College of Registered Nurses of Alberta

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Documentation Standards

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Purpose

The *Documentation Standards* are developed and approved as outlined in Section 133 of the *Health Professions Act* (2000). All **REGISTRANTS**[1] providing nursing care must adhere to these standards. The purpose of these standards is to outline the professional regulatory expectations for registrants in producing clear, accurate and comprehensive accounts of **CLIENT** care within any practice setting.

DOCUMENTATION is a required and essential part of care. It is an integral part of the registrant's practice; and an important tool that registrants use to ensure high-quality client care, regardless of the context of practice, or the format of documentation (paper-based or electronic). The quality of documentation reflects the standard of professional practice. All registrants must document the care they provide in accordance with the College of Registered Nurses of Alberta (CRNA) standards of practice, entry-level competencies, the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (2017), and employer requirements.

Communication

The client care record is a formal legal document that details a client's plan of care, interventions and health services provided. Quality documentation ensures effective communication between care providers to promote safety and **INFORMATIONAL CONTINUITY** within and across settings. It includes the following information:

- the client
- the care provider
- the date and time of the **ENCOUNTER**
- the identified issues being addressed
- the plan of care
- the care provided
- the clinical reasoning for the choice of care
- the client's response and/or outcome of the interventions
- any future care plans

Clear, accurate and comprehensive documentation provides a sound basis for the appropriate measurement of the quality of care, and facilitates the evaluation of the client's progress towards their outcomes and preferred goals. It also contributes to safe client care, quality practice environments, and supports a culture of safety within the health-care system.

[1] Words or phrases in **BOLD CAPITALS** upon first mention are defined in the glossary.

Accountability

Registrants are responsible and accountable for their own nursing practice, and documentation is a part of that responsibility. It serves as a record of the critical thinking and judgment used to determine the best course of action, describing events, interventions, or discussions with clients that led to the nursing action. Documentation also demonstrates how registrants uphold the CNA *Code of Ethics for Registered Nurses* (2017) with clients, by documenting the care they provide and the client's wishes.

Thorough documentation provides a record of nursing insights, reflects the quality of nursing care, and provides a record of the professional nursing care and support that registrants provide to clients and their families. As part of the permanent client care record, clear, accurate and comprehensive nursing documentation provides evidence that the registrant has met the expected requirements of documentation standards in their role in a particular practice setting.

Legal Implications

The client care record is an important legal document that provides evidence of the care provided and can be used to resolve questions or concerns regarding accountability and the provision of care. Documentation is the chronological record that will be considered evidence of the care provided and supports recollection of events. Therefore, clear, accurate and comprehensive documentation is critical, as relying on memory alone is unreliable or invalid. It is common for courts or investigators to use clinical documents to reconstruct events, establish times and dates, and resolve conflict in testimony (Canadian Nurses Protective Society, 2020).

Quality documentation provides specific information (who, what, when, where, how and why) about the care a registrant provided and a record of the client's response to that care. It assists others in confirming that the registrant's care was safe, competent and ethical, met acceptable standards, was provided in a timely manner, and was consistent with employer requirements. To determine what specific information should be included within a client care record, applicable legislation or regulation, standards of practice, and employer requirements should be consulted.

Standards for Documentation

These standards identify the minimum expectations of CRNA registrants when documenting the care or services they provide to clients. The criteria describe how registrants must meet each standard and are not listed in order of importance.

Standard 1: Accountability

Registrants demonstrate accountability for safe, competent and ethical care through documentation by ensuring their documentation of client care is accurate, timely, factual and complete.

Criteria

The registrant must

1.1 adhere to federal and provincial legislation, and standards of practice applicable to documentation relevant to their practice;

1.2 follow employer requirements regarding documentation, including interactions with other databases;

1.3 ensure all entries made in the client care record are authenticated by written signature or by their unique authentication credentials such as user name and password, and are dated and timestamped;

1.4 in a paper client care record, sign all documentation by using their first initial, full legal surname, and **PROTECTED TITLE;**

1.5 only use abbreviations that are approved through employer policy;

1.6 document

- **a)** clearly, legibly, and in English, using established terminology,
- **b)** accurately, completely, and objectively,
- **c)** only the care personally provided (unless in an **EMERGENCY SITUATION** when acting as a designated recorder),
- **d)** all relevant client information in an organized, logical, and sequential manner,
- **e)** **CONTEMPORANEOUSLY**,
- **f)** late entries at the next available opportunity, with the entry clearly identified as

such, and include any additional employer requirements. Document late entries only when able to accurately recall the event or the care provided,

g) in permanent ink when on paper records, and

h) the date and time that nursing care was provided;

1.7 when acting as a designated recorder, identify the individuals providing care and what care each individual provided;

1.8 correct their own documentation errors

a) in a paper client care record, by striking out the documentation error, adding the correct information, the date and time of the new entry, and initialing the amendment so that the author can be clearly identified, and

b) in an electronic client care record, by entering the correct information, the date and time of the new entry, so that the author can be clearly identified;

1.9 when clarifying information after the fact in the client care record, clearly identify the person making the alteration and the date and time following employer requirements. The original entry must be included in the client care record; and

1.10 never delete or modify anyone else's documentation.

