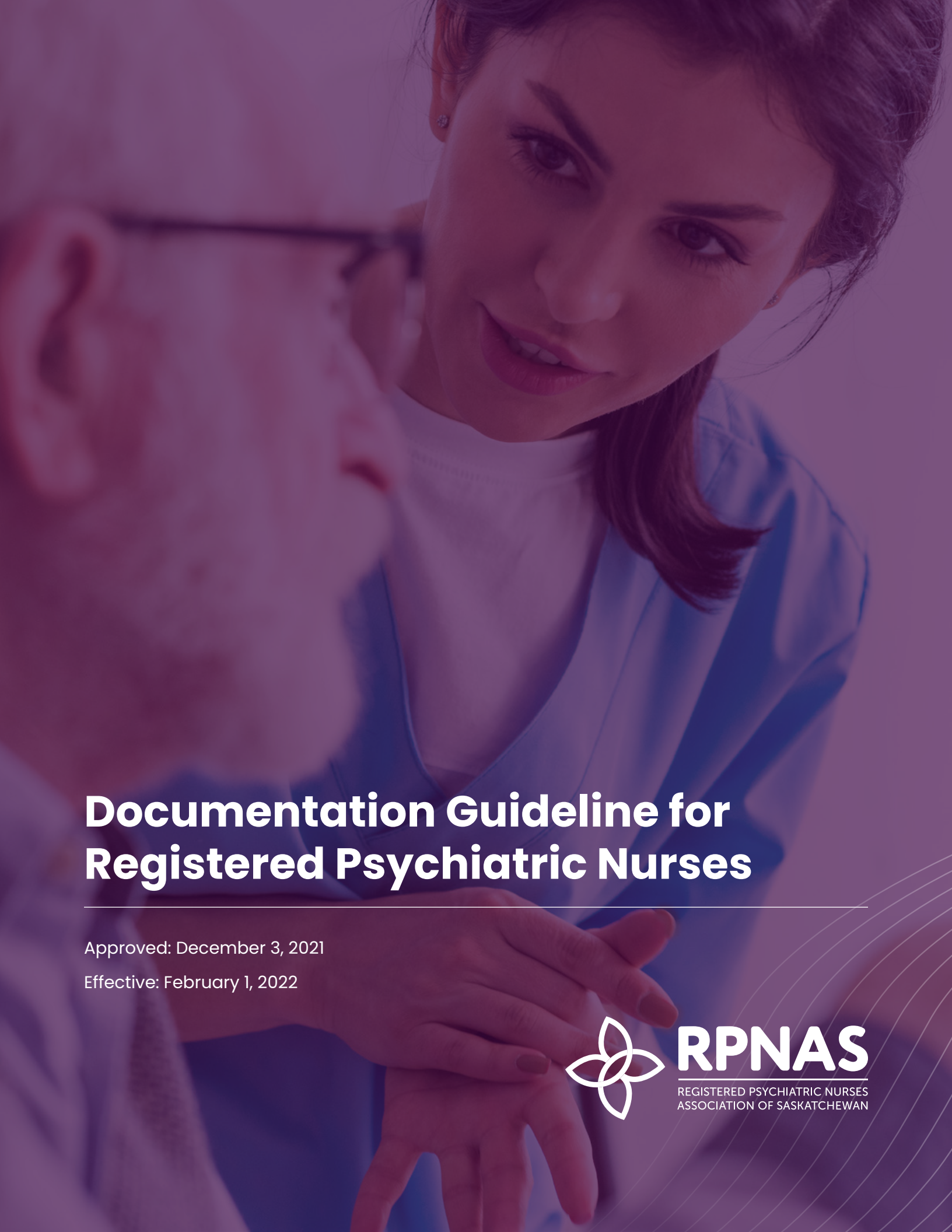

Documentation Guideline for Registered Psychiatric Nurses

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RPNAS

REGISTERED PSYCHIATRIC NURSES ASSOCIATION OF SASKATCHEWAN

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DOCUMENTATION GUIDELINE

PURPOSE OF RPNAS PRACTICE GUIDELINES

The goal of psychiatric nursing practice is to achieve the best possible outcomes for clients. The purpose of RPNAS practice guidelines is to help registered psychiatric nurses (RPNs) be aware of the requirements and obligations of specific aspects of registered psychiatric nursing practice. Practice guidelines provide more specific information related to RPN responsibilities and this document is intended to complement information outlined in the Registered Psychiatric Nurses Act, other legislation, RPNAS Bylaws, Standards of Psychiatric Nursing Practice, Code of Ethics, and other resources that support professional psychiatric nursing practice.

