Documentation in Nursing: 1st Canadian edition (updated 2026)

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TORONTO



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This open access textbook is intended to guide best practices of documentation in the nursing profession. This resource is designed for students in undergraduate nursing programs, and addresses principles of documentation, legislation associated with documentation, methods and systems of documentation, and key trends in the future of documentation. Incorporated into this resource is legislation and practice standards specific to the province of Ontario, Canada.

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Note to Educators Using this Resource

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Learning Outcomes

By the end of this chapter, you will be able to:

- Define documentation.
- Explain the reasons for documentation.
- Apply the principles of documentation.
- Interpret elements related to privacy, confidentiality, and security.
- Demonstrate use of documentation methods.
- Describe documentation systems.
- Practice critical thinking in documentation.
- Identify key trends likely to influence the future of documentation.

Introduction to Documentation

Documentation refers to **paper** or **electronic record keeping** about a client's state of health and their care. Today, electronic record keeping is most common in healthcare; this involves typing directly into a client's chart (health record) using a computerized device. Paper record keeping involves using a pen to write in the client's chart (health record). A paper chart is typically in a three-ring binder or folder and is dedicated to a specific client.

These forms of record keeping are typically referred to using the interchangeable terms the "client's chart" or the "client's health record."

The nurse should **document all phases of the nursing process**, including:

- Assessments, history, and observations of the client's health status including both normal and abnormal findings.
- Diagnostics, planning, and interventions including care, treatment, services, and health teaching.
- Evaluations of the care, treatment, and services provided, noting how the client responded, and any necessary follow-up.

The components of documentation included in the client's chart will depend on the area of care and institution. For example, a nurse working on a cardiac unit will document different findings than a nurse working on a labour and delivery unit, and a client's chart will also vary by institution, such as across hospitals, out-patient clinics, primary care settings, and long-term care facilities.

Points of Consideration

Information and Communication Technologies

Documentation can be facilitated by using **information and communication technologies** (**ICT**); these digital technologies allow "the electronic capture, processing, storage, and exchange of information" (Gagnon et al., 2012, p.241). ICT is an umbrella term used to describe the technology-based tools that nurses use in the clinical environment, including the client's electronic record. As a healthcare provider, you will be expected to use ICT to support interprofessional communication with the client and other providers, as well as to inform client care and clinical decision-making.

The next section explores the reasons for documentation.

References

Gagnon, M., Desmartis, M., Labrecque, M., Car, J., Pagliari, C., Pluye, P., Fremont, P. Gagnon, J., Tremblay, N., & Legare, F. (2012). Systematic review of factors influencing the adoption of information and communication technologies by healthcare professionals. *Journal of Medical Systems*, *36*(1), 241-277. doi: 10.1007/s10916-010-9473-4

Reasons for Documentation

Nurses have **a legal obligation** to document. In Ontario, you must adhere to the practice standard titled *Documentation*, (College of Nurses of Ontario, 2025). This standard will be discussed in more detail later; for now, **Table 1** lists some fundamental reasons why documentation is so important.

Table 1: Why documentation is so important

Reason	Consideration
Communication, continuity of care, and clinical judgment	Documentation is important because it **communicates clinical information** about a client including data related to their state of health and illness. The documentation record is a **vehicle of communication** within the intraprofessional and interprofessional healthcare team. By documenting information, the healthcare team is made aware of assessments, interventions, and responses so that care can be tailored to the client's state of health, needs, and preferences. This allows for a **continuity of care** for the client that is connected and coordinated throughout their experience. Additionally, the documented data allows for healthcare providers to incorporate this information in clinical judgment and decision-making.

Client safety	Linked with communication is the importance of documentation to ensure **client safety**. Client safety involves partnering with other healthcare providers and clients to prevent and minimize unsafe acts, reduce harm, and respond accordingly (Canadian Patient Safety Institute, 2019). Actions to achieve client safety involve timely, clear, and comprehensive documentation, which serves to communicate a common understanding among healthcare providers about information known about the client, and it also facilitates effective decision-making. To decrease the potential for miscommunication and errors, documentation must be accurate and truthful, timely, and complete in terms of including all relevant information. Documentation can include directives and care plans related to client safety, such as the use of bedrails and assistive devices. Documentation of medication administration is important in client safety, as it prevents the likelihood of duplicate administration. Documentation can also alert healthcare providers to findings that require interventions to ensure safety.

Quality improvement	**Quality improvement** involves constant reflection and commitment to working toward best outcomes associated with healthcare systems that are safe, effective, client-centred, timely, efficient, and equitable (Healthcare Excellence Canada, 2026). Chart audits and reviews aid with the evaluation of standards associated with high quality care and the appropriateness of care. These quality improvement initiatives can help identify needed changes in practice and foster evidence-informed approaches to practice. For example, a quality improvement study could reveal high rates of incident reports related to falls, which could prompt in-service or training sessions surrounding the prevention of falls.
Funding	Documentation records can influence provincial and federal **funding**. Certain systems are used to evaluate completed tasks based on documentation records, so it is important to maintain clear and comprehensive records of the care and services provided.

Legal	In addition to supporting high quality and safe client care, it is important to consider the **legal aspects of documentation**. The client record is a legal document that provides evidence of the assessments conducted on the client and the care and services provided. You and/or the client record may be subpoenaed for proceedings related to cases such as negligent practice, coroner's inquests, violence, child welfare, and criminal offenses. These proceedings may take place many years after you have cared for a client, so the data you have documented may be the only way to recall the situation. Therefore, your documentation must be clear, accurate, and reflective of the assessment you performed and the care you provided. There is also a saying: "if it's not documented, it wasn't done" – your documentation notes must be complete, or it will be presumed that care was not provided.
Research	Nurses and other healthcare providers sometimes review documentation records as part of their **research**. For example, they may examine factors related to nurse-sensitive indicators/ outcomes, which will lead to evidence-informed practice. For example, a research project might focus on RN to RPN ratios on a unit and the association with outcomes such a mortality and morbidity, or it might explore documentation notes to assess how nursing discharge teaching after surgery is related to hospital readmission rates.

