College of Registered Nurses of Saskatchewan

Documentation Guideline

Effective: February 17, 2026

Introduction

Registered Nurses (RN) have a professional responsibility to accurately and thoroughly document the care they provide and the outcomes for the client. *The Registered Nurse Practice Standards*, states "...reflect the philosophical values of the profession, clarify what the registered nursing profession expects of its members and informs the public of acceptable practice of registered nurses." (CRNS, 2019). In this document RN includes RNs, RN(AAP)s, NPs and GNs.

Regulatory Authority

The Registered Nurses Act, *1988* (the Act) provides the legislative authority for registered nurse practice in Saskatchewan. Section 15(2) of the Act enables the CRNS to create bylaws that:

- prescribe the powers and procedures of the Council;
- provide for a code of professional ethics;
- set the standards for professional conduct, competency and proficiency of nurses; and,
- further specify categories of practice and the rights and privileges of those categories.

CRNS Bylaw IV details the privileges and obligations of practicing members. Obligations of practicing members include adhering to the *CRNS Code of Conduct*, nursing standards and competencies that are incorporated by reference in Bylaw XV and set the standards for professional conduct, competency and proficiency of nurses.

Through the authority in the Act, Council creates and applies policies and procedures to approve standards and guidelines that set the expectations for registered nursing practice in Saskatchewan. The role of this guideline is to provide information to support the application of the standards and competencies for documentation.

Standards and competencies that apply to documentation include:

- Entry-level Competency: Communicator
  - Documents and reports clearly, concisely, accurately and in a timely manner.
- Standard 1: Professional Responsibility and Accountability
  - Demonstrates effective communication.
- Standard 2: Knowledge-Based Practice
  - Utilizes nursing informatics and other information and communications technology in practicing safe registered nursing care.
- Standard 3: Ethical Practice
  - Communicates respectfully and effectively.

Principles of Documentation

Documentation is a nursing action that produces a written and/or electronic account of pertinent client data, nursing clinical decisions and interventions and the client's responses in a health record. Documentation establishes accountability for care, promotes quality nursing care, facilitates communication among RNs and other health care providers and conveys the contribution of nursing to health care. Documentation is not separate from care and it is not optional. Nursing documentation provides a contemporaneous timeline of care. Documentation can be used to determine what nursing care was provided to the client.

Documentation:

- Identifies the caregiver and records evidence the nursing process was carried out including the client's health outcome and the client's response to the care;
- Promotes continuity of care through intra/interprofessional communication; and
- Demonstrates the RN's accountability to providing safe, competent and ethical care.

Why do RNs Document?

Documentation of client care is required for several purposes.

Communication

Quality documentation supports the exchange of pertinent client information among members of the health care team.

Documentation is used between members of the health care team to ensure continuity of care. After completing documentation, the RN should ask themselves, have I captured the necessary information to ensure that another member of the health care team could seamlessly take over the care of the client and provide safe, competent care?

Those reading the documentation should be able to determine:

1. The care that was provided.
2. The client who received the care.
3. The RN who provided the care.
4. When the care was provided (date and time).
5. Why the care was provided (the assessment of the client) .
6. The client's response to the care provided and the client outcome.

Professional Accountability

In Saskatchewan, all RNs are required to document evidence of safe, competent and ethical care in accordance with the current practice standards, entry-level competencies, *CRNS Code of Conduct* and agency policy.

RNs demonstrate accountability for safe, competent and ethical care through documentation in the client health record. Documentation should reflect the RN's professional judgment, assessment, coordination of care, decisions, actions and evaluations. Documentation must honour the ethical concepts of good practice such as promoting respect, cultural competence and informed decision making.

Professional Liability

Documentation demonstrates that the RN has applied nursing knowledge, skills and judgment that is required by professional and ethical standards, relevant legislation and employer policies.

The client's health record is a legal document. A client's record can be used as evidence in legal proceedings to reconstruct the sequence of events related to the care of a client. The client record can be used to establish the time and date care was provided. It can be used to refresh the memory of those involved in client care and to substantiate or resolve conflicts in testimony.

