

# guiding principles for documentation

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The Nurses Board of South Australia (**nbsa**) has the mandate under legislation to regulate the practice of nursing and midwifery in the public interest and to determine the scope of nursing and midwifery practice. The Board does so with a view to ensuring that the community is adequately provided with nursing and midwifery care of the highest standard and to achieve and maintain the highest professional standards of competence and conduct.

The Nurses Board of South Australia recognises that documentation and record keeping is a fundamental part of nursing and midwifery practice. As guideline principles for documentation, this document is not intended to be an operational framework for documentation within the workplace and does not direct organisational policy in relation to specific documentation scenarios or circumstances. The guiding principles support the development of consistent practice in relation to nursing and midwifery documentation and record keeping and assist nurses and midwives to understand their professional obligation in relation to documentation.

A nurse or midwife can demonstrate that they have fulfilled their professional obligation in relation to documentation where their practice is consistent with these guiding principles. This applies equally to a nurse or midwife whether in a clinical setting providing direct care, a Nurse Manager, Educator or Researcher or a Director of Nursing/ Midwifery role responsible for the development, implementation and review of documentation policy.

The Nurses Board of South Australia upholds that no nurse or midwife may be directed, pressured or compelled by an employer, or any other person in a position of authority, to engage in any practice that falls short of, or is in breach of any professional standard and/or code of conduct or practice.

It should be assumed that any and all nursing or midwifery documentation will be scrutinised at some point.

## **These guiding principles should be read in conjunction with**

- [ANMC National Competency Standards for the Registered Nurse \(December 2005\)](#)
- [ANMC National Competency Standards for the Enrolled Nurse \(October 2000\)](#)
- [ANMC National Competency Standards for the Midwife \(January 2006\)](#)
- [ACMI Competency Standards for Midwives \(2002\)](#)

and the

- [Department of Human Services Medical Record Documentation and Data Capture Standards \(Aug 2000\)](#) as the key reference for medical record quality assurance auditing and accreditation processes in South Australian hospitals
- [Commonwealth Department of Health and Aged Care Documentation and Accountability Manual \(Version 3\)](#) as the regulatory framework from the perspective of the Commonwealth Department of Health and Aged Care and the professional requirements of responsible and accountable aged care practices



## purpose

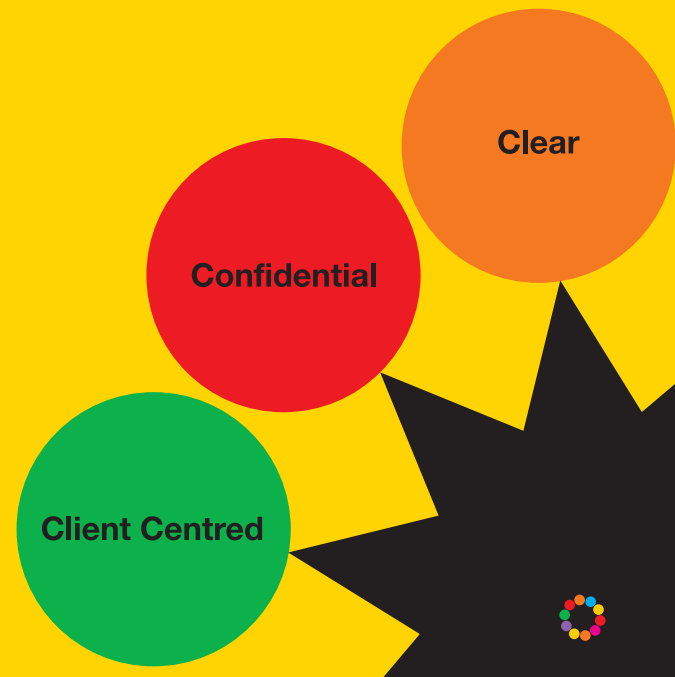
These guiding principles support nurses and midwives, employers, policy makers and managers in documentation practices and policies that demonstrate professional obligation, accountability and legal requirements to communicate and record client information and nursing and midwifery practice.