Population and clinical health insights	Review of client records can provide insight into specific **populations** and **clinical health issues**. For example, reviews of client records can help healthcare providers track data and identify trends across patient groups or institutions. These reviews may provide information related to transmission of diseases and epidemics, effectiveness of interventions, or complications with certain populations. For example, influenza-related hospital admission rates and mortality rates are recorded and tracked each year.

Points of Consideration

Documentation and Violence

Documentation is critically important in cases that involve violence because the client record may be used as a source of evidence in legal proceedings. Therefore, as a nurse you must clearly and comprehensively document your detailed assessment. It is important that you incorporate direct quotes from the client and place them in quotation marks, even if they are expletives involving profanity and obscenity. Photographic images are also necessary to document cases of physical and sexual violence. In cases of bruising, swelling, lacerations, and/or contusions, use a measurement tool as a point of reference.

Consult your institutional policies about photography and record keeping, including guidelines related to designated devices for recording images and how the client is identified in the picture.

Activity: Check Your Understanding



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References

Canadian Patient Safety Institute (2019). *Engaging patients in patient safety: A Canadian Guide*.https://www.healthcareexcellence.ca/resources/engaging-patients-in-patient-safety-a-canadian-guide/

College of Nurses of Ontario (2025). *Documentation*. https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf

Healthcare excellence Canada. (2026). *Why does Canada need a national quality and patient safety framework for health services?* https://www.healthcareexcellence.ca/resources/why-does-canada-need-a-national-quality-and-patient-safety-framework-for-health-services/

Documentation Components

The components included in a client's record (and the names of these components) may vary between institutions and practice settings. A **list of these components** may include:

Admission sheet: This is one of the first items that you will see in the chart of a hospitalized client or in-patient client. It will vary between institutions, but generally includes information about the client including their name, age and date of birth, gender, contact information/address, admission date, reason for admission, and next of kin and/or emergency contacts. Importantly, the admission sheet identifies and highlights in red writing any known allergies. It may also include other health issues, list of current medications, personal items like dentures, glasses or assistive devices, a list of client valuables, and advance directives.

Progress notes or **interdisciplinary notes:** These refer to free-text entry space that allows for open-ended documentation. Many members of the interdisciplinary team may write notes in the same section of the client record, or there may be specific areas for physician notes or nursing notes. These notes will include a record of your assessment and care of the client including the client's health status and/or responses to interventions. You will use specific documentation methods to organize these, as discussed later in this chapter.

Referrals and **consultations:** Here, healthcare providers document expertise about a client's healthcare status/condition and advice related to the plan of care. The format is similar to that of progress notes.

Diagnostic, **laboratory**, and **therapeutic orders:** In these sections, healthcare providers provide orders related to diagnostic tests (e.g., ultrasound, X-ray orders), laboratory orders (e.g., blood, urine tests),

or therapeutic orders (e.g., medications, diet, mobility orders). These are sometimes referred to as "physician orders" or "doctor orders." Nurse practitioners can also provide some of these orders, depending on provincial and territorial body regulations and institutional policies.

Medication administration record: This is commonly referred to as the MAR, which includes a list of all medications that are ordered for the client: medication name, dose, route, frequency, date the medication was ordered, and the date it will expire. It also details any consideration for administration, such as a minimum apical heart rate before administration. Any client allergies are highlighted in red. As the nurse, you must document the date and time, and sign and initial the MAR, when you prepare and provide any medication. Some forms include a space for noting items such as the client's apical pulse or temperature. Electronic MARs are particularly helpful by providing notifications: related to timing of medication to prevent missed doses, when a medication is about to expire, or when a new medication is ordered. Importantly, certain classes of drugs such narcotics require special documentation and witnessing protocols because of the potential for illicit use; consult your institutional policies for guidelines related to documenting narcotic dispensing, administration, and disposal.

Flow sheet and **graphic record**: These are commonly completed by nurses and include the documentation of physiological data like vital signs, pain, and weight. These records can also include routine documentation related to hygiene, mobility, nutrition, and the use of restraints. They allow healthcare providers to observe trends in data over time and recognize cues that require intervention.

Kardex or **summary sheet:** These forms summarize important information that should inform your daily care of the client and must be continually updated during each shift. When it is documented in written form, it may be completed in pencil because it requires frequent updating. However, it is important to note that

it is not a legal document when written in pencil. Therefore, any relevant information included in the Kardex must also be captured in the client's permanent health record. This kind of form includes information such as:

- A stamp on the top with the client's name, hospital identification number, and date of birth.
- Treating physician, client's age, preferred gender, and diagnoses.
- Allergies, resuscitation status, and required safety precautions.
- Emergency contact information.
- Medications.
- Therapeutic orders (e.g., turning, ambulation, mobility aids, diet, dressing changes).
- Tests and procedures.
- Hygiene (e.g., if and how often they can have a shower or bed bath).
- Dressing and wound care instructions.

Nursing care plan: This form includes nursing diagnoses and a plan of care based on specific goals.

Operative procedures: The physician uses this form to document the specific details of a procedure and any complications.

Consent forms, **resuscitation forms**, and **healthcare directives:** These include all completed consent forms for procedures, completed and signed resuscitation forms, and information about any healthcare directives such as a legal document in which the client provides power of attorney for personal or financial care.

Discharge plan and **summaries:** These generally include information about preparation and teaching related to discharge; they should be written in clear and non-medicalized language that the client can understand. They provide specific step-by-step instructions that the client should follow when they are discharged, and may include:

- Education about their condition or disease.
- A list of medication including the name, dose, route, and frequency as well as adverse effects to watch for.
- Guidance surrounding nutrition in terms of the client's diet (i.e., what they should eat, how often, what they should avoid).
- Information about mobility and mobility aids, such as specific goals in terms of activity and exercise (amount and frequency), and information about aids such as crutches or a cane and how to use them.
- Access to resources in the community such as homecare, rehabilitation, and meal-delivery services.
- Information about when to seek healthcare if the client experiences specific symptoms, adverse effects, or complications, and appointments related to follow-up care.
- Finally, this form documents the date/time of discharge and how the client is getting home (e.g., transportation and whether they are accompanied by someone).

