# Documentation in Nursing Practice

As we continue to adapt to the ever evolving and challenging health-care landscape in British Columbia and across the world, now more than ever, documentation plays a vital role.

Whether you're an experienced nurse or just starting out, understanding your professional and legal accountabilities and responsibilities regarding documentation is essential.

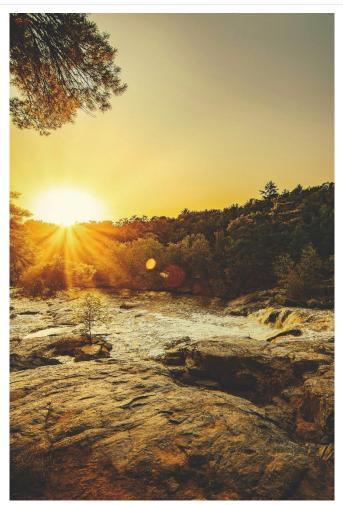
Documentation is essential in nursing. It is a record of client care and a key communication tool among health-care professionals. It ensures continuity of care, supports client safety, and supports legal and ethical responsibilities.

Accurate documentation is critical; errors can lead to misunderstandings, jeopardize client safety, and have ethical and legal consequences. Inaccurate records can negatively affect treatment plans and delay interventions, impacting client outcomes. As we progress through the module, we will highlight some common documentation issues.

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# Territorial acknowledgement



We acknowledge the rights and title of the First Nations whose collective unceded territories encompass the land base colonially known as British Columbia. We give specific thanks to the hən'q'əmin'əm' speaking peoples the xwməθkwəyəm (Musqueam) and selííwitulh (Tsleil-Waututh) Nations and the Skwxwú7mesh-ulh Sníchim speaking Peoples the Skwxwú7mesh Úxwumixw (Squamish Nation), on whose unceded territories BCCNM's office is located. We also give thanks for the medicines of these territories and recognize that laws, governance, and health systems tied to these lands and waters have existed here for over 9000 years.

We also acknowledge the unique and distinct rights, including rights to health and wellness, of First Nations, Inuit, and Métis peoples from elsewhere in Canada who now live in British Columbia. As leaders in the

settler health system, we acknowledge our responsibilities to these rights under international, national, and provincial law.

# Welcome

This module will provide a review of the Documentation practice standard and opportunities for you to reflect on and improve your documentation practices.

Understanding and adhering to BCCNM's standards of practice is vital for all nursing professionals. The documentation standard, as with all standards, should be used in combination with other relevant BCCNM standards.

Documentation shows how a nurse has applied their knowledge, skills, and judgment according to the standards of practice. It also establishes the facts and circumstances, including any communication related to the care given, and helps nurses recall details about a specific situation. Incomplete or biased documentation can reinforce systemic biases, leading to misinformed decisions, inadequate care, and worse outcomes—especially for marginalized groups. Clear, objective records are essential for equitable and safe practice.

By ensuring your documentation is clear, accurate, and accessible, you contribute to better communication among the health-care team, leading to more informed clinical decisions and ultimately improving client outcomes. Furthermore, documentation plays a crucial role in identifying risks and enhancing client safety, which is a shared priority.

We recognize that documentation can be a challenging aspect of a busy workday. It requires time, attention to detail, and a clear understanding of professional and legal standards. This module is designed to provide you with a supportive learning environment where you can review BCCNM's Documentation practice standard and gain practical tips and best practices to enhance your documentation skills. By focusing on these skills, you will not only be meeting your professional and legal accountabilities but also mitigating potential legal and ethical consequences associated with inaccurate or incomplete records.

## Learning objectives

By the end of the module, you will be able to:

- **Explain** why documentation is important, where, what, when, how, and where to complete documentation, and who is responsible for it.
- **Understand** how documentation ensures culturally safe, competent, and ethical client care.
- Outline the legal and professional requirements for documentation.
- **Identify** the key characteristics of high-quality documentation.
- **Incorporate** the *Indigenous Cultural Safety, Cultural Humility, and Anti-racism* practice standard into documentation.
- Recognize some common documentation issues and how to avoid them.
- Explain what to consider when using artificial intelligence for documentation.

#### What to expect



The module is self-paced with knowledge checks, quizzes, and interactive elements. It should take about 30 to 40 mins to complete. The module is divided into lessons, each focusing on specific topics. Lessons build upon one another, allowing you to progress logically through the material.

A certificate of completion is available at the end upon successful completion of the

module. For technical issues, please email webmaster@bccnm.ca.



We value your experience and insights.

You will be asked to complete a brief
survey at the end to share your thoughts.

When you are ready to begin, click on the "Start" button. Once you click this, you can scroll down the page and see the list of lessons.

# Documentation practice standard overview

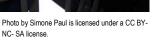
BCCNM's Documentation practice standard outlines your responsibilities and accountabilities for documenting care and services provided to clients. The practice standard applies to all nurses in all practice settings in B.C.

BCCNM's Documentation practice standard promotes principles such as accountability and responsibility, honesty, completeness, timeliness, objectivity, and professional judgment. The standard won't tell you what colour ink to use, or who can document in a code blue situation. For details about the mechanics of documenting, refer to your employer's policies.

Standards set expectations that can be applied based on professional judgment and the context of a nurse's practice. For example, a documentation standard might emphasize accuracy, completeness, and professional judgment. Whenever possible, BCCNM uses standards rather than limits and conditions to provide direction for practice.











#### Documentation self-assessment

How much thought have you given to your documentation lately?

Take a look at this short self-assessment to see how your documentation compares with the standard. This may help you identify areas for improvement to guide your professional development planning for your annual BCCNM Quality Assurance requirements.

1. I document all clinically significant information using the nursing process (assessment, nursing diagnosis, planning, intervention and evaluation) on the client's health record.

Never Rarely Sometimes Often Regularly N/A

2. I document the care I personally provide to the client as soon as possible afterward.

Never Rarely Sometimes Often Regularly N/A

3. I document information reported to other health care providers and their response

Never Rarely Sometimes Often Regularly N/A

4. My documentation is clear, concise, factual, objective, timely, and legible.

Never Rarely Sometimes Often Regularly N/A

5. I avoid generalizations, vague descriptors, stereotypes, assumptions, and subjective judgments.

Never Rarely Sometimes Often Regularly N/A

6. I add my signature and title or initials to each entry I make on the health record.

Never Rarely Sometimes Often Regularly N/A

7. I document comprehensively, in-depth, and more frequently when clients are acutely ill, high risk or have complex health problems.

Never Rarely Sometimes Often Regularly N/A

8. I mark "late entries," recording both the date and time of the late entry and of the actual event.

Never Rarely Sometimes Often Regularly N/A

9. I have read and understand my employers' documentation policies and only document using the approved tools and methods.

Never Rarely Sometimes Often Regularly N/A

10. I maintain the confidentiality of a client's information and client record.

Never Rarely Sometimes Often Regularly N/A

#### **Documentation Practice Standard**

As part of your ongoing practice, it's important to assess how your work aligns with established standards. In this section, you'll review the documentation standard to help identify areas where you may need improvement.

- 1. Nurses document in alignment with:
  - a. Relevant legislation and regulations,
  - b. The BCCNM bylaws and standards, limits, and conditions, and
  - c. Organizational/employer policies and processes.
- 2. Nurses are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by others is documented by those individuals, unless there are exceptional circumstances such as an emergency.
- 3. Nurses document a decision-making process (such as assessment, planning, implementation, and evaluation), as applicable, to show the care they provided.
- 4. Nurses document all relevant information and communication related to the care of the client in a clear, concise, chronological, factual, timely, and legible manner.
- 5. Nurses document using respectful, non-discriminatory language that reflects cultural safety and anti-racism; respects the client's identity, context, and lived experience; and avoids stereotypes and assumptions.
- 6. Nurses document the date and time of each entry. Nurses clearly mark any late entries, recording the date and time of the late entry and the date and time of the actual event.