The client's record assists others in confirming that the nursing care provided was competent and safe, met the established standard of care, was provided promptly, and in a manner consistent with organizational policies. Information gathered should be in accordance with applicable legislation, regulatory requirements and agency policy.

Quality Improvement, Risk Management, and Accreditation

Quality improvement is a framework used to improve ways that care is delivered to clients. Risk management is the identification and assessment of risk. Measures can be instituted to reduce risks to clients, visitors, staff and organizations. Nursing documentation provides data for risk management and quality improvement tools for the RN and the employer. Using information gathered from client records, RNs and employers can identify trends and maximize client safety by identifying and managing risks effectively.

Client records are used in the accreditation process. Accreditation provides health care agencies with an independent, third-party assessment of the organization using standards built upon best practices used and validated by organizations. This process is used to assess what is consistently being done well and what needs to be improved.

Information from the client health care record is gathered and used to evaluate the care provided and outcomes of that care. Comprehensive and accurate documentation provides a sound basis for the measurement of quality of care and helps to facilitate the evaluation of the client towards preferred outcomes.

Funding and Resource Management

Documentation supports the allocation of resources, workload measurement and fiscal utilization. This includes human and physical resources. The information gathered from the client record, workload measurement and client classification systems can be used to determine allocation of funding, staffing requirements and skill mix required for safe, competent care.

Research and Evidence-Informed Practice

Research findings support the development of evidence-informed practice. The client care record is an important source of data for nursing and health research; therefore, accurate and complete documentation is necessary. Data gathered from the client record provides an abundant source of information related to nursing interventions and evaluation of client outcomes. Additionally, the data is used to determine the efficiency and effectiveness of the client care provided.

Who Should Document?

Legal and professional principles dictate that the RN who provided client care should be the individual who documents in the client's health record.

If two or more people are providing care to a client, the RN who is the assigned primary caregiver has the responsibility to document the assessment, intervention and the client's response to the care provided. Any subsequent care provider is expected to review the existing documentation and make any additional entry to the client record as necessary. Any subsequent care provider is responsible for signing their entry in the client health care record. If the entry requires a co-signature, it should be completed according to agency policy. Agency policy related to the co-signing of entries should indicate the intent of a co-signature and in what circumstances co-signing is required. RNs do not routinely need a co-signature for their entries in the client record.

Third-Party Documentation

Third-party documentation or documenting for others is not prudent practice for RNs; however, there are situations where third-party documentation may be appropriate. In these specific situations agency policy should clearly outline under what circumstances a third party may document for another care provider. Some instances where it may be appropriate for a third-party to document care include but are not limited to:

- Designated Recorder – In emergencies, such as Code Blue, where all care providers are not able to document the events of the resuscitation efforts. In this instance, a list of all involved in the resuscitation could be included in the client's health record. Also, it may be appropriate for a third party to document care in instances where it is not practical for client safety reasons for the care provider to document, eg. routine procedural events in specialty areas such as endoscopy, the operating room or delivery room.
- Auxiliary Staff – Individuals who provide direct client care such as unregulated care providers or individuals who are employed by external organizations can only document in the client's health record if agency policy supports the practice. If there is no policy in place to support documentation in the client record by auxiliary staff, it is the responsibility of the RN to document information reported to them by the auxiliary staff. The RN should include the name and status of the person who reported specific care information related to the client.
- Client or Family – In some settings, a client or family member may be asked to record their observations or some component of care in order to optimize the health outcomes of the client and inform the ongoing assessment of the client's health needs. For instance, they may be asked to record the intake and output of a newborn, self-administration of medications, wound drainage amounts or vital sign trends. The agency should provide clear direction as to the RNs responsibility to transcribe, summarize and/or file the information in the client's health record.
- Nursing Students – All nursing students are required to document the care they provide as per agency and academic policies. The CRNS does not support the co-signing of documentation completed by students. Situations may occur where the assigned RN or preceptor may be required to document their assessments, interventions and evaluation. This could occur due to a sudden, significant change in the client's status and any subsequent intervention initiated. As with all care provided, the intervention must be evaluated and documented in the client's health record.

