Practice Directive

Documentation Standards

College of Registered Nurses of Prince Edward Island

College of Licenced Practical Nurses of Prince Edward Island

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Introduction

The College of Registered Nurses of Prince Edward Island (CRNPEI) and the College of Licensed Practical Nurses of Prince Edward Island (CLPNPEI) are legislated to serve and protect the public interest through the regulation of individual registered nurses (RN), nurse practitioners (NP) and licensed practical nurses (LPN). For the purposes of this document the term nurse(s), will refer to all three designations of nurses in Prince Edward Island.

Nurses in Prince Edward Island are accountable to practice within their Code of Ethics, Standards of Practice, and to meet established agency practice policies and procedures.

As self-regulating professions, Nurses are regulated under the authority of the Prince Edward Island *Regulated Health Professions Act* (2013) and corresponding regulations, which outline the accountabilities and responsibilities of Nurses. This includes a Nurses' legal responsibility to practice within their scope of practice and level of competence. Nurses must know what they are authorized and competent to perform, including any limitations in skill, knowledge, and judgement to ensure their practice is within their scope.

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.

Purpose

The purpose of this practice directive is to set a standard for how nurses should document within their practice while remaining accountable to the *CRNPEI Standards for Nursing Practice* or *CLPNPEI Standards of Practice for LPNs in Canada* and the Regulated Health Professions Act (RHPA). This document describes nurses' accountability and the expectations for documentation in all practice settings, regardless of the documentation method or storage.

This practice directive does not provide a standard for the style of documentation to be used in PEI.

Definition 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.

Authorized prescriber: a health care provider authorized by legislation to prescribe drugs and other health products.

Client: a person, family, group or population that is receiving health care services.

Collaboration: working together with one or more members of the health care team, each of whom makes a unique contribution toward achieving a common goal. Collaboration is an ongoing process that requires effective communication among members of the health care team and a clear understanding of the roles of the individuals involved in the collaboration process

Competence: means the ability to integrate and apply the knowledge, skills and judgement required to practice safely and ethically in a designated role and practice setting and includes both entry-level and continuing competencies

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

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

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

Facsimile (fax): 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 health care 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.

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

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

Policy: a broad statement that enables informed decision-making, by defining limits and assigning responsibilities and accountabilities. Policies are formal, non-negotiable, clear, authoritative statements directing professional practice.

Preceptor: a person who teaches, counsels, serves as a role model, and supports the growth and development of another person, in a particular environment, for a limited time, with the specific purpose of familiarizing the other person with a new role.

Progress notes: documentation of the progress of a 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: may be shared, delegated or assigned (see CRNPEI Practice Directive: Delegation).

Telenursing: use of electronic means by nurses to establish communication links with clients and/or other health care 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.

Written: to put information down in writing in a variety of ways such as "handwritten" "electronically written".

Background

Documentation is a nursing action that produces a written and/or electronic account of pertinent client data, nursing clinical decisions and interventions, and client responses. (Perry, Potter, Stockert & Hall 2017). Documentation is an integral part of professional nursing and safe practice. **Documentation is not optional**.

Documentation is a vital aspect of nursing practice, by ensuring continuity and quality of care, providing legal evidence of care, providing evidence for quality assurance and for future health care planning. These benefits demonstrate how crucial proper documentation is in nursing practice.

Principles of Documentation

Nurses must follow their employer's documentation policies, standards and protocols. If no policies exist, nurses may use this practice directive, while relying on their Standards of Practice, best practices and their professional judgment to guide their documentation. Additionally, the nurse has a professional responsibility to advocate for the creation of policies to support nursing documentation.

The following are essential characteristics of nursing documentation:

- Factual, objective and client centered
- Accurate and relevant
- Complete
- Current
- Organized, logical and sequential
- Compliant with standards of practice and other legal requirements.

Factual, objective and client centered

Descriptive and objective information based on first-hand knowledge, the nurse's assessment, and the client's perception of their needs.

Accurate and relevant

Clear and easy to understand information containing sufficient details about the client's care and/or variances in the client's response(s) to care.

Complete

All components of the nursing process including nursing actions and client responses.

Current

Information that is up-to-date and recorded during or, as soon as possible, after the intervention or interaction occurred.

Organized, logical and sequential

Information is in a chronological manner so that nursing decisions, nursing actions and

client responses to actions are evident.

