Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Documentation Standard	Communications	06-008-00
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APPLIES TO:		
All Regulated and Unregulated Health Care Providers		

1. BACKGROUND:

1.1. The health record is a legal document, establishes professional accountability and may be used as evidence in a court of law or professional conduct proceeding. Health records are also used for quality improvement, risk management, funding and resource management.

1.2. This policy will review the process and procedures for recording personal health information to ensure the highest standard of documentation is met.

2. POLICY:

2.1. All health care providers are responsible for comprehensive, concise and accurate documentation of client interactions which they have provided, in the client's health record.

2.2. All health care providers must abide by the professional standards of their regulatory bodies, federal and territorial legislation, Government of Nunavut policies and procedures and accreditation standards regarding the manner in which documentation is done.

2.3. All health care providers shall document in the Government of Nunavut (GN) interactive electronic health record (iEHR) – Meditech, utilizing downtime procedures as required when the iEHR is unavailable.

2.4. Paper based documentation is only permitted to those records approved by the Dept. of Health (i.e. prenatal records). These paper records are typically limited to those not yet available in Meditech.

2.4.1 Documentation is completed in blue or black ink only. No spaces are left blank between entries.

3. PRINCIPLES:

3.1. HCPs are accountable for ensuring their documentation of client care is accurate, timely and complete.

3.2. HCPs safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with standards and legislation.

3.3. Documentation communicates to all HCPs the plan of care, the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions.

3.4. Documentation demonstrates the health care provider's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history.

4. DEFINITIONS:

4.1. **Documentation**: refers to any written and/or electronic recording that describes the status of a client or the client care provided.

4.2. **Downtime Procedures:** paper-based procedures utilized when Meditech is unavailable. This includes documentation in the client's paper chart.
4.3. **Healthcare Provider:** refers to any regulated or unregulated healthcare provider authorized to document in the client's electronic or paper health record.
4.4. **Interactive electronic health record (iEHR):** a digital version of a client's paper chart. EHRs are real-time, client-centred records that make information available instantly and securely to authorized users. Meditech is the GN's iEHR.
4.5. **Authorized users:** refers to all healthcare professional who may access the iEHR client records. Authorized users document using their own signature and designation. Authorized users may vary regionally.

5. GUIDELINE:

5.1. Firsthand Knowledge

5.1.1 The HCP who provides the service or witnesses the event is the person responsible for documentation.

5.1.2 In the event of an emergency situation, a designated recorder will document the actions and care provided by other HCPs.

5.1.2.1 The Designated Recorder should document the presence of all other staff during the emergency and provide the name and designation of any staff when recording the care they provided.

5.1.2.2 HCPs providing care should verify the entries made by the Designated Recorder about care that they have provided by adding an addendum to the iEHR or by initialing the entry in the paper record, whichever is appropriate.

5.1.3 The HCP will continue to be responsible for documenting on their clients in the event of a delayed medivac where medevac staff are on site. Documentation is required until the client departs from the community.

5.2 Contemporaneous and Chronological Document

5.2.1 Documentation shall occur in a timely manner, either during, or immediately after the care has been provided.

5.2.2 Any documentation not completed by the end of the shift must be clearly documented as a **LATE ENTRY.**

5.2.3 The actual time and date of the interaction or service provided must be recorded clearly.

5.2.4 The time of the documentation is automatically recorded in Meditech.

5.2.4.1 The actual time of documentation must be recorded if the client's paper chart is being utilized.

5.2.5 Failure to record events in chronological order may cast suspicion on the accuracy of the record during legal proceedings and thus question the credibility of the HCP and the health record.

5.2.6 In emergency or critical situations documentation should be ongoing and completed immediately following the event.

5.3 Detail and Frequency of Documentation

5.3.1 The frequency of documentation reflects the acuity and complexity of the client's care needs. Documentation is more frequent when the client's status is acute, emergent or complex. Documentation occurs:

i. When there is a response to care provided

ii. When there are changes in client status
iii. When education, recommendations and instructions are provided
iv. After evaluation of interventions
v. When transfer or discharge plans are made or occur

5.4 Document Concisely

5.4.1 Documentation should be concise, factual, objective, and accurate.

5.4.2 Concise documentation contains essential information about the client status or care as succinctly as possible.

5.4.3 Pertinent negative findings that assist in refining the differential diagnosis should be included.

5.4.4 Factual documentation contains accurately perceived data obtained from a variety of sources, e.g., observation, inspection, palpation and auscultation. When recording client statements, utilize quotations with exactly what was said.

