College of Registered Nurses of Saskatchewan

# Documentation Guideline

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## Introduction

In all practice settings, Registered Nurses (RN) have a professional responsibility to produce clear, accurate and comprehensive accounts of client care. Documentation is a key component of safe, ethical and competent nursing practice and can be completed using paper-based or electronic formats. Client care is not complete until the documentation is complete.

Throughout this document, the term RN refers to RNs, Registered Nurses with Additional Authorized Practice [RN(AAP)], Nurse Practitioners (NP), Graduate Nurse Practitioners (GNP) and Graduate Nurses (GN).

## Regulatory Authority

The College of Registered Nurses of Saskatchewan (CRNS) is a profession-led regulatory body established in 1917 by the provincial legislature. The CRNS is accountable for public protection through *The Registered Nurses Act, 1988* (the Act), ensuring registrants are safe, competent and ethical practitioners. The Act provides legislative authority for RN and NP practice in Saskatchewan.

The role of this guideline is to provide guidance that supports the application of the practice standards, entry-level competencies and the *CRNS Code of Conduct* when completing documentation.

RN Practice Standards and Competencies that apply to documentation include, but are not limited to:

- Entry-level Competency: Communicator
  - Documents and reports clearly, concisely, accurately and in a timely manner.
- Standard 1: Professional Responsibility and Accountability
  - Demonstrates effective communication and collaborative practice.
- Standard 2: Knowledge-Based Practice
  - Utilizes nursing informatics and other information and communications technology in practicing safe registered nursing care.
- Standard 3: Ethical Practice
  - Communicates respectfully and effectively.

## Principles of Documentation

Documentation is a nursing action that produces a written and/or electronic account of pertinent client data, nursing decisions and interventions, and the client's responses in the client's health record. Documentation establishes accountability for care, promotes quality nursing care, and facilitates communication among RNs and other health care providers. Documentation is not separate from care and is not optional. Nursing documentation provides a contemporaneous timeline of care and can be used to determine what nursing care was provided to the client.

Documentation:

- identifies the caregiver and records evidence that the nursing process was carried out, including the client's health outcome and the client's response to the care;
- promotes continuity of care through intra/interprofessional communication; and,
- demonstrates the RN's accountability for providing safe, competent and ethical care.

Unofficial communication tools such as a nurse's jot notes, a pocket worksheet, or shift report do not replace the requirement for complete, concise and accurate documentation in a client's permanent health record. RNs ensure that relevant client care information is captured in the client's health record, then follow up by ensuring these temporary items are securely and confidentially destroyed according to employer policy.

## Why Do RNs Document?

Documentation of client care is required for several important purposes.

### Communication

Quality documentation supports the exchange of pertinent client information among members of the multidisciplinary health care team. Members of the health care team use documentation to ensure continuity of care. After completing documentation, the RN should ask themselves: Have I captured all the necessary information to ensure that another member of the health care team could seamlessly take over the care of the client and provide safe, competent care?

Those reading the documentation should be able to determine:

1. The client who received the care.
2. The care and any formal or informal health teaching that was provided.
3. The RN who provided the care.
4. When the care was provided (date and time).
5. Why the care was provided (identified health care need/assessment of the client's health goals, etc.).
6. The client's response to the care provided and the outcome.
7. Any future plans for care.



 

### Professional Accountability

In Saskatchewan, all RNs in all roles are required to document evidence of safe, competent and ethical care in accordance with the current practice standards, entry-level competencies, CRNS *Code of Conduct* and agency policy. If no agency policy exists, the RN should utilize the principles within this guideline and the documents listed above while advocating for the employer to create policy that outlines documentation expectations.

RNs demonstrate accountability for safe, competent and ethical care through documentation in the client's health record. Documentation should reflect the RN's professional judgment, assessment, coordination of care, decisions, actions and evaluations. Documentation must honor the ethical concepts of good practice such as promoting respect, cultural safety and informed decision-making.

