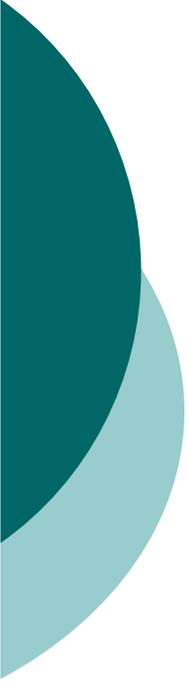


Documentation

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**

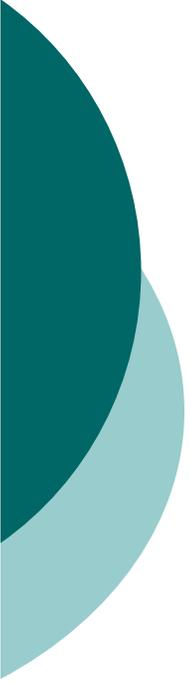


Documentation

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)
14



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

Summary 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

Summary 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

Summary 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:
College of Registered Nurses of Manitoba.

http://www.crnmb.ca/downloads/documentation_web.pdf

Documenting Care, a guide for registered nurses:
College of Registered Nurses of Nova Scotia.

<http://www.crnns.ca/documents/documentcare.pdf>

Grant, A. & Ashman, A. (1997). *A Nurse's Practical Guide to the Law*.
Aurora, ON: Canada Law Book.

Hutchinson, C., Sharples, C (2006) Information governance: practical
Implications for record keeping. *Nursing Standard*. Vol.20, no.36, pp59-64.

Nursing and Midwifery Council (2005) *Guidelines for Records and
Record-Keeping*. NMC, London.