SEIU NURSING DIVISION Healthcare

Quality Assurance Workbook 2014

SEIU Healthcare's Nursing Division is pleased to offer this Quality Assurance Workbook for the third year in a row. This annual tradition reflects our recognition of the professional and compassionate care you provide every day across the healthcare spectrum – in hospitals, long-term care facilities, and in the community and homecare sectors.

This 2014 year is already an exciting year for SEIU Healthcare and for the Nursing Division in particular. With the enhanced scope and increased utilization of registered nurses (RNs) and registered practical nurses (RPNs) in all practice settings, liability coverage has quickly become an important tool in ensuring you are protected. As you may have heard, effective March 31, 2014, all RNs and RPNs practicing in Ontario must have Professional Liability Protection (PLP). That is why SEIU Healthcare is covering the full cost of Professional Liability Protection for every nurse in good standing who is a member of SEIU Healthcare, with no added cost to you. PLP will cover you for medical malpractice, which is defined as negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient.

This year is the first year a RPN will become president of the College of Nurses of Ontario in the organization's 51-year history. Angela Verrier, an RPN from Niagara, was elected to be the next president of the College as of June 4, 2014. The college is the regulatory body for Ontario's 150,000 RNs, RPNs and nurse practitioners (NPs). This election underscores the common roles and interests of RNs, RPNs and NPs in ensuring the quality, integrity and sustainability of Ontario's health-care system.

The challenges we face as a society are growing with our growing healthcare needs, aging population and stagnant economy. SEIU Healthcare is taking these challenges seriously. This year, with your involvement, we'll unveil a new wave of advocacy campaigns aiming to shape public policy and public opinion. We're committed to making sure that policy-makers, employers and the public at large are aware of your professional capabilities and that you're a crucial part of the solution to our growing healthcare needs.

As you use this Workbook to support your professional development, rest assured that we'll continue our efforts to enhance, promote and protect the role of nurses in all practice settings, not only on your behalf but also on behalf of those whose lives you've touched with your warmth, compassion, courage and determination.

Carol McDowell

Nursing Division President, SEIU Healthcare

INTRODUCTION TO QUALITY ASSURANCE (2014)

This is our third annual edition of our "SEIU Nursing Division – Quality Assurance Workbook". It is our hope that you found our previous editions practical as you embarked upon your quality assurance journey for 2013! As we prepare for 2014, it is important that you begin to think about your nursing practice and identify learning opportunities that will ultimately enhance your professional nursing practice!

New to this document this year, is an overview of Professional Liability Insurance Protection! This takes effect March 31, 2014. It is our responsibility to render professional services and nursing care to all patients and families. One of our significant goals of nursing care should be always to promote health and well being.

As nurses, we are responsible and accountable for our own nursing practice. Nurses have a duty and obligation to comply with our professional specific codes of conduct, standards of practice and to maintain our own nursing competence in the chosen field of our profession. It is the responsibility of each individual nurse to provide the highest standards of professional practice. This can only be achieved if we attain and maintain competence now and in the future.

The College of Nurses of Ontario (2009) defines competence as, "the ability of a nurse to apply knowledge, skill, judgment, attitudes, values and beliefs to practice safely and ethically in any designated role and setting. "Continuing competence in our nursing profession is a critical issue for the public and our nursing profession. It is each and every nurse's responsibility to assure continuing competence in the best interest of quality, safe and ethical client care.

Accountable health care professionals must engage in continuous lifelong learning to meet the ongoing challenges that are presented each and every day in our nursing practice. The expansion of knowledge, evidence based practice, changes in client demographics, health systems enhancements and redesign continue to evolve and we must be responsive to these dynamic changes to ensure safe and ethical care to our patients, clients and families.

Nurses must keep abreast of new best practices and evidence through continuous lifelong learning, and participation in continuing education. This continuing education should be used to improve the quality of client care and also meet the College of Nurses of Ontario's Quality Assurance requirements. As integral members of the interprofessional health care team, nurses contribute enormously to quality client care.

