Practice Standards set out baseline requirements for specific aspects of Registered Psychiatric Nurses’ practice. They interact with other requirements such as the CRPNBC Code of Ethics, all the CRPNBC standards of practice, the CRPNBC Bylaws, and relevant legislation.

Registered Psychiatric Nurses (RPNs) must document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes. Documentation is any written or electronically generated information about a client that describes the care or service provided to that client. It is an essential part of nursing practice.

Documentation serves three purposes:

- It facilitates communication.
- It promotes safe and appropriate nursing care.
- It meets professional and legal standards.

Communication: Through documentation, RPNs communicate to other health care providers their nursing assessment and diagnosis of a client’s condition, the plan of care, interventions that are carried out by the RPN and the outcomes of those interventions.

Safe and appropriate nursing care: When RPNs document the care they provide, other members of the health care team are able to review the documentation and plan their own contributions to safe and appropriate care. Documentation also provides data for research and workload management, both of which have the potential to improve health outcomes.

Professional and legal standards: Documentation is a comprehensive record of care provided to a client. It demonstrates how an RPN has applied psychiatric nursing knowledge, skills and judgment according to CRPNBC Standards of Practice. Documentation is generally accepted as evidence in legal proceedings. It establishes the facts and circumstances related to the care given and assists RPNs to recall details about a specific situation.

A practice environment that has the necessary systems, supports and policies in place to enable RPNs to document appropriately is fundamental to safe client care. This Practice Standard sets out requirements for RPNs about documenting client care in the client’s permanent record (e.g. paper or electronically).

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1 Client refers to individuals or groups who require care or service within one of the four domains of psychiatric nursing practice.
PRINCIPLES

1. RPNs are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by other staff members should be documented by those staff members, except in certain circumstances such as an emergency.

2. RPNs document all relevant information about clients in chronological order in the client record. Documentation is clear, concise, factual, objective, timely and legible. RPNs clearly mark any late entries, recording both the date and time of the late entry and of the actual event.

3. RPNs document at the time or immediately after they provide care. Delays may affect the continuity of care, affect the RPN’s ability to recall details about events and increase the possibility of errors. RPNs do not document before giving care. RPNs correct any documentation errors in a timely, honest and forthright manner.

4. RPNs indicate their accountability and responsibility by signing with a unique identifier such as a written signature or an electronically generated identifier (e.g. log-in or user name) and title in a clear and legible manner, or initials when appropriate, to each entry they make in the client record.

5. RPNs carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk or have complex health problems.

6. When caring for clients, RPNs document a clinical decision-making process (e.g. assessment, nursing diagnosis, planning, implementation and evaluation), including information or concerns reported to another health care provider and, that provider’s response.

7. When RPNs provide services to groups of clients (e.g., therapy groups), they use service records (or equivalent) to document the service provided and overall observations pertaining to the group. When RPNs document information about individual clients within the group, they record it in the individual client record.

8. RPNs complete a safety event report (sometimes called an incident report) following an event such as a medication error or fall. The safety event report is not part of the health record. RPNs record facts about any safety event affecting the client in the client’s health record.

9. RPNs have a role in safeguarding the privacy, security and confidentiality of client records. RPNs access a client record only when they have a professional need. RPNs assist clients with the process of accessing information on their client record.

10. RPNs that are self-employed assume responsibility for their client records. They must adhere to relevant legislation and the CRPNBC Bylaws.
APPLYING THE PRINCIPLES TO PRACTICE

a. **Organizational policies:** Familiarize yourself with organizational policy, procedures or restrictions on documentation and follow them, including policies on documenting verbal and telephone client-specific orders, charting by exception, electronic charting systems, Freedom of Information and Protection of Privacy. Document in the designated organization forms and ensure each form clearly identifies the client.

b. **Charting by exception:** Charting by exception (CBE) is acceptable when supported by employer policies and procedures that include standards of care, clinical protocols and assessment parameters. Charting by exception does not refer to “only charting when something happens.” If there is no formal CBE system in place, then chart by inclusion following the principles identified in this Practice Standard.

c. **Abbreviations:** Use only organization-approved abbreviations.

d. **Charting systems:** Various charting systems (e.g., flow sheets and clinical pathways) are acceptable if they enable RPNs to meet this Practice Standard.

e. **Use of title:** Review the Practice Standard *Appropriate Use of Title* so that you are clear on how to use your title when documenting the care or services you provide to clients.

f. **Completeness:** Include an accurate, clear and comprehensive picture of the status of the client and their needs, the interventions of the nurse, the client outcomes, a plan of care, information reported to other health care providers and the provider’s response, advocacy taken on behalf of the client and any other relevant information, including informed consent when required. All records should be clear and legible.

g. ** Appropriateness:** Use client quotes to illustrate objective observations. Avoid labelling clients or drawing subjective conclusions. Avoid generalizations, vague terms and the use of jargon.

h. **Accountability:** Document only the care you provide, do not allow others to document for you and do not document care that anyone else provides. There are two exceptions:

   - In an emergency, when you are designated as recorder, document the care provided by other health professionals.
   - In cases where organizational policy, procedures or restrictions do not allow certain staff members to document in the client record, record what client information was reported to you and by whom.

i. **Errors:** If you make a documentation error, follow organizational policy, procedures or restrictions to correct it, but never modify or delete information that is recorded in the client record. Do not erase or black out an error. Do not squeeze entries between lines or leave blank lines between entries.
j. **Timing:** It is the RPNs’ responsibility to complete documentation when they provide care. Plan your work day to allow time for documentation. If you are unable to document as you provide care due to other work commitments, bring this to your employer’s attention. If extensive time has elapsed between entries, seek guidance before adding notes.

k. **Legal considerations:** Nursing documentation is admissible in a court of law. Recognize that accurate, complete and timely documentation may lead to the conclusion that accurate, complete and timely care was given to the client. The reverse is also true. If the care is not documented, this may lead to the conclusion that it was not done.

l. **Third party information:** Information provided by a third party that is relevant to the client’s circumstances may be recorded in the client’s record, but must include the name of the person providing the information and their relationship to the client and be clearly marked if the information was provided “in confidence.”

m. **Safety event reports:** Safety event reports are for quality improvement purposes. Keep them separate from the client record and do not make any reference to a safety event report in the client’s record.

n. **Privacy:** Recognize the rights of clients and the obligations of public agencies as outlined in the *Freedom of Information and Protection of Privacy Act*. Refer requests for client records to your organization’s client records department. If you are a self-employed nurse, recognize that you are the legal owner of the physical record, but the information contained in it belongs to the client.

o. **Electronic records:** If your organization uses an electronic client record, understand that the same documentation principles apply, although there will be different strategies to record data and to ensure privacy, security and confidentiality.

**FURTHER INFORMATION**

CRPNBC’s Professional Standards, Practice Standards, and Scope of Practice for Registered Psychiatric Nurses: Standards, Limits and Conditions set out requirements for practice that registrants must meet. They are available from the Practice Support section of the CRPNBC website: [https://www.crpnbc.ca/practice-support/](https://www.crpnbc.ca/practice-support/).

For more information on this or any other practice issue, contact a CRPNBC Practice Consultant by email at crpnbc@crpnbc.ca or call 604.931.5200 or 1.800.565.2505.

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