## professional documentation includes

**Any and all forms of documentation by a nurse or midwife recorded in a professional capacity in relation to the provision of nursing or midwifery care and includes written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, shift/management reports, incident reports and nursing or midwifery anecdotal notes or personal reflections (held by the nurse or midwife) or any other type or form of documentation pertaining to that care.**

## professional documentation promotes

- compliance with ANMC competency standards for nurses and midwives
- a high standard of care
- evidence of nursing and midwifery care
- continuity of care
- improved communication and dissemination of information between and across service providers
- an accurate account of assessment, care planning, treatment and care evaluation
- improved goal setting and evaluation of care outcomes
- improved early detection of problems and changes in health status

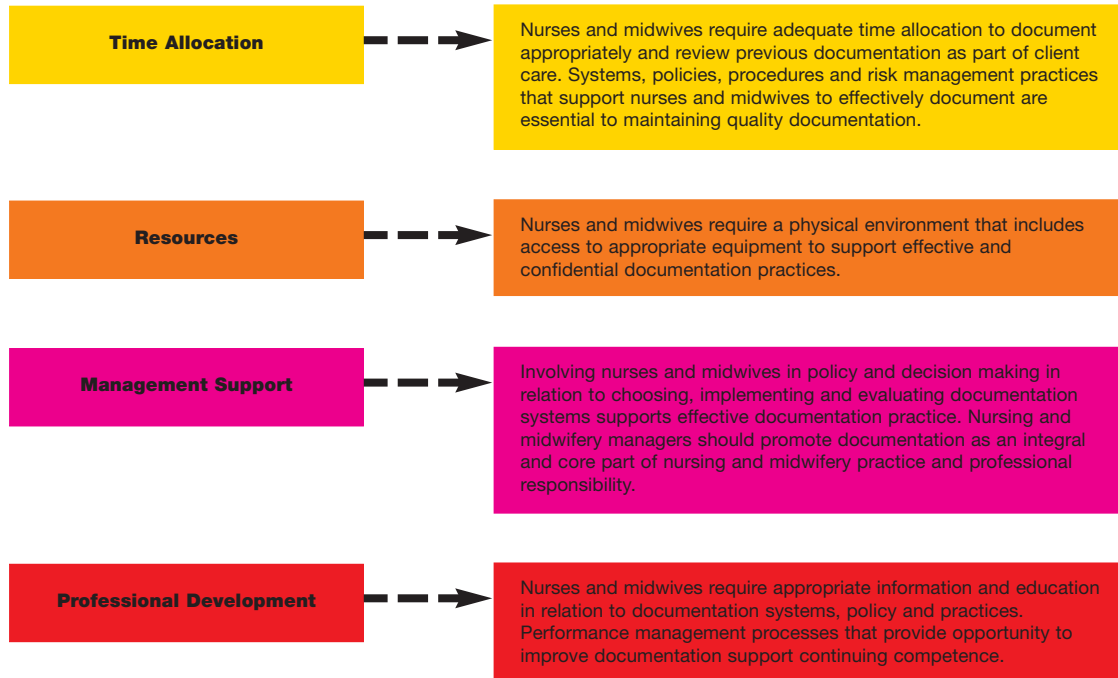


## purpose of professional documentation

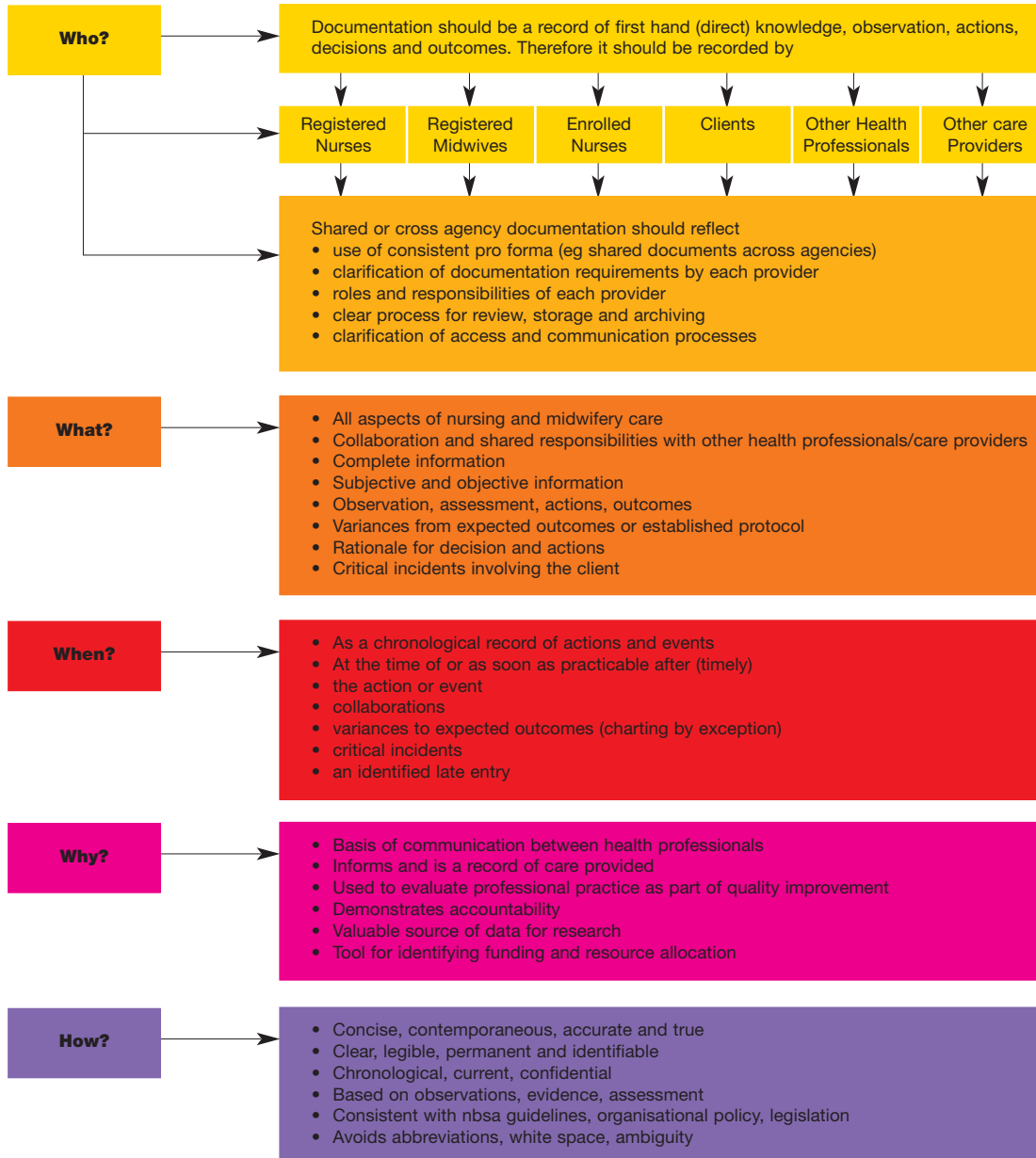


## **maintaining quality documentation**

In meeting the ANMC Competency Standards in relation to documentation, nurses and midwives require



# guiding principles for documentation







## guiding principles for documentation

### guiding principle 1:

#### Comprehensive and Complete

Nurses and midwives have a professional obligation to maintain clear, concise and comprehensive documentation.

# 1

Professional documentation is an integral part of nursing and midwifery practice. It is a primary communication tool between health professionals and forms the basis for evidence of care that can be used for research, legal analysis and determining allocation of resources.

#### comprehensive and complete documentation should

- be a clear, concise and complete record of nursing or midwifery care
