

Documentation Guidelines

for Registered Nurses



College of Registered Nurses of Nova Scotia

Documentation Guidelines for Registered Nurses

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Introduction

Nursing documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic. This document is intended to provide registered nurses (RNs) with guidelines for professional accountability in documentation and to describe the expectations for nursing documentation in all practice settings, regardless of the method or storage of that documentation. The intention of the document is to assist the registered nurse to meet their standards of practice related to documentation.

Registered nurses in Nova Scotia are legally and ethically required to practise nursing in accordance with the *Registered Nurses Act (2006)* and *Regulations (2006)*, the *College's Standards of Practice for Registered Nurses (2012)*, *Entry-level Competencies (2009)* and the *Code of Ethics for Registered Nurses (CNA, 2008)*. According to the Standards¹, **each registered nurse is expected to complete written and/or electronic documentation in a manner that is clear, timely, accurate, comprehensive, legible, chronological, and is reflective of relevant observations.**

Although different documentation systems and technology may be used throughout the province, quality nursing documentation is expected in every area of care or service delivery and in every setting. Nurses must be familiar with, and follow, agencies' documentation policies, standards and protocols. It is recommended that the *College's Documentation Guidelines for Registered Nurses* serve as a basis for the development of agencies' policies on nursing documentation. If there are no agency policies in place related to documentation, it is the professional nurse's responsibility to advocate for the creation of policy to support nursing practice. If despite advocating for the creation of policies, there are still no documentation policies in place, professional nurses need to use their *Standards of Practice*, these guidelines and professional judgment to guide practice.

Definition

Documentation is anything written or electronically generated that describes the status of a client or the care or services given to that client (Perry, A.G., Potter, P.A., 2010). Nursing documentation refers to written or electronically generated client information obtained through the nursing process (ARNNL, 2010). Documentation is an integral part of nursing practice and professional patient care rather than something that takes away from patient care. **Documentation is not optional.**

Professional Principles of Documentation

Nursing documentation must provide an accurate and honest account of what and when events occurred, as well as identify who provided the care. Good documentation has six important characteristics. It should be:

- factual
- accurate
- complete
- current (timely)
- organized
- compliant with standards (Potter & Perry, 2010 p212).

These core principles of nursing documentation apply to **every** type of documentation in **every** practice setting.

¹ 2012 Standards of Practice for Registered Nurses Standard 2 Knowledge Based Practice and Competence Indicator 2.6

Confidentiality

Clients have a right to protection of their privacy with respect to the access, storage, retrieval and transmittal of their records and to receive a copy of their health records for a reasonable fee. The rights of clients and obligations of public agencies are outlined in *Freedom of Information and Protection of Privacy Act* (FOIPOP) and the *Personal Health Information Act* and often are summarized in agency policies.

Technology does not change client's rights to privacy of health information. Whether documentation is paper-based, electronic or in any other format, maintaining confidentiality of all information in a health record is essential, and relates to access, storage, retrieval and transmission of a client's information.

Healthcare professionals should view security of client documentation as a serious issue. Failure to comply with keeping records as required, falsifying or furnishing false information and providing information about a client without consent of the client or agency administration can constitute professional misconduct under the *Registered Nurses Act* (2006).

Documentation, in any format, should be maintained in areas where the information cannot be easily read by casual observers. Although nurses often share client information with the healthcare team, it is important that clients understand that sharing confidential information with team members occurs only in an effort to ensure the provision of quality care.

When health records are maintained in a client's home, there is the potential for family members and/or others (e.g., visitors, guests) to access confidential information. It is important that agencies/facilities have policies in place outlining who should be able to access the health records and how clients and/or family members will be made aware of the importance of maintaining confidentiality.

Why should RN's document?

Clear, complete and accurate health records serve many purposes for clients, families, registered nurses and other care providers. Data from documentation allows for:

Communication and Continuity of Care

- Clear, complete and accurate documentation in a health record ensures that all those involved in a client's care, including the client, have access to information upon which to plan and evaluate their interventions.
- A good test to evaluate whether your documentation is satisfactory is to ask the following question: "If another RN had to step in and take over this assignment, does the record provide sufficient information for the seamless delivery of safe, competent and ethical care?" (CARNA, 2006).
- All members of the health care team require accurate information about clients to ensure the development of an organized comprehensive care plan. The risk of inaccurate or incomplete documentation is: care that is fragmented, tasks that are repeated and therapies which could be delayed or omitted (Perry & Potter, 2012, p209).

Quality Improvement/Assurance and Risk Management

- Clear, complete and accurate nursing documentation facilitates quality improvement initiatives and risk management analysis for clients, staff and organizations.
- Through chart audits and performance reviews documentation is used to evaluate quality of services and appropriateness of care.

Establishes Professional Accountability

- Documentation is a valuable method of demonstrating that nursing knowledge, judgment and skills have been applied within a nurse-client relationship in accordance with the Standards of Practice for Registered Nurses.
- Registered nurses are expected to follow the *Standards of Practice for Registered Nurses (2011)* and *Code of Ethics for Registered Nurses (2008)* when documenting information related to the health status of clients, related situations/circumstances, and care provided.
- Standard 2, Knowledge-Based Practice and Competence, in particular, Indicator 2.6, speaks to the registered nurse's professional accountability related to documentation practices.

Legal Reasons

- The client's record is a legal document and can be used as evidence in a court of law or in a professional conduct proceeding.
- Documentation should provide a chronological record of events in client care and delivery of services.
- Courts may use the health record to reconstruct events, establish time and dates, refresh one's memory and to substantiate and/or resolve conflicts in testimony (CNPS, 2009).

Funding and Resource Management

- Documentation can be used by administrators to support funding and resource management.
- Through chart audits and performance reviews documentation is used to identify the type and amount of services required and provided as well as the efficiency and effectiveness of those services.
- Workload measurements and/or client classification systems, derived as a consequence of client documentation, are used by some agencies to help determine the allocation of staff and/or funding.

Expanding the Science of Nursing

- Health records serve as a valuable and major source of data for nursing and health related research.
- Data obtained from health records is also used in health research to assess nursing interventions, evaluate client outcomes, and determine the efficiency and effectiveness of care. The type of research made possible through the information in health records can enable nurses to further improve nursing practice.

