Original June 2017
Last Revised October 2019

Documentation

I have a small number of staff in the unit I manage who consistently do not complete their documentation in a timely manner, or without frequent errors or omissions. Some of those staff are RNs, and I wonder what is a reasonable expectation regarding documentation. This situation is causing issues with the delivery of safe patient care and is creating additional work for the Health Information Management staff.

- Documentation is an important communication tool that fosters continuity of client care.
- RNs are expected to adhere to all relevant legislation, standards and competencies, and agency policies and procedures related to privacy, documentation and information management (e.g., verbal, written or electronic) (1).
- Quality documentation is an integral part of professional RN practice. It reflects the application of nursing knowledge, skills and judgment, the client's perspective and interdisciplinary communications (2).
- Documentation provides evidence that safe and competent care was delivered, that the care/service met acceptable standards of care, was reasonable and prudent, was provided in a timely manner, and was consistent with agency policies and procedures (3).
- RNs accept professional accountability for their own actions and decisions. This includes the accurate and timely completion of documentation that outlines the care they have provided as part of the client plan of care (4).
- Documentation is not separate from care and is not an optional activity. RNs document and report client care and its ongoing evaluation clearly, concisely, accurately and in a timely manner (5).
- Charting should be timely, frequent, and chronological (6).
- As part of a self-regulating profession, RNs have a responsibility to conduct themselves according to the ethical responsibilities outlined in the *Code of Ethics for Registered Nurses (2017)* and in keeping with the professional standards, laws and regulations supporting ethical practice (7).
- RNs respect, uphold, and enforce policies that protect and preserve the privacy of persons receiving care, including security safeguards in information technology (8).

Quality documentation is an important part of RN practice. What are some actions I could take to foster improvement?

There are several things you might decide to do:

- Review the unit/facility/region policy and procedures on documentation, plus the SRNA *Documentation: Guidelines for Registered Nurses* (2011) document.
- Engage with your staff in discussions about their perceptions of the issues and gather their ideas on how to improve documentation on the unit.
- Identify staff who consistently complete their documentation successfully and have

them identify tips or techniques that work for them. Consider the most effective ways to use this information in the unit. *For example:* Have them share their thoughts with the group or directly mentor others who are struggling.

- Consider setting up an auditing program on the unit where all RNs are involved in performing checks or mini audits. This might increase awareness of all staff related to their participation in the process and may bring out more suggestions for improvement. This could be done in an efficient way that is not overly time-consuming but gives rich data. Pick two to three things to audit at a time.
- Engage staff to examine barriers to effective documentation and try to identify better, more effective ways to chart. Sometimes staff record information in multiple places on multiple forms and it causes problems—be open to making constructive changes that enable all staff to do a better job of documentation.

How should I respond when the staff tell me their documentation is incomplete or incorrect because the unit is so busy?

Complete and accurate documentation is an expectation and requirement of RN practice. Although a very busy work environment might make it more challenging to complete documentation, it is not an excuse for poor quality. Especially when most of your staff consistently meet the standards for complete and accurate documentation.

As a manager, you may wish to clearly outline the general expectations and requirements to ensure that all your staff members are aware. You may also need to provide short-term supports for staff members who are struggling (e.g., staff who are new to the facility/unit and documentation system, etc.). If there are, however, individual staff members who consistently continue to produce poor quality documentation despite the provision of every reasonable support, you may need to consider performance management to ensure that this situation is resolved satisfactorily.

SRNA Resources

Code of Ethics for registered nurses (2017)
Registered Nurse Practice Standards (2019)
Registered Nurse Entry-Level Competencies (2019)
Documentation: Guidelines for Registered Nurses (2011)

External Resources

Canadian Nurses Protective Society Webinars
CNPS InfoLaw - Quality Documentation: Your Best Defence

Resource Key		
Number	**Resource**	**Reference**
1	Documentation: Guidelines for Registered Nurses (2011)	page 15
2	Documentation: Guidelines for Registered Nurses (2011)	page 17
3	Documentation: Guidelines for Registered Nurses (2011)	page 6
4	SRNA Registered Nurse Practice Standards (2019)	Indicator 1, page 3
5	SRNA Registered Nurse Entry-Level Competencies (2019)	Competency 3.8, page 8
6	Documentation: Guidelines for Registered Nurses (2011)	page 16
7	Canadian Nurses Association (CNA) Code of Ethics (2017).	A1, page 8
8	Canadian Nurses Association (CNA) Code of Ethics (2017).	E7, Page 14

RN is used to represent all SRNA members including NPs and RN(AAP)s.