Compliant with standards of practice and other legal requirements

Information reflects the delivery of safe, competent, ethical and compassionate nursing care and is consistent with standards of practice (*CRNPEI Standards for Nursing Practice*, Standard 2.6; *CLPNPEI Standards of Practice for LPNs in Canada*, Standard 1.9), employer policies and provincial and/or federal legislation.

Confidentiality

Health care professionals must recognize the importance of securing client documentation to avoid breaches. Failure to comply with legislation, falsifying information or providing information without the client or employer's consent may constitute professional misconduct.

Sharing confidential information is only acceptable to support the provision of quality care within the health care team who are a part of the client's circle of care. Documentation, in any format, must be maintained in areas where the information cannot be accessed by casual observers or those not directly involved in the care of the client.

Health records maintained in a client's home must be stored in a manner to reduce the risk of family members or others (e.g., visitors, guests) accessing confidential information. Employers and self-employed nurses should have policies outlining who has access to the health records and how clients and their family members are made aware of the importance of maintaining confidentiality.

Technology does not change a client's rights to privacy of their health information. Maintaining confidentiality (including access, storage, retrieval and transmission) of the client's health record is essential regardless of its format.

Why is Documentation Important?

Documentation is important to create a health record of a client's experience with the health care system (Ioanna, Stiliani & Vasiliki, 2007; Beach and Oates, 2014). Nursing documentation demonstrates what the nurse does for or with the client (Jefferies, Johnson & Griffiths, 2010) and is one part of the broader interprofessional documentation that forms the client health record. The health record is made up of several interprofessional tools and documentation that provides evidence of the care, treatment or service a client receives (Beach and Oates, 2014). Quality documentation is important in today's health context for a variety of reasons as discussed below.

Purpose of Nursing Documentation:

Communication among the health care team

Quality documentation supports the exchange of pertinent client information amongst the interprofessional care team.

Continuity of Care

All members of the health care team require accurate information about the client to ensure the development of organized, comprehensive care plans. Inaccurate or incomplete documentation can lead to fragmented care, repetition of tasks and delay or omission of therapies (Perry, Potter, Stockert & Hall 2017).

Professional Accountability

Documentation is a key accountability within the nurse client relationship to indicate the care, services and interventions provided based on nursing assessment and client response which is included in a complete record. Documentation is a key feature of the professional standards and Code of Ethics for nursing.

Legal

The client's health record is a legal document and can be used as evidence in a court of law or professional conduct proceedings. Courts may use the health record to reconstruct events, establish time and dates, refresh one's memory and substantiate and/or resolve conflicts in testimony (CNPS, 2009). When documentation is not done, it is possible to conclude that the care was not given.

Quality Assurance

Through chart audits and performance reviews documentation is used to evaluate the quality of services and appropriateness of care.

Funding and Resource Management

The analysis of quality documentation supports the allocation of resources, workload measurement and fiscal utilization (Potter, Perry, Stockert & Hall 2017).

Research

Data obtained from health records is used in health research to assess nursing interventions, to evaluate client outcomes and to determine the efficiency and effectiveness of care.

Who has a Role in Documentation?

First-Hand Knowledge

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

There may be situations when a nurse realizes after their shift, and after leaving the workplace, they did not document care they provided. For example, a nurse leaves and realizes they have forgotten to document an issue and calls back to the workplace to inform their colleague. In these rare circumstances another nurse, if requested, can document the information with the date, time and designation of the person from which it was received as per employer policy. Once the nurse with first-hand knowledge returns to the workplace, they must add their own note confirming that the third-party note is accurate and add additional information if necessary.

Third-Party Documentation

In general, third-party documentation is not recommended. Considering that this nurse is not performing the action, there is an increased risk for errors or omissions. Additionally, third-party documentation is generally not considered as valid evidence in a court of law. Third-party documentation should only be used in rare circumstances, such as a designated record (Code Blue Sheet, Critical Event Form) during emergency situations. In these scenarios, employer policy should outline the practice, as well as the documentation responsibilities of the designated recorder.

Unregulated Care Providers

Unregulated care providers should document the care they provide. Nurses should avoid documenting care given by others including unregulated care providers taking employer policy into account.

Designated Recorder

In emergency situations (e.g., cardiac arrest) where it may not be possible for the nurse providing care to document, it is acceptable to have a designated recorder. Employer policy should support the practice of designated recorders in these situations.

Client or Family

In some settings, a client or their family members may be permitted to document their observations and the care they provided in the client record. Employer policy should outline this process, if accepted by the employer and the practice setting, for the client and their family members, as well as the documentation responsibilities of nurses.

