Practice Standard
for Registered Nurses and Nurse Practitioners

Documentation

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

CRNBC’s Professional Standards require nurses¹ to document timely and appropriate reports of assessments, decisions about client² status, plans, interventions and client outcomes. Documentation is any written or electronically generated information about a client that describes the care or service provided to that client. It is an essential part of nursing practice.

Documentation serves three purposes: 1) it facilitates communication; 2) it promotes safe and appropriate nursing care; and 3) it meets professional and legal standards.

1. **Communication:** Through documentation, nurses communicate to other health care providers their nursing assessment and diagnosis³ of a client’s condition,⁴ the plan of care, interventions that are carried out by nurses, and the outcomes of the interventions.

2. **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.

3. **Professional and legal standards:** Documentation is a comprehensive record of care provided to a client. It demonstrates how a nurse has applied nursing knowledge, skills and judgment according to CRNBC Standards of Practice. Documentation is 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.

¹ Nurse refers to the following CRNBC registrants: registered nurses, nurse practitioners, licensed graduate nurses and employed student registrants.

² Client refers to individuals, families, groups, populations or entire communities who require nursing expertise.

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 (Registered) and Nurse Practitioners Regulation, registered nurses have the authority to diagnose conditions. Registered nurses on the CRNBC-certified practice roster and nurse practitioners have additional authorities to diagnose diseases and disorders.
A practice environment that has the necessary systems, supports and policies in place to enable nurses to document appropriately is fundamental to safe client care.

This practice standard sets out requirements for nurses about documenting client care on paper or electronically.

**Principles**

1. **Nurses are responsible and accountable for documenting on the health record the care they personally provide to the client.** Care provided by other staff members is best documented by those staff members, except in certain circumstances such as an emergency (e.g. a cardiac arrest).

2. **When caring for clients, nurses document using a logical process (e.g. assessment, nursing diagnosis, planning, implementation and evaluation), including information or concerns reported to another health care provider and that provider’s response.**

3. **Nurses document all relevant information about clients in chronological order on the client’s health record.** Documentation is clear, concise, factual, objective, timely and legible. Nurses clearly mark any “late entries,” recording both the date and time of the late entry and of the actual event.

4. **Nurses document at the time they provide care or as soon as possible afterward.** Delays may affect the continuity of care, affect the nurse’s ability to recall details about events and increase the possibility of errors. Nurses do not document before giving care. Nurses correct any documentation errors in a timely, honest and forthright manner.

5. **Nurses indicate their accountability and responsibility by adding their signature and title, or initials as appropriate, to each entry they make on the health record.** Nurses ensure that entries in electronic health records are made using their own unique identifier (e.g. log-in or username).

6. **Nurses carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk or have complex health problems.**

7. **When nurses provide services to groups of clients (e.g., therapy groups, public health programs), 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 on the individual client’s health record.

8. **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 health record. Nurses record facts about any safety event affecting the client on the client’s health record.

9. **Nurses who have responsibility for client records ensure that the records are retained for a minimum period of 16 years after either the date of last entry or the client’s 19th birthday, whichever is later, except as otherwise required by law.**
Applying the Principles to Practice

Familiarize yourself with agency policies on documentation and follow them, including policies on documenting verbal and telephone orders and completing safety event reports.

Document on the designated agency forms and ensure each form clearly identifies the client. Use only agency-approved abbreviations. Realize that various charting systems (e.g., flow sheets, clinical pathways) are acceptable if they enable nurses to meet this practice standard.

Review the Practice Standard *Appropriate Use of Titles* to be clear how to use your title when documenting the care or services you provide to clients.

Use client quotes to illustrate objective observations. Avoid labelling clients or drawing subjective conclusions. If you are covering for another nurse's clients, be sure to document any relevant information that arises during that period of time.

Document only the care you provide, do not allow others to document for you, and do not document care that anyone else provides. There are two exceptions: 1) in an emergency, such as a cardiac arrest when you are designated as recorder, document the care provided by other health professionals; and 2) in cases where agency policy does not allow certain staff members to document on the health record, record what client information was reported to you and by whom.

If you make a documentation error, follow agency policy to correct it, but never modify or delete information that is recorded on the health record. Do not erase or black out an error.

Do not squeeze entries between lines or leave blank lines between entries.

If extensive time has elapsed between making entries, seek guidance before adding notes.

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 it is not documented, it may lead to the conclusion that it was not done.

Document any advocacy you undertake on the client's behalf.

Understand that safety event reports are for quality improvement purposes. Keep them separate from the health record and do not make any reference to a safety event report in the client's health record.

If your agency uses an electronic health record, understand that the same documentation principles apply, although there will be different strategies to record data.

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

CRNBC's Standards of Practice (Professional Standards, Practice Standards, and Scope of Practice Standards) set out requirements for practice that registrants must meet. They are available from the Nursing Standards section of the CRNBC website, www.crnbc.ca

Appropriate Use of Titles Practice Standard (pub. 343)

Medication Administration Practice Standard (pub. 408)

Legislation Relevant to Nurses Practice booklet (pub 328)

Nursing Documentation booklet (pub. 151)

Privacy and Confidentiality Practice Standard (pub. 335)

Professional Standards for Registered Nurses and Nurse Practitioners (pub. 128)

Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions (pub. 688)

Scope of Practice for Registered Nurses: Standards, Limits and Conditions (pub. 433)

For more information on this or any other practice issue, contact CRNBC's Practice Support Services by e-mail at practice@crnbc.ca or call 604.736.7331 (ext. 332) or 1.800.565.6505.