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PRACTICE STANDARD

Nurses: Documentation

Introduction

Documentation is any information entered in the client record that relates to the care or services provided to a **client** by a **nurse**. Through documentation, nurses communicate nursing assessments, the plan of care, interventions ordered or carried out, and outcomes to other health professionals, supporting safe and coordinated care.

Documentation forms a comprehensive record of care provided to a client. It reflects a nurse's application of knowledge, skill, and judgment, and can influence future care decisions. Documentation is widely accepted as evidence in legal proceedings and helps nurses recall specific situations. Clients may also request access to their records.

This practice standard sets the expectations nurses must meet when documenting in the client record.

Standards

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, 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 clients' (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 AI-assisted documentation entries at the time they provide care or as soon as possible afterward.

Glossary

Client: individual receiving nursing care or services from a nurse.

Client's Representative: individual with legal authority to give, refuse, or withdraw consent to healthcare on a client's behalf, including:

a. "committee of the patient" under the *Patients Property Act*,

b. parent or guardian of a child under 19 years of age with parental responsibility to give, refuse or withdraw consent to health care for the child under section 41(f) of the *Family Law Act,*

c. representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a client,

d. temporary substitute decision maker chosen under section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*, or

e. substitute decision maker chosen under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act.*

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

Revision history

Version #	Approved by board	Bylaw in-force	Description
1.0	March 1, 2026	April 1, 2026	Initial publication

Effective April 1, 2026, this practice standard, and any amendments to it, is made a bylaw under the authority of the *Health Professions and Occupations Act, B.C.*

Pub no.: 986