Critical incidents: You may be required to report and submit forms related to specific incidents. Regulation 965 of the Public Hospitals Act (1990) defines a critical incident as "any unintended event that occurs when a patient receives treatment in a hospital, (a) that results in death, or serious disability, injury or harm to the patient, and (b) does not result primarily from the patient's underlying

medical condition or from a known risk inherent in providing treatment." You will need to inquire about your workplace policies concerning critical incident reporting. In Ontario, hospitals are required to "report critical incidents involving medications and intravenous fluids" (Ontario Ministry of Health and Long Term Care, as cited in ISMP Canada, n.d.). This type of reporting is important to ensure patient safety by clarifying how the incident occurred and inform changes in practice so that unsafe acts are less likely in the future (Canadian Nurses Protective Society, 2005).

Workload measurement: You may be required to complete this kind of documentation. There are many types of workload measurement systems including common ones such as GRASP or other systems developed in-house. These tools and systems allow organizations and leaders to monitor client care needs (e.g., number of care hours required) and nurse staffing requirements (Griffiths et al., 2020). They are often used for quality improvement, securing funding, and decision-making concerning allocation of nurses. When required, you will usually complete these at the end of each shift; they may involve electronic tracking of the amount time spent with each client performing tasks such as measuring vital signs, administering medications, caring for wounds, etc.

Points of Consideration

Incident Reporting

As a nursing student, you must also refer to your university department and clinical placement office with

regard to policies about what type of incidents must be reported.

Activity: Check Your Understanding



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References

Canadian Nurse Protective Society (2005). *What is meant by "patient safety"?* https://www.cnps.ca/index.php?page=95

Griffiths, P., Saville, C., Ball, J., Jones, J., Pattison, N., & Monks, T. (2020). Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion. *Int J Nurs Stud*, 103.

ISMP Canada (n.d.). Ontario critical incident learning. https://www.ismp-canada.org/ocil/

Public Hospitals Act R.R.O. 1990, Regulation 965. *Hospital Management*. https://www.ontario.ca/laws/regulation/900965#BK1

Electronic Documentation Systems

Clinical documentation is increasingly being recorded, either partially or completely, using **electronic documentation systems**. This type of documentation occurs via a computerized device such as a desktop computer, laptop, tablet, and sometimes a smartphone. In order to access the system, healthcare professionals must sign in with a username and password that is unique to them. This security feature is a benefit of electronic systems in comparison to paper charting because it identifies who enters the client's record and also restricts who enters the system. Also, this security feature helps protect the client's privacy with electronic systems in comparison to written records.

Common electronic documentation systems used in healthcare settings include electronic medical records (EMR) and electronic health records (EHR).

- **EMRs** are used and sometimes built for a single organization or practice, with a focus on the collection of medical data (e.g., specific to physicians). Common examples include electronic documentation systems used in the practices and clinics of primary care providers that do not connect to systems outside of those organizations.
- **EHRs** are generally developed with *interoperability* as a key function, meaning that all providers who use the same health information system can access and exchange information across organizations and providers.

In general, recent trends have been favouring the development and

use of EHRs, and the following sections focus specifically on these systems.

Purpose and vision of EHRs

The primary aim of EHRs is to **facilitate seamless care for clients** by providing a way to capture and access real-time client data. EHRs can improve interprofessional communication, coordinate care among providers, and foster effectiveness and efficiency in care.

EHRs can help eliminate gaps in care that can arise from the inability to share information across institutions and/or geographic boundaries. These systems provide access to longitudinal and comprehensive health records of clients, along with documentation and other clinical tools to support care provision by individual healthcare providers and teams.

Case Study

An unconscious client is brought to the emergency department. The nurse reviews the client's EHR and notes that they have recently been seen by a community cardiologist for chest pain; the nurse also notes that the client is allergic to aspirin (ASA). The emergency physician reads the client's recently prescribed medications and diagnostic imaging from their consult with the cardiologist. Together, this information allows the healthcare team to make informed decisions about the client's care, based on their individual history and detailed list of recent interventions. As a result, the client's prognosis improves,

the length of stay in hospital is reduced, and fewer resources are required to determine a baseline or **differential diagnosis** for the client.

Commonly used EHR vendors

You will encounter **numerous types of EHRs** during your clinical placements and future practice. These EHRs vary in their **functionality**, **look**, **feel**, and **usability**. Healthcare organizations purchase an EHR system from a vendor based on their needs, capacity, and type of care provision (acute, public health, long-term care, primary care).

Common EHRs used in acute Canadian health settings include those built by large private vendors such as: EPIC, Cerner, Meditech, and Allscripts. Some healthcare organizations have built their own EHR systems (e.g., the Electronic Patient Record System developed by the University Health Network in Toronto). Other vendors are used outside of acute care (e.g., PointClickCare is commonly used in long-term care facilities).

Given the **variability in vendors** used in different organizations and care settings, what is most important for clinical documentation is to recognize the components of EHRs that are common across different types of systems. Although you are expected to understand and know how to use EHRs in organizations where you are placed or where you work, you will first receive orientation and training at these specific organizations.

Common components of EHRs

EHRs are digitized versions of paper charts, and they all include

information similar to that collected for paper charts, as discussed above. However, because they are electronic, they also have functions that allow for data entry, viewing, and exchange of various types of client information (e.g., health history, progress notes, diagnostic and laboratory results, therapeutic orders).

Both electronic and paper charts use **structured data elements** and **unstructured data elements,** as outlined in **Table 2**. However, a key difference in clinical documentation is that the technological capacity of an EHR allows structured data to be easily aggregated and analyzed.

Table 2: Structured and unstructured data elements

Data Elements	Consideration and Examples
Structured data elements: These are built-in templates or structures that guide healthcare providers when entering data. They require providers to fill out specific fields (e.g., vital signs, medication dose), often by selecting a system-provided option. Sometimes it will look like a drop-down menu and you click on the option or you enter the information in space provided. Sometimes you are provided options such as "within normal limits" (or "within defined limits"), which means the patient data is normal according to the specified limits. For example, normal heart rate in adults is 60 to 100 beats per minute. Thus, you would be provided the option in documentation to tick off "within normal limits." In the context of an EHR, structured data have inherent meaning and can be used in meaningful ways in other functions of the EHR (e.g., trending data, triggering warnings or reminders).	**Example 1**: A nurse enters the value of 140/80 in the EHR data entry field titled "blood pressure." The EHR recognizes "140" as meaning systolic blood pressure in millimetres of mercury and "80" as meaning diastolic blood pressure in millimetres of mercury. **Example 2**: The nurse begins to document a wound assessment. As the nurse begins to type *wound odour* in the wound assessment data entry field, the system provides automated suggestions in a drop-down menu including *no odour*, *increasing malodour*, and *foul odour*, and the nurse selects one.

