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1.0 PURPOSE

1.1 To ensure effective documentation on patient care and progress.

2.0 POLICY

2.1 All staff nurses are accountable for ensuring that documentation of patient's care is accurate, timely and complete.

3.0 PROCEDURE

3.1 The staff nurse is responsible for:
- 3.1.1 Documenting the correct patient's record at beginning of shift and as required using 24-hour clock.
- 3.1.2 Providing a documented update on patient's condition and progress.
- 3.1.3 Documenting nursing actions performed.

3.2 Systems Charting is the method used for documenting the Nursing Notes in all clinical areas.

3.3 Whenever possible, nursing documentation should be done at the time of action.

3.4 All entries are to be dated on actual day and time recorded, not retrospectively.

3.5 Documentation may be either written or electronic format.

3.6 **Written Documentation**
- 3.6.1 Handwriting must be clear and legible at all times.
- 3.6.2 Whiteout correction fluid **must not** be used to alter documentation.
- 3.6.3 Spaces are not to be left between entries and signatures. A line must be placed through any space or line, which is not completely used.
- 3.6.4 All entries must be written in blue permanent ink. Highlighter pens should not be used. All entries must be dated, timed and signed with name and title printed clearly at the end of the entry.
- 3.6.5 Notes are not to be destroyed.

Sample of written documentation

Date & Time	System	Patient Care Progress Record
1.12.09 0730 hrs		Received patient handover. Emergency equipment checked. Oxygen and suction in working order.
	CNS	Alert and oriented. Obeys commands.
	CVS	Haemodynamically stable. HR = 62bpm (sinus rhythm), BP = 110/70 mmHg. Nil complaints of chest pain voiced.
	Resp	Chest clear. SaO_2 = 98% on room air. Nil complaints of SOB.
	GIT	Tolerating oral diet well. No nausea or vomiting. Bowel sounds present. Patient continues 1.2L/day fluid restriction.

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Date & Time	System	Patient Care Progress Record
		Bowels not opened for 4/7 - given Importal with no effect.
	GUT	Urine output 1.5ml/kg/hr; satisfactory
	Skin	Skin intact. Right radial arterial line insitu - site NAD. Right jugular CVL insitu - site NAD.
	Infusions	Patient receiving Dopamine and Normal Saline via CVL.
	Other	Patient mobilizing independently.
		Joe Bloggs, SNII
1.12.09 0930 hrs		Patient seen by Dr Smith - for Abdominal Ultrasound 3.12.09 at 1330 hrs - patient aware.
		Joe Bloggs, SNII

3.7 **Electronic Documentation**

3.7.1 Ensure proper/appropriate clear descriptive communication is used.

3.7.2 Document all relevant data.

3.7.3 Protect your username and password as these are your electronic signatures.

3.7.4 Log off the system when not in use.

3.8 Never delete, alter or modify another staff member's documentation.

3.9 Only abbreviations from the PSCC hospital approved list should be used.

3.10 Care given by any other member of the health care team should be clearly documented. Date, time, reason of care, name, profession and bleep number, if relevant, should be included.

3.11 Document all objective and subjective data.

3.12 To prevent transcribing errors when documenting the administration of drugs or fluids in the Nursing Notes, only the *name* of the drug or fluid should be entered. Do not enter the dose or volume.

3.13 Record data in the following order:

3.13.1 CNS
3.13.2 CVS
3.13.3 Resp
3.13.4 GIT
3.13.5 GUT
3.13.6 Skin/Integument
3.13.7 Infusions
3.13.8 Other

3.14 Use a new line for each system.

3.15 **For written errors**

3.15.1 Errors should be crossed out, initialled and re-entered.

e.g.

JB

1.12.09 1100hrs Morphine administered intramuscularly to the ~~left gluteus maximus~~ right gluteus maximus.

Joe Bloggs, SNII

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3.15.2 Omissions should be labelled "Late Entry" with date and time of entry recorded. e.g.

1.12.09 1100hrs Late Entry - patient commenced fasting 1200 hours for Cardiac Cath procedure. *Joe Bloggs,* SNII

3.15.3 Ensure original documentation remains visible.

3.16 **For electronic errors**

3.16.1 Enter the "Add Remark" icon on the computerised charting system.

3.16.2 Enter the correct information and save using username and password.

4.0 DISTRIBUTION

4.1 All nursing units / wards.

5.0 REFERENCES

College of Nurses of Ontario. Practice Standard, (Revised 2008). *Documentation.* Available from: http://www.cno.org/docs/prac/41001_documentation.pdf [accessed 21 January 2010].

Registered Nurses Association of British Columbia. Nursing Practice Guidelines, (revised March 2007) *Documentation*. Available from: http://www.crnbc.ca/downloads/151.pdf [accessed 3rd February 2010]

6.0 APPLICABILITY

6.1 All nursing staff.

Prepared by:	Reviewed by:	Reviewed by:	Approved by:
Chairperson, NP Committee	Director of Nursing	Director of TQM	PSCC Director
10/03/2010	10.4.10	13.04.2010	14-4-2010
Date	Date	Date	Date