

PRACTICE STANDARD FOR BCCNM NURSES

Documentation

Practice Standards set out requirements related to specific aspects of nurses' practice. They link with other standards, policies, and bylaws of the BC College of Nurses and Midwives and all legislation relevant to nursing practice.

Documentation includes any written and/or electronically generated information about a client¹ that describes the care or service provided to that client. Nurses² document timely and appropriate reports of assessments, decisions about client status, plans, interventions, and client outcomes.

Documentation serves three key purposes:

- **Communication:** Through documentation, nurses communicate to other health care providers their nursing assessment and diagnosis³ of a client's condition⁴, the plan of care, interventions that are carried out by the nurse, and the outcomes of those interventions.
- **Safe and appropriate nursing care:** When nurses document the care they provide, other members of the health care team are able to review the documentation and plan their own contributions to safe and appropriate care. Documentation also provides data for research and workload management, both of which have the potential to improve health outcomes.
- **Professional and legal standards:** Documentation is a comprehensive record of care provided to a client. It demonstrates how a nurse has applied their knowledge, skills, and judgment according to the standards of practice. Documentation is also generally accepted as evidence in legal proceedings. It establishes the facts and circumstances related to the care given and assists nurses to recall details about a specific situation.

Employers provide the organizational supports and systems necessary for nurses to meet the Standards of Practice.

¹ "Clients" include individuals, families, groups, populations, or entire communities receiving nursing care or services from a nurse.

² "Nurse" refers to all BCCNM nursing registrants, including: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

³ Nursing diagnosis is a clinical judgment of an individual's mental or physical condition to determine whether the condition can be ameliorated or resolved by appropriate interventions of the nurse to achieve outcomes for which the nurse is accountable.

⁴ Under the Nurses (Licensed Practical) Regulation, Nurses (Registered) and Nurse Practitioners Regulation, and the Nurses (Registered Psychiatric) Regulation, nurses have the authority to diagnose conditions. Registered nurses and registered psychiatric nurses on the BCCNM-certified practice roster and nurse practitioners have additional authorities to diagnose diseases and disorders.

Principles

1. Nurses are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by others should ordinarily be documented by those individuals, unless there are exceptional circumstances such as an emergency.
2. Nurses document using a decision-making process (e.g., assessment, nursing diagnosis, planning, implementation and evaluation) to show the care they provided.
3. Nurses document information or concerns reported to another health care provider and that provider's response.
4. Nurses document in a clear, concise, factual, objective, timely, and legible manner.
5. Nurses document all relevant information about clients in chronological order in the client record.
6. Nurses document at the time they provide care or as soon as possible afterward. Nurses clearly mark any late entries, recording both the date and time of the late entry and of the actual event.
7. Nurses correct any documentation errors in a timely, honest, and forthright manner.
8. Nurses do not document before giving care.
9. Nurses indicate their accountability and responsibility by signing with a unique identifier (such as a written signature or an electronically-generated identifier) and their title, in a clear and legible manner to each entry they make in the client record.
10. Nurses carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk, or have complex health problems.
11. When nurses provide services to a group of clients, they use service records (or equivalent) to document the service provided and overall observations pertaining to the group. When nurses document information about individual clients within the group, they record it in the individual client's record.
12. Nurses complete a safety event report (sometimes called an incident report) following an event such as a medication error or a fall. The safety event report is not part of the client record. Nurses record facts about any safety event affecting the client in the client record.
13. Nurses who are self-employed or have responsibility for client records adhere to relevant legislation and BCCNM Bylaws.

Applying the principles to practice

- Familiarize yourself with organizational policies, procedures, or restrictions on documentation and follow them, including policies on documenting verbal and telephone orders and completing safety event reports.
- If your organization uses an electronic client record, understand that the same documentation principles apply, although there will be different strategies to record data, and to ensure privacy, security, and confidentiality.