Unstructured data elements: These are free-text entry sections that allow open-ended documentation of the client data. They may include progress notes and nurses' notes, given the narrative nature of these types of documentation. Documentation of unstructured data involves the same principles as those used for paper charts (communication, accountability, and security, as discussed in the next section). Due to technological limitations, this unstructured information cannot currently be used in a meaningful way by the EHR in other functions. EHRs are currently unable to summarize or identify trends in these data, but this is an area of emergent research and methods are being developed to allow systems to *understand* unstructured narrative data.	**Example 1**: The nurse enters a note: "The client described walking for twenty minutes a day with no shortness of breath. The client uses a cane to support their balance." This is unstructured in that the system does not have a way of understanding the meaning of any data entered in this field (e.g., whether it relates to mobility, nutrition, allergies).

Points of Consideration

Status of EHR

EHR deployment, maturity, and use varies among organizations, provinces, and territories. It is important to note that EHRs are not simple replacements of paper records: EHRs affect workflow significantly in terms of how nurses work, document, and manage information. Currently, they do not reduce duplication of records or documentation.

Activity: Check Your Understanding



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Principles of Documentation

As a nurse, you are legally obligated to complete documentation. You should refer to the **legislative** and **regulatory requirements** for documentation in the province or territory that you work. In Ontario, you should first **closely review** the Documentation practice standard found at: CNO Documentation

As per the CNO (2025a), there are three documentation principles:

- Communication.
- Documentation requirements.
- Information security.

There are several indicators that facilitate nurses' application of the three documentation principles to their practice. **Table 3, 4, and 5** present common questions related to the indicators for the above three principles.

Table 3 focuses on communication: the requirement that "Effective communication is a foundational documentation accountability that promotes safe and quality nursing care. Nurses must apply their knowledge, skill and judgment when documenting, ensuring their documentation is a clear, complete and accurate representation of the client's health status including the nursing care provided and any significant interactions." (CNO, 2025a, p. 6).

Table 3: Communication

Questions	Considerations	Additional EHR Considerations
"What does it mean to document both **objective** and **subjective** data?"	In addition to providing care, you must document using a combination of subjective (what the client says) and objective (what you observe) data.	Comprehensive documentation of subjective and objective data will require using both structured and unstructured data elements.
"How do I ensure that my documentation is a **complete record** of the nursing process?"	A complete record includes of all phases of the nursing process: assessment (e.g., subjective and objective data); plan of care and interventions (e.g., hygiene care, assistance with mobility, treatments such as turning the client and medications, health teaching); and evaluation of the care you provide (e.g., how did the client respond?). In addition, a complete record includes all relevant communication and attempts at communication with the healthcare team including the client and family. CNO (2025) indicates that documentation of communication should include the communication mode, the person's name and designated title (when applicable), and the discussion outcome.	No additional considerations.

"What do I need to consider so that my documentation is **clear**, **relevant**, **individualized** to the client, and with **minimal duplication**?"	Your documentation must be precise and coherent so others can understand. Vague and obscure documentations can lead to misinterpretation. Documentation should be specific and individualized to each client. Your documentation should balance being comprehensive and concise. This will become easier with practice. Try to include all relevant information and omit unimportant information. For example, a client may tell you a story that is irrelevant to their reasons for seeking care or your assessment; do not include this. Try to be succinct and avoid documenting the same thing twice.	Structured data should be entered according to the structures included in the EHR. For example, the EHR may require a specific format to enter the value for the field "blood pressure." Unstructured data should be documented using the same best practices as those used for paper documentation.

"How do I ensure that my documentation is **free from discrimination**?"	You are responsible for adhering to the Ontario Human Rights Code Ontario Human Rights Code when documenting. This means that you should be respectful of a client's identity and how you refer to it in your entries (e.g., race, ethnic origin, citizenship, sex, sexual orientation, gender identity, gender expression). As an example, you should be respectful of how a client self identifies (e.g., pronoun usage).	No additional considerations.

Table 4 focuses on documentation requirements: the requirement that documentation is "consistent, appropriate, and accurate … [and] support accessibility, ensure continuity, and uphold legal as well as professional accountabilities" (CNO, 2025, p. 8).

Table 4: Documentation requirements

Indicator	Consideration	Additional EHR Considerations
"How do I record the **date** and **time** of my documentation?"	Use the 24-hour clock (also called military time; see **Figure 1**). Generally, the documentation date and time should reflect the time of your documentation entry as opposed to the time you provided the care. However, when documenting vital signs, medication administration, or other procedures, you should specifically note the time that the task was performed.	EHRs capture your digital identity and time stamps of your activities.

How do I ensure that a **unique identifier** is used to sign documentation entries?	First, note that "registered nurse" and "nurse" are protected titles in Ontario, and you can only use them as a designation if you are registered with the CNO (2020). Your educational institution will discuss with you what designation you should use as a nursing student. You must provide your full legal name (printed), signature, and initials on a main sheet. Your name and designation must be consistent with your CNO registration and can only be in English or French. Typically, a signature is written in cursive (as opposed to printed) and is something that is unique to you, usually includes your first and last name or first initial and last name.	EHRs provide ways of including your signature and designation electronically. They may require you to sign on and off digitally, include your digital identity, password, and time stamps of your activities, and limit or restrict access to certain functions for students.

"How do I ensure that my documentation is **timely** and when do I indicate it as a **late entry**?"	You are expected to document promptly after an assessment or providing care. Do not wait until the end of your shift to document, and never document prior to providing care. Sometimes it may not be possible to document promptly because another client or nurse requires your assistance; in this case, document as quickly as you can and identify it as a "late entry." You will still include the time that you are documenting, and in the first line include something like "Late entry. Assessment and care provided at XX" (and specify the time the care was provided). Each workplace should have policies and procedures concerning late entries; if not, you should advocate for them.	Documentation date and time are captured by the EHR along with your digital identity and time stamps of your activities.
"What does it mean to document in a **chronological order**?"	Chronological order means that your documentation is arranged in order of time: from what happened first to what happened last.	No additional considerations.