RNs who do not provide direct client care (e.g., administrators, educators, researchers) still have a professional responsibility to maintain records and demonstrate professional accountability for their nursing practice. Records of nursing practice must be in accordance with legislation and organizational policies; however, they may differ from other forms of direct client care documentation.

### Professional Liability

Documentation demonstrates that the RN has applied knowledge from nursing and other disciplines and utilized nursing skills and judgment that are required by professional and ethical standards, relevant legislation and employer policies.

The client's health record is a legal document and can be used as evidence in legal proceedings to reconstruct the sequence of events related to the care of a client. The client's health record can be used to establish the time and date care was provided. It can be used to refresh the memory of those involved in client care and to substantiate or resolve conflicts in testimony. It may also be referenced in professional conduct investigations and discipline hearings. The manner in which information is gathered should be in accordance with applicable legislation, regulatory requirements and agency policy.

The client's health record assists others in confirming that the nursing care provided was competent, ethical and safe; met the established standard of care; was provided promptly; and in a manner consistent with regulatory expectations and agency policies.

Self-employed nurses are expected to have policies and processes in place related to documentation and the collection, storage, dissemination and disposal of client health records and information (NSCN, 2025). This includes RNs who are employers and those who operate an independent practice. Please refer to the Self-Employed Practice Guideline for additional guidance.

### Quality Improvement, Risk Management and Accreditation

Quality improvement is a framework used to improve the ways that care is delivered to clients. Risk management is the identification and assessment of risk. Measures can be instituted to reduce risks to clients, visitors, staff and organizations. Nursing documentation provides data for risk management and quality improvement tools for the RN and the employer. Using information



 

gathered from client health records, RNs and employers can identify trends and maximize client safety by identifying and managing risks effectively. Documentation plays a crucial role in identifying risks and enhancing client safety, which is a shared priority between employers and RNs.

Client health records are used in the accreditation process. Accreditation provides health care agencies with an independent, third-party assessment of the organization using standards built upon best practices used and validated by organizations. This process is used to assess what is consistently being done well and what needs to be improved.

Information from the client's health record is gathered and used to evaluate the care provided and outcomes of that care. Comprehensive and accurate documentation provides a sound basis for the measurement of quality of care and helps to facilitate the evaluation of the client towards preferred outcomes.

### Funding and Resource Management

Documentation supports the allocation of resources, workload measurement and fiscal utilization. This includes human and physical resources. The information gathered from the client health record, workload measurement and client classification systems can be used to determine allocation of funding, staffing requirements and the appropriate skills mix required for safe, competent care.

### Research and Evidence-Informed Practice

Research findings support the development of evidence-informed practice. The client's health record is an important source of data for nursing and health research; therefore, accurate and complete documentation is necessary. Data gathered from the client's health record provides an abundant source of information related to nursing interventions and evaluation of client outcomes. Additionally, the data is used to determine the efficiency and effectiveness of the client care provided.

## Who Should Document?

Legal and professional principles dictate that the RN who provided the client care should be the individual who documents in the client's health record.

If two or more people are providing care to a client, the RN who is the assigned primary caregiver has the responsibility to document the assessment, intervention and the client's response to the care provided. Any subsequent care provider is expected to review the existing documentation and make any additional entries to the client's health record as necessary. Any subsequent care provider is responsible for signing their entry into the client's health record. If the entry requires a co-signature, it should be completed according to agency policy. Agency policy related to the co-signing of entries should indicate the intent of a co-signature and in what circumstances co-signing is required. RNs do not routinely need a co-signature for their entries in the client's health record.