Who should document?

First hand knowledge only

Legislation and *Standards of Practice* of the profession require nurses to document the care they provide demonstrating accountability for their actions and decisions. First hand knowledge means the professional who is doing the recording is the same individual who provided the care. In situations where two or more people provide care or services, the RN who has the primary assignment is expected to document the assessment, interventions and client response, noting as necessary the role of other care providers. However, the second provider is expected to review the documentation and make an additional entry if necessary.

If the client is receiving services from two or more different agencies or departments that have separate records (i.e., Health and Justice) it is important that the RN record the care s/he provided in all relevant documents. Agency policy must clearly articulate where documentation is to occur on the health record to ensure consistency.

There may be times when it is not possible to record first hand so the information must be recorded by a third party. If the information is recorded as reported from another source the RN must use quotation marks to identify that source. It may also be necessary to record why third party documentation occurred. Even when third party documentation occurs it may be necessary for the registered nurse to document her/his nursing care of the patient.

Self-employed nurses must adopt a documentation system and develop appropriate policies, including those related to the storage, retrieval and retention of health records.

The College's Guide for Self-Employed Practice provides direction on the documentation requirements for self-employed nurses and is available by contacting the College or visiting the College website at www.crns.ca/SelfEmployed

The following are situations in which third party recording or additional documentation may occur:

Auxiliary Staff

Agencies need to ensure that all care providers demonstrate necessary competence with regard to documentation. To ensure accuracy of information, auxiliary staff should document the care they provide and observations they make. In some agencies, unregulated care providers (UCP) are permitted to document care in the permanent health record (electronically and paper-based). In other agencies, however, UCP's may have access only to notes not contained on the permanent client health record. Agency policies need to indicate who may document in client health records and what practice is to be followed. Although not recommended, if an agency's policy specifies that auxiliary staff are not to record information, registered nurses should document the reports given to them by auxiliary personnel, including the individual's name and status. If possible, auxiliary staff should read and initial (if using a paper-based system) documentation related to care they provided.

Designated Recorder

In situations where it is not practical for safety reasons for the professional implementing the care to document, it is acceptable practice to have a designated recorder. An example may be during procedural events in areas such as the emergency department, operating room or the delivery room where the nurse providing care cannot physically document because of sterility and/or because safety of the client could be

compromised if the nurse was to leave the patient to document. Another example is a Code Blue situation where the health professionals providing the care have limited time to document. Organizational policy should support the practice of designated recorders in these situations.

Client or Family

In some settings it may be acceptable practice that a client, family member and/or sitter to document observations and care. Some examples include a mother documenting newborn intake and output or a client performing peritoneal dialysis documenting information about exchanges in their home chart. Agency policy should outline what should be documented and by whom, as well as the responsibilities of nurses with respect to the documentation.

Students

Students are learners and not employees. All students are expected to document the care they provide in accordance with agency and academic policies. Co-signing notes written by students is not acceptable and may add a level of accountability which the RN would not otherwise incur (SRNA, 2011). It may be necessary for the RN preceptor to document their own assessment, interventions and evaluations. The need for this extra level of documentation must be based within agency policy and upon professional judgment. For example, if a client developed an acute or complex problem the RN preceptor should document her/his assessment and response to the problem in addition to the student's documentation (SRNA, 2011).

Co-signing and Countersigning Entries

Co-signing refers to a second or confirming signature on a witnessed event or activity (ARNNL, 2010). Co-signing entries made by other care providers is not a standard of practice and, when poorly defined, can blur accountability (CNO, 2003, p10). If two nurses are involved in an assessment or the delivery of care, both nurses should document, according to agency policy. Agency policies should clearly describe how documentation should be completed when two nurses are required to be involved in an aspect of care. For example, if two registered nurses are required to hang a unit of packed-cells, and both must sign the health record, the intent of a co-signature should be clearly stated in policy. In this case, agency policy would likely indicate that the co-signature is confirmation that the nurse (co-signee) witnessed that the correct unit was given to the correct client. Co-signing implies shared accountability. **It is imperative that the person co-signing actually witnessed or participated in the event** (SRNA, 2011).

Countersigning is defined as a second or confirming signature on a previously signed document, a blind signature – which is not witnessed (SRNA, 2011). This is not best practice and is generally not supported, but may be effectively utilized as a quality control process. For example, an RN reviews a chart to determine if all the orders are accurately transcribed or all required interventions are completed. Agency policy and procedure should be in place to support this practice. Countersigning does not imply that the second person provided the service but it does imply that the person approved or verified that the service or record was completed.

What should RN's document?

All Aspects of the Nursing Process

Documentation which reflects the nursing process demonstrates that an RN has fulfilled her/his duty of care. It also demonstrates the unique contribution of nursing to the care of clients. Nurses should record data collected through all aspects of the nursing process. As a general rule, any information that is clinically significant should be documented.

To determine what is essential to document, for each episode of care or service the health record should contain:

- a clear, concise statement of client status (including: physical, psychological, spiritual)
- relevant assessment data (include client/family comments as appropriate)
- all ongoing monitoring and communications
- the care/service provided (all interventions, including advocacy, counseling, consultation and teaching)
- an evaluation of outcomes, including the client's response and plans for follow up
- discharge planning.

Failure to document evaluation is a common deficiency in charting. **It is imperative to demonstrate the effectiveness of care/services.** An RN should document answers to the following questions as appropriate: What were the client outcomes? What additional nursing actions were implemented as consequence of client outcomes? For example, did the vital signs stabilize? Did the pain subside? If not, what was the action?

Plan of Care

Effective client-focused documentation should also include a plan of care. A plan of care is a written outline of care for individual clients and is part of the permanent record. The plan of care must be clear to everyone reading the chart. Effective plans of care must be up-to-date and useful to meet the needs and wishes of individual clients. If a standardized plan of care format (e.g., care maps, clinical pathways) is not used, the nurse should ensure that her/his notes identify a plan of care for each assigned client.