- 7. Nurses carry out more comprehensive, in-depth, and frequent documentation when clients are acutely ill, are high-risk, or have complex health needs.
- 8. Nurses document client-specific concerns escalated to another health professional, the transfer of care (if applicable), and that professional's full name, title, and response.
- 9. Nurses document at the time they provide care or as soon as possible afterward.
- 10. Nurses do not document care before care is given.
- 11. Nurses ensure that unique client identifiers are on every page or part of the client record.
- 12. Nurses indicate their accountability and responsibility by signing each entry in the client record with a unique identifier (such as a written signature or an electronically generated identifier) and their regulated nursing title.
- 13. Nurses correct any documentation errors:
  - a. In a timely manner,
  - b. By taking the appropriate steps to mitigate any negative impacts of the documentation error, if applicable,
  - c. In a manner that ensures the original information is visible/retrievable, and
  - d. Following organizational/employer policies and processes.
- 14. Nurses respect the client's (or the client's representative, as applicable) right to access their own client records and request correction of the information if they believe there is an error or omission, following organizational/employer policies and processes.

#### Use of Artificial Intelligence

- 15. Nurses only use artificial intelligence (AI) to assist with documentation when:
  - a. They have the approval to use AI by their organization/employer, and
  - b. Their organization/employer has AI policies and processes.
- 16. Nurses who use AI to assist with their documentation:

- a. Remain solely accountable for the accuracy, objectivity, and completeness of their documentation entry, and
- b. Review and validate their Al-assisted documentation entries at the time they provide care or as soon as possible afterward.

# The "why" of documentation

#### Consider this scenario

#### Sam's situation

It's a typical day in a bustling hospital ward. Sam is preparing medication when Tara approaches, looking anxious.

**Tara**: (looking worried) Sam, I just realized I didn't document a client's last dose of blood pressure medication. I was swamped with other tasks this morning, and I forgot to record it in the electronic record.

**Sam**: Have you administered the medication?

**Tara**: Yes, I gave it. I just didn't enter it in the record. What should I do? Should I just document that I gave it now? I don't want to look like I can't do my job.

#### Pause and reflect:

What would be the consequences if Tara documented that they gave the blood pressure medication later than they actually did? Consider how falsifying documentation can create a misleading record of care and potentially hide adverse events or delays in treatment. Think about other situations where the timing of an intervention is critical and how inaccurate documentation could impact client safety and the understanding of the care provided by the entire team.

If you were Sam, what would you recommend Tara do in this situation? Consider how acknowledging and documenting errors truthfully contributes to a culture of safety and continuous improvement within a health-care team, as highlighted by Nurse Sam's guidance. Think about what supports your workplace has in place for nurses to address documentation errors.

# The 'why' of documentation

Documentation is how nurses create a record of their care for use by other health-care professionals, groups, and individuals directly or indirectly involved with health care. Nurses spend 20-30 percent of their workday completing some form of documentation.

Clear, accurate, accessible documentation is a crucial part of safe, effective, and ethical client care. Documentation is a professional and legal requirement of your nursing practice.

Documentation is used for many purposes. Three main ones are:

1

#### Communication

Your documentation informs other health-care professionals about your assessments, diagnoses, plan of care, nursing interventions and their outcomes, and evaluation of care. Effective documentation ensures the team is aware of the client's status, supports clinical decisions, and maintains care quality. Poor or absent documentation can negatively affect client outcomes. Be aware that documentation can influence the client's future care.



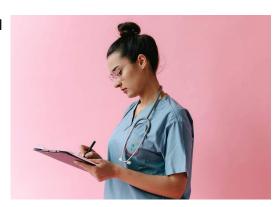
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# Safe and appropriate care

Documentation creates a complete picture of a client's care, helping the team plan their own actions. Clear, accurate, and timely documentation ensures important information is shared, promoting consistent, high-quality care.

It also indirectly impacts outcomes by serving as a tool to:

- Evaluate care and outcomes,
- Identify risks and improve safety,
- Allocate resources like staffing, and
- Support research for evidence-based practices.

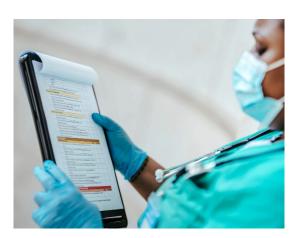


3

#### **Professional and legal standards**

**Professional standards:** Documentation shows how you meet standards and apply knowledge, skills, and judgment. It's a professional responsibility for all nurses, regardless of their role or practice setting.

**Legal standards:** Documentation serves as evidence in legal proceedings, such as lawsuits and disciplinary hearings, establishing facts about the care provided. It may be examined to ensure care was:



- Reasonable and prudent,
- Aligned with BCCNM standards and employer policies and procedures,
- Delivered promptly.

While no specific laws in B.C. dictate how nurses should document, relevant legislation should be understood and applied to your practice. Refer to your employer's policy about where to document a safety event and how to reference it in the client record.

Resource: <u>Legislation Relevant to Nurses' Practice</u>

#### Let's return to Tara

Tara forgot to document the administration of a client's medication and wonders how to fix the situation. Let's see how Sam guides Tara:

**Sam**: Tara, mistakes happen. However, you need to document the medication administration. You can't document that you gave it without noting the oversight. Document the time the medication was administered and include a note about why the documentation was delayed.

**Tara**: (frowning) But won't that look bad?

**Sam**: It's important to be honest and transparent and acknowledge your mistake as soon as you become aware of it. If there's an adverse reaction or if their blood pressure spikes, your documentation will show that you gave the medication at the scheduled time. If the doctor comes by to review the record and sees the missing entry without an explanation, it could look like the medication wasn't given at all. Documentation is not just a legal and professional requirement; it's vital for client safety and team communication about care. Also, check the hospital's policy to see if any further action is required.

This scenario highlights why keeping accurate and timely documentation is important. It helps ensure that everyone is on the same page and that clients receive the best care possible. Plus, having a supportive team where you can openly discuss and learn from mistakes makes a big difference.

# The "where" of documentation

#### Client health record

Anyone who receives health care or treatment will have a health record. The client health



record is where all health professionals record the detailed account of a client's health history, diagnoses, treatments, medications, responses to care, and care planning. Health records can be paper, electronic, or a combination of both. Health records are legal documents.

If care is not documented in the client record, there is no evidence it was provided. Oral reports and separate notes do not replace proper documentation, and non-

permanent documentation tools (e.g., nursing "cheat sheets") must be disposed of appropriately.

Health-care agencies provide specific documentation tools for nurses to organize and document care. While some tools are standardized across the agency, others may be unit-specific, with workplace guidelines outlining their use. Documentation tools become part of the official client record.

# Privacy and confidentiality

As a nurse, you have a legal and professional duty to protect client information.



Documentation, in any format, should be securely stored to prevent access by unauthorized individuals.

Staying logged into an electronic health record (EHR) is the same as leaving a paper chart open for anyone to view, including staff and visitors. Always log off when not using the EHR. When managing client information, you must maintain confidentiality, such as when you are accessing, storing, retrieving, and transmitting information. If you breach confidentiality—such as by failing to comply with legislation or sharing data without client consent—can result in professional misconduct.