### Third-Party Documentation



 

Third-party documentation or documenting for others is generally not a prudent practice for RNs; however, there are situations where third-party documentation may be appropriate. In these specific situations, agency policy should clearly outline under what circumstances a third party may document for another care provider. Some instances where it may be appropriate for a third-party to document care include, but are not limited to:

- Designated Recorder – In emergencies, such as Code Blue, where all care providers are not able to document the events of the resuscitation efforts. In this instance, a list of all those involved in the resuscitation could be included in the client's health record.
  It may also be appropriate for a third party to document care in instances where it is not practical for client safety reasons or principles of asepsis for the care provider to document (e.g., procedural events in specialty areas such as endoscopy, the operating room or delivery room).
- Auxiliary Staff – Individuals who provide direct client care, such as unregulated care providers (UCP) or individuals who are employed by external organizations can only document in the client's health record if agency policy supports the practice. If there is no policy in place to support documentation in the client record by auxiliary staff, it is the responsibility of the RN to document information reported to them by the auxiliary staff. The RN should include the name and status of the person who reported specific care information related to the client. More information can be found in the resource Working with Unregulated Care Providers.
- Client or Family – In some settings, a client or family member may be asked to record their observations or some component of care in order to optimize the health outcomes of the client and inform the ongoing assessment of the client's health needs. For instance, they may be asked to record the intake and output of a newborn, self-administration of medications, wound drainage amounts, or vital sign trends and symptoms. The agency should provide clear direction as to the RN's responsibility to transcribe, summarize and/or file the information in the client's health record.
- Nursing Students – All nursing students are required to document the care they provide as per agency and academic policies. The CRNS does not support the co-signing of documentation completed by students. However, situations may occur where the assigned RN or preceptor may choose to or be required to document their own assessments, interventions and evaluation based on their professional judgment. This could occur due to a sudden, significant change in the client's status and includes any subsequent intervention initiated. As with all care provided, the intervention must be evaluated and documented in the client's health record.

Third-party documentation can lead to errors or inaccuracies in the client's health record that may affect the provision of safe, competent care for the client. In the case of litigation, documentation that has been completed by a third party may not be admissible in a court proceeding, or the credibility of the documentation may be called into question.

### Use of Artificial Intelligence

Artificial intelligence (AI) tools used to support clinical documentation must be compliant with any applicable provincial and federal health information and privacy legislation and regulations and be agency-selected and approved. RNs who utilize these tools should do so in alignment with the practice standards, entry-level competencies, *Code of Conduct*, *Artificial Intelligence in Nursing Practice* resource, agency policy/processes and after completion of any employer-required education or training.



 

RNs retain professional responsibility for oversight of digital health tools such as AI and recognize that it may augment but cannot replace their assessment, clinical judgment, critical thinking, decision-making or delivery of client care. To ensure patient safety, AI outputs must align with evidence-based care. RNs remain solely responsible for the accuracy and completeness of any documentation entries that rely on AI use.

## How Should RNs Document?

### Legibility and Spelling

All entries should be recorded using professional language, established terminology and according to agency policy. When documenting in the client's health record, the RN needs to make certain that what is documented is legible and that the spelling is correct. Legibility and accuracy demonstrate nursing competence and attention to detail. Illegible entries and misspelled words can lead to treatment errors resulting in client harm and could have legal implications. Documentation in a paper-based format requires the use of permanent ink, and as outlined in employer policy.

### Abbreviations

The use of abbreviations, acronyms or symbols can improve efficiency in documentation if their meaning is well understood by all. Abbreviations and symbols that are obscure, obsolete, poorly defined, or that have multiple meanings can lead to errors and confusion. The Institute for Safe Medication Practices (ISMP) offers resources related to abbreviations and the dangers of using them when documenting. Only abbreviations approved by the employer should be used in the client's health record.

When using electronic documentation formats to complete professional documentation or communication, do not use symbols such as emojis/emoticons.

### Blank/White Spaces

RNs should not leave any blank or white spaces in the body of their documentation, as it presents an opportunity for others to alter previously completed documentation. When documenting, ensure that documentation is completed in an organized, logical and sequential manner. Draw a line through any remaining blank space and end the entry with a signature and designation.

When filling out a flowsheet, fill in all the blocks or spaces with the appropriate, agency-approved symbols. Do not use ditto marks when documenting to indicate a repetition of information as it is unsafe, inappropriate and leaves blank/white space. Always follow agency policy regarding documentation requirements and the use of blank/white spaces.