"What should I consider in terms of ensuring my hand-written documentation is **legible** and completed in **permanent ink**?"	Your hand-written documentation must be legible, meaning that it can be read and understood by others: if your cursive writing is poor, consider printing. Permanent ink is specified because you are generally not permitted to use pencil to document. Black ink is usually best because it yields the best photocopies, but red and blue ink is required for certain vital sign graphs.	One advantage of EHRs is the avoidance of legibility issues related to hand-written documentation.
"**Who** should complete the documentation note?"	Only document your own observations and actions. Do not document the observations and actions of other healthcare providers except in situations where you are a designated recorder, such as during code situations. Co-signing of documentation notes is not permitted.	No additional considerations.
"How do I **correct** a documentation note when an **error** is made while documenting?"	It is vital that any error in a written documentation note remains visible. Do not scribble over the error or use correction fluid. Unless there is a specific organizational policy, draw a single line through the error and initial it. Some organizations have policies such as writing the word "error" and including the date/time and your signature.	In an EHR, you can add an additional note referencing the error. It will capture this information along with your digital identity and time stamps of your activities. Some EHRs have specific functions to address errors in documentation. You will become familiar with the conventions used in each.

24-hour clock	Standard time	24-hour clock	Standard time	24-hour clock	Standard time
0000	midnight	0800	8 am	1600	4 pm
0100	1 am	0900	9 am	1700	5 pm
0200	2 am	1000	10 am	1800	6 pm
0300	3 am	1100	11 am	1900	7 pm
0400	4 am	1200	Noon	2000	8 pm
0500	5 am	1300	1 pm	2100	9 pm
0600	6 am	1400	2 pm	2200	10 pm
0700	7 am	1500	3 pm	2300	11 pm

Figure 1: The 24-hour clock and standard time.

Clinical Tip

The 24-hour Clock

Understanding the 24-hour clock can be confusing after 1 pm (standard time). Simply add or subtract when converting: for example, if the standard time is 2:15 pm, add 12 hours for the 24-hour clock time of 1415. If you are

provided the time of 2230, subtract 12 hours for the standard time of 10:30 pm.

Table 5 focuses on information security: the requirement that "nurses secure and protect personal health information by maintaining privacy and confidentiality, which includes acting in accordance with relevant legislation, standards of practice and employer/organizational policies" (CNO, 2025a, p. 10).

Table 5: Information security

Indicator	Consideration	Additional EHR Considerations
"Who has the right to **access** the client's health record?"	You and any healthcare provider have the right to access the client record, IF you are involved in providing care for the client. You do not have the right to access a client's record if you are not a healthcare provider involved in the care for that client. Clients and their substitute decision-maker have the right to view and/or acquire a copy of their health information/record unless there are grounds not to do (CNO, 2025b). For example, you may decide, in collaboration with the healthcare team, to not permit viewing of the record if this could result in harm to the client's treatment and/or recovery. You should document when a client views the record or if a decision was made to not permit the client to do so.	No additional considerations.

"How do I maintain **confidentiality** of client health information?"	You are responsible for securing the client's record so that only individuals who are involved in the client's care are permitted access to it. Keep written records in a secure location. Never leave a chart open or unattended, and return it to the secure location when you are finished documenting. If it is necessary to refer to another client while documenting in a client's record, use initials to refer to the other client.	You are responsible for ensuring that access to an EHR with your unique identifier (username and password) remains secure. Never share your login information. You should create strong passwords, change passwords regularly, and always sign out when you are done. Never leave a client's EHR open and visible to others.
"What are my accountabilities when using **artificial intelligence** (AI) to support my documentation?	Typically not applicable when paper charting.	You are responsible for obtaining informed consent when using AI. This should be done in accordance with the organization where you are employed. For example, some organizations post a written announcement on the wall indicating that AI is used.
"How do I ensure the security of client information upon **transmission** of information?"	Ensure that only healthcare team members have access to the client record.	Secure messaging and technologies should be used when transmitted information electronically.

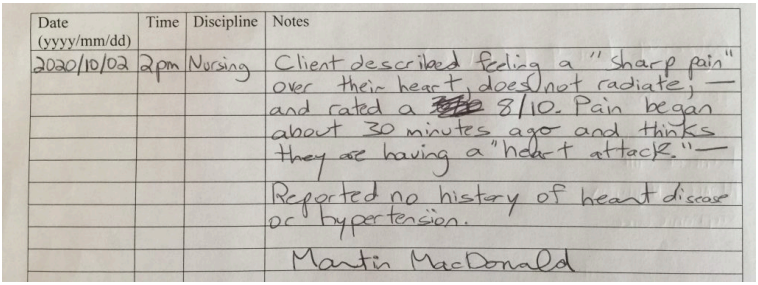
Points of Consideration

Many **abbreviations** and **symbols** used in healthcare have multiple meanings and can be incorrectly interpreted by others. Only use abbreviations and symbols that are included on an approved list in the organization where you practice; if there is no list, don't use any. The use of structured data elements is one advantage of EHRs in ensuring consistency in the meaning of terms. When documenting unstructured data elements, the same considerations as paper records apply.

In **paper charting**, always document in the next available space. For example, in a written progress note, document on the next line; on a vital sign graph, document in the next column. Never leave empty spaces. In a progress note, if there is insufficient space to write a word on a line, draw a line and continue your note in the next line. If there is insufficient space to complete your note towards the end of a page, write "continued on next page" and sign your name and designation. Then, on the next page, re-enter the date, time, and write "continued note." EHRs differ in terms of layout and interface; you will become familiar with the conventions used in each. One benefit of EHR is that documentation is automatically is inserted in the next available space, so no empty space or lines are left.