Admission, Transfer, Transport and Discharge Information

Accurate and concise documentation on admission, transfer, transport and discharge provides baseline data for subsequent care and follow up. Agency policy should identify expectations on recording communication between practitioners when client's care is transferred. Nursing documentation should reflect information on the client's status at discharge, any instructions provided (verbal and written), arrangements for follow-up care and evidence of the clients understanding, and family involvement as appropriate.

Client Education

RN's provide a wide range of client education on a daily basis. Accurate documentation of this education is essential to enable communication and continuity of what has been taught. Lack of documentation about client education diminishes this important aspect of care. The following aspects of client education should be documented in the health record:

- both formal (planned) and informal (unplanned) teaching
- materials used to educate
- method of teaching (written, visual, verbal, auditory and instructional aids)
- involvement of patient and/or family
- evaluation of teaching objectives with validation of client comprehension and learning
- any follow up required.

Risk Taking Behaviours

RN's are held accountable to the *Code of Ethics For Registered Nurses* (2008) in which the nurse has an ethical responsibility to respect a client's informed choice which includes choices related to lifestyle and treatment, which may be risky to their overall health (ARNNL, 2010). The nurse must document the objective data related to the risk taking behaviors and should be cautious as to not place a value judgment on the behaviors. The nurse should also document her/his response to the risk taking behavior and any education they provide related to the potential consequences of the behavior. It is not acceptable to document the patient as "non-compliant". Instead, the nurse should document the objective data that describe this behavior. If the risk taking behavior results in a situation in which mandatory reporting must occur, such as child abuse, the RN is required to follow the legislation and document appropriately. Examples of risk taking behaviors include (ARNNL, 2010):

- eating foods identified as a dietary restriction
- threatening self-harm
- ambulating when bed rest is advised
- missing follow-up appointments
- leaving against medical advice
- refusing or abusing medications and/or illicit drugs
- tampering with medical equipment.

Incident Reports

An incident is an event which is not consistent with the routine operations of the unit or of client care (Perry and Potter, 2010). Examples of incidents include patient falls, medication errors, needle stick injuries, or any circumstances that places clients or staff at risk of injury. Incidents are generally recorded in two places, in the client's medical record and in an incident report, which is separate from the chart.

Documentation in the chart is used to ensure continuity in client care and should be accurate, concise, factual, unbiased and recorded by the person who witnessed the event. The nurse should avoid using the words "error", "incident" or "accident" in the documentation. It is recommended the nurse first document an incident in the health record to ensure continuity and completeness, and then complete an incident report in accordance with facility policies and procedures (Grant & Ashman, 1997).

Incident reports (also called occurrence reports) are separate from the patient record and are used by organizations for risk management, to track trends in systems and client care and to justify changes to policy, procedure and/or equipment. Information included in an occurrence/incident report is similar to the information included in a client's health record, however, the incident/occurrence report would also include additional information with respect to the particular incident (e.g., "a door was broken" or "this was the fourth such occurrence this week"). Information recorded is not directly related to the care of the client. Agency policy should clearly describe processes necessary to complete an incident/occurrence report

The purpose of a health record and occurrence/incident report differs. Therefore, for the sake of clarification, the nurse should avoid documenting "refer to incident report" in a client's health record.

Medication Administration

Agencies should have specific policies and procedures related to documentation of medication administration. The general requirements for this type of documentation include:

- Date
- Actual time medications are administered
- Names of medications
- Routes of medications
- Sites of administration when appropriate
- Dosage administered
- Nurses signature/designation

For more information about Medication Administration see the College's *Medication Guidelines for Registered Nurses* (www.crnns.ca/documents/MedicatonGuidelines2011.pdf)

If signatures are used, a master list matching the caregiver's initials with a signature and designation is to be maintained in the health record. Each healthcare provider (e.g., respiratory therapists, physiotherapists) should sign for the medications they administer, except in emergency situations. In emergency situations, registered nurses may sign for medications administered by other healthcare providers as long as this is supported by agency policy (see Co-Signing, p8).

As part of the nursing process it is important that pre-administration assessment data and post-administration evaluation data should be documented as warranted by the classification of medication or a client's physical/mental condition.

Verbal Orders and Telephone Orders

The expectation is that authorized prescribers will write medication orders whenever possible. However, registered nurses can accept verbal medication orders from authorized prescribers (either face-to-face or by telephone) when it is in the best interest of a client and there are no reasonable alternatives. Situations in which verbal orders would be considered acceptable include:

- urgent or emergency situations when it is impractical for a prescriber to interrupt client care and write the medication order
- when a prescriber is not present and direction is urgently required by a registered nurse to provide appropriate client care.

Authorized prescribers should review and countersign verbal orders as soon as reasonably possible or within the timeframe indicated in an agency's policy. To ensure that a verbal or telephone medication order is complete, registered nurses should check for the following:

Guidelines for Taking/Recording Telephone Orders

- Write down the time and date on the physicians' order sheet.
- Write down the order exactly as given by the physician.
- Read the order back to the physician to ensure it is accurately recorded.
- Record the physician's name on the order sheet, state "telephone order", print your name and sign the entry, along with your designation (e.g., "RN").

- client's name
- medication name
- dosage form (e.g., tablet, inhalant)
- route of administration
- exact strength of concentration
- dose (in unit of measurement)
- frequency of administration
- quantity and duration
- purpose or indication for the medication (i.e., appropriate for client's treatment plan)
- prescriber's name and designation.

When prescribers transmit medication orders via the telephone they generally do not have the benefit of conducting direct assessments of clients' conditions and, therefore, base their decisions solely on a registered nurse's assessment of the clients receiving the medications.

Comprehensive documentation of RNs' assessments can reduce the likelihood of errors, however, errors can still occur as a result of poor communications or inaccurate transcriptions. Since negative client outcomes can result from these types of errors, telephone orders, and verbal orders are actually discouraged.

Collaboration with other Health Care Professionals

There is a current trend toward interdisciplinary practice which is supported through the Model of Care Initiative in Nova Scotia (MOCINS). Creating interdisciplinary communication and documentation is crucial in developing a strong interdisciplinary practice (Harper, 2007). This way of documenting is intended to eliminate duplication, enhance efficient use of time and enrich client outcomes through team collaboration. Collaborative documentation enables healthcare professionals of all disciplines to share the same documentation tools. Examples of such tools are clinical pathways which reflect interdisciplinary care and integrated, interdisciplinary patient progress notes.