Students

Students are expected to document the care they provide in accordance with the institutional and academic policies. Nurses co-signing documentation written by students is not necessary. However, it may be necessary for the nurse who is acting as the preceptor to document their own assessments, interventions and evaluations. The nurse is always responsible to follow institutional policy and use professional judgement.

Self-Employed Nurses

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

Co-signing and Countersigning Entries

Co-signing refers to a second or confirming signature of a witnessed event or activity. Co-signing entries made by other care providers is not a standard of practice and when poorly defined, can blur accountability. If two nurses are involved in an assessment or the delivery of care, both should document according to employer policy. For example, if two nurses are required to hang a unit of blood, and both must sign the health record, the intent of a co-signature should be clearly stated in policy. In this case, employer policy could indicate that the co-signature is confirmation that the nurse (co-signee) witnessed that the correct unit of blood was given to the correct client. Co-signing implies shared accountability therefore the person co-signing needs to witness or participate in the event.

Countersigning is defined as a second or confirming signature on a previously signed document, which is not witnessed. This is not best practice and is generally not supported but may be used as a quality control process. For example, in a 24-hour chart review, a nurse reviews a chart to determine if all the orders are accurately transcribed, or all required interventions are completed. Countersigning does not imply that the second person provided the service, but it does indicate that the person approved or verified that the service or record was completed. If this practice is deemed necessary by the employer, policy and procedures should be in place to support this practice.

Key Elements of Nursing Documentation

Date, Time, Signature, and Designation

Documentation in the health record begins with date and time and ends with the recorder's signature and designation. Signatures and initials need to be identifiable and follow specific employer policies. 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.

Employer policy needs to support the method in which date and time are documented. For example, is a 24-hour or 12-hour clock used and what is the consistent written format of the date. A consistently designated timepiece should be used to record time (e.g. cardiac monitor or specially mounted wall clock). If the care provider is unable to use this timepiece the documentation should reflect what timepiece was used to record time.

Objectivity vs Subjectivity

Objective information deals with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations (Merriam-Webster Online, 2017). 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 the client's response.

Subjective data is modified or affected by personal views, experience, or background (Merriam-Webster Online, 2017). Subjective data may include information provided by a client as well as from the client's 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. Subjective information should provide accurate examples of what was said using quotes along with identification of the individual who made the statement. For example, the 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" or "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" are not acceptable when used without supporting factual information because they lack clarity.

Avoid Bias and Labels

Only document conclusions that can be supported by data and avoid value judgments or unfounded conclusions. Select neutral terminology or describe observed behaviours. For example, rather than stating that the “client is drunk” it would be correct to state, “noted an odour of alcohol and speech was slurred.” Instead of noting, “client is aggressive” it would be correct to state, “client shouting and using obscene language.”

Legibility and Spelling

Correct spelling and legibility of nursing documentation demonstrate attention to detail and nursing competence. Misspelled words or illegible entries can result in misinterpretation of information and could result in client harm. Spelling errors can result in serious treatment errors, for example, the names of certain medications, such as digitoxin and digoxin can result in a serious event. Slang and unapproved shorthand must not be used for the same reasons, misinterpretation can result in serious events.

All entries in a paper-based system should be written legibly in accordance with employer policy.

Abbreviation, Symbols and Acronyms

The use of abbreviations, symbols or acronyms can be an efficient form of documentation if their meaning is well understood. Abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors. Use only those abbreviations, symbols and acronyms on a current agency-approved list.

To review the list of error-prone abbreviations developed by the Institute of Safe Medication Practices, use the link provided.

Blank (White) Space

Blank or white space in paper-based documents should be avoided as this presents an opportunity for others to add information unknown to the original author. The accepted practice is to draw a single line entirely through the white space, including before and after the nurse’s signature. Fill in all blocks or spaces on flow sheets according to employer policy.

Errors and Changes

Inaccurate documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to employer policy. The content in question must remain 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

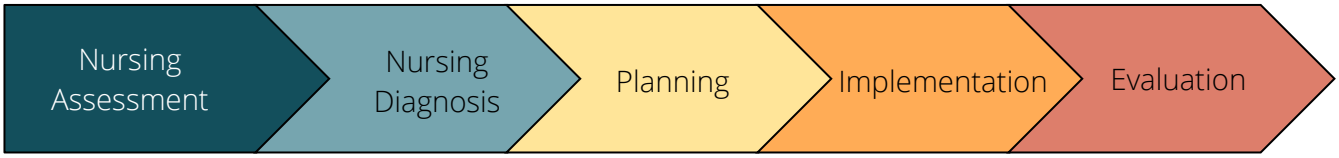
obliterate an error. The accepted practice to correct an error in a paper-based system is to strike-through the word(s) with a single line, above the line, write “mistaken entry” and insert your initials, along with the date and time the correction was made. The correct information must be added as a new entry.