- be factual, accurate, true and honest record
- be timely **[\*1]**
- be legible and permanent (including photocopies/faxes)
- be representative of professional observations and assessment
- be a contemporaneous record of care **[\*2]**
- include date and time (including record of late entries, changes or additions) **[\*3]**
- avoid duplication of information
- identify the person who provided/documented the care (including signature, printed name and designation) **[\*4]**
- identify the source of information (such as information provided by another nurse, midwife, other health care professional/provider or family) **[\*5]**
- contain meaningful and relevant information (avoids meaningless phrases such as 'slept well' or 'usual day')
- minimise transcription of data **[\*6]**
- be easy to interpret over time **[\*7]**
- avoid use of abbreviations (other than those approved and documented in organisational policy by the employer) **[\*8]**
- include detailed documentation in relation to critical incidents **[\*9]**
- include documentation in relation to variance to expected outcome (eg reporting by exception)
- facilitate registered nurses' and midwives' supervision of documentation by enrolled nurses and/or unlicensed healthcare workers. **[\*10]**

*Postscripts to principle 1 pg 11*



## guiding principles for documentation

### guiding principle 2:

#### Collaborative and Client Centred

Documentation is client centred, collaborative and appropriate to the setting in which the care is provided.

Nurses and midwives may document for individual clients, their families and groups of clients or populations. Nursing and midwifery documentation may record diverse information within and across services and settings. Given the diversity of nursing and midwifery care, employers, nurses and midwives must consider how, by whom and for what purpose information is to be used.