Registered nurses need to ensure their documentation within an interdisciplinary tool accurately reflects their unique contribution of nursing to the care of clients. Nurses should not simply "sign off" the flow sheet or care map if they have not contributed to the client's care. Signing off the chart implies you have provided care that is documented and you will be held accountable for the care that was provided.

When nurses collaborate with members of the interdisciplinary team and develop and/or modify the plan of care based on the collaboration, they should document the following:

- date and time of the contact
- name(s) of the people involved in the collaboration
- information provided to or by healthcare providers
- responses from healthcare providers
- orders/interventions resulting from the collaboration
- the agreed upon plan of action
- anticipated outcomes.

For example, if a nurse seeks clarification from a physiotherapist related to mobilization of a patient the nurse should record the reason for seeking clarification, the name of the healthcare provider providing the clarification, the action s/he took as the RN, and the expected outcome.

Date, Time, Signature and Designation

Documentation in the health record usually begins with date and time and ends with the recorder's signature and designation. Signatures and initials need to be identifiable and follow specific agency policy. Personal initials can only be used if a master list matching the caregiver's initials with a signature and designation is maintained in the health record.

Agency policy needs to support the method in which date and time is documented. For example, is a 24-hour or 12-hour clock used and what consistent written format does the date follow? A consistent timepiece should be used to record time (e.g., cardiac monitor). If you are unable to use this timepiece your documentation should reflect what you are using to record time.

How Should RN's document?

Clear, Concise, Unbiased and Accurate

Objectivity vs Subjectivity

Objectivity means expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam-Webster Online, 2012). Objective data is observed (e.g., crying, swelling, bleeding) or measured (e.g., temperature, blood pressure) and includes interventions, actions or procedures as well as a client's response.

Subjectivity is characteristic of or belonging to reality as perceived rather than as independent of mind (Merriam-Webster Online, 2012). Subjective data may include statements or feedback from a client as well as from family members or a friend.

Documentation should include objective statements related to the nursing process. At times it may be necessary to include subjective statements in the documentation to enhance the understanding of the client's care. When documenting subjective information provide accurate examples of what was said using quotes appropriately along with identification of the individual who made a particular statement. For example, client states, "I am pain-free today" or "I understood the information provided".

Avoid generalizations

Avoid generalizations and vague phrases or expressions such as "*status unchanged*", "*assessment done*", "*had a good day*", "*slept well*", "*up and about*". Such vague statements are conclusions without supported facts. Be specific and use complete, precise descriptions of care. The use of words such as "*appears*", "*seems*", or "*apparently*" is not acceptable when used without supporting factual information because they suggest that a nurse did not know the facts and demonstrates uncertainty. An exception may be when the supposed fact cannot be verified. For example, "appears to be sleeping", may be appropriate as the only means of verification would be to wake the client and ask if s/he was actually asleep.

Avoid bias and labels

Do not document value judgments or unfounded conclusions; document only conclusions that can be supported by data. It is not acceptable for RNs to make value judgments or culturally insensitive comments. These comments might suggest or imply a dislike for a client, which could be interpreted to mean that the care provided was substandard (ARNNL, 2010). Select neutral terminology or describe observed behaviors. For example, rather than stating that the "client was drunk" it would be correct to state, "noted an odor of alcohol

and speech was slurred". Instead of noting, "client is aggressive" it would be correct to state, "client has been shouting and using obscene language". Write each entry with the knowledge that the client has a right to read their own chart and keep in mind you should only document what can be verified (ARNNL, 2010).

Legibility and Spelling

Correct spelling and legibility of nursing documentation demonstrates a level of competency and attention to detail. Misspelled words and or illegible entries can result in misinterpretation of information and could result in client harm. Some spelling errors can result in serious treatment errors. For example, the names of certain medications, such as *digitoxin* and *digoxin* or *morphine* and *hydromorphone*, are similar and must be transcribed carefully to ensure that the client receives the right medication (Perry and Potter, 2010).

All entries in a paper-based system should be written legibly using black ink, or in accordance with agency policy. The use of black ink is best for optical scanning technology, which is used in many clinical areas across Nova Scotia. Never use pencil, gel pens, or colored highlighters as they are not permanent, can be erased or changed and do not photocopy or scan readily for storage purposes. Also, do not use colored paper as information recorded may not be legible when scanned or photocopied.

Try not to change pens while writing an entry of an event as this may give the impression that the entry was not completed in its entirety at one time. If you must change pens, document the reason why.

Blank (White) Space

There should be no blank or white space in paper-based documents as this presents an opportunity for others to add information unbeknownst to the original author. Agency policy should support nursing documentation that does not allow white space to occur. An accepted practice is to draw a single line completely through the white space, including before and after your signature. Fill in all blocks or spaces on flow sheets with the agency policy approved symbol/comment (e.g. check mark, initials, n/a or X mark). The use of ditto (") marks to indicate repetition of information is unsafe and inappropriate and leaves excess white space (ARNNL, 2010),

Abbreviation, Symbols and Acronyms

The use of abbreviations, symbols or acronyms can be an efficient form of documentation if their meaning is well understood by everyone. Abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors, cause confusion and waste time. Use only those abbreviations, symbols and acronyms that are on a current agency-approved list or an agency approved reference text. Many agencies today are referring to the list of unsafe abbreviations developed by the Institute of Safe Medication Practice (<http://www.ismp.org/tools/errorproneabbreviations.pdf>) in their policy on abbreviation, symbols and acronyms.

If there is neither an agency-approved list nor an approved reference text, widely understood abbreviations may be used in a single health record entry when the meaning is spelled out immediately after the abbreviation's first appearance in that entry. For example, a legend on a flow sheet depicting "P" as "poorly", "R" as "restless", and "S" as "sound".

Mistaken Entry/Errors and Changes/Additions

Inaccuracies in documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to agency policy. The content in question must remain clearly visible or retrievable so that the purpose and content of the correction is clearly understood. If an error occurs in paper-based documentation, do not make entries between lines, do not remove anything (e.g., monitor strips, lab reports, requisitions, checklists), and do not erase or use correction products, stickers or felt pens to hide or obliterate an error. Also, under no circumstance should chart pages or entries be re-copied because of a documentation error. If information is difficult to read, add pertinent information in a 'note to chart' or 'note to file'.