To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove chart pages. Entries should not be re-copied or removed because of a documentation error.

Failing to correct an error appropriately (according to employer policy) or correcting or modifying another person’s documentation may be interpreted as falsification of a record. Falsifying records is considered professional misconduct.

Nursing Process

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, including:



Providing Care to Groups

When documenting for groups or communities the documentation should provide a clear picture of:

- The needs or goals of the group or community
- The nurse’s actions based on the needs’ assessment
- The outcomes and evaluations of those actions

Information about individual clients within the group or community may be recorded in the individual client’s health record. Employer policy will direct where this information is recorded.

Client Receiving Care from Two or More Agencies or Departments

If the client is receiving services from two or more agencies or departments that have separate records it is important that the nurse follows the employer policy and records the care they provided in all relevant documents.

Plan of Care

The plan of care must be included in effective client-focused documentation for every client. A plan of care is a written outline of care for individual clients and is part of the permanent record.

Admission, Transfer, Transport, and Discharge Information

Accurate and concise documentation on admission, transfer, transport and discharge provides baseline data for planning subsequent care and follow up.

Nursing documentation at the time of admission to care or service must be thorough, complete and follow employer policy, which should include reason for admission, status at admission and a full admission assessment. Admission refers to any entry to care or service, in a facility or in community. Employer policies should identify expectations about recording communication between practitioners when a client's care is transferred.

Documentation at the time of transport must include details of care provided to date, care provided during transport, status at the time of transport and during transport and transfer of care report. Nursing documentation should include information on the client's status at discharge, any instructions provided (verbal and written), arrangements for follow-up care and evidence of the client's understanding, and the client's family involvement.

Client Education

Accurate documentation of education provided by nurses in the nurse client relationship is essential to enable effective communication and continuity 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
- methods of teaching (written, visual, verbal, auditory, repeat demonstration and instructional aids)
- involvement of client and/or family
- evaluation of teaching objectives with validation of client comprehension and learning
- any follow up required

Risk-Taking Behaviours

Nurses have an ethical responsibility to respect a client's informed choice, even if these choices may be risky to their overall health. The nurse must document the objective data related to the risk-taking behaviours and avoid placing a value judgment on the

behaviours. The nurse should also document information they provide to the client about the risk-taking behaviour and any potential consequences of the behaviour. It is not acceptable to document the client as “non-compliant.” Instead, the nurse should document the objective data that describes the behavior.

If the risk-taking behaviour results in a situation in which mandatory reporting must occur, the nurse is required to follow the applicable legislation and document appropriately.

Reportable Event

A reportable event or occurrence is an event which is not consistent with the routine, expected care of a client or the standard procedures in place in a practice setting (Perry, Potter, Stockert & Hall 2017). Examples include patient falls, medication errors, needle stick injuries, or any circumstance that places clients or staff at risk of injury. Reportable events which involve clients are generally recorded in two places: in the client’s health record and in a reportable event reporting system (or form) which is separate from the chart.

Documentation of a reportable event in the chart should be recorded by the person who witnessed the event. The documentation should be accurate, concise, factual, unbiased and should not contain the words “error”, “incident” or “accident”. The nurse should first document the event in the health record to ensure continuity and completeness, and then complete a reportable event record in accordance with employer policies.

Reportable event reports (also called occurrence reports, incident reports, or adverse event reports) are separate from the client record and are used by agencies for risk management, to track trends and to justify changes to policy, procedure and/or equipment. Information included in a reportable event is similar to the information included in a client’s health record, however, the reportable event record also includes additional information about the particular reportable event (e.g., “a door was broken” or “this was the fourth such occurrence this week”), which is not directly related to the care of the client. Employer policy should clearly describe the processes necessary to complete a reportable event record.

Medication Administration

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

- Date
- Actual time medications are administered
- Name(s) of medications
- Route(s) of medications
- Sites of administration when appropriate
- Dosage administered
- Nurses signature/designation

Each individual health care provider (e.g., respiratory therapists, physiotherapists) should sign for the medications they administer, except in emergency situations. In emergency situations, nurses may sign for medications administered by other health care providers if this is supported by employer policy.

