Guidelines on **Documentation and Electronic Documentation**

Re-endorsed by Annual Conference 2010

Nurses and midwives, along with other members of the health care team, are responsible for producing and maintaining patient/client health care records (paper or electronic), which enable the provision of effective continuing care. The health care record is not a legal document, but a mechanism which allows the health care team to: communicate effectively; deliver appropriate, individualised care; evaluate the progress and health outcomes of patients/clients; and retain the integrity of health information over time. However, the health care record has the potential to be admitted into evidence, if relevant, in legal proceedings. Producing the health care record requires comprehensive, accurate, high quality documentation.

Nurses and midwives are accountable for the care they provide, a principle, which is enshrined in the *Code of Professional Conduct for Nurses in Australia* (Australian Nursing and Midwifery Council, 2003) and may be enacted through legislation in NSW in the form of the *Nurses and Midwives Act 1991*. Clear, relevant and accurate documentation is an essential component of nurses' and midwives' accountability and provides a mechanism for nurses and midwives to account for their professional actions. High quality documentation is therefore critical.

Requirements for quality documentation

The following principles are intended to provide nurses and midwives with clear direction for producing and maintaining high quality, defensible documentation:

1. Document fact

Fact is what the nurse or midwife saw, heard or did in relation to the patient's care and condition. This is what should be documented. Nurses and midwives should avoid non-committal documentation, for example the use of words such as *appears* or *seems*, which do not reflect factual documentation. An extension of this principle is that nurses and midwives should write health care records objectively. Irrespective of where the nurse or midwife is recording information, that is the nursing notes, incident forms or statements, documentation should always remain factual and objective and not subjective or emotive.

2. Document all relevant information

This will be dictated by consideration of the individual circumstances of each patient. Nurses' and midwives' documentation should be made with respect to the total condition of the patient, not just a clinical specialty.

In particular, nurses and midwives should document any change in the condition of the patient, any actions/treatments and their effect, and who was notified of such a change. Nurses and midwives should also document whether the patient's

condition has remained unchanged during their shift, as responsibility for the patient is handed over with each change of shift.

Nurses and midwives should always document, in the relevant notes or on the relevant chart, any deliberate omission of an ordered treatment or procedure and why it was omitted. If a record is not made it may be presumed that the treatment or procedure was merely overlooked or forgotten. Documentation regarding a change in a patient's condition should be made with absolute clarity. This will include an exact record of what aspect of the patient's condition was of concern, who was informed of the patient's condition, exactly what they were told and the response received.

3. Document contemporaneously

Nurses and midwives should record entries in the patient's notes as soon as possible after the events to which reference is being made have occurred, with the date and time for each entry recorded. All entries should also include the author's signature, printed name and designation. This clearly indicates when the record was made and by whom and ensures more reliable documentation. Nurses and midwives should never pre-date or pre-time any entry on a patient's chart. If an observation is made or a medication is given at a certain time, that time should be recorded on the chart.

4. Maintain the integrity of documentation

This principle refers to the requirement to preserve all that is recorded in a patient's record, even if an error is made. Nurses and midwives should not attempt to change or delete errors made in the patient's notes. An attempt to change or delete an entry could be interpreted as an attempt to cover up events or mislead others.

For paper records, the error should be left so that it is legible, with a single line through it, and initialled. The correct entry should then be recorded on the next line or column.

For electronic documentation, a new entry should be inserted to identify and correct the previous error.

Documentation should not include breaks between entries; this ensures that information cannot be added after the fact.

Occasional mistakes are inevitable; if they are clearly identified as mistakes or errors and corrected the potential for misinterpretation is removed.

It is important to note that poor documentation can provide the foundation for a disciplinary complaint against a nurse or a midwife and could lead to disciplinary action.

Note: These guidelines should be read in conjunction with NSW Health Policy Directive PD 2005_127 *Principles for creation, management, storage and disposal of health care records.*