#### client centred documentation should

- be appropriate to the specific needs of the client/client population and context of the care
- support shared and/or cross agency documentation processes **[\*11]**
- be a record of independent and/or collaborative actions with other health professionals or care providers **[\*12]**
- be relevant to the setting in which the care occurs (including client held records, electronic records and mobile record systems)
- identify objective and subjective data when documenting assessment of the client needs/health status **[\*13]**
- be an individualised, comprehensive and current plan of care
- support and promote client choices/preferences that guide the focus of the care plan
- be based on professional observation and assessment not personal judgement (non judgemental) **[\*14]**
- clearly document problems that have arisen and actions taken to rectify/address these
- be based on professional judgment in determining the frequency of documentation required
- document consistent with policy, standards and legislation
- include document evidence of consent or refusal relevant to a nursing or midwifery intervention where required
- utilise appropriate supporting documentation systems and pro forma **[\*15]**
- record any intervention, advice or information given or received via telephone

*Postscripts to principle 1 pg 13*

# 2



## guiding principles for documentation

### guiding principle 3:

#### Confidential

Nursing and midwifery documentation will maintain client confidentiality in all care settings.

# 3



Nurses and midwives have legislative, professional and ethical obligation to protect client confidentiality. This includes maintaining confidential documentation and client records.

Electronic information, mail and communication systems are increasingly used as effective means of maintaining and transferring documentation and information in the health care environment. Precautions must be taken to ensure that nurses and midwives are fully informed of appropriate, safe and secure use of electronic information systems.

Clients have a legal right to access their records through Freedom of Information legislation (*Freedom of Information Act 1991*) and also increasingly participate in writing and/or holding their own documentation/records.

#### confidential documentation should

- maintain the confidentiality of the person who is the client
- include practices that protect confidentiality of information and data
- be stored and archived confidentially
- maintain confidentiality of electronic documentation and information **[\*16]**
- include practises that maximise the confidentiality of documentation and records in diverse settings (eg mobile/client held records)
- communicate/disclose relevant information with relevant others only
- manage, store and/or destroy all copies appropriately
- include practices that maximise security of records from unauthorised access, loss or theft during transfer, transmission (ie electronic transfer) or transportation
- allow access to only those who have authority to access it **[\*17]**
- dispose of documentation (where appropriate to destroy) in a manner which maintains confidentiality (eg confidential bins/shredding)
- meet requirements for storage and disposal scheduling
- meet requirements for privacy **[\*18]**

*Postscripts to principle 1 pg 15*



**appendices**

**postscripts to guiding principles**



## postscripts to guiding principle 1

- [\*1]** As a general rule legal proceedings tend to find that written records are considered more accurate and credible when recorded in a timely manner and are considered more reliable than information recorded after a delay, based on memory. Timeliness should be seen to mean at the time the nurse or midwife undertook/provided the care as soon as practicable after the care was provided.
- [\*2]** Chronological entries present a clear sequence of the care provided over time and facilitate better communication between care providers. Late entries should be appropriately recorded as soon as possible.
- [\*3]** For documentation to be reliable it should clearly state when care was provided. Ensuring entries are made as close to the time of the care or event is essential. Where this has not occurred late entries may be made (and clearly identified). Late entries must only be made when the nurse or midwife can accurately recall the event. For this reason, making a late entry must be voluntary and should be clearly identified as a late entry. Changes or additions should be minimised as they can lead to confusing records and perceptions of poor care and decision making practices. Changes or additions should not obscure or delete any previously recorded entry. Changes must only be made to the nurse's or midwife's own documentation.
- [\*4]** Nurses and midwives may obtain information from a third person that is relative to the client's care (eg a family member). In these circumstances the information documented should include its source. An exception to this is if the source is another client in which case they will not be identified by name (*eg client in next bed stated...*).
- [\*5]** The nurse or midwife who provided the care / observed the event should be the person who documents the information. An exception may be where a specific scenario has a designated recorder (such as in a cardiac arrest), or where one nurse or midwife assists another to provide care (such as another nurse or midwife to support a client to ambulate). Where a nurse or midwife is documenting information (as a designated recorder) the recorder should identify the other person/s (and their role or professional designation) as part of the care provided.
- [\*6]** Transcription of data may increase the risk of documentation error due to, for example misinterpretation of the information. Nurses and midwives should not transcribe medication orders unless they are an authorised prescriber (eg a nurse practitioner or midwife with authorisation from the **nbsa** to prescribe medications).
- [\*7]** Legal or regulatory proceedings may occur some time after the event. Timely written records are considered more credible than verbal accounts after the event (more influenced by memory). Nursing and midwifery documentation is admissible in legal proceedings and may occur without the person being present or providing additional clarification. Therefore it is important that documentation is able to be clearly interpreted and understood over extended periods of time and as *stand alone* information without further clarification or explanation from the person who wrote it.
- [\*8]** Abbreviations and symbols can be an effective and efficient form of documentation. It is important that their meaning is clearly understood by the health provider using them and/or reading them. Abbreviations that are obscure, poorly defined and open to broad interpretation or have multiple meanings can lead to confusion and error in relation to client care. Abbreviations should only be used where they are approved and defined by organisational policy or established and acknowledged by the profession using them (*eg prn pro re nata – as needed*).