### Errors or Changes in Documentation

Inaccurate documentation can and does contribute to the incidents of adverse events for clients. Errors and/or changes to the client's health record should be corrected according to agency policy for accuracy and to avoid falsifying the record. *The Registered Nurses Act, 1988* states "… the discipline committee may find a nurse guilty of professional misconduct if the nurse has … falsified



 

a record with respect to the observation, rehabilitation or treatment of a client."

Should the client's health record become illegible (e.g., water spill), keep the illegible record and follow agency policy to address the situation.

When correcting documentation:

- the incorrect information must remain visible or retrievable (in the case of electronic charting) so that the purpose and content of the correction are understood;
- do not make entries between the lines;
- do not remove anything from the client record, such as monitor strips or lab reports;
- do not use correction tape or stickers to hide or obliterate the error;
- never remove pages from the client's health record;
- cross through the word or words with a single line and above the entry write "mistaken entry"; and,
- include initials, and the date and time the correction is made.

In the case of electronic charting, the RN may be required to have permission or access to make changes to the client's health record. Refer to agency policy on how to address errors in the electronic record.

### Electronic Documentation

When completing electronic documentation, the same principles of documentation apply as for paper-based documentation. RNs have the same ethical and legal obligations to maintain confidentiality of client health records when documenting in an electronic format as they have for paper-based charting. Electronic documentation may need additional safeguards, such as encryption, to prevent unauthorized access to the client's health records.

To ensure the security of client health records, policies, procedures and specific technologies need to be in place. To minimize the potential for a breach, RNs should consider the following:

- create strong passwords and change them frequently and according to agency policy;
- do not share your password or any other access information with others;
- do not log on for others or allow them access to your electronic profile;
- log off or lock the screen when you are leaving the terminal, even briefly;
- take all reasonable safeguards to protect the monitor from visualization by others when making entries in client health records;
- report unauthorized access or use of your electronic signature to your employer; and,
- never delete or modify anyone else's documentation in the electronic health record.

### Confidentiality

*The Health Information Protection Act* (HIPA) is the legislation that outlines the requirements to ensure the privacy and confidentiality of client health records.

A trustee that has custody or control of personal health information must establish policies and procedures to maintain administrative, technical and physical safeguards that will:



 

(a) protect the integrity, accuracy and confidentiality of the information;

(b) protect against any reasonably anticipated:

(i) threat or hazard to the security or integrity of the information;

(ii) loss of the information; or,

(iii) unauthorized access to or use, disclosure or modification of the information; and,

(c) otherwise, ensure compliance with this Act by its employees. (HIPA, 2003).

The CRNS *Code of Conduct* provides direction for RNs regarding privacy and confidentiality: "RNs are expected to: protect the privacy and confidentiality of clients' personal health information as outlined in legislation and regulatory documents" (CRNS, 2026, p. 8).

At all times, the RN must maintain the privacy and confidentiality of client health records, regardless of what method of documentation is used. Information regarding the client and their care should only be shared with those directly involved in the client's care. RNs should only access the health records of clients currently in their care.

Do not discuss the client's assessment, observations, treatment or conversations with other clients or staff who are not involved in the client's care. Health records that are maintained in a client's home should be stored in a manner that reduces the risk of people who are not involved in the client's care from accessing the health record and violating the client's privacy or confidentiality.

Transport client health records and documentation only when authorized and in a secure manner. At times, client information may be sent via email, text or fax. When sending client information electronically, the RN should observe the following:

- always follow agency policies regarding the transmission of client information via email, text or fax;
- use only secure networks when communicating with other health care providers about a client;
- ensure health information is being transmitted to a unique and accurate email address or the correct phone/fax number to minimize unintended access;
- place a copy of the information in the client's health record, if possible;
- include a confidentiality warning message indicating that the information being sent is confidential and that the message is only to be read by the intended recipient and must not be copied or distributed;
- proofread messages before sending;
- ensure printers are in a secured area away from public access;
- ensure all printed materials are secured and are appropriately disposed of when no longer required (e.g., shredded according to agency records retention policy); and,
- be diligent when sending information electronically. Ensure that addresses and numbers are verified as correct before sending, that only the required information is sent and that the transmittal was completed.