Third-party documentation can lead to errors or inaccuracies in the client record that may affect the provision of safe, competent care for the client. In the case of litigation, documentation that has been completed by a third-party may not be admissible in a court proceeding or the credibility of the documentation may be called into question.

How Should RNs Document?

Legibility and Spelling

All entries should use professional language and terminology and be completed according to agency policy. When documenting in the client's health record the RN needs to make certain that what is documented is legible and that spelling is correct. Legibility and accurate spelling demonstrate competency and attention to detail. Illegible entries and misspelled words can lead to treatment errors resulting in client harm and could have legal implications.

Abbreviations

The use of abbreviations, acronyms or symbols can improve efficiencies in documentation if their meaning is well understood by all. Abbreviations and symbols that are obscure, obsolete, poorly defined or that have multiple meanings can lead to errors and confusion. The Institute for Safe Medication Practices (ISMP) has created documents related to abbreviations and the dangers of using them when documenting (see ISMP website). Only abbreviations approved by the employer should be used in the client health care record.

Blank/White Spaces

RNs should not leave any blank or white spaces in the body of their documentation as it presents an opportunity for others to alter previously completed documentation. When documenting ensure that documentation is completed in the sequence that care occurred. Draw a line through the remaining blank space and end the entry with signature and designation. When filling out a flowsheet, fill in all the blocks or spaces with the appropriate, agency approved symbols. Do not use ditto marks when documenting to indicate a repetition of information as it is unsafe, inappropriate and leaves blank/white space. Always follow agency policy regarding documentation requirements and the use of blank/white spaces.

Errors or Changes in Documentation

Inaccurate documentation can and does contribute to the incidents of adverse events for clients. Errors and/or changes to the client's health record should be corrected according to agency policy for accuracy and to avoid falsifying the record. *The Registered Nurses Act, 1988* states "... the discipline committee may find a nurse guilty of professional misconduct if the nurse has ... falsified a record concerning the observation, rehabilitation or treatment of a client."

Should the client's health record become illegible (eg. water spill) keep the illegible record and follow agency policy to address the situation.

When correcting documentation:

- the incorrect information must remain visible or retrievable (in the case of electronic charting) so that the purpose and content of the correction is understood;
- do not make entries between the lines;
- do not remove anything from the client record such as monitor strips or lab reports;
- do not use correction tape or stickers to hide or obliterate the error;
- never remove pages from the client record;
- cross through the word or words with a single line and above the entry write "mistaken entry"; and,
- include initials, date and time the correction is made.

In the case of electronic charting, the RN may be required to have permission or access to make changes to the client's health record. Refer to agency policy on how to address errors in the electronic record.

Electronic Documentation

When completing electronic documentation, the same principles of documentation apply as for paper-based documentation. RNs have the same ethical and legal obligations to maintain confidentiality of client records when documenting in an electronic format as they have for paper-based charting. Electronic documentation may need additional safeguards, such as encryption, to prevent unauthorized access to the client health records.

To ensure the security of client health records policies, procedures and specific technologies need to be in place. To minimize the potential for a breach RNs should consider the following:

- Create strong passwords and change them frequently;
- Do not share your password or any other access information with others;
- Log off or lock the screen when you are leaving the terminal;
- Protect the monitor from visualization by others when making entries in client records;
- Report unauthorized access or use of your electronic signature to your employer; and,
- Do not log on for someone else.

Confidentiality

The Health Information Protection Act (HIPA, 2003), is the legislation that outlines the requirements to ensure the privacy and confidentiality of client health records.

