

Guide to Good Nursing Practice Nursing Documentation

Preamble

Documentation is considered as a vital communication tool among healthcare professionals. Nursing documentation is an integral part of clinical documentation and is a fundamental nursing responsibility. Good documentation ensures continuity of care, furnishes legal evidence of the process of care and supports evaluation of patient care. Nurses must balance clinical documentation with respect to legal imperatives. Accurate and complete documentation of client's symptoms and observations is critical to proper treatment and management. Entries documented on a client's clinical record are a legal and permanent document.

Definition

'Nursing documentation' is any written or electronically generated information that describes the care or service provided to a particular client or group of clients. Through documentation, nurses communicate to other healthcare professionals their observations, decisions, actions and outcomes of care. Documentation is an accurate account of what occurred and when it occurred.

Principles

In the process of documentation, the nurse needs to consider the following:

1. Enforce local policies and procedures or protocols of documentation at practice setting and that nurse follows these at all times.
2. Ensure clear, concise, accurate, complete, objective, legible and timely documentation to fulfil both clinical and legal imperatives.
3. Exercise professional judgment and apply knowledge and skills in the given situation.

Responsibilities of the nurse

1. The nurse understands his/her accountability for documenting on the clinical record the care he/she personally provides to the clients.
2. The nurse documents the care process including information or concerns communicated to another health care provider.
3. The nurse documents all relevant information about clients in chronological order with date and time.
4. The nurse carries out comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk or have complex health problems.
5. The nurse documents timely the care he/she provides.
6. The nurse corrects any documentation error in a timely and forthright manner.
7. The nurse remarks any late entry, if indicated, with both date and time of the late entry and of the actual event.
8. The nurse indicates his/her accountability by adding his/her signature and title as approved by his/her organization to each entry and correction he/she makes on the clinical record.
9. The nurse safeguards the privacy, security and confidentiality of clinical record by appropriate storage and custody.
10. The nurse updates himself/herself with contemporary documentation knowledge.

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Endorsed by Nursing Council of Hong Kong
(March 2010)