## Breach of confidentiality

As highlighted in the discussion on where to document, nurses have a legal and professional duty to protect client information. It is essential to distinguish between information that must be documented—such as suspected abuse or neglect—and information that is not relevant to care or legal requirements.

Documenting sensitive information inappropriately, such as details of a heated argument about child support payments that do not raise safety concerns, may constitute a breach of confidentiality and can have serious legal and ethical consequences. Documentation must comply with legislation such as the *Freedom of Information and Protection of Privacy Act (FOIPPA)* and be guided by professional standards to ensure both client safety and privacy are upheld.



Note: The sample documentation shown in this module is presented in written format for clarity and ease of understanding. We have not included examples from electronic health records (EHRs), as these systems vary widely and are difficult to accurately recreate in this format.

Consider if the following documentation meets privacy and confidentiality standards:

Leeza Chins PHN: 31097 DOB: April	4827567	
Date	Time	Notes
8/14/24	1100	Client vital signs stable. NPO for her procedure at 1230 today. Client visited by her ex-husband, John Chinsky, at 10:30. They had a heated argument about child support payments and their ongoing custody battle over their two children, Emily and James. John said "there is no way you are getting a dime out of me" and threw some legal documents on the floor. Client called John a "deadbeat" as he stormed out.~ A.N, RPN

This documentation (*choose all that apply*)

- a. Appropriately captures client interactions with the ex-husband.
- b. Inappropriately discloses private, irrelevant information.
- c. Violates the client's privacy.
- d. Contravenes ethical principles prioritizing client confidentiality.
- e. Erodes trust between the client and health-care professionals.
- f. Is clear, concise, and includes all relevant facts.

#### **Expected practice**

Document only information relevant to the client's health care; avoid including unrelated personal details. If the client's emotional state impacts care (e.g., increased anxiety), note it without disclosing specific personal information, e.g., "Client became upset after a visitor left and may require emotional support."

Adhere to privacy regulations, including laws governing client confidentiality, such as the Personal Information Protection Act (PIPA).

## Client safety event reports

Client falls, medication errors, or other potentially harmful situations happen. There are many names for this report— "incident report" and "adverse events report" are common ones. Most workplaces require nurses to document safety events for quality improvement and risk management purposes.

The safety event report itself is generally not part of the client record. Only information relevant to the care of the client is documented in the client's record. Document the facts of the event and any care provided to the client as a result of the event in the client record.

#### For example:

Client reported he "slipped and fell" in the bathroom. Fall not witnessed. Client reports no injuries from the fall. Client helped to bed and vital signs taken. Dr. Wilson called at 745 and informed of the incident. Orders to monitor neuro vital signs q4hrs for 24 hours.

Refer to your workplace policies regarding when and how to complete a safety event report.

Topic 6 of 11

# The "what" of documentation

Nursing documentation includes any written and electronic information about an individual, family, group, population, or community describing the care or service provided by a nurse.

A review of actual documentation shows that nurses are often challenged to know what to document. Incomplete or unclear documentation can negatively impact care and have ethical and legal consequences. Here are some best practices:

## **Entry details**

Always include the date, time, your signature, and nursing title. Follow workplace policies to make sure it's clear who provided the care.



#### **Client assessment**

Document factual data (measurable and observable facts) and your interpretation, avoiding vague terms, stereotypes, assumptions, or judgments. Record data from the client or family in their own words.

- Factual data is observable, measurable, and verifiable information, such as vital signs (blood pressure, heart rate) or physical observations (skin color, swelling). It's based on facts, not personal thoughts or judgments. Use neutral language when documenting behaviour (e.g., "noted an odour of alcohol, speech was slurred" instead of "client was drunk"). Avoid vague terms like "appears" or "seems," and unclear expressions like "status unchanged" or "had a good day" that lack detail.
- Data from the client or family and reflects personal experiences or feelings (e.g., pain level, dizziness). Document their exact words with context, such as "client reports headache after skipping breakfast."
- Objectively document conversations about client trauma or strengths



- Check yourself for biases and/or lack of knowledge. Ask the client if they are accessing other types of care, for example, a traditional healer.
- Document any legal changes to client care such as completion of a Mental Health Act form 4 or a representation agreement.

#### Plan of care

Keep nursing care plans updated by documenting changes and evaluations.



#### **Interventions**

Document all nursing actions, medication administration, teaching, and client responses. Examples of interventions to document include: client assessment before and after giving PRN medications; information about admission, transfer, transport, and discharge of clients.



#### Informed choice conversations

Document details of these conversations. Avoid value judgments (e.g. "noncompliant"). If the client's decision creates a situation where mandatory reporting must occur (you think a child or youth under 19 years of age is being abused or neglected), report appropriately.



## Consultations/referrals

Document all communications with other health professionals and traditional and/or spiritual healers, including time, place, method, and outcomes. For example, instead of only documenting "Dr. aware" you should also include the physician's name and title, when they were contacted, and their response or lack of response. Not adequately documenting communication with another



care professional leaves your care open to interpretation. Accurate and complete documentation protects you from being inappropriately assigned blame in a situation where you acted appropriately.

## Apply your knowledge

Ada Green, 89, is recovering from bowel surgery and was found in the bathroom by Janie in visible distress—anxious, diaphoretic, clutching their abdomen, and struggling to breathe, reporting significant pain (7/10) and shortness of breath. Ada also appeared confused, unable to recall when they took their medications, ate, or what time it was. Vital signs showed elevated temperature (38°C), increased heart rate (pulse 110), low blood pressure (100/70 mmHg), rapid breathing (28 breaths/min), and slightly reduced oxygen saturation (92%).

What information about Ada from this initial encounter is important for Janie to document? (Choose all that apply)

- a. Ada's comments, "I'm in so much pain" and "I can't seem to catch my breath"
- b. Which medication Ada didn't take
- c. Ada's lack of orientation to time
- d. Vital signs
- e. Respiratory status

Janie documented Ada's pain, confusion, and vital signs and administered prescribed analgesics. Janie called Ada's physician, Dr. Roberts, who said they would be on the unit in a few hours. Janie recorded details of the call (time, physician's name, instructions, and their response).

What information from her conversation with the physician should Janie document? (Choose all that apply).

- a. Physician's response
- b. Time of the call
- c. Physician's name
- d. What the physician said

Later, Janie finds Ada more confused, disoriented to time and place, trying to remove their gown, and attempting to get out of bed, asking, "Where am I? Why are you keeping me here?" Janie documented this acute change in Ada's mental status, noting their confusion, disorientation, and comments.

What is the most appropriate way to document Ada's status change? (Choose all that apply)

- a. Client uncooperative and climbing out of bed. Accused nurse of holding them prisoner.
- b. Client alert, oriented to person.
- c. A+Ox2
- d. Acute change in mental status. Unaware of time and place. Speech clear but saying, "Where am I? Why are you keeping me here?" Trying to remove gown and get out of bed.

Documentation of Ada's status is critical for continuity of care. Janie's documentation of Ada's altered health status and their communication with the physician provides clear evidence of Janie's care.

## Inaccurate or incomplete documentation

Building on our discussion of what constitutes essential information in documentation, this section highlights the issues of inaccurate or incomplete entries. Failing to include key details, as outlined in the previous lesson such as client assessments, interventions, and responses, can lead to significant negative impacts.

Inaccurate or incomplete documentation includes such things as:

 Mistakes in documenting data such as vital signs, medication administration, or client responses.

