



Canadian Nurses
Protective Society

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Quality Documentation: Your Best Defence

The Canadian Nurses Protective Society (CNPS) frequently receives requests for information regarding documentation problems or concerns. Registered Nurses working in all areas of patient care encounter issues relating to documentation in both paper and electronic form.¹ Some of the more frequently asked questions are addressed below.

What is the purpose of documentation?

Documentation is necessary for:

- Communication between health care providers;
- Meeting legislative requirements;
- Quality improvement;
- Research;
- Legal proof of health care provided: nursing documentation is relied upon by the courts as evidence of what was done or not done when a patient sues.

Licensing bodies have documentation standards in place to which you are held accountable.² Failure to meet these standards can result in disciplinary action against you.³ It can also undermine or destroy your defence in a lawsuit. Proper and thorough documentation is likely to be your best defence in a legal proceeding.

What are the legal implications of charting?

The courts look to the patient's chart for a chronological record of all aspects of the patient's care from the time of admission until discharge. Courts use nursing documentation at trial to reconstruct events, establish times and dates, refresh the memories of witnesses and to resolve conflicts in testimony.

The patient's chart may also be entered as evidence at a trial to support your defence. Your lawyer will rely heavily on your charting to establish that your nursing actions were "reasonable and prudent" in the circumstances and to show that you did not cause the patient's injuries. Conversely, the patient's lawyer will use the patient's chart to try to show that you failed to meet the standard of care of a reasonable prudent nurse.

In one lawsuit a nurse's note played a major role in the dismissal of a case against a hospital and its nurses. The court found the emergency room physician negligent for failure to make a risk assessment of the patient based on the urgent nature of the nurse's note. The judge stated: "... nurses' notes must form the basis or starting point for an emergency room doctor's opinion, and of course the treatment he subsequently renders."⁴

What is the impact of not recording your nursing care?

The Supreme Court of Canada addressed this issue in *Kolesar v. Jefferies*. A patient who had a spinal fusion was, post-operatively, returned to a surgical unit and the next morning he was found dead. The chart was important in establishing liability because there were no nursing entries from 22 00 hours until 05 00 hours, when the death was discovered. The absence of nursing documentation allowed the court to infer that "nothing was charted because nothing was done."⁵

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**More than
liability
protection**

If you have an obligation to perform a *specific* nursing act on a patient, such as taking vital signs, and you fail to chart that you have done so, the court may infer that the act was not performed.

Omissions will generally work against you unless there is other credible evidence to demonstrate that your nursing care was indeed given. Several years after the event, however, there may not be other reliable evidence to support you.

Is it necessary to chart contemporaneously?

For accuracy, the courts have stressed the importance of recording at the time of an event or as close to it as is prudently possible.⁶ Undue delay between the occurrence of the event and the recording may result in a court refusing to admit the record as proof of the truth of the event and questioning the credibility of the information or witness.

If a late entry must be made, it should be done in accordance with the nursing practice standards and documentation policies of your institution or health authority.

Is third party charting acceptable?

Generally it is not. Because of evidentiary rules and the potential for cross-examination in court, the nurse or other health care provider who has first-hand knowledge of the event must be the person who documents it. An exception is made for a designated recorder during an emergency response.

How much documentation is enough?

The frequency and amount of charting detail are dictated by a number of factors including:

- Facility/agency policies and procedures;
- The complexity of the health problems;
- The degree to which the patient's condition puts him at risk; and
- The degree of risk involved in the treatment or care.

Documentation should be concise, factual and objective. While agency policies and professional standards for documentation should be followed, nursing recording should be more comprehensive, in-depth and frequent if the patient is very ill or exposed to high risk.

How does electronic documentation differ?

Electronic documentation carries a higher risk of breach of confidentiality. Policies and procedures, as well as specific technologies, are required to protect the confidentiality of the patient's health record and system security. This is especially true for transfer of information. Otherwise, the basic principles of documentation set out in this bulletin remain the same.

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1. Electronic forms can include computerized records, e-mails, facsimiles and video tapes.
 2. Many professional nursing licensing bodies have documentation guidelines for their members, e.g. College of Nurses of Ontario, *Documentation* (Toronto: Author, 2004).
 3. For example, in Saskatchewan it is considered professional misconduct under *The Registered Nurses Act, 1988*, S.S. 1988-89, c. R-12.2 to falsify a record with respect to the observation, rehabilitation or treatment of a client (s. 26(2)(i)).
 4. *Skinner v. Royal Victoria Hospital*, [1993] O.J. No. 1054 at para.187 (Gen. Div.) (QL).
 5. *Kolesar v. Jeffries* (1976), 9 O.R. (2d) 41 at 48 (H.C.J.), varied 12 O.R. (2d) 142 (C.A.), aff'd (sub nom. *Joseph Brant Memorial Hospital v. Koziol*) [1978] 1 S.C.R. 491.
 6. In *Ares v. Venner* [1970] S.C.R. 608 at 609 the Court held: "Hospital records, including nurses' notes, made *contemporaneously* [CNPS emphasis] by someone having a personal knowledge of the matters then being recorded and under a duty to make the entry or record, should be received in evidence as *prima facie* proof of the facts stated therein."

N.B. In this document, the feminine pronoun includes the masculine and vice versa.

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