College of
REGISTERED
PSYCHIATRIC NURSES
of Alberta

GUIDELINES

Charting and Documentation

December 2016

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INTRODUCTION

The College of Registered Psychiatric Nurses of Alberta (CRPNA) Practice Standards (2013) require Registered Psychiatric Nurses to document timely and accurate reports of relevant observations, assessments, and decisions about client status, plans, interventions, and evaluations of client outcomes.

Documentation is any written or electronically generated information about a client that describes the care or service provided to the client. Whatever the format used to document, the client care record is a formal, legal document that details a client's health care and progress. These health records may be paper or electronic documents such as electronic medical records, faxes, emails, audio or video tapes and images.

The term "DOCUMENTATION "as used in this document refers to any written or electronically generated information about a client that describes client status, or the care or services provided to that client. (Potter, Perry, Ross-Kerr, & Wood, 2009)

This guideline on documentation applies to all Registered Psychiatric Nurses (RPN) in all practice settings using every type of documentation system. Documentation is not separate from care and is not optional. Documentation is an integral part of psychiatric nursing practice and provides a clear, concise and timely picture of the status of the clients, the actions of the Registered Psychiatric Nurse and the client outcomes.

REASONS FOR DOCUMENTATION

Documentation serves three purposes:

FACILITATES COMMUNICATION

Through documentation Registered Psychiatric Nurses communicate with other health care providers their assessments about the status of clients and any intervention and the outcomes of those interventions.

PROMOTES SAFE AND APPROPRIATE NURSING CARE

When a Registered Psychiatric Nurse documents the care they have provided, other members of the health care team can assess the clients progress and determine which interventions are effective and which are ineffective and identify and document changes to the plan of care as needed.

MEETS PROFESSIONAL AND LEGAL STANDARDS

Documentation is a valuable method for demonstrating that within the therapeutic client-nurse relationship, the Registered Psychiatric Nurse applied sound nursing knowledge, skills and judgement according to professional standards. Documentation is generally accepted as evidence in legal proceedings such as lawsuits, coroners' inquests, and

disciplinary hearings at the work site and through professional regulatory bodies. In a court of law it looks at the client's chart for a chronological record of all aspects of the client's care from the time of admission until discharge.

CRPNA Code of Ethics & Standards of Psychiatric Nursing Practice, September 2013
Standard 2 Indicator 5. Applies documentation principles to ensure effective written/electronic communication

ASSUMPTIONS RELATED TO CHARTING AND DOCUMENTATION GUIDELINES

- Apply at all times to all Registered Psychiatric Nurses regardless of client care settings
- Establishes that client confidentiality is established and upheld at all times
- Provide expectations of all registered members of the profession
- Enables sound decision making
- Supports effective communication between health care providers

DOCUMENTATION MEASURES FOR RPNs:

- Responsible and accountable for documenting on a health record the care they have personally provided to the client including informed consent from the client.
- Document all relevant information about clients in chronological order, in a clear, concise, factual, objective, timely and legible manner.
- Document at the time or immediately after care is provided. Delays affect the continuity of care, affect the ability to recall details and increase possibility of error.
- Documentation does not take place prior to care.
- Complete documentation includes signature of writer and title in a clear and legible manner, or initials if appropriate after each entry.
- Electronic entries are made only using own unique identifier (log-in, user name).
- Comprehensive, in-depth and frequent documentation is required for all clients who are acutely ill, high risk or have complex health/mental health problems.
- Document clinical decision making (assessment, diagnosis, planning, implementation and evaluation) including communication with other care providers including name and outcomes of decision.

- When providing services to groups of clients utilize agency service records or equivalent to document service provided and overall observations pertaining to that group.
- Record client specifics from the group on the individual client health record.
- Use only agency approved abbreviations.
- Access client health information only for purposes that are consistent with professional responsibilities
- Comply with the applicable privacy legislation and follow employer/agency policies regarding collection, use(includes access to) disclosure, retention and security of health information
- Obtain informed consent from the client to use and disclose information to others outside the circle of the health care team and in accordance with relevant legislation
- Document late entries clearly, indicating both the date and time of the later entry and the date and time of the actual event.
- Documentation errors should be corrected in a timely, honest and forthright manner and clearly shows the person making the alteration, the date and time, the original entry must also be included in the client care record.
- Self-employed RPNs are responsible for the ownership and access to health records and requirements arising through provincial and federal information management and privacy legislation. At all times client files (electronic or paper) must be properly secured and maintained to ensure client confidentiality

APPLYING THE CRITERIA TO PRACTICE

Agency policy

RPNs must know and follow agency documentation policies including those for verbal and telephone orders, fax orders, charting by exception, electronic charting systems and all legislative regulations

Abbreviations

RPNs must only use agency approved abbreviations

Use of title

RPNs must use their full signature and title unless agency policy allows for initials and title

Accountability

RPNs are accountable for documenting only the care provided unless in an emergency situation where an RPN has been deemed a recorder then can document the care provided by other health professionals. If an agency does not allow for certain staff to document on the health record, an RPN may record what client information has been reported and by whom.

Errors

Correct errors according to agency policy, never modify or delete information that is already recorded on the health record. Do not erase or black out errors. Do not try to squeeze an entry between lines of other documentation or leave blank lines between entries. Correcting, modifying or changing or altering someone else's documentation is illegal and considered to be professional misconduct.

Timing

Documentation is done at point of care or immediately after care is provided.

Legal considerations

Courts use the health care record and nursing documentation at a trial to reconstruct events, establish times and dates, refresh memories of witnesses and to resolve conflicts in testimony. It can also be used to support your defence to establish your nursing actions were "reasonable and prudent" in the circumstances. On the other hand if no care is documented this may lead to a conclusion no care was provided.

Electronic records

The same documentation criteria apply although there will be different strategies to record date and to ensure privacy, security and confidentiality. Follow agency policy and guidelines for electronic documentation.

REFERENCES

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