- Omitting critical information, such as allergies, adverse reactions, or previous history.
- Incomplete documentation or under documenting assessments, interventions, client responses, education, or discharge instructions.
- Incorrect or inconsistent information that may mislead health-care professionals and result in inappropriate care or client harm.

Consider whether this documentation is accurate and complete:

	John Doe
	PHN 2109876543
	DOB Oct 5, 1965
Date/Time	Notes
Aug 4, 2024 1000	The data
1000	Changed dressing on right leg before discharging home. $\sim$ AN, RN

The documentation lacks key details, including:

- Wound description: No mention of size, colour, drainage, or signs of infection.
- Type of dressing and technique: Missing details on the dressing type, changes, solutions used, or whether sterile/clean techniques were followed.
- Client response: No mention of how the client tolerated the procedure or pain experienced.
- Discharge: No mention of time of discharge, education or discharge instructions provided.

#### Impacts of incomplete documentation:

- Client care: Lack of information may hinder proper care, leading to complications, ineffective treatment, sepsis, death.
- Communication gaps: Incomplete notes can cause breakdowns in care coordination, resulting in inconsistent care.

 Legal and professional issues: Incomplete records may create legal challenges, as they don't fully capture the care provided.

#### **Expected practice**

Include all relevant details—interventions, client response, and follow-up instructions and education—to ensure continuity of care, support clinical decisions, and ensure client safety.

## Failure to document communication

Not documenting communications with other health-care professionals, clients, or family members can lead to fragmented care and an incomplete understanding of the client's

condition and preferences (including cultural preferences), and potentially cause client harm. This can lead to miscommunication about what was conveyed and agreed upon, especially when adverse events occur.

Consider whether this documentation is adequate:

		Jamil Carron
		PHN 2108123098
		DOB Nov 5, 1975
Date	Time	Notes
8/14/ 24	1500	Client reported new onset of dizziness and nausea. Dr.
		aware· ~ AN, RN

This documentation: (choose all that apply)

- a. Fine the way it is.
- b. Should include the doctor's name and their response.
- c. Should include the nurse's factual assessment data.
- d. Concise, clear, and factual.
- e. Incomplete.

#### **Expected practice**

Document all communications with health-care professionals, including time, place, conversation content, and received instructions. Also, record discussions with the client or family regarding changes in condition and treatment plans, as well as any follow-up actions taken, such as administering medications or updating care plans.

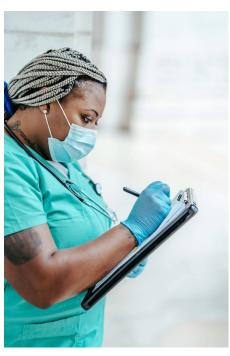
#### Here's a revision:

		Jamil Carron
		PHN 2108123098
		DOB Nov 5, 1975
Date	Time	Notes
8/14/ 24	1515	Client reported new onset of dizziness and nausea at 1445. Notified Dr. Smith at 1450. Dr. Smith instructed to administer 4 mg of Ondansetron IV for nausea and to monitor the client's vital signs every 15 minutes for the next hour. Ondansetron administered at 1500 as ordered. Vital signs at 1500: BP 110/70, HR 78, RR 16, Sp02 98% on room air. Informed client of the plan to monitor his condition closely and reassured him that the medication should help alleviate the nausea. Client verbalized understanding. Charge nurse updated on client's status at 1510. ~ AN, RN

This revised example provides a clear and complete record of nursing assessment, interventions and communication, and records all steps taken in response to the client's symptoms. This helps maintain continuity of care and protects both the client and the health- care team.

Topic 7 of 11

# The "when" of documentation



Timely, complete, and accurate documentation is a legal and professional requirement for nursing practice, even in busy environments. Follow workplace policies on documentation frequency

Document care as soon as possible after providing it to ensure accuracy, especially with rapidly changing client conditions. Increase documentation frequency for complex or high-risk clients and avoid relying on memory. Never complete documentation before care is given.

Document care in chronological order—from what happened first to what happened last—to reflect changes in a client's health status, helping others understand the care provided.

If you cannot document immediately, a 'late entry' is required. Adhere to workplace policies on late entries, clearly label them as such, and record both the documentation time and the actual time of care.

# Late or untimely documentation

As highlighted in the 'when to document' section, timely documentation is paramount.

Delaying documentation, as illustrated in the following scenario where events at 14:00 are not

documented until 17:30, undermines the accuracy and accessibility of the client record, potentially leading to unsafe conditions and questions legal credibility.

Timely documentation is essential for accuracy and safe care. Delayed documentation can lead to unsafe conditions, missed treatments, and memory lapses that compromise client safety and record reliability. In legal contexts late documentation may be questioned, diminishing its credibility.

Consider whether this documentation is appropriate:

Date	Time	Focus	Notes
8/14/24	1515	Pain	Client complaining of a headache. Will give analgesic. ~ AN, RN
8/14/ 24	1730	CVS	At 1400, client complained of severe chest pain and shortness of breath. Administered nitroglycerin and oxygen at 4 L/min via nasal cannula. Called the physician and received orders for an ECG and additional nitroglycerin if pain persisted. ECG completed. The client's chest pain seemed to resolve. The client was monitored until 15:00 and appeared stable. ~ AN, RN

What is the issue with this documentation? (select all that apply)

- a. Not identified as a late entry
- b. Uses vague language
- c. Not timely
- d. Incomplete documentation of physician call
- e. Lacks client assessment documentation

#### **Expected practice**

Document critical events, interventions, and client responses as soon as possible to ensure accuracy and provide up-to-date information for the health-care team.

If documentation is late, clearly label it as such, including the event time and documentation time, and ensure the entry is factual and complete. Follow employer policies for late entries.

Topic 8 of 11

# The "how" of documentation

### Characteristics of effective documentation

Review the cards to learn more about effective documentation characteristics.



Document information objectively based on personal knowledge, assessments, and the client's needs.



Follow workplace policies for correcting errors openly and honestly. Avoid altering someone else's documentation; inform the person of any mistakes for them to correct.



Include nursing actions and client responses, reflecting a decision-making process and critical thinking.



Misspelled words and illegible entries can lead to misinterpretation and serious treatment mistakes; poor legibility may indicate carelessness.



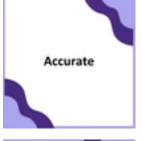
Document information during or immediately after care interactions.



Ensure documentation reflects safe, competent, ethical nursing care consistent with legal and workplace requirements.



Use abbreviations as per workplace policies. The Institute for Safe Medication Practices in Canada (ISMP) has a <u>list of dangerous abbreviations</u> that should be avoided in documentation.



Provide clear, understandable details about care provided and any changes in client responses.



Present information in chronological order to show nursing decisions and client responses.



# Self-employed nurses

Self-employed nurses must meet the Documentation practice standard and have a documentation system that complies with legal, ethical, and professional standards. What they document will depend on the type of service offered; however, you are required to document all aspects of client care including:

- Client information: Comprehensive and accurate client information including medical history, assessments, diagnoses, and treatment plans.
- Care provided: Document all care provided, including details of interventions. client responses, and any changes in the treatment plan.
- Date and time: Ensure all entries are dated and timed accurately to provide a clear timeline of care.

B.C.'s Health Professions Act states all nurses must retain clinical records for a time specified by BCCNM bylaws. As a self-employed nurse, and thus the employer, it is important that you are aware of these requirements. See B.C.'s <u>Limitation Act</u> (opens in a new tab), the <u>Medicare</u> <u>Protection Act</u> (opens in a new tab), and the <u>Personal Information Protection Act</u> (opens in a new tab), for other legal requirements regarding health records.