> A trustee that has custody or control of personal health information must establish policies and procedures to maintain administrative, technical and physical safeguards that will:
>
> (a) protect the integrity, accuracy and confidentiality of the information;
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> (b) protect against any reasonably anticipated:
>
> (i) threat or hazard to the security or integrity of the information;
>
> (ii) loss of the information; or,
>
> (iii) unauthorized access to or use, disclosure or modification of the information; and,
>
> (c) otherwise, ensure compliance with this Act by its employees. (HIPA, 2003).

The *CRNS Code of Conduct*, provides direction for RNs regarding privacy and confidentiality, "RNs are expected to: protect the privacy and confidentiality of clients' personal health information as outlined in legislation and regulatory documents" (CRNS, 2026 p. 8).

At all times the RN must maintain the privacy and confidentiality of client health records, regardless of what method of documentation is used. Information regarding the client and their care should only be shared with those directly involved in the client's care. RNs should only access the records of clients currently in their care.

Do not discuss the client's assessment, observations, treatment or conversations with other clients or staff who are not involved in the client's care. Clients may request and receive copies of their health records according to agency policy.

At times, client information may be sent via email, text or fax. When sending client information electronically, the RN should observe the following:

- Always follow agency policies regarding the transmission of client information via email, text or fax;
- Use only secure networks when communicating with other health care providers about a client;
- Place a copy of the information in the client health record if possible;
- Proofread messages before sending;
- Ensure all printed material are secured and are appropriately disposed of when no longer required (eg. shredded); and,
- Be diligent when sending information electronically. Ensure that addresses and numbers are verified as correct before sending, that only the required information is sent, and that the transmittal was completed.

What Should RNs Document?

Point of care RNs are required to document all aspects of the nursing process: assessment, planning, implementation and evaluation. Documentation of the care provided must be consistent, clear, factual and reflect the RN's critical thinking when providing client care.

The following should be recorded by the RN in the client's health record:

- A clear and concise statement of the client's status (physical, psychological and spiritual);
- All relevant assessment data (including client and family comments as appropriate);
- All ongoing monitoring and communications;
- The care provided to the client including interventions (treatments, advocacy, counseling, consultation, client and family teaching); and,
- Evaluation of the care provided, including the client's response and any impact for discharge planning.

Objective vs. Subjective

Objective information is facts related to the client's status that are observed or measured. This includes assessment, interventions and the client's response to care provided. RNs should document all aspects of client care utilizing the nursing process and using objective statements. RNs should avoid vague or opinionated documentation as it can misrepresent assessment findings and interfere with the continuity of care. Also, RNs should avoid generalizations, bias and labels. Document only information that can be supported by data.

Subjective information is affected by personal views, experiences and background. Subjective information may be provided by the client and/or family. Subjective statements may improve the understanding of the client's experience related to the care provided. If such statements are included, identify who made the comments and use quotes to signify comments.

Date, Time, Signature and Designation

Entries in the client health record begin with the date and time of the care provided and end with the signature and designation of the person making the entry. There can be variations from agency to agency as to how to document date, time and signature. RNs should be aware of and follow agency policy when documenting.

Admission, Transfer, Transport and Discharge Information

Documentation of the admission, transfer, transport and discharge provides a baseline for future care of the client. The client's health record should indicate what information was provided to the client for any transitions in care. Documentation in the client's health record should include the client's status at the time the information was provided, the information that was given to the client, any arrangements for follow-up, the client's apparent understanding of the information provided to them and any family involvement. Again, agency policy should provide direction for the recording of communication between practitioners or the services arranged.

Health Care Team Collaboration

All communications that occur among members of the health care team must be recorded in the client's health record. The date, time and information presented and discussed by members of the health care team, the responses of others and the plan of action determined by the team should be captured and documented in the client record. All forms of communication, written, verbal and electronic should be documented. As well, unsuccessful attempts to contact other health care providers and the measures taken to address the client's needs should be recorded (e.g. discussion with the charge nurse, contacting another care provider).