5.4.5 Objective documentation is the recording of facts or conditions without distortion of personal bias. Objective data is observed or measured and includes interventions, actions or procedures as well as the client's response. Avoid generalizations and vague expressions such as 'status unchanged'. Document only conclusions that can be supported by data and avoid value judgments or unfounded conclusions.

5.5 Consultations

5.5.1 Document all nurse-initiated consultations, showing timely reporting of any abnormal findings, medical direction given, and action taken.

5.5.2 All verbal physician/Nurse Practitioner (NP) orders to prescribe, modify, or discontinue treatment should be clearly recorded.

5.5.3 Whenever physician/NP orders are verbally verified for accuracy, this discussion should also be clearly documented in the record.

5.5.4 When an NP is consulted, it is the responsibility of both the nurse and the NP to document the interaction as per Policy 07-043-00 *Nurse Practitioner Consultation Process.*

5.6 Document refusal of treatment/discharge against medical advice

5.6.1 Include in documentation:

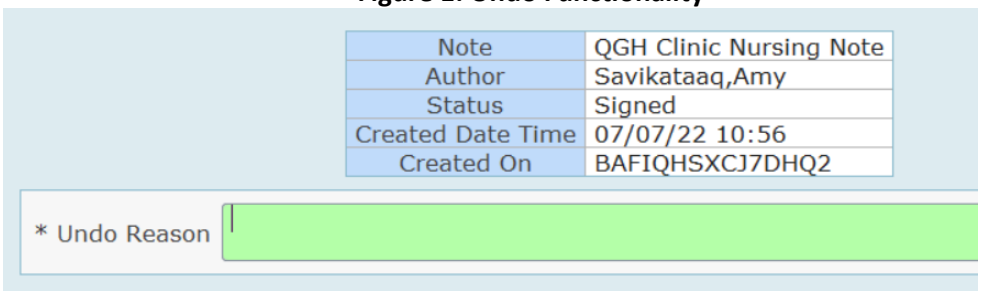
i. The circumstances of the refusal
ii. The information provided to the client/family regarding potential consequences of refusal
iii. Any additional client teaching provided
iv. Any treatment or medication provided and reasons to seek medical attention.
v. Complete the form included with Policy 07-039-00 *Informed Refusal of Treatment.*

5.7 Correction of Errors

5.7.1 There are two options to correct an error on the EMR or Meditech

5.7.1.1 If a note is completed on the wrong patient in the EMR on Meditech, the HCP who completed the note can delete the note using the Undo functionality. A reason for deleting the note is a mandatory free text section. Refer to Figure 1.

Figure 1: Undo Functionality



5.7.1.2 This note will no longer be visible in the EMR for clinicians to view but will remain in the electronic chart which is accessible to health records staff and is the legal chart from which all documentation requests are taken.

5.7.1.3 The other option is to do an addendum. This would be used to correct an error that was made in a note or to add something that may have been forgotten initially.

5.7.1.4 Anyone can place an addendum on any note as the original note has not been altered. The HCP is only adding to the note.

5.7.1.5 The original note will be titled Original Note and the addendum will state Addendum entered and is electronically signed by the person doing the addendum with a date and time stamp of the addendum. Refer to Figure 2.

Figure 2: Creating an Addendum

5.7.2 In the paper record, errors are corrected by drawing a single line through the erroneous entry only by the HCP who made the original entry.

5.7.3 Entries may not be obliterated with correction fluid or pen.

5.7.4 The correction is initialed by the HCP.

6 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Reference Sheet 03-002-00 Common Government of Nunavut Acronyms

Reference Sheet 03-003-00 Common Abbreviations
Policy 06-009-00 Documentation Format
Policy 07-039-00 Informed Refusal of Treatment
Policy 07-043-00 Nurse Practitioner Consultation Process

7 REFERENCES:

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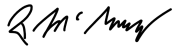
Approved By:	Date:
	2023-03-09
Jennifer Berry, Assistant Deputy Minister – Operations, Department of Health	
Approved By:	Date:
	2023-03-09
Robert McMurdy, A/Chief Nursing Officer	