#### Over documentation

While thoroughness, as discussed in the characteristics of effective documentation, is crucial, it's equally important to avoid over documentation. Including unnecessary information, as seen in the following example with details about the client's favourite cuff and jokes, can obscure critical clinical data and make it harder for other health-care professionals to identify important changes.

Over documentation is unnecessary information, excessive repetition, or irrelevant information that clutters the record and makes it harder to find critical details.

## Consider whether this example provides important details:

			Robert Simara PHN 3109749863 DOB Mar 15, 1941
Date	Time	Focus	Notes
8/14/24	7ime	Head to toe assessment	Blood pressure: 94/62 mmHg, measured

This documentation includes clinically irrelevant details and could distract other health-care professionals from the essential clinical information such as the client's elevated respiratory and heart rates.

## **Expected practice**

Document clinically relevant nursing care, avoiding unnecessary information that can obscure critical data.

#### Here's a revised version:

			Robert Simara PHN 3109749863
Date	Time	Focus	DOB Mar 15, 1941 Notes
Dute Time		Blood pressure 94/62 mmHg, client	
8/14/24	/24 0800	Cardíovascular	denies lightheadedness; Pulse: 108 bpm,
			rhythm regular but tachycardic,
			Respiratory rate 24 breaths per minute,
			using accessory muscles to breath,
			Oxygen saturation 99% on room air;
			Skin is warm and moist to touch,
			capillary refill 5 secs, pitting edema to
			lower legs bilaterally; Temperature:
			36.8°C. ~ AN, RN

# Inconsistent use of terminology and abbreviations

As emphasized in the characteristics of effective documentation, clear communication is essential. Inconsistent use of terminology and non-standard abbreviations, such as using both "SOB" and "dyspnea" interchangeably, can create ambiguity and lead to misunderstandings, potentially compromising client safety. Always refer to workplace policies on acceptable abbreviations, as mentioned in the previous lesson.

Consider whether this example provides important details:

Wynn Chang			
PHN 2128475967			
DOB: Jan 1,	2001		
Date	Time	Notes	
		Pt. c/o SOB at 08:30. Listened to lungs, found BBS, but pt.	
8/14/24	0900	still appears SOB. Gave O2 @ 2 L/min NC. Monitored O2	
		sats, which stayed around 92%. Pt. appears stable now, but	
		RR still seems slightly up. ~ A.N, LPN	
w	4400	Client reports dyspnea again. Lung sounds clear.	
""	1100	Administered oxygen via nasal prongs at 2 liters per	
		minute. SpO2 levels remained stable at 92%. Respiratory	
		rate is elevated, but client is otherwise stable. Will reassess	
		in an hour. Will continue to monitor.~ A.N., LPN	

This documentation uses inconsistent terms. Each entry uses different terms and abbreviations, such as "SOB" for "shortness of breath" in one note and "dyspnea" in another. The first note mentions "BBS" (bilateral breath sounds), while the second states, "lung sounds clear," and "O2 sats" is used in one entry while "SpO2 levels" appears in another.

This inconsistency can confuse health-care professionals reviewing the notes, especially if terms and abbreviations are not commonly understood. For instance, someone who doesn't know the acronym "SOB" might not understand the client's condition right away. Always refer to workplace policies on acceptable abbreviations.

#### **Expected practice**

Use standardized terminology consistently, such as "shortness of breath" or "dyspnea." Follow workplace policies for documentation, including approved abbreviations, to ensure uniformity. Spell out abbreviations for clarity. Do not use abbreviations for critical information that all health-care team members must understand.

#### PAUSE AND REFLECT

Think about your documentation. Have you used terms or abbreviations that could have been misunderstood by others?

Consider specific abbreviations or jargon common in your practice setting that might not be universally understood by all members of the health-care team, especially new staff or those from different disciplines. Reflect on a recent note you wrote and ask yourself if someone unfamiliar with your usual terminology would clearly understand the information being conveyed and if you have consistently adhered to workplace policies on approved abbreviations.

Use the fillable Documentation Self-Assessment PDF to complete activity #3.

#### False documentation

Falsification involves intentionally altering, fabricating, or misrepresenting client records. Health records are legal documents; it's criminal and unethical practice to falsify documentation. It compromises client safety, leads to incorrect treatment decisions, and erodes trust in the health-care system.

Review the cards below to learn more about these false documentation practices that should be avoided.



Changing entries to reflect actions that didn't occur, such as falsely documenting medication administration or normal vital signs.



Deliberately leaving out significant details, like adverse reactions or changes in a client's condition.



Adding information to a record with a false date, such as documenting a wound assessment performed later.



Documenting actions or observations that never happened, like claiming a specific intervention was performed.



Entering incorrect details about a client's history, diagnosis, or treatment or misrepresenting assessments or care to cover oversights or claim responsibility for unprovided care.



Documenting medication administration under another nurse's name to divert medications.



Repeating previous shift documentation without proper assessment or care.

# Artificial intelligence and documentation

Artificial Intelligence (AI) is an emerging technology that uses computers and machines to perform tasks that normally use human intelligence such as learning, reasoning, and problem-

solving. All technology can enhance efficiency in nursing documentation but poses several challenges:

- Misinterpretation: Al may generate inaccurate information from ambiguous or
  - incomplete data; nurses must verify that AI-generated documentation is correct.
- Bias: Al algorithms may contain biases depending on how they were built.
- Contextual limitations: Al may not capture the personal and contextual nuances of care that nurses provide, risking incomplete documentation.



- **Technical glitches**: Al failures may affect documentation timeliness and client care.
- Recording errors: Al could inaccurately log completed care that was not performed.
- **Data privacy risks**: Al requires vast amounts of data, increasing the risk of data breaches or misuse of sensitive client information.

Nurses only use AI when it is approved by their employer, and the employer has AI policies and processes in place. When using AI to assist with documentation, nurses are solely accountable and must review and validate the entry, and ensure the accuracy, objectivity, and completeness of their documentation entries.

# Culturally safe and non-discriminatory documentation

Nurses must document nursing care for Indigenous and clients from equity-denied communities in a culturally safe, non-discriminatory, and anti-racist way. This requires you to be aware of your own values, assumptions, beliefs, and privileges embedded in your own knowledge and practice, and consider how this may impact your therapeutic relationship with Indigenous and other clients. When documenting client care for Indigenous Peoples, keep in mind BCCNM's *Indigenous Cultural Safety, Cultural Humility, and Anti-racism practice standard*.

Before documenting, reflect on and identify stereotypes, assumptions, or biases you may hold that may impact your care of people from equity-denied communities. Evaluate and seek feedback on your own behaviour. Seek out opportunities to unlearn and relearn about the negative impact of discrimination and Indigenous-specific racism on clients accessing the health-care system.

Reflect on how your privileges, biases, values, belief structures, behaviours, and positions of power may impact the therapeutic relationship you have with Indigenous and other clients. Recognize how trauma (personal or intergenerational) may impact client's life and be thoughtful and respectful of this, including seeking permission before engaging in assessments or treatments.

Document client care with these principles in mind:

#### Use inclusive and non-judgmental language

- Avoid stereotypes and assumptions based on client background, race, or ethnicity. Use neutral, factual language without judgment.
- Respectfully ask if clients identify as Indigenous,
   2SLGBTQIA+, or with other cultural or personal identity they wish to share.



Photo by Elizabeth Spike is licensed under a CC BY-NC-SA license.