Telepractice

Telepractice is any nursing care or service delivered by an electronic means such as video or audio conferencing, telephone calls, fax or email communication. When documenting telehealth services, the RN shall document the date and time of the communication, the name and contact information of the client, age of the client if it is relevant and the reason for the call. As the RN may not be able to visually or physically assess the client, they must use good communication skills and ask probing questions to gather information of the signs and symptoms that the client is experiencing. The use of a specific protocol or algorithm for decision making, if applicable, should be included in the documentation. Any information, referrals or agreements on the next steps and follow-up plans for the client must be documented.

As with all care provided consent for care needs to be obtained. The RN providing telehealth needs to ensure that the client confirms an understanding of the information provided to them including the risks and benefits of virtual care, that the platform being used to provide virtual care may not be secure and that a breach of privacy may occur. Clients should be advised to have their telepractice session in a private location to ensure confidentiality. All information provided, including client consent needs to be accurately and thoroughly documented in the client record.

Client Education

RNs document both formal and informal teaching provided to the client. The materials, the method(s) of teaching, as well as the involvement of the client and the family should be entered into the client record. Lastly, an evaluation of client/family comprehension of the information provided should be documented.

Risk-Taking Behaviors

The *CRNS Code of Conduct* (the Code) states, "RNs are expected to act in clients' best interests by respecting their autonomy, care preferences, choices and decisions" (2026, p. 4) even if the client chooses to engage in risk-taking behaviours.

When a client chooses to engage in risk-taking behaviours or refuses medical care or advice, it is vital that the RN document the information that was provided to the client and the outcome of the discussion with the client in a fair and unbiased manner. Some agencies may have specific forms that must be completed. If the client's risk-taking behaviour is a violation of the law that requires mandatory reporting (e.g. child abuse) the RN is required to document as required by relevant legislation. If the RN is questioning the capacity of the client to understand the information that has been provided and their choice to engage in risk-taking behaviors, the RN should consult relevant legislation, agency policies and consult with their manager for direction.

Adverse Events and Incident Reports

At times, a client may suffer an adverse event such as a fall, injury, an incorrect dosage or missed dose of medication. Should an adverse event occur, the RN shall objectively record the event and care provided. RNs should avoid the use of the words error, incident or accident when documenting. Assumptions, conclusions and judgments about the event should not be included in the documentation. Most agencies have specific reporting forms to document adverse events. Agency policy should be followed when completing incidents reports. Incident reports are generally separate from the client's health record but the completion of an incident reporting form following an adverse event should be included in the client's health record. Reporting of adverse events is important from a quality improvement perspective. Incident reports can identify system issues that need to be addressed to support client and staff safety.

When Should RNs Document?

RNs should document frequently, chronologically and promptly. All documentation should be completed according to agency policy.

Documenting frequently helps to ensure the accuracy of the information being entered in the client record. The frequency of documentation and the amount of detail required in the chart entry are determined by several factors: the complexity of the client's health problems, the degree to which a client's condition puts them at risk of deterioration or harm, the degree of risk involved in a treatment or component of care, changes in the care plan, and any transitions in the client care such as admission, discharge, transfer or transport.

Chronological entries into the client's health record are important as they can reveal patterns and changes in the client's health status. Chronological entries provide for clear

communication of the client's status and the care provided. Chronological entries into the client's health record assist all health care providers to understand what care was provided based on the assessment of the client by the RN. Also included should be an evaluation of the care provided, including the client's response.

RNs should document assessments, interventions and evaluation treatment or care provided in a timely manner. Document in a timely manner, meaning as close to real-time as possible in order to ensure accuracy of details and timely communication to the team, Documentation should never be completed before it actually takes place.

Late entries

If an RN fails to document information in the client's health record at the time care is provided, a "late entry" can be made in the client's health record to document the information according to agency policy. When making the new entry it must be clearly identified as a "late entry." In the client's health record specify the date and time that the new note is entered. Clearly identify the event or previous note that the new entry is related to.

Conclusion

Documentation of client care should be completed promptly with as much detail required to present an accurate and thorough representation of the client's health status and the nursing care provided. This enhances continuity of care and safety for the client. RNs demonstrate professional responsibility and accountability through consistent and accurate documentation.

References

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