Activity: Check Your Understanding

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https://pressbooks.library.torontomu.ca/documentation/?p=29#h5p-7



Date (yyyy/mm/dd)	Time	Discipline	Notes
2020/10/02	2pm	Nursing	Client described feeling a "sharp pain" over their heart, does not radiate, and rated a ~~8~~ 8/10. Pain began about 30 minutes ago and thinks they are having a "heart attack." Reported no history of heart disease or hypertension. Martin MacDonald

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.library.torontomu.ca/documentation/?p=29#h5p-14

References

College of Nurses of Ontario

(2025a). *Documentation*. https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf

College of Nurses of Ontario (2025b). *Confidentiality and privacy – personal health information*. https://www.cno.org/Assets/CNO/Documents/Standard-and-Learning/Practice-Standards/41069_privacy.pdf

Privacy, Confidentiality, and Security

It is important that you use information and communication technologies in ways that maintain public trust in the nursing profession. An important part of this is to protect client's privacy and maintain confidentiality.

In Canada, federal and provincial/territorial legislation governs privacy rights related to the protection of personal information. Two federal privacy laws are enforced by the Office of the Privacy Commissioner of Canada: the **Privacy Act** and the **Personal Information Protection and Electronic Documents Act (PIPEDA)**. The Privacy Act relates to how the government protects the **privacy of a person's information** and a person's right to access and correct personal information that the government collects, uses, or discloses (Minister of Justice, 2019). The PIPEDA applies to **private-sector organizations** that collect, use, and disclose personal information. While these laws provide umbrella rules about privacy and protection of personal information, specific personal health information is provincially/territorially legislated.

In Ontario, as a healthcare provider or a student in a healthcare provider program, you should familiarize yourself with the 2004 **Personal Health Information Protection Act (PHIPA)**, which **legislates the collection, use, and disclosure of personal health information** by health information custodians. You are bound to comply with PHIPA. In circumstances where there may be conflict between the PHIPA and your Ontario College of Nursing standard, you must legally comply with the Act.

The following definitions used in the PHIPA are important:

- **Personal health information** is defined as identifying information about an individual in oral or recorded form that

relates to physical or mental health, provision of health care (including identifying a provider of health care), a plan of service, donation of body parts or bodily substance, payments or eligibility of healthcare, health number, substitute decision-makers, and any records held by a health information custodian. See **Table 6** for examples of what is/is not considered personal health information (PHIPA, 2004, S.O. 2004, c. 3, Sched. A).

- **Health information custodians** are defined as anyone involved in delivering healthcare services and in control of personal health information, e.g., nurses, doctors, pharmacists, physiotherapists, personal support workers, case managers, laboratory technicians (PHIPA, 2004, S.O. 2004, c. 3, Sched. A).

Table 6: Personal health information

Examples of Personal Health Information	Not Considered Personal Health Information
• Blood type. • A diagnosis. • X-ray results. • Room number. • Name of attending physician. • Payment for a procedure.	• Aggregated data where individuals are not identified, e.g., information about an outbreak in a region. • Health patterns or behaviours in groups, like flu shot uptake among certain populations. • Identification of cases of communicable diseases without personal health information.

Based on this legislation, you have have a responsibility to protect client's personal health information and maintain confidentiality. In addition to not sharing data with individuals not involved in the client's care, you must also protect the client's chart from inappropriate access. For example, paper charts are typically kept at

the nurse's station in a hospital or facility. You must take reasonable steps not to leave them unattended on a table. Electronic charts provide the additional security feature of signing in with a username and password to protect the client's privacy and help ensure that someone who should not have access does not have access. This additional security feature makes electronic charts less risky in terms of privacy breaches.

The PHIPA (2004) sets out rules to balance the need for health information with a person's right to privacy. Importantly, the PHIPA applies to both health information custodians, like healthcare providers, and to persons who may receive personal health information from health information custodians. For example, a nurse may complete a form that is submitted to an insurance company: in this scenario, the nurse is the health information custodian and the insurance company is the recipient of personal health information.

Healthcare organizations such as hospitals must implement information practices that comply with the act. The PHIPA (2004) requires that health information custodians take **reasonable steps** to ensure that personal health information is accurate, current, and complete, and also that it is protected from loss, theft, or unauthorized use or disclosure. For more information, please visit: https://www.ontario.ca/laws/statute/04p03

The use of personal health information is restricted to members of the healthcare team involved in the client's care. PHIPA (2004) specifies that **consent is required** for the collection, use, and disclosure of personal health information. The fact that an individual provides information to a healthcare provider typically implies consent. Implied consent can be assumed if the client has been provided information about "collection, use and disclosure of personal health information" (CNO, 2025, g. 5). Whereas expressed consent (verbally or in writing) is required when the client's personal health information is shared with any individual outside of the healthcare team, with a few exceptions (CNO, 2025). A brief

overview of disclosure of personal health information exceptions are listed in **Table 7**.

Table 7: Disclosure exceptions (adapted from PHIPA, 2004, S.O. 2004, c. 3, Sched. A).

Exception	Consideration
Disclosure to other individuals working in the healthcare system.	• When it is not possible to obtain consent from the client in a timely manner and there is a reasonable need for care. • In order for a custodian to receive funding (e.g., a clerk files a claim for OHIP reimbursement). • If misconduct is reported or suspected, an investigation can be carried out without the consent of the client.
Disclosure to public health authorities.	• A custodian may disclose information to public health authorities (e.g., the chief medical officer of health or a medical officer of health) if the disclosure is made for the purpose of the Health Protection and Promotion Act. • In cases of suspected child abuse, disclosure to Children's Aid Society.
Disclosure to family.	• For contacting a relative, friend, or substitute decision-maker of an individual who is incapacitated, injured, or ill and unable to consent. • Necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group.

Disclosure for proceedings.	• A client's information can be shared for the purpose of a legal proceeding if it has been subpoenaed.
Disclosure for research.	• A custodian may disclose information for research if it has been approved by the organization's research ethics board (REB).
Disclosure for planning and management of a health system.	• Personal health information may be disclosed for the purpose of analysis or compiling statistical information related to the management, evaluation, or monitoring of allocation of resources to or planning for all or part of the health system, including the delivery of services.
Disclosure to a health data institute.	• Personal health information may be disclosed to an approved health data institute for analysis of the management, evaluation, or monitoring of the allocation of resources to or planning for all or part of the health system.

Points of Consideration

Who Owns the Client Record?