• Explore client decisions for opting in or out of care choices - avoid terms such as "non-adherent", "'non-compliant'. Explore a client's choice of treatments or providers.

#### **Acknowledge cultural practices**

 Document relevant cultural beliefs and practices that influence health decisions without judgment and only with the client's consent.



- Include cultural requirements in care plans (e.g., traditional foods, medicines, healers, family involvement).
- Connect with patient navigation, support services, or translation services.

## **Highlight systemic challenges**

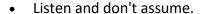
- Consider social determinants of health (e.g., access issues) that affect care and avoiding blame on the client.
- Consider systemic issues that affect access to care license. (client mentions the effects of colonization, residential schools, Indian hospitals, foster care, adoption, the "Sixties Scoop", etc.).



Photo by G Wayne Dwornik is licensed under a CC BY 2.0

## **Practise cultural humility**

- Acknowledge your biases and learning needs regarding cultural and practices of Indigenous Peoples and other cultures.
- Document clients' preferences based on cultural beliefs. This acknowledges the client's expertise in their own health.
- Photo by Simone Paul is licensed under a CC BY-NC-SA



## **Access language translation**

- Use certified translators for non-English speakers and document consent for their use. Avoid using family members or non-professional translators, as this can lead to miscommunication.
- Document clients' preferred language and their ability to understand instructions.



#### Document with anti-dicrimination in mind

 Focus on the impact of Indigenous-specific and other racism on health. Report acts of racism to leadership or the relevant health regulatory college.



#### **Practise cultural safety**

- Document adjustments made to interventions respecting cultural values.
- Document client feedback regarding cultural saf



## **Recognize power dynamics**

- Ensure documentation respects client autonomy and decision-making.
- Document advocacy efforts for clients' cultural practices or against discrimination.



By following these principles, your documentation shows respect for cultural differences, avoids perpetuating Indigenous-specific racism or bias, and promotes equitable, respectful care for all clients.

## Vague or biased language

Building on the principles of culturally safe and anti-racist documentation and the need for factual, objective, non-discriminatory, and anti-racist language, this section addresses the issues of using vague or biased language. Using subjective comments, assumptions, or

stereotypes, as demonstrated in the documentation about Sara, can lead to misinterpretations, biased care, and a failure to uphold professional standards and cultural safety for clients.

Documentation must be factual and objective, relying on observable and measurable information unless you are recording a client's experience. Problems arise when subjective comments, inferences, or judgments are made without supporting data.



Vague language, like "client is doing well," can lead to misinterpretations and ambiguity as it lacks specific data and is subjective. Using vague language can make documentation difficult to understand, leading to miscommunication among the care team.

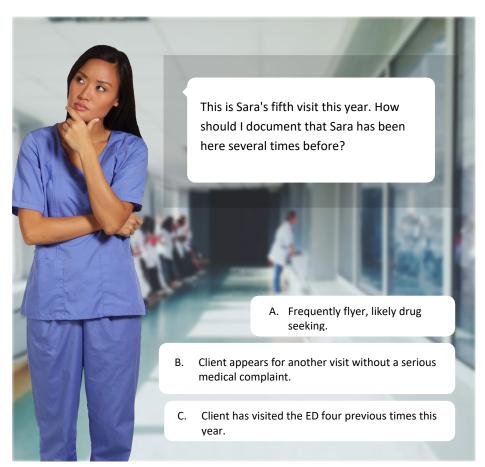
Biased or judgmental language, including personal opinions, assumptions, or stereotypes can lead to biased care and is unprofessional.

# Scenario

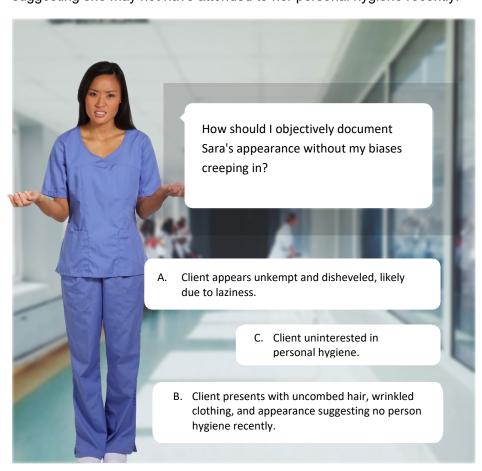


Amy is working on her documentation practices, specifically removing biased and judgmental language. Can you guide her through identifying and replacing biased or inappropriate language in documentation?

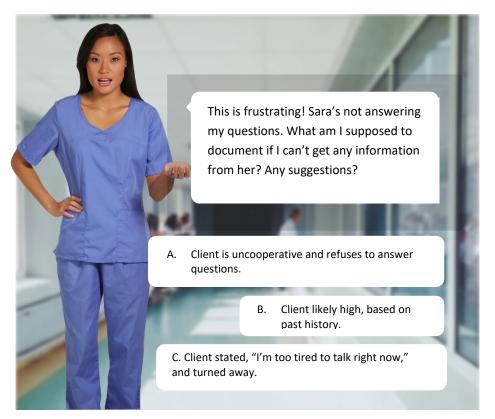
Amy's client, Sara, has visited the ED four times in the past year with complaints of shortness of breath. Previous diagnostics haven't revealed any significant findings. Amy recognizes Sara.



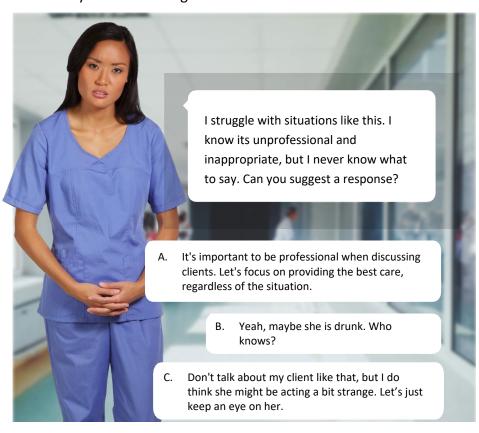
Sara's appearance is disheveled, with uncombed hair, wrinkled clothing, and an overall appearance suggesting she may not have attended to her personal hygiene recently.



Amy asks Sara questions about her health and reason for the visit, but Sara doesn't respond to her questions, avoids eye contact, and complains of fatigue.



Another nurse approaches Amy making derogatory comments about her client and saying that she is likely "drunk" or "high".



#### Scenario end

Using clear, unbiased language helps build trust, ensures understanding, and supports safe, respectful care for all clients

As nurses, it's essential to ensure that our documentation is respectful, accurate, and inclusive, particularly when documenting client information or interacting with diverse populations, ensuring it aligns with BCCNM standards, cultural sensitivity, cultural humility, and anti-racism best practices.

# **Matching activity**

Match the first column - the appropriate or objective language, with the second column - the inappropriate or non-objective language.

Overreacting	Missed a scheduled appointment	
Probably	Is observed to be	
Appears	Demonstrates reluctance to engage	
Drunk	Expressing extreme anxiety in response to	
	minor stimulus	
Difficult	Demonstrating signs of intoxication	
Irresponsible	Based on available information, it seems that	

Topic 9 of 11

# The "who" of documentation

Many nurses work in a team with other nurses and health-care professionals. You may find yourself wondering if you should document actions carried out by another health-care professional or what to do if you are asked to document care provided by another nurse.

Document only the care you personally provided. Documenting someone else's actions blurs accountability and may lead to inaccuracies. Each professional should record their own care, however, there are some situations where workplace policies allow you to document for someone else:

## **Emergency situations:**

In emergencies (e.g., cardiac arrest), you may document for others, as outlined by workplace policies.