Agency policy should guide nurses to the accepted means of correcting errors. A generally accepted practice to correct an error in a paper-based system is to cross through the word(s) with a single line, above the line write "mistaken entry" and insert your initials, along with the date and time the correction was made and enter the correct information.

To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove pages. A client alternate decision maker, or another care provider, may request changes or additions to documentation. When the nurse who completed the original documentation is informed of such a request s/he should refer to agency policy.

Failing to correct an error appropriately (according to agency policy) or correcting or modifying another's documentation may be interpreted as falsification of a record. Falsifying records is considered professional misconduct according to the definition under Section 2(as)(ix) of the *Registered Nurses Act (2006)*

Client Care Provided Through Electronic Means

Today in Nova Scotia, many agencies have moved towards electronic means of providing many aspects of care. From entering requests for tests and consultations to reporting of diagnostics testing, to the documentation of care provided, electronic documentation is part of the everyday care of clients.

"Online nursing documentation is defined as a technology that automates the capture of clinical care data. This can include assessment data, clinical findings, nursing plans of care, nursing interventions (along with results), patient progress toward goals, critical pathways, medication administration, risk assessments, discharge planning, patient education and more" (Kirkley & Renwick, 2003, p647). Electronic documentation of care can also include, but is not limited to, faxes, e-mail and/or telenursing.

There are many benefits to electronic documentation such as:

- Time efficient for detailed assessments
- Standardization of assessments and care plans with the ability to customize as required
- Large amounts of data can be stored in a small space
- Information can be automatically transferred or "populated" to other areas of the chart
- Increased security such as password protected access to client charts.

Telenursing

Another document published by the College of Registered Nurses of Nova Scotia (the College), entitled **Telenursing Practice Guidelines (2008)**, provides additional information on documentation related to nursing services provided via electronic means (e.g., telephone-based client consultations, telehealth).

As in paper-based documentation systems, the reliability and trustworthiness of an electronic system is essential and the principles of good documentation must be maintained. While the basic principles of documentation used in paper-based systems would also apply in the case of electronic-based systems (e.g., computers, telephones, voice recording machines, videos) these new methods of recording, delivering and receiving client data are posing new and constant challenges for agencies and nurses - both in terms of confidentiality and security and in ensuring continuing education for healthcare providers.

Agencies must have clear policies and guidelines to address these challenges and other issues related to technologies in documentation and registered nurses must advocate for agency policies/guidelines that reflect and support quality, evidence-based practice. Agency policies related to electronic documentation should clearly indicate how to:

- correct documentation errors and/or make 'late entries'
- prevent the deletion of information
- identify changes and updates in a health record
- protect the confidentiality of client information
- maintain the security of a system (e.g., regularly changing passwords, issuing access cards, virus protection, encryption, well maintained firewalls)
- track unauthorized access to client information
- use a mixture of electronic and paper-based methods, as appropriate (policy should ensure continuity of care is maintained)
- back-up client information
- document in the event of a system failure
- obtain access to a specific group or area of information.

All entries made and/or stored electronically are considered a permanent part of a health record and may not be deleted (e.g., e-mail and fax messages, including fax cover sheets; telehealth encounters). Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

Faxing

Facsimile (fax) transmission of client information between healthcare providers is convenient and efficient. In spite of this there is significant risk to the confidentiality and security of information transmitted via fax due to the possibility of transmitting to unintended recipients. Agency policy should guide nurses in the acceptance and transmission of faxes for the purposes of client care.

The confidentiality and security of transmitting client information via facsimile can be enhanced when nurses:

- verify fax numbers and fax distribution lists stored in machine of sender prior to dialing
- carefully check activity reports to confirm successful transmissions
- note, on cover sheet, that the information being transmitted is confidential, and request verification that a misdirected fax has been immediately destroyed without being read
- make a reasonable effort to ensure that the fax will be retrieved immediately by the intended recipient or will be stored in a secure area until collected
- verify that information received is legible and complete (CRNBC, 2007).

Email

The use of electronic mail (e-mail) transmission by healthcare organizations and healthcare professionals is becoming more widespread because of its speed, reliability, convenience and low cost. However, like faxes,

there is significant risk to the security and confidentiality of e-mail messaging. Messages can inadvertently be read by an unintended recipient and while the message can be erased from the local computer, they are never deleted from the central server and could be retrieved by unauthorized personnel. It is not recommended as a method for transmitting clients' health information.

In instances where an e-mail message is considered to be the preferred option to meet client needs, there must be a reasonable belief that the transmission is secure (e.g., use of encryption software, user verification, secure point-to-point connections). Agencies should also develop specific policies for transmitting client information via e-mail to cover items such as the use of specific forms for e-mail purposes, the procedure to obtain consent to use e-mail, and the use of initials, names, and hospital/ agency numbers.

When should RN's document?

Timely, Chronologically and Frequently

Contemporaneous documentation, defined as the completion of documentation as close as possible to the time of care, enhances credibility and accuracy of health care records (CARNA, 2006). Documentation should never be completed before it actually takes place.

Documenting events in the chronological order in which they took place is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications enabling healthcare providers to understand what care was provided, based on what assessment data, and then any outcomes or evaluations of that care (including client responses).

The frequency and amount of detail required in documentation is, generally, dictated by a number of factors, including:

- facility/agency policies and procedures
- complexity of a client's health problems
- degree to which a patient's condition puts him/her at risk
- degree of risk involved in a treatment or component of care.

While agency policies on documentation should be followed to maintain a reasonable and prudent standard of documentation, nursing recording should be more comprehensive, in-depth and frequent if a patient is very ill, very unpredictable or exposed to high risk (Canadian Nurses Protective Society, 2007, p.2).

