

Nursing Documentation Standards

(Revised 2002)

For registered Nurses and Registered
Practical Nurses in Ontario

College of Nurses of Ontario

Assessment

A nurse meets the standards by:

- Using objective and subjective data in documenting assessments
- Documenting all relevant data
- Avoid unfounded conclusions, value judgments or labeling

Third Party Information

Nurses may obtain relevant info about a client or an incident from another person such as a family member or friend.

Core Standards for Documentation

A nurse maintains documentation that is:

- Clear, concise and comprehensive
- Accurate and true
- Relevant
- Reflective of observations, not unfounded conclusions
- Timely and completed only during or after giving care

Nursing Documentation Standards, CNO (Rev 2002) Page 6

Core Standards for Documentation

A nurse's documentation:

Includes date and time of the care or event,
and of the recording when it is a late or
forgotten entry

Nursing Documentation Standards, CNO (Rev 2002) Page 6

Core Standards

- Legible and non-erasable
- Permanent and retrievable
- Confidential
- Client Focused

Nursing Documentation Standards, CNO (Rev 2002) Page 6

Core Standards for Documentation

A nurse's documentation contains meaningful information, avoid phrases such as "good night, "up and about" or "usual day".

Nursing Documentation Standards, CNO (Rev 2002) Page 6

Charting by Exception

Is a shorthand method of documentation rather than an absence of documentation.

Nurses evaluate the client against well-defined standards or norms or outcomes, and progress towards the outcomes

Challenges the long held legal belief of "if it was not charted then it was not done"

Replaced with new premise: "all standards have been met with a normal or expected response unless documented otherwise"

Nursing Documentation Standards, CNO (Rev 2002), Apdx 2

Timing

Information documented during or immediately after care is provided or an event occurred is considered more reliable than information recorded later and based on memory

Chronological entries present a clear picture of events and facilitate better communication between care providers

Document forgotten or late entries at the next available entry space

Document both the date and time of the entry and the date and time care was given

Avoid leaving empty lines for another to document