## Client/family documentation:

When clients or family document care, follow workplace policies for adding or transcribing their notes into the health record.







# Apply your knowledge

It is day shift change and Luca is handing off care to Yusef (a newly graduated nurse). Before leaving, Luca tells Yusef that they completed the care for Ms. Juulsen but didn't get a chance to document it. Luca tells Yusef, "Just write that I provided care, Ms. J's night was fine, vitals were

normal when I did them at 2200, and they slept well all night." Luca leaves before Yusef can fully comprehend what Luca said.

Confused and not sure what to do, Yusef documents: "2200 – Vitals stable, client slept well, no complaints. Luca provided care."

What is the most significant issue with Yusef's documentation in this scenario?

- a. Yusef didn't clarify Luca's instructions.
- b. Yusef documented information without directly assessing the client.
- c. Yusef forgot to document the care he provided.
- d. Yusef wrote in a way that wasn't clear.

#### What should Yusef have done instead?

- a. Documented what Luca told him without questioning it.
- b. Asked Luca to stay and document their own care when she mentioned she didn't have a chance to do it earlier.
- c. Documented that he did not assess the client.
- d. Checked Ms. Juulsen's vitals before documenting.

What is the primary concern in Yusef's documentation for Luca in this scenario?

- a. Breach of confidentiality
- b. Lack of accuracy and truthfulness
- c. Incomplete documentation
- d. Duplicate charting

#### **PAUSE AND REFLECT**

Based on your self-assessment at the beginning and what you have learned, identify two to three areas in your own documentation that you could improve.

Begin by considering why the issue might be happening. Do you need to learn more about documentation? Or are there other factors that influence what you document?

Next, think about what strategies could you put in place to help you in completing effective and appropriate documentation. An example has been provided to get you started.

Documentation practice	Reasons why this is happening	Strategies to avoid this practice
Example: I sometimes use vague and biased language when documenting about clients.	Example: I am often documenting in a hurry and often write the first thing that comes to mind.  I wasn't aware that some of the words I was using were biased.	Example: Pause and reflect critically on what I want to communicate before I put it in the client record.  Seek out some educational resources on how to reduce bias in my practice.

Congratulations! You have finished the module content.

Please continue to the final quiz.

# Final quiz

The final quiz consists of 10 questions. To complete this module, you must obtain a score of 80%. You have unlimited attempts.

- 1. Which of the following is NOT a characteristic of high-quality nursing documentation?
  - a. Timely and completed as close to the event as possible.
  - b. Includes personal opinions about the client's behaviour.
  - c. Based on facts.
  - d. Clear, concise, and easy to understand.
- 2. True or False: It is acceptable to document for another nurse if you trust their judgment and are busy and they believe the care was provided as stated.
  - a. True
  - b. False
  - 3. You are taking over care for a client and notice that the previous nurse documented vitals that seem inconsistent with the assessment you perform. The documentation states vitals were stable, but you find that the client's blood pressure is elevated. What should you do?
    - a. Correct the previous nurse's documentation and lower the recorded blood pressure.
    - b. Document your own assessment and notify the health-care provider of the elevated blood pressure.
    - c. Ignore the discrepancy since your own assessment is what matters now.
    - d. Ask the client if they noticed any changes in their condition overnight.
- 4. Clara documents "0645: Client reported difficulty sleeping last night, stating, 'I was tossing and turning all night.' Client grimaced while repositioning and rated pain as 6/10. Vitals at 0300: BP 130/80, HR 88, RR 16." What is the main issue with this entry?

- a. Lacks timeliness
- b. Uses subjective, vague language
- c. Uses language that reflects bias
- d. Includes too much detail
- 5. Leah is caring for Mr. Lewis who is admitted to the psychiatric inpatient unit with a delusional disorder. Mr. Lewis has an episode of aggression during the night and Leah had to call the physician for orders. After the night shift, Leah documents, "Client was agitated during the night, slept off and on, no voiced concerns." What is missing from this documentation? (choose all that apply)
  - a. Objective data about the client's health status
  - b. Specific client interventions that were performed
  - c. Client's response to interventions.
  - d. Data given by the client
  - e. Call to physician and their response
  - f. All of the above
- 6. Hareem walks into a client's room and discovers the client lying on the floor next to his bed. Hareem knows he will need to fill out an incident report but wonders what he should document in the client record. Which of the following is the most appropriate entry to include in the client's medical record?
  - a. The client fell out of bed. Assisted back to bed. Copy of incident report attached.
  - b. Entered the room and found client conscious and lying on the floor next to the bed. Vital signs stable. Client denies injury. Assisted back to bed.
  - c. Client had been dizzy and was told to ring the call bell if they wanted to get up. Client didn't ring the call bell and fell trying to get up. Returned to bed with waist restraint applied.
  - d. The client fell and was found lying on the floor. Incident report completed

7.	True or False: Documentation should reflect only what is observed and stated by the client,
	without personal judgment or interpretation.

- a. True
- b. False
- 8. What is the best way to document when a client declines a treatment?
  - a. "Client was non-compliant and refused treatment again."
  - b. "Client declined treatment, saying, 'I don't want it right now."
  - c. "Client refused treatment because they don't care about their health."
  - d. "Client refused to participate due to laziness."

- 9. What is a key characteristic of complete documentation?
  - a. All relevant details are included, but unnecessary information is avoided.
  - b. Documentation contains some missing information that will be added later.
  - c. The nurse uses terms like "fine" and "okay" to summarize care.
  - d. Important information is delayed to save time during a busy shift.
- 10. What should a nurse do if they are asked to document care they did not provide?
  - a. Document it as requested to help the other nurse.
  - b. Refuse to document and report the request to a manager.
  - c. Politely ask the nurse to document their own care.
  - d. Document the care but indicate it was provided by the other nurse.

Topic 11 of 11

# **Summary**

You've completed the **Documentation in Nursing Practice** module. As you've learned, documentation is much more than a record, it's a critical part of safe, competent, and ethical nursing care.

## **Key takeaways:**

- **Documentation** is a professional, legal, and ethical responsibility that supports client safety, continuity of care, and accountability.
- High-quality documentation is clear, factual, timely, complete, and objective—and avoids vague, biased, or judgmental language.

- Culturally safe and anti-racist documentation means being aware of your own biases and documenting with respect for each client's identity, context, and experience.
- You are responsible for documenting the care you personally provide. Never document on behalf of someone else unless permitted in emergencies under workplace policy.
- Artificial Intelligence tools can assist with documentation, but only when employerapproved. You remain fully accountable for the accuracy and integrity of any Al-assisted entries.
- **Inaccurate, incomplete, or false documentation** can have serious consequences—for your clients, your practice, and public trust in the profession.

By strengthening your documentation practices, you're not only meeting standards—you're helping to ensure equitable, safe, and effective care for every client.

#### Your thoughts, please

To help us create resources that meet your needs, please complete the 2-minute survey below to let us know what you think. Your feedback will help us improve this and future resources we create for our learners. Thanks in advance!

Take the survey

#### **Certificate of completion**

Thank you for completing this module! To receive a certificate of completion, please fill in your name and the date on the certificate below and save or print.



# CERTIFICATE OF COMPLETION

# **Documentation in Nursing Practice**

presented to



Thank you for completing this learning module.
Please continue to apply this knowledge
to your nursing practice.