Reflective practice is the key to maintaining our nursing competence! Reflective practice is a process that we continuously do each and every day when we enact nursing. Do you reflect on the clients you cared for? Do you think about what went well during that experience? Do you think of how you or your colleagues could have perhaps cared differently for a client and their family? This is reflective practice!

REFLECTIVE PRACTICE AND COMPETENCE

Reflective practice or self-assessment has gained popularity in nursing as a means to promote professional practice and assist nurses to maintain and improve their practice. For many nurses, selfassessment is acceptable as it is an independent way of improving one's own practice. It allows the individual nurse to consider his/her practice within the context of their own practice environment.

According to MacKay and Campbell (2001), defining competence can be challenging. Recognizing that this reference is somewhat dated, they did articulate what can be described in a variety of ways both within and outside the profession of nursing. Many authors acknowledge that defining competence is difficult because

of the complexity of the concept. However, there appears to be three (3) common threads amongst all definitions of competence:

1. Competence relates to the ability of a nurse to practice in a specific role;
2. Competence is influenced by the practice setting;
3. Competence is the integration of knowledge, skills, judgment, and abilities.

The College of Nurses of Ontario defines individual competence as "the nurses' independent ability to use his/her knowledge, skill, judgment, values, attitudes and beliefs to perform in a given role, situation and practice setting (CNO, 2002). Standards of practice are "authoritative statements that describe the responsibilities for which practitioners are accountable; are used to protect the public, and monitor the quality of performance. " (Campbell & Mackay, 2001). The College of Nurses of Ontario (2002) has clearly defined professional standards we as nurses must adhere to, one of which is competence. There are very specific indicators that we must ensure are embedded into our nursing practice.

SELF-REGULATION IMPORTANT – WHY IS IT IMPORTANT FOR ME TO UNDERSTAND AS A PROFESSIONAL NURSE?

As a professional nurse, understanding the concept of self-regulation is important because of its definition. Whether you are a novice, advanced beginner or expert nurse, you understand that protecting the public is at the core of your chosen profession.

Self-regulation defines the practice of any given profession, and describes the parameters within which it should function, including the requirements and qualifications to practice the nursing profession. The College of Nurses of Ontario's ultimate responsibility is to protect public interest from unqualified, incompetent and unethical health care providers. There are two important aspects about selfregulation:

1. First, the consumer rights must be protected and promoted through the advocacy role of the nurse.
2. Secondly, the public lacks the specialized knowledge about their health and the health care system.

Therefore, because of this unequal balance of knowledge and power, health care professionals have been monitoring their own professions to insure the public of ethical and safe practice.

WHAT IS SELF-REGULATION?

For any profession, there are two approaches to regulation. The first one is regulation by the government (or third party); and self regulation by the profession. With self-regulation, the government delegates to a profession the power to regulate its members/peers. The intent is not to advance the profession, but to promote and protect the public interest.

In 1989, a report entitled, "Striking a New Balance", was prepared by the Health Professions Legislation Review (HPLR), to create a comprehensive review of the regulation of health professionals in Ontario.

The fundamental principle of this report is outlined below:

> *"The public is the intended beneficiary of regulation, not the members of the professions. Thus the purpose of granting self-regulation to a profession is not to enhance its status or to increase the earning power of its members by giving the profession a monopoly over the delivery of particular health services. "*
>
> *(Health Professions Legislative Review:Striking a New Balance, 1989)*

The foundation of self-regulation rests with the concept that the profession has a commitment to the philosophy that public protection comes first. This regulation assures the public that they are receiving safe and ethical care from competent, ethical and qualified nurses.

It defines the practice boundaries of the nursing profession, including the requirements and qualifications to practice. Self-regulation allows a professional body to act on behalf of the government in regulating its members. The government realizes that the profession has unique knowledge necessary to establish standards of practice and evaluate its membership.

Professional Liability Protection (PLP)

The Importance of Protecting Your Nursing Career – Professional Liability Protection (PLP)
Professional liability issues are of great concern in our nursing profession today. There was a time when health care professionals were not lawsuit targets; clients would never consider bringing forth an action against a nurse who helped them. Our practice environments have changed exponentially! Today the public, regulatory bodies and legal systems have high expectations of health care professionals and as a result are more inclined to question our practice and the care linked to it.