**[\*9]** Organisational policy usually requires reporting of critical incidents be documented on a purpose specific form. Regardless of whether a separate report is required, nurses and midwives have a professional obligation to document such incidents in the client health care record as a true and honest record of the event and the actions taken in response to it.

**[\*10]** Nurses and midwives document the care they provide as a record of their accountability for their actions and decisions. For this reason the **nbsa** recommends that enrolled nurses (and where delegated - unlicensed healthcare workers) document as a first hand record of the care they provide. Registered nurses and midwives should appropriately facilitate and supervise this practice.

Co-signing entries made by an enrolled nurse or other care providers (such as unlicensed healthcare workers) is not a required standard of practice but may be an organisational policy. To ensure nursing and midwifery accountability remains clear, organisations that implement co-signing policies should present clear process and rationale for this practice.

#### *Example*

*A registered nurse co-signs an enrolled nurse's entries in the client record where the enrolled nurse has recorded her/his objective observations (including vital signs) of the client. Does co-signing indicate that the registered nurse agrees with the enrolled nurse's actions/decisions, has witnessed the care provided, has verified the observations or has read the entry as required by the organisational policy?*



## postscripts to guiding principle 2

**[\*11]** Increasingly, particularly in community settings, records may be held (or owned) by the client and/or may be shared across a number of organisations or service providers. These organisations may also share responsibility for these records. When keeping shared records, consideration must be given to each organisation's and individual's responsibility in relation to recording data/events, access (to read/document in), retaining/archiving records, review of documentation (eg care plans) and informing others of change. Such consideration may identify the need to retain copies of shared records within negotiated protocols.

The **nbsa** supports the principle of shared records where all care providers involved in the care of a client make entries in a single record in accordance with an agreed local/interagency protocol.

**[\*12]** Nurses and midwives often collaborate with other health professionals and care providers. This may involve speaking with a medical practitioner or allied health professional and may occur in person or using such means as telephone, case conferences, teleconferencing and other electronic or communication technologies.

This may also involve shared documentation (including pro forma, client progress notes, history taking etc). This collaboration is documented in the client record and should include information in relation to the nature of the collaboration, the persons involved and the plan of actions and/or outcomes agreed upon and any determination in terms of continued collaboration.

**[\*13]** Documentation should record the nursing and midwifery actions, care and information provided. It should also include the client's perceptions/needs (where expressed), their response to illness and any refusal of treatment. Subjective data is an important component of assessing the client's health status and care needs. It must also be supported by objective assessment based on observation and evidence. Nursing and midwifery documentation reflect dignity and respect for the client, their significant support network and other members of the health care team.

**[\*14]** Nurses and midwives document conclusions and decisions supported by data. Documentation does not reflect value judgements about a client, their behaviour or their circumstances. Value judgements or any other unfounded conclusions may be interpreted as fact and have the potential to influence (even unconsciously) others in their assessment of the client and/or their relationship with the client.

### *Example*

*Nurses and midwives should avoid statements such as 'client uncooperative' or 'client depressed'. Documentation reflects observed behaviour such as 'client refuses bath, shouts and shakes fist' or 'client showing signs of depression; not eating, difficulty getting to sleep, early waking, staying in room, no interest in engaging with others'.*







## postscripts to guiding principle 3

**[\*15]** Flowcharts and observation charts etc document routine care information (eg activities of daily living, vital signs, intake and output, pain). Such additional charting is part of the permanent documentation record and can also be used as evidence in legal proceedings. Other regularly used proforma may include admission history, diagnostic assessment tools and diagrams, checklists or any other form of documentation that supports nursing or midwifery care.