# **Answer Key**

#### Page 16

This documentation (choose all that apply)

- a. Appropriately captures client interactions with the ex-husband.
- b. Inappropriately discloses private, irrelevant information.
- c. Violates the client's privacy.
- d. Contravenes ethical principles prioritizing client confidentiality.
- e. Erodes trust between the client and health-care professionals.
- f. Is clear, concise, and includes all relevant facts

#### Page 20 Apply your knowledge

Ada Green, 89, is recovering from bowel surgery and was found in the bathroom by Janie in visible distress—anxious, diaphoretic, clutching their abdomen, and struggling to breathe, reporting significant pain (7/10) and shortness of breath. Ada also appeared confused, unable to recall when they took their medications, ate, or what time it was. Vital signs showed elevated temperature (38°C), increased heart rate (pulse 110), low blood pressure (100/70 mmHg), rapid breathing (28 breaths/min), and slightly reduced oxygen saturation (92%).

What information about Ada from this initial encounter is important for Janie to document? (Choose all that apply)

- a. Ada's comments, "I'm in so much pain" and "I can't seem to catch my breath"
- b. Which medication Ada didn't take
- c. Ada's lack of orientation to time
- d. Vital signs
- e. Respiratory status

54

Janie documented Ada's pain, confusion, and vital signs and administered prescribed

analgesics. Janie called Ada's physician, Dr. Roberts, who said they would be on the unit in a

few hours. Janie recorded details of the call (time, physician's name, instructions, and their

response). What information from her conversation with the physician should Janie document?

(Choose all that apply).

a. Physician's response

b. Time of the call

c. Physician's name

d. What the physician said

Later, Janie finds Ada more confused, disoriented to time and place, trying to remove their

gown, and attempting to get out of bed, asking, "Where am I? Why are you keeping me here?"

Janie documented this acute change in Ada's mental status, noting their confusion,

disorientation, and comments. What is the most appropriate way to document Ada's status

change? (Choose all that apply)

Client uncooperative and climbing out of bed. Accused nurse of holding them prisoner

b. Client alert, oriented to person.

C. A+Ox2

d. Acute change in mental status. Unaware of time and place. Speech clear but saying,

"Where am I? Why are you keeping me here?" Trying to remove gown and get out of

bed.

Page 24

This documentation: (choose all that apply)

Fine the way it is.

b. Should include the doctor's name and their response.

c. Should include the nurse's factual assessment data.

- d. Concise, clear, and factual.
- e. Incomplete.

## Page 26

What is the issue with this documentation?

- a. Not identified as a late entry
- b. Uses vague language
- c. Not timely
- d. Incomplete documentation of physician call
- e. Lacks client assessment documentation

#### Page 40 Scenario

This is Sara's fifth visit this year. How should I document that Sara has been here several times before?

- Frequently flyer, likely drug seeking.
- Client appears for another visit without a serious medical complaint.
- c. Client has visited the ED four previous times this year.

How should I objectively document Sara's appearance without my biases creeping in?

- Client appears unkempt and disheveled, likely due to laziness.
- b. Client uninterested in personal hygiene.
- c. Client presents with uncombed hair, wrinkled clothing, and appearance suggesting no person hygiene recently.

This is frustrating! Sara's not answering my questions. What am I supposed to document if I can't get any information from her. Any suggestions?

a. Client is uncooperative and refuses to answer questions

- b. Client likely high, based on past history
- c. Client stated, "I'm too tired to talk right now." And turned away.

I struggle with situations like this. I know it's unprofessional and inappropriate, but I never know what to say. Can you suggest a response?

- a. It's important to be professional when discussing clients. Let's focus on providing the best care, regardless of the situation.
- b. Yeah, maybe she is drunk. Who knows?
- c. Don't talk about my client like that, but I do think she might be acting a bit strange. Let's keep an eye on her.

#### Page 42 Matching activity

Overreacting - Expressing extreme anxiety in response to minor stimulus

Probably – Based on available information, it seems that

Appears – Is observed to be

Drunk – Demonstrating signs of intoxication

Difficult - Demonstrates reluctance to engage

Irresponsible - Missed a scheduled appointment

#### Page 43 Apply your knowledge

It is day shift change and Luca is handing off care to Yusef (a newly graduated nurse). Before leaving, Luca tells Yusef that they completed the care for Ms. Juulsen but didn't get a chance to document it. Luca tells Yusef, "Just write that I provided care, Ms. J's night was fine, vitals were normal when I did them at 2200, and they slept well all night." Luca leaves before Yusef can fully comprehend what Luca said.

Confused and not sure what to do, Yusef documents: "2200 – Vitals stable, client slept well, no complaints. Luca provided care."

# What is the most significant issue with Yusef's documentation in this scenario?

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- b. Yusef documented information without directly assessing the client.
- c. Yusef forgot to document the care he provided.
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#### What should Yusef have done instead?

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- b. Asked Luca to stay and document their own care when she mentioned she didn't have a chance to do it earlier.
- Documented that he did not assess the client.
- d. Checked Ms. Juulsen's vitals before documenting.

# What is the primary concern in Yusef's documentation for Luca in this scenario?

- Breach of confidentiality
- b. Lack of accuracy and truthfulness
- Incomplete documentation
- d. Duplicate charting

- 1. Which of the following is NOT a characteristic of high-quality nursing documentation? b. Includes personal opinions about the client's behaviour. 2. True or False: It is acceptable to document for another nurse if you trust their judgment and are busy and they believe the care was provided as stated. b. False 3. You are taking over care for a client and notice that the previous nurse documented vitals that seem inconsistent with the assessment you perform. The documentation states vitals were stable, but you find that the client's blood pressure is elevated. What should you do? b. Document your own assessment and notify the health-care provider of the elevated blood pressure. 4. Clara documents "0645: Client reported difficulty sleeping last night, stating, 'I was tossing and turning all night.' Client grimaced while repositioning and rated pain as 6/10. Vitals at 0300: BP 130/80, HR 88, RR 16." What is the main issue with this entry?
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  - Uses language that reflects bias

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  - e. Call to physician and their response
  - f. All of the above
  - 6. Hareem walks into a client's room and discovers the client lying on the floor next to his bed. Hareem knows he will need to fill out an incident report but wonders what he should document in the client record. Which of the following is the most appropriate entry to include in the client's medical record?
    - a. The client fell out of bed. Assisted back to bed. Copy of incident report attached
    - b. Entered the room and found client conscious and lying on the floor next to the bed. Vital signs stable. Client denies injury. Assisted back to bed.
    - c. Client had been dizzy and was told to ring the call bell if they wanted to get up. Client didn't ring the call bell and fell trying to get up. Returned to bed with waist restraint applied.
    - d. The client fell and was found lying on the floor. Incident report completed
  - 7. True or False: Documentation should reflect only what is observed and stated by the client, without personal judgment or interpretation.
    - a. True

b. False

## 8. What is the best way to document when a client declines a treatment?

- a. "Client was non-compliant and refused treatment again."
- b. "Client declined treatment, saying, 'I don't want it right now."
- c. "Client refused treatment because they don't care about their health."
- d. "Client refused to participate due to laziness."

## 9. What is a key characteristic of complete documentation?

- a. All relevant details are included, but unnecessary information is avoided.
- b. Documentation contains some missing information that will be added later.
- c. The nurse uses terms like "fine" and "okav" to summarize care.
- d. Important information is delayed to save time during a busy shift.

## 10. What should a nurse do if they are asked to document care they did not provide?

- a. Document it as requested to help the other nurse.
- Refuse to document and report the request to a manager.
- Politely ask the nurse to document their own care.
- Document the care but indicate it was provided by the other nurse.