Professional liability protection provides financial compensation for members of the public who have been harmed as a result of malpractice or negligence by a professional (CNO, 2013).

The Minister of Health and Long-Term Care recently communicated to all Health Regulatory Colleges that requirements for members to have and maintain professional liability protection must be in place on or before March 31, 2014. This is in keeping with the Regulated Health Professions Act (RHPA, 1994).

The RHPA establishes the Minister of Health's powers and as such has declared that all regulated health care professionals maintain professional liability protection. As nurses, you have daily contact with colleagues, patients and families in your work environments. These individuals are dependent upon your nursing knowledge, skills, judgment and competence.

Professional liability protection (PLP) helps protect you from allegations of errors, omissions and negligent acts, whether or not they have any merit. As a nurse, you are a professional and the legal system expects you to have extensive knowledge and training in your area of nursing expertise. You are also obligated to perform these essential services for which you were hired according to your professional standards and code of conduct and within your defined scope of practice.

There is not a nurse today that goes to work with the intent of causing risk or harm to their clients or families. We are all human and errors can and will occur. We all have the potential to make errors. It's part of being human. This isn't about being a "negligent nurse". It is about protecting any nurse who may inadvertently make an error on the job while caring for our clients.

As a responsible health care professional, it is imperative we be proactive in preparing ourselves should such an event arise in our nursing practice. With appropriate PLP "rather than the error becoming the definition of who you are as a nurse, it can serve as a valuable learning experience that leads to improvement in your practice" (RPNAO, 2013).

New Professional Liability Protection Requirements – We Have You Covered!

At its September 19, 2013, meeting the College's Council approved a by-law that requires all members except those in the Non-Practicing Class to hold Professional Liability Protection (PLP).

This by-law sets out the minimum PLP coverage that members must hold and comes into effect March 31, 2014. All members of the College are accountable for ensuring their PLP coverage meets the minimum requirements set out in the by-laws.

There are some important points that all nurses must be aware of:

1. As of March 31, 2014, every nurse registered to work in Ontario will need to have professional liability insurance as per the bylaws of the College of Nurses of Ontario (CNO).
2. The CNO has specifically identified the policy requirements nurses will need to have. As a member of SEIU Healthcare, this coverage meets the CNO's new professional liability coverage requirements.

Not only does SEIU Healthcare meet the CNO requirements, it exceeds these new requirements!
SEIU Healthcare Nurses – 'We Have You Covered'

Medical Malpractice is defined as negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient. In most cases, it includes failure to meet a 'standard of care' or failure to deliver care that a reasonably prudent nurse would deliver in a similar situation.

Most common malpractice claims against nurses can be summarized in the following six categories:

- Failure to follow standards of care
- Failure to use equipment in a responsible manner
- Failure to communicate
- Failure to document
- Failure to assess and monitor
- Failure to act as a patient advocate

Nurses are being held to higher standards of care than ever before. With greater demands in our practice settings; higher nurse to patient ratio, limited resources, greater medical treatment complexities and an increasingly litigious society, your SEIU Healthcare insurance program will be in your corner when you need the coverage most.

QUALITY ASSURANCE – COLLEGE OF NURSES OF ONTARIO (2014)

Nurses are lifelong learners who continually assess and improve their practice. To help accomplish this, the College of Nurses of Ontario's QA Program guide reflection on day-to-day practice. Nurses then identify professional development opportunities based on their individual needs.

These professional development opportunities form the basis of a plan that guides the continuing competence activities nurses undertake. The activities occur every day and throughout the year in practice situations. Meeting this obligation is an important way to promote high practice standards and maintain the public's trust in registered nurses.

Case Study: A Practice Challenge for a Long Term Care RPN
Erica is a RPN who works in a long term care (LTC) facility who has been asked by a number of her residents and families if they should receive the flu vaccine this year. She has received a lot of questions lately about the side effects of immunizations and has had discussions with residents and families who are considering

whether or not to get this vaccination. Erica identifies this as an area that she needs more information on to better answer the tough questions people are asking.