For more information about Medication Administration see the CRNPEI/CLPNPEI Medication Administration Practice Directive.

Verbal Orders and Telephone Orders

Authorized prescribers are expected to write orders whenever possible. Verbal orders must only be accepted in emergent or urgent situations where the prescriber cannot document their medication orders. Telephone orders should be limited to situations when the prescriber is not present. The prescriber is accountable to review and co-sign their verbal or telephone orders as soon as reasonably possible or within the timeframe indicated in an employer's policy.

For more information about verbal and telephone orders see the CRNPEI/CLPNPEI Medication Administration Practice Directive.

Text and Email Orders

Increasing numbers of healthcare professionals are using mobile devices to communicate prescriber orders by text message or email. This type of communication is discouraged due to the risk of breaching confidential health information and incomplete communication of client status.

Unauthorized disclosure of the client's personal health information (PHI) is a risk because mobile devices can store and retain data on the device itself. Also, mobile devices are vulnerable to loss and theft because of their small size and portability (CNPS, 2013). Encryption and the use of strong passwords are the most effective way to safeguard a client's PHI. Without encryption, any emails, voicemails, pictures or text could be inappropriately accessed or disclosed if the mobile device is lost, stolen or inadvertently viewed by another person.

Vital information related to the context of the client assessment may be lost when using text or email to communicate. Text can be subject to interpretation and lead to inappropriate, incomplete, or insufficient prescriber orders.

Text or email should not be used for provider convenience; however, if text or email communication is the only way health professionals can communicate in the best interest of the client, employers or self-employed nurses must have policies to support this practice. Additionally, whenever possible, employer-issued mobile devices should be used to send client related texts and emails as opposed to personal devices.

When sending client related emails or texts, it is important to remember that these communication tools are legal documents, like that of paper and electronic charting. As such, the nurse should ensure that they proofread the message for typos and grammatical errors, use a professional tone, and ensure that the content of the

message abides by employer policies and standards.

Documentation of text and email orders must also occur in the client's health record. A copy of the text or email message can be added to the record as acceptable documentation.

See CRNPEI Practice Directive: Technology in Practice

Collaboration with Other Health Care Professionals

Interdisciplinary communication and documentation support interdisciplinary practice and can eliminate duplication, enhance efficient use of time and enrich client outcomes. Collaborative documentation enables health care professionals of all disciplines to share the same documentation tools. Examples of such tools are care pathways and progress notes.

Nurses need to ensure their documentation within an interdisciplinary tool accurately reflects the unique contribution of nursing to the care of clients.

When nurses collaborate with members of the interdisciplinary team to develop and/or modify the plan of care, 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 health care providers
- responses from health care 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 client the nurse should record the reason for seeking clarification, the name of the health care provider responsible for the clarification, the action they took and the expected outcome.

Client Care Provided Through Electronic Means

In Prince Edward Island, many employers have implemented electronic means of documenting care provided. Electronic documentation is now a routine part of the care of many clients. This could include entering requests for tests and consultations, reporting diagnostics testing or documenting care.

A client's electronic health record is a collection of the personal health information of a single individual, entered or accepted by health care providers, and stored electronically, under security. As with traditional paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care.

Entries made and stored in an electronic health record are considered a permanent part of the record and must not be deleted. Client information transmitted electronically must be stored (electronically or in hard copy) and, if relevant, may be subject to disclosure in legal proceedings.

Employers need to have clear policies and guidelines to address challenges and issues related to documentation for electronic health records. Nurses must follow employer policies/guidelines that reflect and support quality, evidence-based practice. Employer 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 the 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, if required
- ensure continuity of care is maintained
- ensure client information is saved correctly (backed-up)
- document in the event of a system failure or "downtime"
- obtain access to a specific group or area of information.

Using Fax Technology to Transmit Client Information

Facsimile (fax) transmission of client information between health care providers may occur. There is significant risk to the confidentiality and security of information transmitted via fax due to possible transmission to unintended recipients. Employer 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 fax should include the following guidelines:

- locate fax machines in secured areas away from public access
- 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
- shred any discarded faxed information containing client identification
- carefully check activity reports to confirm successful transmission
- include a cover sheet with a Confidentiality Statement that identifies the fax document as confidential and instructs unintended recipients to immediately destroy the document without reading it
- advocate for secure and confidential fax transmission systems and policies.