INTRODUCTION

Documentation of client care is a professional responsibility of RPNs and is recognized as one of the most important underpinnings of quality care, upon which nursing activities centre. Documentation is just as important as the direct care RPNs provide. Accurate documentation of client care has an important effect on the care that is provided, as it is the basis upon which client care decisions are made. Information on the client care record that is inaccurate or incomplete puts the client at risk of receiving improper or potentially harmful care.

This document is intended for use by graduate psychiatric nurses (GPNs) and RPNs to support the principles of quality documentation practices. It may also be used by employers of RPNs to review facility documentation policies to ensure the workplace supports registered psychiatric nursing standards. It may also serve as a resource to assist in the development of quality improvement initiatives aimed at improving patient outcomes through quality documentation practices.

PRACTICE REQUIREMENT

All RPNs are required to document client care in a clear, factual, objective, timely, and accurate manner that is reflective of the care they provided. Effective communication with the client and healthcare team is essential for client safety within any setting. These expectations apply to all GPNs and RPNs, regardless of their role, job description, or area of practice.

RPNs are responsible for practicing within professional and employer requirements. RPNs who are self-employed have additional responsibility to ensure that their documentation practices align with relevant legislation and RPNAS requirements.

PURPOSE OF DOCUMENTATION

When done properly, documentation benefits the client, the RPN, and other members of the healthcare team. The systematic implementation of the nursing process (assessment, diagnosis, planning, intervention, and evaluation) and utilization of current nursing care plans serve as the basis for information contained in the client care record. When completed in a clear and concise manner, nursing documentation captures the holistic nature of the practice of the RPN, the partnership between the client and nurse, and serves to monitor and influence client care.

Documentation includes any written and/or electronically generated information about a client that describes the care or service provided to that client (British Columbia College of Nurses and Midwives [BCCNM], 2020, p. 1). A client may be an individual, family, group, community, or population.

The purpose of nursing documentation is to:

- Support collaboration between the client and nursing team regarding the plan of care
- Facilitate effective communication
- Support continuity of client care
- Demonstrate professional accountability
- Meet legal requirements
- Support quality improvement and risk management initiatives
- Assist in the development of quality research

DOCUMENTATION PRINCIPLES

Documentation must be:

- Factual, accurate and comprehensive
- Contemporaneous – written as close to the time of, or as soon as possible after, the care was provided
- Written based on the care the RPN has given, or situations witnessed
- Free of non-specific phrases that are subjective (e.g., had a good day; appears to be sleeping)
- Based on the RPN's personal knowledge
- Derived from the client assessment, observations, interventions, and evaluation of care outcomes

- Is individualized and includes client perspectives and strengths as well as identified goals and expressed needs
- Accurately dated, timed (using 24-hour clock) and signed (including professional designation) for every entry
    - The RPN never documents care before it has been given, including but not limited to medication administration
- Completed as frequently and as detailed as the client condition dictates and in accordance with agency clinical standards and policy
- Written neatly, concisely, and legibly
- Inclusive of only agency approved abbreviations and symbols
- Free of blank spaces
    - In the event blank space is left after completion of the progress note draw a single line through the remaining white space and leave enough room for your signature and professional designation at the end of the line
    - On forms or flow sheets every space must be filled. If the item is not applicable to the client a "N/A" should be noted
- Free of spelling and grammatical errors
- Written in indelible ink

Late Entries

Late entries must be documented in accordance with agency clinical standard and policy. If an entry was missed, it must still be documented in the client care record even though it will not be in chronological order. A statement such as "Late Entry" must precede the entry and state the time the care occurred.

