# Documentation: Standards for Registered Nurses and Nurse Practitioners

***(Not in effect until approved)***

# Purpose

This standard applies to registered nurses (RNs) and nurse practitioners (NPs), herein referred to as **REGISTRANTS**[1]. This document outlines the professional regulatory expectations for registrants in producing clear, accurate and comprehensive accounts of **PATIENT** care within any practice setting.

Registrants must meet all the criteria in this standard to ensure accurate and timely documentation in patient records, accountability, effective communication and security of patient information.

## Criteria

The registrant must

**1.** Adhere to federal and provincial legislation, code of ethics and standards of practice regarding documentation.

**2.** Be aware that documentation acts as legal proof of health services or professional services provided.

**3.** Ensure all entries made in the patient record are authenticated by

**3.1.** written signature signed using legal name and protected title, or

**3.2.** unique authentication credentials such as username and password, and

**3.3.** are dated and timestamped.

**4.** If using abbreviations, acronyms and symbols, use an approved list.

**5.** Ensure documentation

1 Words and phrases displayed in BOLD CAPITALS upon first mention are defined in the Glossary

**5.1.** is clear, legible, and in English, using established terminology,

**5.2.** is accurate, complete, and objective,

**5.3.** includes only the care personally provided (unless in an emergency when acting as a designated recorder),

**5.4.** includes relevant patient information presented in an organized, logical, and sequential manner,

**5.5.** is documented **CONTEMPORANEOUSLY**, or

**a.** if a late entry, documented at the next available opportunity, with the entry clearly identified as such.

**6.** When acting as a designated recorder, identify the individuals providing care and the care each individual provided.

**7.** Never delete or modify existing documentation in the patient record.

**8.** For documentation that requires correction

**8.1.** if electronic record, follow procedures for correcting entries,

**8.2.** if written documentation, draw a line through the incorrect entry and write 'error' above it, sign and date it, then create a new entry with the correct documentation.

**9.** Record a complete account of all health or professional services provided, including but not limited to

**9.1.** initiation and maintenance of the patient profile that includes medication reconciliation, allergies, past medical history, social history,

**9.2.** identified issues and concerns,

**9.3.** assessment findings and clinical diagnosis (for NPs) or nursing diagnosis (for RNs),

**9.4.** outcomes and intervention(s) evaluation and **ADVERSE EVENT(S)**,

**9.5.** follow-up care and referral,

**9.6.** education provided and patient understanding,

**9.7.** communication with all members of the patient care team, including family and legal guardians,

**9.8.** appointment information such as,

**a.** appointment date and time,

**b.** missed/cancelled appointments,

**c.** plan of care,

**d.** diagnostic tests order and indications,

**e.** specialist referrals made and status of referral, and

**f.** interventions provided.

**10.** Adhere to privacy legislation and standards when maintaining privacy and confidentiality of the patient record.

**11.** Obtain consent from the patient and document prior to disclosing information to others outside the circle of care as outlined in legislation.

**12.** Utilize reasonable safeguards such as implementing security of authentication credentials in electronic records to ensure confidentiality and security of the patient's health information.

## Glossary

**ADVERSE EVENT(S)** – An event that results in unintended harm to the patient, and are related to the care and/or services provided to the patient, rather than the patient's underlying medical condition.

**CONTEMPORANEOUSLY** – The completion of the patient record notes at the time of the event or as close to it as prudently possible.

**PATIENT(S)** – The term patients can refer to clients, residents, families, groups, communities and populations.

**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.