Clients have the right to access their own personal health information. In 1992, the Supreme Court of Canada ruled that although the institution or physician owns the physical client record, the client owns the contents of it and has the right to receive a full copy of the record, except in certain situations where the likelihood of this act would cause harm to the client (as cited by Canadian Medical Protective Association, n.d.a, 2019).

Activity: Check Your Understanding



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References

College of Nurses of Ontario (2020). *Legislation and regulation: A introduction to the Nursing Act, 1991.* https://www.cno.org/globalassets/docs/prac/41064_fsnursingact.pdf

College of Nurses of Ontario (2025). *Confidentiality and privacy – Personal health information.* https://www.cno.org/globalassets/docs/prac/41069_privacy.pdf

Minister of Justice. (2019). *The Privacy Act.* https://laws-lois.justice.gc.ca/PDF/P-21.pdf

Personal Health Information Protection Act. (2004). https://www.ontario.ca/laws/statute/04p03

Methods of Documentation

Several **methods of documentation** are used to organize a nurse's notes, sometimes referred to as progress notes. Decisions about which method to use may depend on the organization where you work, which sometimes specify certain methods. Otherwise, it is usually a matter of personal preference.

In this section, three main documentation methods are presented: charting by exception, narrative, and nursing process. Another method that is sometimes used to inform documentation is SBAR (Situation, Background, Assessment, and Recommendation), as discussed in a previous chapter, but this was typically designed to inform verbal communication.

Charting by exception. This method is not commonly used, but some specific units find it helpful. Typically, it involves charting when a finding is not normal. A specific setting will provide a list of normal ranges or normal activities, and you will only document a note if the client's activities or your assessment findings are outside of the norms. For example, a normal finding may be no signs of infection on an incision: you would only document if the client exhibits signs of infection such as redness, swelling, or discharge.

Narrative involves **chronological** documentation that follows a **storied** format and **sequential order**. For example, you would document when the client's symptoms first started, what they did to treat them, and how they responded to the treatment. A storied format involves attending to 'what,' 'when,' 'who,' and 'how' – what happened, when did it happen, who was involved, how the client responded, etc. For example: "8-year-old client fell off bike. Client's mother indicated that he experienced a loss of consciousness for about 20 seconds, was confused when he awoke, and got a headache within 20 minutes. She brought him to the emergency, arrived within 30–40 minutes of the fall." As you can see, this documentation note is both chronological and storied.

The **nursing process** is used to inform documentation in which the nurse focuses on the client's **issue/concern/problem,** followed by the plan and action to address the issue, and an evaluation of how the client responded. This method is also called problem-focused documentation. Several approaches are used for this kind of documentation:

- DAR (data, action, response)
- APIE (assessment, plan, intervention, evaluation)
- SOAP (subjective, objective, assessment, plan) and its derivatives including
- SOAPIE (subjective, objective, assessment, plan, intervention, evaluation).

These methods share commonalities; see **Table 8**.

Table 8: Methods used to document the nursing process

DAR	APIE	SOAPIE	Comments
Data	Assessment	Subjective and objective data assessment	Assessment refers to your analysis of the available data. For example, it may include the health problem/issue and nursing diagnosis (e.g., risk for falls, risk for infection). Assessment guides the next steps in terms of planning and interventions.
Action	Plan and implementation/ intervention	Plan and intervention	Action refers to what you did to address the problem (e.g., repositioning the client, providing pain medication). Planning and intervention are similar to action. They may be combined or separated into different items: planning refers to realistic and measurable interventions to be implemented (e.g., education, mobility, safety interventions, vital sign frequency); intervention refers to what was done.
Response	Evaluation	Evaluation	Response and evaluation refer to the outcome of the intervention (did it work? how did the patient respond?)

Methods of Documentation - Examples

Examples of four methods of documentation are included in this section. In each of the examples, the following is printed at the end "Nurse's signature, designation", but ensure that you sign your name and insert your specific designation.

Narrative method of documentation – Loss of consciousness

Case summary: A 47-year-old client, identifies as transfemale with pronoun they/their, came into the emergency department after losing consciousness from being struck in the head from a boating accident. According to the client's partner, the client regained consciousness within one minute.

Date (yyyy/mm/dd)	Time	Discipline	Notes
2025/10/14	1330	nursing	Client stated it was their first sailing lesson and they were "hit square in the forehead with the mast and I was out." The client was unconscious for less than one minute according to their partner who was in the boat. After the accident, they immediately sailed back and came to the ER. Client states "I have a headache." Rates pain 3/10. No dizziness, nausea or vomiting. Vital signs are stable. Client is alert and orientated to person, place, time and self. No difficulty speaking, understanding or answering assessment questions. No weakness or incoordination. Gait is coordinated. Firm hand grasp bilaterally. No history of falls. Pupils are round, equal in size at 3mm, and reactive to light bilaterally. No change in vision. Glasgow coma score 15. The centre of client's forehead has a red swollen lump approximately 4cm in diameter. Discussed concussion protocols and critical finding signs and symptoms that need immediate medical attention. Encouraged to limit physical and cognitive activities that provoke symptoms and to not engage in physical activities that are higher risk of another concussion while still having symptoms. Client and partner verbalized understanding of critical finding signs and symptoms and to seek care if symptoms get worse or additional symptoms appear. Client will follow up with primary care provider within 24 hours to discuss a gradual return to physical activity plan. Nurse's signature, designation ———————

DAR – Stress

Case summary: A 17-year-old client, identifies as male with pronouns he/his, came into the clinic following a high school counsellor's suggestion after sharing feeling worried about going to university.

Date (yyyy/mm/dd)	Time	Discipline	Notes
2025/10/19	1645	nursing	**D:** Client stated, "I'm feeling really worried about starting university on my own." Client asked questions about how to control restless mind and how to manage his stress. Vital signs stable. Client restless, fidgeting legs during interview, and chewing on fingernails. **A:** Discussed client's fears about transitioning to university. Collaborated with client in identifying stress management techniques client can do prior to going into university including developing a peer support network, positive self talk, and walking daily. Discussed how to access potential resources at university site including learning supports and mental health supports. Follow up appointment booked for three weeks. **R:** Client acknowledged resources provided and stated will try to increase his exercise to help focus their restless mind, continue to meet with the school counsellor to discuss feelings, and will try to practice positive self-talk when feelings of fear begin to become overwhelming. Client noted that he will check out the university website for supports. Client stated, "I think I will be able to follow these strategies and I will check out the supports in the next couple of weeks." Nurse's signature, designation ————————————

APIE – Nutrition

Case summary: A 62-year-old client, identifies as male with pronouns of he/his, who is one month post cerebrovascular accident on a rehab unit. The client is on a thickened diet as a result of dysphagia.