Standard 2: Communication and Safe Provision of Care

Registrants document the nursing care they provide ensuring it is a complete, accurate, objective, and person-centred representation of the client's needs and perspectives, the registrant's interventions, and the client's care outcomes.

Criteria

The registrant must

2.1 record a complete account of their nursing care and decision-making processes of the client's needs and perspectives, including

a) identified issues and concerns,

b) assessment findings,

c) diagnosis,

d) plan of care,

e) intervention(s) provided, and

f) evaluation of the client care outcomes;

2.2 document the following aspects of care:

a) relevant objective information related to client care

b) follow-up of client assessments, observations, or interventions completed

c) meet the expectations for medication management and documentation as outlined in the *Medication Management Standards*(2022a)

d) formal and informal educational/teaching activity provided to the client and family

e) any **ADVERSE EVENT** or **ADVERSE OUTCOME**

f) communication with other care providers, including name, protected title (if applicable) and outcomes of discussion

g) communication with clients following discharge from care according to employer requirements

h) the client's response and outcomes to the care and interventions provided

Standard 3: Security

Registrants protect the client's health information by maintaining privacy and confidentiality, and act in accordance with relevant legislation, regulations, standards of practice and employer requirements.

Criteria

The registrant must

3.1 adhere to all relevant privacy legislation, the *Privacy and Management of Health Information Standards* (CRNA, 2022b), and employer requirements;

3.2 obtain valid **CONSENT** from the client to disclose information to others outside the **CIRCLE OF CARE**, following relevant legislation and employer requirements, including

a) taking reasonable steps to maintain the security and confidentiality of health information that is transferred or disclosed;

3.3 when documenting in an electronic client care record

a) use only their own assigned accounts to access and enter information into a client care record, and

b) take reasonable steps to maintain the security of their authentication credentials for information systems, such as user name and password, and use reasonable safeguards as outlined in relevant legislation and employer requirements.

Glossary

Adverse event – An event that results in unintended harm to the client, and are related to the care and/or services provided to the client, rather than the client's underlying medical condition (Canadian Patient Safety Institute, n.d.).

Adverse outcome – Refers to a deterioration of the client's condition that is unexpected, based on the plan of care.

Circle of care – The group of care providers treating a client who need information to provide that care. If the client's identified circle of care is outside of the traditional medical care (physicians, nurses, supportive care), consent to share relevant client information may have to be obtained (Alberta Health Services, 2020).

Client – The term client(s) can refer to patients, residents, families, groups, communities and populations.

Consent – Agreement by an individual to the disclosure of their health information. To be valid, consent "(1) must be provided in writing or electronically and must include:

a) an authorization for the custodian to disclose the health information specified in the consent,

b) the purpose for which the health information may be disclosed,

c) the identity of the person to whom the health information may be disclosed,

d) an acknowledgement that the individual providing the consent has been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent,

e) the date the consent is effective and the date, if any, on which the consent expires, and

f) a statement that the consent may be revoked at any time by the individual providing it."

(Health Information Act, 2000, s 34)

Contemporaneously – The completion of the client care record notes at the time of the event or as close to it as prudently possible. This enhances the credibility and accuracy of client care records.

Documentation – Any written or electronically generated information about a client that describes client status, or the care or services provided to that client.

Emergency situation – Sudden onset of severe or urgent symptoms that require immediate attention, such that a delay in treatment would place an individual at risk of serious harm.

Encounter – A client's interaction with the health system and the nurse, related to a particular occurrence.

Informational continuity – The transfer of relevant client information between multiple care providers and locations. Includes accumulated knowledge about the client's preferences, values and context (Alberta Health Services , 2020).

Protected title – The titles, abbreviations and initials used by registrants of the CRNA according to the *Registered Nurses Profession Regulation* (Alta Reg 232/2005).

Registrant(s) – Includes registered nurses (RNs), graduate nurses, certified graduate nurses, nurse practitioners (NPs), graduate nurse practitioners, and RN or NP courtesy registrants on the CRNA registry.

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