Errors

Errors in documentation must be identified and corrected in accordance with agency clinical standard and policy.

- Corrections are made by drawing a single line through the word(s) so the information is still readable
- Information must never be blacked out or permanently covered using correction tape, correction fluid, etc.
- Date, time and initial the error then insert the correct information

- Some agencies require the word “error” or “void” be written above the incorrect information
- For correction to electronic documentation follow the process within the electronic system

PRACTICE EXPECTATIONS

- The Registered Psychiatric Nurse:
- Is responsible and accountable for documenting the care they provide in the client care record
- Recognizes that documentation is a valuable tool for demonstrating sound psychiatric nursing knowledge, skills, and judgment within the context of the therapeutic client-nurse relationship
- Makes decisions about documentation requirements based on assessment of client condition and context (including what and how often to document)
- Ensures documentation is informed by relevant legislation, regulatory, legal, ethical, and professional standards
- Adheres to employer policies related to documentation
- Documents based on data collected through all aspects of the nursing process. This includes assessment, formulating a nursing diagnosis, planning, implementation, and evaluation of outcomes
- The RPN documents all relevant information about the client in chronological order in the client record and is clear about when the care was provided
- Documents the required information to coordinate and carry out the client’s treatment and/or care plan
- Never alters, modifies, or destroys client care records in any way
- Safeguards the privacy, security, and confidentiality of client care records and upholds the laws of relevant privacy legislation and informed consent
    - To maintain confidentiality, client information must only be accessed by health care providers involved in the client’s care.
    - Exceptions to the RPN’s obligation to protect client confidentiality exist. Exceptions include when there is a Court Order or a Duty to Warn. RPNs in independent practice and those who are employees are required to know how the exemption applies to their practice context and whether they are authorized to make decisions about disclosures under the exemptions (Canadian Nurses Protective Society [CNPS], 2014). This includes management of requests from law enforcement personnel.

    - All RPNs have a duty to report suspected child abuse and neglect.
    - The RPN is required to check the agency's clinical standard and policy for further information pertaining to disclosure of client information
- Follows all applicable electronic documentation standards and guidelines
- Does not assume responsibility for documenting for another health care provider. An exception is made for a designated recorder during an emergency response. See agency clinical standard and policy for specific requirements in an emergency.

WHAT TO DOCUMENT

The RPN documents psychiatric nursing assessments, diagnoses, planning, interventions, evaluation, and client responses. This includes:

- The client's perceptions and expressed needs/goals
- The client's status, including both subjective data (what the client says using direct quotes when possible) and objective data (what the RPN observes and/or measures) and any changes to client condition
- A documented plan of care that is clear, current, relevant, and individualized to meet client(s) needs and goals
- Changes to the plan of care
- Communications (and attempts to communicate) with another care provider and the other care provider's response
- Information related to the performance of nursing assessments, procedures, and interventions, including teaching, advocacy, and discharge planning
- Evaluation of care provided/client outcomes and any additional actions taken
- Relevant communications with, and comments made by the client, the client's family, substitute decision maker, or other supports
- Informed consent, as per agency clinical standard and policy or independent practice requirements, when the psychiatric nurse initiates a treatment or intervention authorized under their scope of practice
- Informed discharge when a service is being discontinued

(BCCNM, 2020; CNPS, 2020)

FREQUENCY AND COMPREHENSIVENESS

Documentation must be sufficiently detailed to provide a clear picture of the client's condition and the care received. When a client is acutely ill, in a high-risk situation, receiving a high-risk treatment, has complex health care needs, or whose condition has suddenly changed, the RPN carries out more comprehensive, in-depth, and frequent documentation (BCCNM, 2020; CNPS, 2020).

More comprehensive, in-depth, and frequent documentation may also be required during transitional periods, such as handovers, shift change, admissions, discharges and during other critical periods of client care (BCCNM, 2020; CNPS, 2020).