- Information provided by a third party that is relevant to the client's circumstances may be recorded in the client's record. It should include the name of the person providing the information and their relationship to the client and be clearly marked if the information was provided "in confidence."
- Document only the care you provide, do not allow others to document for you and do not document care that anyone else provides. Exceptions include:
 - In an emergency, such as when you are designated as recorder, document the care provided by other health professionals.
 - In cases where organizational policies, procedures, or restrictions do not allow certain individuals to document in the client record, record what client information was reported to you and by whom.
- When you are covering for another nurse, be sure to document any relevant information that arises when caring for a client.
- Decision-making processes used in providing nursing care should be sufficiently documented to provide an accurate, clear and comprehensive picture of the status of the client and their needs, the interventions of the nurse, the client outcomes, a plan of care, information reported to other health care providers and the provider's response, advocacy taken on behalf of the client and any other relevant information, including informed consent when required.
- Recognize that, in a court of law, accurate, complete, and timely documentation may lead to the conclusion that accurate, complete, and timely care was given to the client. The reverse is also true. If care is not documented, it may lead to the conclusion that it was not done. All records should be clear and legible. Various charting systems are acceptable if they enable nurses to meet this practice standard.
- Use client quotes to illustrate objective observations. Avoid labelling clients or drawing subjective conclusions.
- Some organizations may use charting by exception. This method of charting includes standards of care, clinical protocols, and assessment parameters. It does not refer to charting only when something happens. When charting by exception, apply the principles set out in this practice standard along with any applicable organizational policies, procedures, or restrictions.
- Delays in documentation may affect the continuity of care and the nurse's ability to remember details about events, and may increase the possibility of error.
- If you make a documentation error, follow organizational policy, procedures or restrictions to correct it, but never modify or delete information that is recorded in the client record.
- It is the nurse's responsibility to complete documentation when they provide care. Plan your work day to allow time for documentation. If you are unable to document as you provide care due to other work commitments, bring this to your employer's attention. If extensive time has elapsed between entries, seek guidance before documenting additional notes.

- Initials may be used when supported by organizational policies, procedures, or restrictions (e.g., signing medication administration records).
- Review the BCCNM practice standard *Appropriate Use of Title* so that you are clear on how to use your title when documenting the care or services you provide to clients.
- Understand that safety event reports are for quality improvement purposes. Follow your organization's documentation policies, procedures, or restrictions when reporting safety events.
- Nurses have a role in safeguarding the privacy, security and confidentiality of client records. Nurses assist clients with the process of accessing information on their client record, in accordance with relevant legislation and organization policies, procedures, or restrictions. Refer also to the *Privacy & Confidentiality* practice standard and Part 8 of the [BCCNM Bylaws](#).
- Ensure that the client records are retained in accordance with the *Freedom of Information and Protection of Privacy Act*, the *Personal Information Protection Act*, the federal *Privacy Act*, any other relevant legislation, and Part 8 of the BCCNM Bylaws.
- If you are a nurse practitioner, review the Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions to understand your additional documentation requirements.

For More Information

- [Appropriate Use of Titles practice standard](#)
- [Medication Administration practice standard](#)
- [Privacy and Confidentiality practice standard](#)
- [Legislation Relevant to Nurses Practice](#)
- [Professional Standards for Licensed Practical Nurses](#)
- [Professional Standards for Registered Nurses and Nurse Practitioners](#)
- [Professional Standards for Registered Psychiatric Nurses](#)
- [Registered Psychiatric Nurses' Code of Ethics](#)
- [Scope of Practice for Licensed Practical Nurses: Standards, Limits and Conditions](#)
- [Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions](#)
- [Scope of Practice for Registered Nurses: Standards, Limits and Conditions](#)
- [Scope of Practice for Registered Psychiatric Nurses: Standards, Limits and Conditions](#)

For more information on this or any other practice issue, contact BCCNM's Standards Support by completing an [intake form](#).

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