The following table demonstrates how as clients change the frequency of documentation should also change:

	Low	Medium	High
Acuity	→		
Complexity	→		
Variability	→		
Frequency of Documentation	→		

(CRNBC, 2007)

Late, Delayed or Lost entries

As stated, documentation should occur as soon as possible after an event has occurred. When it is not possible to document at the time of or immediately following an event, or if extensive time has elapsed a late entry is required. Late entries should be defined by agency policy. Late entries or corrections incorporating omitted information in a health record should be made, on a voluntary basis, only when a nurse can accurately recall the event or care provided. Late entries must be clearly identified (e.g., "Addendum to Care"), and should be individually dated. They should reference the actual time recorded as well as the time when the care/event occurred and must be signed by the nurse involved.

A delayed entry may occur when two nurses enter data on the same patient. Delayed entries must be entered on a chart on the same shift that the care was provided and/or the event occurred, even if the information is not entered in chronological order. Delayed entries should be made according to agency policy.

In the event of a lost entry, the RN may be asked to re-construct the entry. Falsifying records is considered professional misconduct according to the definition under Section 2(as)(ix) of the *Registered Nurses Act (2006)* so the nurse must clearly indicate the information recorded as a replacement for a lost entry. Lost entries should be made according to agency policy. If the care/event cannot be recalled, the new entry should state that the information for the specific time of the event has been lost.

Conclusion

Quality documentation is an integral part of professional RN practice. It reflects the application of nursing knowledge, skills and judgment, the clients' perspective and interdisciplinary communications. These guidelines will support RN's to contribute to the development of agency policy and promote evidence-informed practice, which enables RNs to meet the *Standards of Practice for Registered Nurses* every day in client care.

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Glossary of Terms

Accountability: the obligation to acknowledge the professional, ethical, and legal aspects of one's role, and to answer for the consequences and outcomes of one's actions. Accountability resides in a role and can never be shared or delegated.

Adverse event: an unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by healthcare management (Adverse Events in Canadian Hospitals Study Report, CIHI-CIHR, 2004).

Agency: facility or organization through which health services are provided or offered (e.g., district health authorities, hospitals, community health centres, physicians' offices, home care programs).
Authorized prescriber: a healthcare provider authorized by legislation to prescribe drugs and other health products. In Nova Scotia, authorized prescribers include physicians, dentists, nurse practitioners, midwives, optometrists, and pharmacists.

Client: the individual, group, community or population which is the recipient of nursing services and, where the context requires, includes a substitute decision-maker for the recipient of nursing services (*RN Act, 2006*).

Collaborate: Building consensus and working together on common goals, processes, and outcomes. (*CNA Code of Ethics*)

Competence: the ability to integrate and apply the knowledge, skills and judgment required to practice safely and ethically in a designated role and practice setting and includes both entry-level and continuing competencies (*RN Act, 2006*).

Competent: having or demonstrating the necessary knowledge, skills and judgments required to practice safely and ethically in a designated role and setting. (CRNNS, 2009).

Competency: the integrated knowledge, skills, judgment and attributes required of a registered nurse to practice safely and ethically in a designated role or setting. (Attributes include, but are not limited to, attitudes, values, and beliefs.) (*CNA Code of Ethics, 2008*).

CRNNS: College of Registered Nurses of Nova Scotia; the regulatory/licensing body for registered nurses and nurse practitioners in the province of Nova Scotia.

Documentation: refers to charts, charting, recording, nurses' notes, progress notes. Documentation is written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client.

Electronic Health Record (EHR): health record of an individual that is accessible online from many separate, interoperable automated systems within an electronic network (Health Canada). See Enterprise Medical Record.

Electronic Patient Record: an electronic method of storing, manipulating and communicating medical information of all kinds including text, images, sound, video and tactile senses, which are more flexible than paper-based systems. Often referred to as a medical record, it contains a client's (patient) entire medical history and information crucial to future care.

Electronic documentation: a document existing in an electronic form to be accessed by computer technology.

Electronic message system (e-mail): a system that transmits messages in electronic form over a communications network of computers.

Encryption: a process of disguising data information as “ciphertext,” or data that will be unintelligible to an unauthorized person.

Enterprise Medical Record (EMR): stores all clinical data entered on a client in the Nova Scotia Hospital Information System (NSHIS).

Intervention: task, procedure, treatment, function, drug or action with clearly defined limits.

Facsimile: a system of transmitting and reproducing graphic matter (as printing or still pictures) by means of signals sent over telephone lines.

Firewall: a computer or computer software that prevents unauthorized access to private data (as on a company’s local area network or intranet) by outside computer users (as on the Internet).

Health record: a compilation of pertinent facts on a client’s health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care (e.g., hospital admission, series of home visits). All healthcare professionals providing care create the pertinent facts documented in a client’s health record. Health records may be paper documents (i.e., hard copy) or electronic documents such as electronic medical records, faxes, e-mails, audio or videotapes, or images.

Legal reviews: review of a health record when requested for legal purposes.

Policy: broad statement that enables informed decision-making, by prescribing limits and assigning responsibilities/accountabilities. In terms of professional practice, policies are formal, non-negotiable, clear, authoritative statements directing professional practice. Policies are realistic and achievable, based on evidence or best practice, and should reflect the mission, vision, values and strategic directions of an organization (Cryderman, 1999, p.16).

Password: a sequence of characters required for access to a computer system.

Patient Care System (PCS): within the Nova Scotia Hospital Information System (NSHIS) this is where the list of caregiver clients and caregiver intervention lists are accessed in order to document care. Documentation flows to the Enterprise Medical Record (EMR).

Practice of nursing: the application of specialized and evidence-based knowledge of nursing theory, health and human sciences, inclusive of principles of primary health care, in the provision of professional services to a broad array of clients ranging from stable or predictable to unstable or unpredictable, and includes:

- (i) assessing the client to establish the client’s state of health and wellness,
- (ii) identifying the nursing diagnosis based on the client assessment and analysis of all relevant data and information,
- (iii) developing and implementing the nursing component of the client’s plan of care,
- (iv) co-ordinating client care in collaboration with other health care disciplines,
- (v) monitoring and adjusting the plan of care based on client responses,
- (vi) evaluating the client’s outcomes,

(vii) such other roles, functions and accountabilities within the scope of practice of the profession that support client safety and quality care, in order to