**[\*16]** In relation to electronic documentation systems consider

- maintaining confidentiality of passwords or any other access information changing a password as per the organisation's policy or more frequently if security risk has been identified
- using passwords that are not easily deciphered (eg date of birth that can be accessed in personnel record)
- being aware of policies and procedures related to electronic access to confidential information
- fully logging off when not using the system (or when leaving a terminal)
- maintaining confidentiality of any hard copy information reproduced from the electronic system
- protecting the confidentiality of information as it is displayed on monitors (including consideration of the location and direction of monitors) never deleting electronic information
- only accessing information for which the nurse or midwife has a professional need to access
- using only secure electronic information and communication systems approved by the organisation
- use of confidentiality statements and warnings on email transmissions (ie only to be read by intended recipient)
- verifying that the information is legible and complete when receiving electronic documentation (eg medical orders being confirmed by fax)
- ensuring the recipient has been informed so as to retrieve faxed documentation as soon as possible.

**[\*17]** Freedom of Information legislation provides an exception to the requirement to maintain the confidentiality to documentation and client records. Nurses and midwives should be fully informed as to their legal obligation and organisational policy and procedure in relation to this legislation.

**[\*18]** The *Department of Premier and Cabinet Circular PC012* identifies "*Information Privacy Principles Instruction*" which includes principles for collection, storage, access, correction, use and disposal of personal information. Nurses and midwives should be fully informed as to their legal obligation and organisational policy and procedure in relation to these instructions.



## related documents, resources and acknowledgements

### Australian Nursing and Midwifery Council (ANMC)

National Competency Standards for the Registered Nurse (December 2005)  
National Competency Standards for the Enrolled Nurse (October 2000)  
National Competency Standards for the Midwife (January 2006)  
Competency Standards for Midwives (2002)  
Code of Professional Conduct (2003)  
Code of Ethics (2002)

### Nurses Board of South Australia Standards

Standard for Medication Management (2002)  
Standard for Use of Restraint (2002)  
Standard for Therapeutic Relationships and Professional Boundaries (2002)  
Professional Standards Statements for Nurse Practitioner Practice (2002)  
Standard for Authorisation of an Enrolled Nurse to Practise without the Supervision of a Registered Nurse (2002)  
Standard for Delegation by a Registered Nurse or Midwife to an Unlicensed Healthcare Worker (2005)  
Scope of Practice Decision Making Tool (2005)

### Australian and New Zealand College of Mental Health Nurses Inc (ANZCMHN)

ANZCMHN. (1995). Standards of Practice for Mental Health Nurses in Australia

### Australian College of Midwives Inc (ACMI)

Competency Standards for Midwives (Australian College of Midwives Inc) (2002)  
Code of Ethics (Australian College of Midwives Inc) (2001)  
Guidelines for Midwifery Practice (Australian College of Midwives Inc) (2003)  
Draft Standards for Midwifery Practice (Code of Practice has been rescinded)

### Other Australian Nursing and Midwifery Regulatory Authorities

Nursing Board of Tasmania  
*Standards for nursing documentation* (February 2003)  
Nursing Board of Western Australia  
*Management of patient information and documentation guidelines*  
Queensland Nursing Council  
*Draft Scope of Practice Framework Information Sheet Professional Documentation Standards* (May 2005)

## references

College of Nurses of Ontario *Practice Standards Documentation* (2004)

American Health Information Management Association  
*Long Term Care Health Information Practice and Documentation Standards* (Sept 2001)

College of Registered Nurses of Nova Scotia  
*Documenting Care A Guide for Registered Nurses* (first printed 1997, revised 2002)

Commonwealth Department of Health and Aged Care  
*Documentation and Accountability Manual* (Version 3)

Information Privacy Principles Instructions  
Department of Premier and Cabinet Circular PCO12 (1992)

Nursing & Midwifery Council  
*Guidelines for records and record keeping* (April 2002)

Navuluri, Ramesh B., (2001)  
*Documentation: What, Why, When, Where, Who and How? Research for Nursing Practice* Spring 2001

Richmond J (Edit) *Nursing Documentation writing what we do Ausmed Pub2001*

South Australian Department of Human Services  
*Medical Record Documentation and Data Capture Standards* August (2000)

Staunton & Chiarella *Nursing and the Law* 5th Edit Churchill Livingstone 2003







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