Information contained must be specific and meaningful for the provision of safe and competent care. The RPN is expected to use professional judgment to apply documentation standards and guidelines within their environment and to the charting system used by their agency. Regardless of the environment, the RPN uses professional judgment to adjust the frequency and comprehensiveness of their documentation depending on client complexity and need.

ADVERSE EVENTS AND INCIDENT REPORTS

Adverse events such as client falls, medication or treatment errors, and other forms of harm should be objectively recorded in the client's care record. Information should include the nature of the actual or potential occurrence, the RPN's assessment, care provided, outcome evaluation, and any follow up interventions provided. Agencies usually have separate incident forms that are used by risk management departments to track trends and patterns of adverse events over time. The RPN has a professional responsibility to document the event in the client's record as well as complete the incident report. Agency clinical standards and policy should be followed when documenting in the client care record and on incident report forms.

CO-SIGNING

Many facilities have policies that require the co-signing of information by two professionals. In these situations, the policies must be clear as to what the co-signer is committing to. To maintain clear accountability, it is important that the purposes of co-signing are well defined, documented in clinical standard and/or policy, and clearly understood by RPNs. RPNs must be certain what it is they are co-signing, why a co-signature is required and if they are comfortable attesting to the information that has been documented. RPNs must never co-sign information of which they have no first-hand knowledge of being true.

LEGAL IMPLICATIONS

The client care record is a permanent legal document which provides an accounting of what has occurred during the nurse-client relationship. It is often utilized when questions of wrongdoing or professional incompetence/misconduct arise or to investigate adverse events and allegations of negligence.

In the event of legal proceedings, the courts utilize the client care record to form a chronological understanding of what has occurred from the time the client was admitted until time of discharge and to address conflicts in testimony (CNPS, 2020). Poorly constructed notes may have several negative consequences. First, it may lead the courts to assume that the care provided was of poor quality or not provided at all. Second, it may call into question the credibility of the client care record. Last, it may call into question the credibility of the RPN.

CONCLUSION

Documentation is a vital part of registered psychiatric nursing practice. Quality documentation serves to improve communication between the client, nurse, and other healthcare providers, promote continuity of care, and assist in the early detection of client problems. It also serves as evidence of the care that was provided and the resulting outcomes.

Clear, concise, and accurate documentation of the nursing process demonstrates the RPN's commitment to safe, effective, and ethical care by showing accountability for one's psychiatric nursing practice. Documentation demonstrates that the RPN has applied the nursing knowledge, skill, and judgment required within the standards of psychiatric nursing practice, within the therapeutic nurse-client relationship.

Documentation must contain the core principles outlined in this guideline to meet professional, agency and legal requirements. RPNs are therefore responsible for keeping up to date with current best practices in documentation.

ADDITIONAL RESOURCES

RPNAS Practice Program

RPNAS offers free, confidential consultation via email or the phone to help psychiatric nurses, employers, healthcare providers, the public and others understand psychiatric nursing practice in Saskatchewan. In addition to one-on-one consultation, RPNAS also offers education to teams that may benefit from learning more about a specific area of psychiatric nursing practice.

For practice consultation contact RPNAS Director of Nursing Practice at info@rpnas.com.

Canadian Nurse Protective Society

Canadian Nurse Protective Society (CNPS) offers education, legal advice, and risk management services to nurses. RPNAS members are eligible for CNPS legal services through their Professional Liability Protection. Visit CNPS's website for resources.

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APPENDIX A: STANDARDS OF PSYCHIATRIC NURSING PRACTICE RELEVANT TO DOCUMENTATION

Standards of psychiatric nursing practice (2019) that apply to documentation include:

Standard 2: Competent, evidence-informed practice

- 2.3 Uses communication skills effectively.
- 2.7 Documents the application of the clinical decision-making process in a responsible, accountable, and ethical manner.
- 2.8 Applies documentation principles to ensure effective written/electronic communication.
- 2.12 Establishes, maintains, and coordinates a plan of care based on a comprehensive psychiatric nursing assessment.

Standard 3: Professional responsibility and accountability

- 3.10 Uses technology, electronic communication, and social media responsibly and professionally.