NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NEW SOUTH WALES BRANCH

GUIDELINES ON **DOCUMENTATION AND ELECTRONIC DOCUMENTATION**

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NSW Nurses and Midwives' Association
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Guidelines on Documentation and Electronic Documentation

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. Documentation provides evidence of the nurses or midwives decision making and of the care planned, as well as evidence of critical thinking and professional judgment. 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 clinical documentation.

Nurses and midwives are accountable for the care they provide, a principle, which is enshrined in the regulatory standards, codes and guidelines that govern nursing and midwifery[1] and may be enacted through legislation in NSW in the form of the Health Practitioner Regulation National Law (NSW) No 86a[2]. 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 clinical 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 comprehensive and accurate documentation that demonstrates their practice decisions and ensures quality care and patient safety:

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, not influenced by emotions, opinions, or personal feelings; they need to be based on fact and be measurable and

observable. Irrespective of where the nurse or midwife is recording information, that is the nursing notes, incident forms or statements, documentation

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 condition of the person receiving care, not just a clinical specialty or condition.

Nurses and midwives should document any change or concerns in the condition of the patient, any actions/treatments and their effect, what follow up is required if needed and who was notified of such a change. Nurses and midwives should also document whether the condition of the person receiving care has remained unchanged during their shift, as responsibility and accountability 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 and that the appropriate health professional was informed of the omission. 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 the condition of the person receiving care should be made with absolute clarity. This will include an exact record of what aspect of the condition of the person receiving care was of concern, who was informed of the condition of the person receiving care, exactly what they were told, and the response received. Documentation must be considered to include all documents that make up the medical record and therefore all must be completed. With consideration of this duplication of information should be minimised.

3. Document contemporaneously

Nurses and midwives should record entries in the notes of the person receiving care as soon as possible after the events to which reference is being made to ensure an accurate account of events, with the date, time and 'nursing' (paper only) for each entry recorded. All entries should also include the author's signature, printed name and designation (paper only). For electronic records it is important to ensure you are logged in under your name. This clearly indicates when the record was made and by whom and ensures more reliable documentation. Nurses and midwives should never pre-date, pre-time or do block entries at any time on the chart of the person receiving care. If an observation is made or a medication is given at a certain time, that time should be recorded on the chart as close to that time as possible.

Late entries should be rare, not a normal part of nursing or midwifery practice. If late entries are required, they need to be identified as such.

4. Maintain the integrity of documentation

This principle refers to the requirement to preserve all that is recorded in the record of the person receiving care, even if an error is made. Nurses and midwives should not attempt to change or delete errors made in the notes of the person receiving care. 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. A single line and initial can also be used within electronic records to indicate the 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.

Documentation is an account of the professional actions of the nurse or midwife. It is the most credible source to the judgement and critical thinking related to care provided. With poor documentation possibly contributing to a finding of negligence.

NOTE

1. These guidelines should be read in conjunction with NSW Health Policy Directive PD2012_069: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_069.pdf.

REFERENCES

1. http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx
2. http://www.austlii.edu.au/au/legis/nsw/consol_act/hprnl460