I’m worried that I could be sued one day if I don’t chart enough. How much charting is enough so that I am “legally covered?”

There are no laws in B.C. stating specifically how and what nurses must document. There are, however, professional standards of practice and statutory regulations that guide your documentation practices.

Your employer is responsible for developing documentation polices that reflect provincial and federal government statutes (e.g., British Columbia Coroners Act) and/or other relevant documents (e.g., Guidelines for the Protection of Health Information).

Your documentation could be used in a court of law to determine if the care provided met the required professional standards of practice and the agency policies. It can also provide a record for the nurse who may not remember the details of the clinical situation, given that it can be several years before a case goes to court.

The CRNBC Practice Standard Documentation defines documentation as “any written or electronically generated information about a client that describes the care or service provided to that client – and it is an integral part of nursing practice.”

Furthermore, documentation serves three purposes:

- to facilitate communication;
- to promote safe and appropriate nursing care; and
- to meet professional and legal standards.

Through documentation, nurses communicate their observations, decisions, actions and the outcomes of those actions for clients. Documentation provides an accurate account of what occurred and when it occurred.

Nurses may document information pertaining to individual clients or groups of clients.

**Individual Clients**

When caring for an individual client, the nurse’s documentation provides a clear picture of the status of the client, the actions of the nurse, and the client outcomes. Nursing documentation clearly describes:

- an assessment of the client’s health status, nursing interventions carried out, and the impact of these interventions on client outcomes;
- a care plan or health plan reflecting the needs and goals of the client;
- needed changes to the care plan;
- information reported to a physician or other health care provider and, when appropriate, that provider’s response; and
- advocacy undertaken by the nurse on behalf of the client.

Examples of nursing activities that must be documented are:

- all pertinent data collected in the course of providing care, including data collected through technology such as monitoring devices (e.g., strips produced during cardiac or fetal monitoring).

**Groups of Clients**

When providing service to groups of clients (e.g., therapy groups, public health programs), service records (or an equivalent) are used to document the service provided and overall observations pertaining to the group. Similar to documentation for individuals, documentation for groups reflects the needs assessment, plans, actions taken, and evaluation of the group outcomes.

Documentation of services provided to a group of clients describes:

- the purpose and goal of the group;
- the criteria for participation;
- intervention activities and group processes; and
- an evaluation of group outcomes.

Pertinent information about individual clients within the group is documented on individual client health records, not on the group service record. When documenting on an individual client health record, names of other group members are not identified.

As a student nurse I was taught to always chart soon after I performed an assessment or intervention. Now that I work as a float nurse, I have noticed that there is a lot of variation by nurses as to when they chart. How soon am I
supposed to chart after performing an assessment or intervention?

A There is no specified timeframe for when a nurse is to document. The timeliness of documentation is guided by professional standards of practice and agency policies. As a nurse, you are accountable for your documentation and need to consider the principles that guide practice.

The CRNBC Practice Standard Documentation directs nurses to “document at the time they provide care or as soon as possible afterward, as delays affect the continuity of care, cloud the memory of events and increase the possibility of errors.”

The timeliness of documentation depends upon the client. When clients are more acute, complex, and/or variable, documentation should be more frequent than when clients are less acute, less complex and/or less variable.”

Agency policies should provide direction regarding the expected frequency of documentation. Agency policies should also include:
- the method of documentation; processes for recording “late entries”;
- listing of acceptable abbreviations (or the name of a reference text in which acceptable abbreviations are found); and
- how to handle verbal and telephone orders; and information regarding storage, transmittal and retention of client information.

In situations where policy changes are necessary, nurses advocate for the appropriate changes.

Q Sometimes I am so busy that I am unable to complete all of the client assessments expected of me according to our protocols. What do I chart about missing the assessment?

A The documentation of any missed nursing care is dependent on the individual circumstances. CRNBC’s Professional Standards for Registered Nurses and Nurse Practitioners state that registered nurses are responsible and accountable for maintaining standards of nursing practice and professional conduct as determined by CRNBC and the practice setting. At a minimum, you would document any actions you took to ensure your client’s well-being, including the assessments and nursing interventions you were able to complete, and whether you communicated any concerns to other individuals (e.g., other staff at shift change; attending physician). Your documentation should be objective and factual, and include enough information that your completed assessments and
What do Workplace Representatives do?

- Assist registered nurses to use the CRNBC Standards of Practice
- Assist registered nurses to understand their responsibilities as a self-regulating professional
- Provide a communication link between practising registered nurses and CRNBC
- Assist colleagues with questions about practice issues
- Arrange educational workshops or discussions on topics such as documentation, quality practice environments, continuing competence and medication administration
- Provide a link to CRNBC resources such as Practice Support books, fact sheets, and practice articles

Practice Resources available through Workplace Representatives:

- Bulletin board — an onsite resource for CRNBC news, activities, policy updates and practice resources
- Publications Reference Manual — hard copy resource for CRNBC publications

Interventions could be understood by another health care provider. As well, depending on the potential or actual risk to your client or future clients, agency policy will provide you with direction on whether or not an Unusual Occurrence/Incident Report should be completed.

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