Clients may request and receive copies of their health records according to agency policy.

## What Should RNs Document?



 

Point-of-care RNs are required to document all aspects of the nursing process: assessment, planning, implementation and evaluation. Documentation of the care provided must be consistent, clear, factual, objective and reflect the RN's critical thinking when providing client care.

The following should be recorded by the RN in the client's health record:

- a clear and concise statement of the client's status (physical, psychological and spiritual);
- all relevant assessment data (including client and family comments as appropriate);
- all ongoing monitoring and communications;
- the care provided to the client, including interventions (basic nursing care, treatments, advocacy, counseling, consultation, client and family health teaching); and,
- evaluation of the care provided, including the client's response and any impact for discharge planning.

### Objective vs. Subjective

Objective information is considered to be any facts related to the client's status that are observed or measured. This includes assessment, interventions and the client's response to care provided. RNs should document all aspects of client care utilizing the nursing process and using objective statements. RNs should avoid vague or opinionated documentation as it can misrepresent assessment findings and interfere with the continuity of care. RNs should avoid generalizations, bias and labels. Incomplete or biased documentation can reinforce systemic biases leading to misinformed decision-making, inadequate care or an absence of care and worse outcomes, especially for marginalized groups of people. Document only information that can be supported by data. Clear, factual and objective health records are essential for equitable and safe practice.

Subjective information is affected by personal views, experiences and background. Subjective information may be provided by the client and/or family. Subjective statements may improve the understanding of the client's experience related to the care provided. If such statements are included, identify who made the comments and use quotes to signify comments. Record these as accurately as possible.

### Date, Time, Signature and Designation

Entries in the client health record begin with the date and time of the care provided and end with the signature and designation of the person making the entry. There can be variations from agency to agency as to how to document date, time and signature. RNs should be aware of and follow agency policy when documenting.

### Admission, Transfer, Transport and Discharge Information

Documentation of the admission, transfer, transport and discharge provides a baseline for future care of the client. The client's health record should indicate what information was provided to the client for any transitions in care. Documentation in the client's health record should include the client's status at the time the information was provided, the information that was given to the client, any arrangements for follow-up, the client's apparent understanding of the information provided to them and any family/significant other's involvement. Again, agency policy should provide direction for the recording of communication between practitioners or the services



 

arranged.

### Health Care Team Collaboration

All client-specific communications that occur amongst members of the multidisciplinary health care team must be recorded in the client's health record. The date, time and information presented and discussed by members of the health care team, as well as any decisions to develop or modify the plan of care, should be captured and documented in the client's health record. All forms of communication— written, verbal, and electronic, should be documented. As well, unsuccessful attempts to contact other health care providers and the measures taken to address the client's health care needs should be recorded (e.g., discussion with the charge nurse, contacting another health care provider).

### Virtual Care

Virtual care is any nursing care or service delivered by electronic means such as video or audio conferencing, telephone calls, fax or email communication. When documenting virtual care nursing services, the RN shall document in a manner congruent with in-person visits including the date and time of the communication, the name and contact information of the client, the age of the client and the reason for the virtual care. As the RN may not be able to visually or physically assess the client as in person, they must use good communication skills and ask probing questions to gather information about the signs and symptoms that the client is experiencing. The use of a specific protocol or algorithm for decision-making, if applicable, should be included in the documentation along with any assessment data. Any information, referrals or agreements on the next steps and follow-up plans for the client must be documented.

As with all care, informed consent for care needs to be obtained. The RN providing virtual care needs to ensure that the client confirms an understanding of the information provided to them including the risks and benefits of virtual care, and that although steps have been taken to protect client privacy the platform being used to provide virtual care that a breach of privacy may still occur.

