

RA – 5.1 DOCUMENTATION POLICY

INTENT: To ensure clear, accurate, accessible, efficient management of information, improving accountability, organization and communication.

To ensure each client receiving care has access to his or her records in accordance with individual health and safety requirements.

To ensure information is kept confidential.

To maintain complete and current records, and to provide a consistent record keeping system within Resource Ability.

Nursing documentation serves the following main purposes:

- 1) **Communication:** Nurses communicate to other health care providers their nursing assessments and diagnosis of a client’s condition, the plan of care, interventions that are carried out by the nurse, and the outcomes of those interventions.
- 2) **Safe and appropriate nursing care:** When nurses document the care they provide, others members of the health care team are able to review the documentation and plan their own contributions to safe and appropriate care. Documentation also provides data for research and workload management, both of which have the potential to improve health outcomes.
- 3) **Professional and legal standards:** Documentation is a comprehensive record of care provided to a client. It demonstrates how a nurse has applied their knowledge, skills, and judgement according to the standards of practice. Documentation is also generally accepted as evidence in legal proceedings. It establishes the facts and circumstances related to the care given and assists nurses to recall details about a specific situation.

Definitions:

Documentation – “Documentation includes any written – or electronically generated information about a client that describes the care or service provided to that client.”
(BCCNP Practice Standards/Documentation)

Home Chart – Client record that remains in the home so long as Resource Ability is providing service.

School Chart – Client record which is an extension of the home chart used to document in the school environment. All essential documentation is derived from the “Home Chart” but stored in a separate, smaller, more portable binder to facilitate easier use at school. May be securely stored at the client’s school or travel with the client as assessed by the nursing team, depending on individual circumstances.

Office Chart – Client records that have been removed from the home chart and stored securely at head office for reference and record keeping. Additional chart documents may be stored at offsite secure storage as needed.

Communication Book – A coiled book of lined paper, labeled with the client’s name and contact information. Remains part of the client chart and property of Resource Ability.

POLICY STATEMENTS

- 1- Nurses are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by others should ordinarily be documented by those individuals, unless there are exceptional circumstances such as an emergency.
- 2- Nurses document a decision-making process (e.g., assessment, nursing diagnosis, planning, implementation and evaluation) to show the care they provided.
- 3- Nurse’s document information or concerns reported to another caregiver, and that caregiver’s response.
- 4- Nurses document in a clear, concise, factual, objective, timely, and legible manner.
- 5- Nurses document all relevant information about clients in chronological order in the client record. Utilize established logs, checklists, and records as outlined by Resource Ability in the “Instruction for management of chart and paperwork” care guideline.
- 6- Nurses document at the time they provide care or as soon as possible afterward. Nurses clearly mark any late entries, recording both the date and time of the late entry and of the actual event.
- 7- Nurses correct any documentation errors in a timely, honest, and forthright manner.
- 8- Nurses do not document before giving care.
- 9- Nurses indicate their accountability and responsibility by signing with a unique identifier (such as a written signature or an electronically-generated identifier) and their title, in a clear and legible manner to each entry they make in the client record.
- 10- Nurses carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk, or have complex health problems.
- 11- Documentation in the clinical record should be done in black or dark blue ink. This ensures permanency and the ability to scan/copy documents clearly as needed in the future.
- 12- Nurses complete a (“Unusual Occurrence Form” WHRC3.18) following an event such as a medication error, injury or a fall. The Unusual Occurrence Form is not part of the client record.

Nurses record facts about any event affecting the client in the client record. Additional documentation may be required as per WorkSafeBC.
(Policy statements adapted from BCCNP Practice Standards for Nursing documentation. May/2020)

PROCEDURE

-The home chart is the comprehensive onsite record for all client care, assessment findings, and nursing interventions. All appropriate and required documentation will be done in the home chart.

-If the client has nursing care at school, a School Chart may be created. The School Chart may be used to facilitate ease of use and portability so long as it contains all essential documentation including but not limited to:

1. Emergency Action Plan with up-to-date contact information
2. Physicians Orders
3. Medication Administration Record
4. Client specific Equipment, Care, and procedure checklists
5. Nursing Notes
6. Communication Book
7. Other supporting documents required to perform safe client care

-See guideline “Instruction for Management of Chart and Paperwork” for more information on use of a School Chart.

-School Charts must either:

1. Travel with the client between home and school in order to ensure that personal information contained within the chart is secure.
2. If the School Chart is kept at the school, it must be stored in a secure location i.e. Locked teachers’ drawer/cupboard, student’s locked locker, secure area in the school office with other student records.

-A Communication book will also be kept with each home chart for communication between all care givers. This can be used by nurses and family caregivers to share information, changes, updates, and general information as it pertains to the client’s care. It is not part of the legal formal documentation and serves as more of a written “report”.

-All records will include the appropriate documentation, and be managed as outlined in NSS guideline “Instruction for management of chart and paperwork” and in accordance with BCCNP documentation guidelines as referenced in the policy statements above.

-Chart documents may be requested by the client or guardian by completing WHRC form 5.01 Records of Individuals Receiving Services (Form: Access to Individual Records – Consent to Release Information Form) and submitting to Resource Ability head office attention to the program manager.

FORMS: Physicians Order Form
 BiPaP Monitoring Form
 Medication Administration Record
 Blood Sugar Record
 Care Checklist
 CPaP Monitoring Form
 Equipment checklist
 Feed Administration Record
 Vital Signs Record
 Seizure Record
 Suction Record
 Ventilation Record
 O2 Monitoring Record

References:

https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Pages/documentation.aspx

NSS Guideline “Instruction for Management of Chart and Paperwork”

WHRC Policies

5.01 Records of individuals receiving services

3.18 Unusual Occurrence Form