- (A) promote, maintain or restore health,
- (B) prevent illness and disease,
- (C) manage acute illness,
- (D) manage chronic disease,
- (E) provide palliative care,
- (F) provide rehabilitative care,
- (G) provide guidance and counseling, and
- (H) make referrals to other health care providers and community resources,

and also includes research, education, consultation, management, administration, regulation, policy or system development relevant to subclauses (i) to (vii)

(Registered Nurses Act, 2006)

Practice of nurse practitioners: means the application of advanced nursing knowledge, skills and judgment in addition to the practice of nursing in which a nurse practitioner in collaborative practice may, in accordance with standards for nurse practitioners, do one or more of the following:

- (i) make a diagnosis identifying a disease, disorder or condition,
- (ii) communicate the diagnosis to the client and health care professionals as appropriate,
- (iii) perform procedures,
- (iv) initiate, order or prescribe consultations, referrals and other acts,
- (v) order and interpret screening and diagnostic tests, and recommend, prescribe or reorder drugs, blood, blood products and related paraphernalia,

and also includes research, education, consultation, management, administration, regulation, policy or system development relevant to subclauses (i) to (v).

(Registered Nurses Act, 2006).

Professional misconduct: includes such conduct or acts relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonorable or unprofessional which, without limiting the generality of the foregoing, may include:

- (i) failing to maintain the College of Registered Nurses of Nova Scotia Standards for Nursing Practice,
- (ii) failing to uphold the code of ethics adopted by the College,
- (iii) abusing a person verbally, physically, emotionally or sexually,
- (iv) misappropriating personal property, drugs or other property belonging to a client or a registrant's employer,
- (v) inappropriately influencing a client to change a will,
- (vi) wrongfully abandoning a client,
- (vii) failing to exercise discretion in respect of the disclosure of confidential information,
- (viii) falsifying records,
- (ix) inappropriately using professional nursing status for personal gain,
- (x) promoting for personal gain any drug, device, treatment, procedure, product or service that is unnecessary, ineffective or unsafe
- (xi) publishing, or causing to be published, any advertisement that is false, fraudulent, deceptive or misleading,

(xii) engaging or assisting in fraud, misrepresentation, deception or concealment of a material fact when applying for or securing registration or a licence to practise nursing or taking an examination provided for in this Act, including using fraudulently procured credentials

(*Registered Nurses Act, 2001*).

Professional practice issue: any issue or situation that either compromises client care/service by placing a client at risk, or affects a nurse's ability to provide care/service consistent with the *Standards of Practice for Registered Nurses, Code of Ethics*, other standards and guidelines, or agency policies or procedures (Resolving Professional Practice Issues, CRNNS, 2012).

Progress notes: documentation of the progress of client's problems by all health team members. Nurses' notes are one component of the progress notes.

Responsibility: an activity, behaviour or intervention expected or required to be performed within a professional role and/or position: may be shared, delegated or assigned. (*Standards of Practice For Registered Nurses, 2012.*)

Self-regulation: the relative autonomy by which a profession is practised within the context of public accountability to serve and protect the public interest. The rationale for self-regulation is the recognition that the profession is best able to determine what can be practised, how it is to be practised, and who can practise, as long as the public is well served.

Scope of practice: the roles, functions and accountabilities which members of a profession are legislated, educated and authorized to perform.

Scope of employment: the range of responsibilities defined by an employer.

Telehealth: the delivery of health related services, enabled by the innovative use of technology, such as videoconferencing, without the need for travel. Telehealth can refer to transmission of medical images for diagnosis (referred to as store and forward telehealth) or groups or individuals exchanging health services or education live via videoconference (real-time telehealth).

Telenursing: use of electronic means by registered nurses to establish communication links with clients and/or other healthcare professionals in the delivery of professional nursing services.

Voicemail: an electronic communication system in which spoken messages are recorded or digitized for later playback to an intended recipient.

Appendix A- Legislation affecting Nursing Documentation

Federal

Access to Information Act

<http://laws-lois.justice.gc.ca/eng/acts/A-1/index.html>

Controlled Drugs and Substances Act

<http://laws-lois.justice.gc.ca/eng/acts/C-38.8/index.html>

Personal Information Protection and Electronic Documents Act

<http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html>

Privacy Act

<http://laws-lois.justice.gc.ca/eng/acts/P-21/index.html>

For information on where to obtain copies of current federal legislation, call the Government of Canada Inquiry Centre at 1-800-O Canada or visit the Department of Justice website at <http://laws.justice.gc.ca>.

Provincial

Freedom of Information and Protection of Privacy Act

<http://nslegislature.ca/legc/statutes/freedom.htm>

Health Act

<http://nslegislature.ca/legc/statutes/health.htm>

Health Protection Act

<http://nslegislature.ca/legc/statutes/healthpr.htm>

Homes for Special Care Act

<http://nslegislature.ca/legc/statutes/homespec.htm>

Hospitals Act

<http://nslegislature.ca/legc/statutes/hosptls.htm>

Occupational Health and Safety Act

http://nslegislature.ca/legc/statutes/occp_h_s.htm

Personal Health Information Act

<http://nslegislature.ca/legc/index.htm>

Registered Nurses Act

<http://nslegislature.ca/legc/statutes/registnur.htm>

For more information or to obtain copies of current provincial legislation, visit the Government of Nova Scotia Publications website <http://www.gov.ns.ca/snsmr/publications/> (go to Acts, Statutes and Regulations).

Appendix B- Practice Exercise

Questions - Workbook

Ms. Jones is a 24-year-old single mother just getting off the night shift. She reports to the Emergency Department (ED) in the early morning with shortness of breath. She has cyanosis of the lips. She has had a productive cough for 2 weeks. Her temperature is 38.2, blood pressure 110/76, heart rate 108, respirations 32, rapid and shallow and there is noted use of accessory muscles, O₂ Saturation is 95% on room air. Breath sounds are diminished in both bases, with coarse rhonchi in the upper lobes. You receive her for care from the triage nurse.

How would you document your initial assessment?

The physician orders the following:

- Arterial Blood Gases
- CBC
- Chest x-ray
- Salbutamol 4 puffs and Ipratropium 4 puffs by MDI with spacer q 20 mins x 3

You start to carry out the orders and another ED nurse, Janice, offers her assistance. You review the chart and orders with Janice and ask her to obtain the ABG sample while you administer the medications.