Clients should be advised to have their virtual care session in a private location to protect their confidentiality. All information provided, including client consent, needs to be accurately and thoroughly documented in the client's health record.

### Client Education

RNs document both formal and informal teaching provided to the client. The materials, the method(s) of teaching, as well as the involvement of the client and the family, should be entered into the client's health record. Lastly, an evaluation of client/family comprehension of the information provided should be documented.

### Client Choice and Risk-Taking Behaviors

The CRNS *Code of Conduct* (the Code) states, "RNs are expected to act in clients' best interests by respecting their autonomy, care preferences, choices and decisions" (2026, p. 4) even if the client chooses to engage in risk-taking behaviors.

When a client chooses to engage in risk-taking behaviors or refuses medical care or advice, the

 

RN documents the information that was provided to the client and the outcome of the discussion with the client in a fair and unbiased manner. Respectful documentation includes situational facts and avoids judgment. Some agencies may have specific forms that must be completed. If the client's risk-taking behavior is a violation of the law that requires mandatory reporting (e.g., child abuse), the RN is required to document according to relevant legislation. If the RN is questioning the capacity of the client to understand the information that has been provided and their choice to engage in risk-taking behaviors, the RN should consult relevant legislation, agency policies and their employer for direction.

### Adverse Events and Incident Reports

At times, a client may suffer an adverse event such as a fall, injury, or a medication administration error such as an incorrect dosage, incorrect medication, or a missed dose of medication. Should an adverse event occur, the RN shall objectively record the event, the care provided and any interventions that were required. RNs should avoid the use of the words error, incident or accident when documenting in the client's health record.

Assumptions, conclusions and judgments about the event should not be included in the documentation. Most agencies have specific reporting forms to document adverse events. Agency policy should be followed when completing incident reports. Incident reports are generally separate from the client's health record, but a notation about the completion of an incident reporting form following an adverse event should be included in the client's health record.

Reporting adverse events is important from a quality improvement perspective. Incident reports can identify system issues that need to be addressed to support client and staff safety.

## When Should RNs Document?

RNs should document frequently, chronologically and promptly. All documentation should be completed according to agency policy.

Documenting frequently helps to ensure the accuracy of the information being entered in the client's health record. The frequency of documentation and the amount of detail required in the entry are determined by several factors: the complexity of the client's health needs, the degree to which a client's condition puts them at risk of deterioration or harm, the degree of risk involved in a treatment or component of care, changes in the care plan, and any transitions in the client care such as admission, discharge, transfer or transport. As complexity and client acuity increase, documentation should become more frequent.

Chronological entries into the client's health record are important as they can reveal patterns and changes in the client's health status. Chronological entries provide clear communication of the client's status and the care provided. Chronological entries into the client's health record assist all members of the multidisciplinary health care team to understand what care was provided based on the assessment of the client by the RN. Also included should be an evaluation of the care provided, including the client's response. Accurate and up-to-date information enables all team members to develop and carry out appropriate and comprehensive care plans.

RNs should document assessments, interventions and evaluation of treatment or care provided in a

 

timely manner. This means documenting as close to real-time as possible to ensure accuracy of details and timely communication to the team.

Documentation should never be completed before nursing care takes place (e.g., client assessment, medication administration, a nursing treatment). Documenting care that you intend to perform but have not provided may be considered as dishonest and creates a risk for both the client and the RN.

### Late entries

Nursing care should be planned to include time for documentation. When it is not possible to document at the time of or immediately following an event, a late entry is required. When documenting late entries, seek advice from the employer or follow employer policy and authorizing mechanisms (NSCN, 2025). When making the new entry, it must be clearly identified as a "late entry." In the client's health record, specify the date and time that the new note is entered. Clearly identify the event or previous note that the new entry is related to.

## Conclusion

Documentation of client care should be completed promptly with as much detail as is required to present an accurate and thorough representation of the client's health status and the nursing care provided. This enhances continuity of care and safety for the client. RNs demonstrate professional responsibility and accountability through consistent and accurate documentation.



 

# References

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