The rationale for the above guidelines include:

- decreasing the likelihood of an unintended breach of client confidentiality.
- ensuring that the fax was sent and is not sitting in the queue to be resent or accessed by someone else.
- safeguards that make the unintended recipient accountable for any actions they may take with information incorrectly sent to them.
- contributes to quality practice environments.

Client information received or sent by fax is a form of client documentation and must be stored electronically or printed in hard copy, appropriately labelled with the necessary client information and placed in the client's health record. Faxes are part of the client's permanent record and can be subject to disclosure in legal proceedings.

Email

The use of electronic mail (e-mail) transmission by health care employers and health care professionals is becoming more widespread because of its speed, reliability, convenience, and low cost. However, like faxes, there is a significant risk of security and confidentiality in email messaging. Messages can inadvertently be read by an unintended recipient and while the message can be erased from the local computer, it main remain in a central server, if applicable, and could be retrieved by unauthorized personnel. It is not recommended as a method for transmitting clients' health information.

The use of email should include consideration of the following guidelines:

- Obtain client consent before transferring health information by email as dictated by policy.
- Transmit email using special security software (e.g. encryption, user verification or secure point-to-point connections).
- Do not share your password for email.
- Check that the email address of the intended recipient(s) is correct prior to sending.
- Ensure transmission and receipt of email is to a unique email address.
- Maintain confidentiality of all information, including information reproduced in hard copy.
- Printers should be in secured areas away from public access.
- Retrieve printed information immediately.
- Include a confidentiality warning indicating that the information being sent is confidential and that the message is only to be read by the intended recipient and must not be copied or forwarded to anyone else.
- Never forward an email received about a client without the client's written consent.
- Follow employer policies to ensure secure and confidential email systems.

The rationale for the guidelines include:

- transmitting information by email has a higher risk than other forms of communication
- the use of encryption software provides a safeguard against hacking and unauthorized access of client information
- sharing passwords allows possible unauthorized access to client information
- unauthorized access can result in accountability by the account owner for any activity in their name.
- decreases the likelihood of an unintended breach of client confidentiality
- safeguards that make the unintended recipient accountable for any actions they may take with information incorrectly sent to them.
- contributes to quality practice environments.

Telenursing

Giving telephone advice is not novel to nursing, but what is changing is the number of people accessing telephone "helplines" to assist them in their decision-making about how and when to access health care services. Nurses are increasingly required to provide telephone advice as an efficient, responsive, and cost-effective way to provide health services or support self-care. Nurses must adhere to employer policies and guidelines related to the provision of telephone advice.

Nurses that provide telehealth are required to document the telephone interaction. Documentation may occur in a written form (e.g. logbook or client record form) or via computer. Minimum documentation includes the following:

- date and time of the call (including voice mail messages left or received)
- client's name, telephone number and another identifier (such as date of birth)
- reason for the call, assessment findings, signs and symptoms described, specific protocol or decision tree used to manage the call (where applicable), advice or information given, any referrals made, agreement on next steps for the client and the required follow-up.

See CRNPEI Practice Directive: Technology in Practice

Timing of Documentation

Timely, Chronological, and Frequent

Documentation should occur as close as possible to the time of care to enhance credibility and accuracy of the healthcare record. Documentation must not be completed prior to an intervention or event taking place.

Documenting events in chronological order is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications, regarding the care provided, the assessment data, and outcomes or evaluations of that care, including client responses.

The frequency and amount of detail required in documentation is generally dictated by several factors:

- employer policies and procedures
- complexity of a client's health status
- client acuity
- degree of risk involved in a treatment or component of care

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

Late or Lost Entries

As stated above, 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 or corrections incorporating omitted information in a health record should be made only when a nurse can accurately recall the event, or the care provided.

Late entries must be clearly identified, individually dated, and follow employer policy. The late entry should reference the actual time of documentation as well as the time when the care/event occurred and must be signed by the nurse involved. If extensive time has elapsed between the care and the documentation entry, seek guidance from your employer before adding notes.

Legislation affecting Nursing Documentation

Federal Level

Access to Information Act
http://laws-lois.justice.gc.ca/eng/acts/A-1/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

Provincial Level

FOIPP
https://www.princeedwardisland.ca/sites/default/files/legislation/f-15-01-freedom_of_information_and_protection_of_privacy_act.pdf

Regulated Health Professions Act
https://www.princeedwardisland.ca/sites/default/files/legislation/r-10-1-regulated_health_professions_act.pdf

Health Information Act
Health Information Act (princeedwardisland.ca)

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