What would you document? What would you expect Janice to document?

The physician finishes the assessment and, based on the findings, Ms. Jones is diagnosed with pneumonia. You and the physician go together to discuss this with Ms. Jones. When the physician communicates the diagnosis and discusses the treatment plan with Ms. Jones she becomes upset. She states that she needs to have a cigarette and to think about how she will afford the treatment medication. She states that she probably won't fill the prescription for the antibiotic because she needs to buy cigarettes to help deal with her nerves and her kids. She is angry and swears at both you and the physician.

How would you document this interaction with Ms. Jones?

You discuss some payment options with Ms. Jones to assist her pay for her medications and she agrees to try some of these. The physician discharges her home.

How would you document this interaction with Ms. Jones?

Responses for Practice Exercise

The following responses are examples of how this situation could be documented using a narrative documentation system.

Ms. Jones is a 24-year-old single mother just getting off the night shift. She reports to the Emergency Department (ED) in the early morning with shortness of breath. She has cyanosis of the lips. She has had a productive cough for 2 weeks. Her temperature is 38.2, blood pressure 110/76, heart rate 108, respirations 32, rapid and shallow and there is noted use of accessory muscles, O2 Saturation is 95% on room air. Breath sounds are diminished in both bases, with coarse rhonchi in the upper lobes. You receive her for care from the triage nurse.

Example 1

The physician orders the following:

- Arterial Blood Gases
- CBC
- Chest x-ray
- Salbutamol 4 puffs and Ipratropium 4 puffs by MDI with spacer q 20 mins x 3

You start to carry out the orders and another ED nurse, Janice, offers her assistance. You review the chart and orders with Janice and ask her to obtain the ABG sample while you administer the medications.

Example 2

The physician finishes the assessment and, based on the findings, Ms. Jones is diagnosed with pneumonia. You and the physician go together to discuss this with Ms. Jones. When the physician communicates the diagnosis and discusses the treatment plan with Ms. Jones she becomes upset. She states that she needs to have a cigarette and to think about how she will afford the treatment medication. She states that she probably won't fill the prescription for the antibiotic because she needs to buy cigarettes to help deal with her nerves and her kids. She is angry and swears at both you and the physician.

Example 3

You discuss some payment options with Ms. Jones to assist her to pay for her medications and she agrees to try some of these. The physician discharges her home.

Example 4

DATE & TIME	FOCUS NOTES
Nov 15/12 0815	Client reports to ED with C/O SOB, states "I just can't seem to catch my wind and I am coughing up green phlegm for the last two weeks". On auscultation and inspection breath sounds decreased in bases bilaterally, coarse rhonchi bilaterally in upper lobes, accessory muscles use noted bilaterally, breathing is shallow and lips are cyanotic. Vitals signs assessed; Temp 38.2 BP 110/76, HR, 108, RR 32, O2 Sat 95% R/A. -----N. Scotia, RN
0820	Assessment findings reported to Dr. Halifax---N. Scotia, RN
0825	Client assessed by Dr. Halifax-----N. Scotia, RN

DATE & TIME	FOCUS NOTES
Nov 15/12 0850	Orders received, lab and x-ray request sent----- <i>N. Scotia, RN</i>
0900	Client chart and assessment findings reviewed with N.
	Scotia, RN. Orders received for ABG. Procedure explained
	to client and consent for test obtained. ABG obtained from
	RT radial artery. Patient reports no pain at the site. Pressure
	and dressing applied to site. Sample sent to lab-----
	----- <i>J. Dartmouth, RN</i>
0905	Salbutamol IV puffs and Ipratropium IV puffs by MDI with spacer given to client----- <i>N. Scotia, RN</i>
0920	Patient reports "my breathing is easier" On auscultation and inspection breath sounds remain decreased in bases bilaterally, coarse rhonchi bilaterally in upper lobes, no accessory muscles use noted ,lips pink, RR30 shallow, HR 102, O2 Sat 96% R/A ----- <i>N. Scotia, RN</i>
0925	Salbutamol IV puffs and Ipratropium IV puffs by MDI with spacer given to client----- <i>N. Scotia, RN</i>
0940	Patient reports "I am feeling much better" On auscultation and inspection good air entry noted , coarse rhonchi bilaterally in upper lobes, no accessory muscles use noted, lips pink, RR28 shallow, HR 102, O2 Sat 97% R/A-----
	----- <i>N. Scotia, RN</i>
0945	Salbutamol IV puffs and Ipratropium IV puffs by MDI with spacer given to client----- <i>N. Scotia, RN</i>
1000	Lab and x-ray results on chart, Dr. Halifax notified-----
	----- <i>N. Scotia, RN</i>

DATE & TIME	FOCUS NOTES
Nov 15/12 1015	Diagnosis explained to client by Dr. Halifax and treatment options discussed. Client becomes flushed and raises her voice to express her need to have a cigarette and think about the treatment options. She states "I can't buy the pills or puffers, I need my smokes to deal with my kids and all the stuff in my life" She states " I bet this isn't a problem for you high and mighty doctors and nurses" The client uses a profane phrase in reference to Dr. Halifax-----N. Scotia, RN

DATE & TIME	FOCUS NOTES
Nov 15/12 1020	Dr. Halifax leaves the room. Options such as drug samples and the client assistance fund is discussed with the client. Forms for the client assistant fund are given to the client and assistance is given to complete the form. The client smiles and states, "Thanks for your help. I know now I can get the pills I need to make me better." Options for smoking cessation are also discussed and the client agrees to take the information on this treatment and states "I don't know if I can do this all at once"-----N. Scotia, RN
1040	Dr. Halifax aware patient is in agreement with treatment plan and orders received to discharge patient-----N. Scotia, RN
1045	Client teaching initiated on proper MDI with spacer administration, client able to demonstrate proper technique. Instructions given to client on when to return to the ED or family physician office. Discharge assessment preformed; On chest auscultation and inspection good air entry noted, faint rhonchi bilaterally in upper lobes, no accessory muscles use noted, lips pink, Temp 37.8 RR24 even and deep, HR 102,BP 110/64 O2 Sat 98% R/A-----N. Scotia, RN
1100	Client discharged home ambulatory with her mother-----N. Scotia, RN