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DOCUMENTATION: STANDARDS FOR PERSONAL SUPPORT WORKERS

Purposes of Documentation:

- **Communication**: Through documentation, Personal Support Worker's (PSWs) communicate to other health care providers of a client/resident/patient's /resident/patient's condition, the plan of care, interventions that are carried out by the PSW, and the outcomes of those interventions.
- **Safe and appropriate nursing care**: When PSWs document the care they provide, other members of the health care team are able to review the documentation and plan their own contributions to safe and appropriate care. Documentation also provides data for research and workload management, both of which have the potential to improve health outcomes.
- **Professional and legal standards**: Documentation is a comprehensive record of care provided to a client/resident/patient/resident/patient. It demonstrates how a PSW has applied their knowledge, skills, and judgment according to the standards of practice. Documentation is also generally accepted as evidence in legal proceedings. It establishes the facts and circumstances related to the care given and assists PSWs to recall details about a specific situation.

Employers should provide the organizational supports and systems necessary for PSWs to meet the Standards of Practice.

Principles

1. PSWs are responsible and accountable for documenting in the client /resident/patient's record the care they personally provide to the client/ resident/patient. Care provided by others should ordinarily be documented by those individuals, unless there are exceptional circumstances such as an emergency
2. PSWs document a decision-making process (e.g. planning, implementation, and evaluation) to show the care they provided.
3. PSWs document information or concerns reported to another health care provider and that provider's response.
4. PSWs document in a clear, concise, factual, objective, timely, and legible manner.
5. PSWs document all relevant information about client /residents/patients in chronological order in the client/resident/patient's record.
6. PSWs document at the time they provide care or as soon as possible afterward. PSWs clearly mark any late entries, recording both the date and time of the late entry and of the actual event.
7. PSWs correct any documentation errors in a timely, honest, and forthright manner.
8. PSWs do not document before giving care.

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9. PSWs indicate their accountability and responsibility by signing with a unique identifier (such as a written signature or an electronically-generated identifier) and their title, in a clear and legible manner to each entry they make in the client/resident/patient record.

10. PSWs carry out more comprehensive, in-depth and frequent documentation when client/resident/patient's are acutely ill, high risk, or have complex health problems.

11. When PSWs provide services to a group of client/resident/patient's they use service records (or equivalent) to document the service provided and overall observations pertaining to the group. When PSWs document information about individual client/resident/patients within the group, they record it in the individual client/resident/patient's record.

12. PSWs complete a safety event report (sometimes called an incident report) following an event such as a fall. The safety event report is not part of the client/resident/patient record. PSWs record facts about any safety event affecting the client/resident/patient in the client/resident/patient record.

13. PSWs who are self-employed or have responsibility for client/resident/patient records adhere to relevant legislation.

Applying the principles

- Familiarize yourself with organizational policies, procedures, or restrictions on documentation and follow them, including policies on documenting verbal and telephone orders and completing safety event reports.

- If your organization uses an electronic client/resident/patient record, understand that the same documentation principles apply, although there will be different strategies to record data, and to ensure privacy, security, and confidentiality.

- Information provided by a third party that is relevant to the client/resident/patient's circumstances may be recorded in the client/resident/patient's record. It should include the name of the person providing the information and their relationship to the client/resident/patient and be clearly marked if the information was provided "in confidence."

- Document only the care you provide, do not allow others to document for you and do not document care that anyone else provides. Exceptions include:

    - In an emergency, such as when you are designated as recorder, document the care provided by other health professionals.

    - In cases where organizational policies, procedures, or restrictions do not allow certain individuals to document in the client/resident/patient record, record what client/resident/patient information was reported to you and by whom.

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- When you are covering for another PSW, be sure to document any relevant information that arises when caring for a client/resident/patient.
- Decision-making processes used in providing PSW care should be sufficiently documented to provide an accurate, clear and comprehensive picture of the status of the client/resident/patient and their needs, the interventions of the PSW, the client/resident/patient outcomes, a plan of care, information reported to other health care providers and the provider's response, advocacy taken on behalf of the client/resident/patient and any other relevant information, including informed consent when required.
- Recognize that, in a court of law, accurate, complete, and timely documentation may lead to the conclusion that accurate, complete, and timely care was given to the client/resident/patient. The reverse is also true. If care is not documented, it may lead to the conclusion that it was not done. All records should be clear and legible. Various charting systems are acceptable if they enable PSWs to meet this practice standard.
- Avoid labelling client/resident/patient's/resident's/patient's or drawing subjective conclusions.
- Delays in documentation may affect the continuity of care and the PSW's ability to remember details about events and may increase the possibility of error.
- If you make a documentation error, follow organizational policy, procedures or restrictions to correct it, but never modify or delete information that is recorded in the client/resident/patient record.
- Understand that safety event reports are for quality improvement purposes. Follow your organization's documentation policies, procedures, or restrictions when reporting safety events.
- PSWs have a role in safeguarding the privacy, security, and confidentiality of client/resident/patient records. PSWs assist client/resident/patient's/resident's/patients with the process of accessing information on their client/resident/patient record, in accordance with relevant legislation and organization policies, procedures, or restrictions.

Footnotes

"Clients/Residents/Patients" include individuals, families, groups, populations or entire communities receiving nursing care or services from a Personal Support Worker (PSW).

Modelled after the British Columbia College of Nurses & Midwives Documentation Practice Standards