Date (yyyy/mm/dd)	Time	Discipline	Notes
2020/11/25	0930	nursing	**A:** Client stated "I'm getting use to eating my new diet and I've not choked since starting it." Added thickener to client's coffee. Client ate 90% of the meal. **P:** Will reinforce dysphagia eating techniques with client each day. **I:** Reviewed dysphagia eating techniques with the client: tilting chin down, small bites, placing food on unaffected side of mouth, eat slowly, and avoid talking while eating. Gave praise to client for eating independently and using correct eating techniques: swallowing twice after each mouthful, using a teaspoon portion size of food to unaffected side of mouth. **E:** No signs of aspiration. Client practiced head tilt and placement of food towards unaffected side. Documented meal intake. Ordered additional thickener package for client's meal tray. Left phone message for speech language therapist and occupational therapist to re-assess client's progress. Nurse's signature, designation —

SOAP or SOAPIE – Elimination

Case summary: A 41-year-old client, identifies as female with pronouns she/her, on a postpartum unit 2 days after having a caesarean section (C/S). The client delivered a healthy 8lb baby.

Date (yyyy/mm/dd)	Time	Discipline	Notes
2020/11/02	1030	nursing	**S:** Client commented feeling abdominal discomfort in left lower quadrant, rated 5/10, stating "I'm getting worried because I still have not had a bowel movement, it's been four days" and is "worried it will hurt because of my hemorrhoids." Client stated drinking 500cc of water today and eating about half of her meals. **O:** Bowel sounds audible in all four quadrants. Tympany predominates throughout, with slight dullness over LLQ. Abdomen firm and tender on touch. No nausea or vomiting. **A:** Constipation related to medication during C/S, limited mobility, low fibre diet and minimal water intake. **P:** Will assess client's knowledge. **I:** Educated the client on the importance of increasing water intake to 6 to 8 glasses, eating the high fiber diet provided by the hospital, and walking around unit once an hour to assist with peristalsis and bowel movements. Demonstrated how to support incision area when getting up to go for a walk to decrease discomfort or pulling of incision. Provided teaching resources on postpartum constipation and caesarean sections. Provided client 500cc of water. Assisted client out of bed to go for a walk with family. **E:** Client drank water and stated will record fluid intake. Client had 400mg of Ibuprofen for abdominal discomfort. Will monitor diet and follow up to determine if constipation continues and further interventions are needed. Nurse's signature, designation —

The Future of Documentation

There are several trends to consider in terms of the future of documentation.

First, it is important to consider the **role of the client** in documentation. There is still a lingering sense among some healthcare providers that clients shouldn't be permitted to view their own personal health information. This is rooted in a legacy of paternalism, whereby healthcare providers were once deemed the sole authority on health. As we shift toward a client-centred approach, where clients are treated as experts on their own health, it makes sense for healthcare providers to acknowledge that clients own their own health data. Indeed, the development of new technologies has given rise to personal health records (PHRs), which are patient-held and patient-owned versions of health records that contain much of the same information as EHRs. Countries with established and robust national EHR are also moving toward facilitating clients' open access to these records.

Another element to consider in moving forward is **data literacy** for clients. In this context, data literacy refers to a person's ability to read and understand relevant healthcare-related information. This is becoming more important because clients increasingly want access to their health records, and many hospital institutions and laboratory testing services now provide a direct portal for clients to access their own information. Therefore, it is important that data are recorded in ways that can be easily interpreted by clients and/or that healthcare providers are trained and prepared to help clients understand the data.

It is reasonable to expect that most health systems and organizations will move towards **EHR documentation** primarily or exclusively. This increasing shift toward documentation in EHRs has important implications for documentation practices and care provision among nurses.

- Nurses will need flexibility and adaptability to be able to learn and effectively use different EHR systems that may vary across different practice settings whilst concurrently ensuring high quality and consistent documentation practices.
- Nurses will need to be able to navigate and use EHRs in ways other than documentation. For example, they may need to interpret EHR dashboards, which are summaries of real-time individual client information that are displayed on the main page of an EHR.
- EHRs are becoming more sophisticated, and artificial intelligence is being used to support data-driven clinical decision making. Basically, this means that data documented in the EHR can be used to build algorithms to predict aspects of clinical care or client outcomes (e.g., risk). These predictions are then used within the EHR to provide warnings, alerts, or guidance for healthcare providers to inform the provision of care. The quality of artificial intelligence systems relies primarily on the quality of documentation within the EHR, so the importance of ensuring accurate, complete, and consistent documentation cannot be overemphasized.

Points of Consideration

Artificial Intelligence

As a healthcare provider, you should be aware of the biases inherent to artificial intelligence (AI) (College of Physicians and Surgeons of Ontario, [CPSO], 2026). Programs are designed by individuals who all have inherent

biases. If a program is created with a bias, the bias will be systematized into the algorithm. Therefore, AI should be considered a clinical aid to supplement, and should not replace your own clinical judgment.

References

College of Physicians and Surgeons of Ontario. (2026). *Advice to the profession: Using artificial intelligence in clinical practice.* https://www.cpso.on.ca/physicians/policies-guidance/advice-to-the-profession/using-artificial-intelligence-in-clinical-practice

Key Takeaways

Key Takeaways

- Documentation includes paper and/or electronic record-keeping of a client's state of health and their care.
- Nurses are legally obligated to complete accurate, timely, and comprehensive documentation.
- In Ontario, nurses must adhere to College of Nurses of Ontario practice standards related to documentation.
- The PHIPA is an important provincial legislation, and nurses are obligated to comply with it.

Glossary

differential diagnosis

The process of determining the possible causes or diseases for the presenting symptoms.

structured data elements

Refer to built-in templates or structures that guide the type of data to be entered in a specific field.

unstructured data elements

Refer to free-text entry that allows for the open-ended documentation of client data.