Erica does some self-directed research on the Public Health Agency of Canada (PHAC) and the Centre for Disease Control (CDC) and the World Health Organization (WHO) websites about the vaccine safety and common concerns from those that have received the immunization. She locates a nationally recognized resource that can be given to residents and families and checks with her employer if she can make it available when questions are asked.

The next time Erica is asked a tough question she feels better prepared to provide information to assist residents in their decision making. After checking in with a few of her residents about the helpfulness of the information, Jane is pleased to find they appreciate receiving comprehensive information about their immunization.

Erica shares her approach with her colleagues, who decide to use the resource across the team. Erica is engaging in the continuous cycle of Quality Assurance and is meeting the College of Nurses of Ontario's requirements.

It is a simple as this! As nurses, we do this each and every day in our nursing practice.

Nurses are lifelong learners who continually assess and improve their practice. By participating in CNO's Quality Assurance Program throughout the year, nurses indicate to the public that they are maintaining their competence to practice and that they take their professional development obligation seriously. Meeting this obligation is an important way to maintain the public's trust in nurses.

The College of Nurses has determined for this year that nurses will only need to identify two (2) learning goals and record them accordingly. Unlike previous years, the CNO determined which standard or guideline we needed to reflect upon in order to meet our QA requirements. Once you have identified your learning goals, you then need to link them to the most appropriate standard and/or guideline.

The College's QA (Quality Assurance) Program (2014) is based on the principle that lifelong learning is essential to continuing competence.

Nurses in every setting demonstrate their commitment to continually improving their nursing practice by engaging in practice reflection, and by setting and achieving learning goals.

Every nurse registered in the General or Extended classes is required by law to participate in QA.

The College consulted with nurses across the province to develop its QA Program, which is designed to:

- support nurses in practicing according to the College's standards of practice
- help nurses develop the practice areas in which they have identified learning needs
- increase the public's confidence in the nursing profession.

The CNO meets this obligation through its QA Program, which includes the following components:

1. Self-Assessment

2. Practice Assessment and

3. Peer Assessment.

Self-Assessment

Quality Assurance Self-Assessment is a self-directed, two-part process that results in a Learning Plan. You are required to complete your Self-Assessment every year.

Through the process of self-assessment, you identify your areas of strength, and learning needs. You are required to develop two learning goals each year. Once you have a learning goal, you choose the College practice document to which it relates. Each goal may be based on the same practice document or two different ones, whichever meets your learning needs.

There are two parts to the Self-Assessment component:

Part A: Practice Reflection
By reflecting on your practice, you discover what your strengths and learning needs are. Getting peer input can help you identify strengths and learning needs that you missed or didn't think about, building on your own reflection. This will help you to continually improve your competence as a nurse.

When reflecting, consider how the following elements have an impact on your practice:

Advances in technology: The introduction of new, innovative or different skills, processes or knowledge into a nurse's practice setting. For example, learning how to use a new electronic documentation system in your nursing practice may be an issue you have identified.

Changes in the practice environment: Changes that require additional knowledge, skill and judgment for a nurse to deliver safe and ethical nursing care; for example, changes in the client population, nursing care delivery systems or legislation.

Entry-to-practice competencies: Expectations that all nurses must maintain throughout their careers.

Interprofessional care: The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

You will use the results of your practice reflection –– your identified learning needs –– to develop learning goals and your Learning Plan.

If you use the Practice Reflection worksheet in my QA, (www. cno. org) then your learning needs are automatically transferred to your Learning Plan.

Part B: Developing and maintaining a Learning Plan to meet your learning needs
The results of Practice Reflection will form the basis of your Learning Plan.

Your Learning Plan is a record of the activities you did to help you maintain your competence as a nurse.

You can use my QA to add your learning goals and learning activities to your plan. Remember, you have to choose the practice standard your goal relates to.

The College expects nurses to update their Learning Plan regularly and to keep it for two years.

Component 1: Self Assessment

All members participate in this 2 step process

Part A:

This process involves:

- Reflecting on your practice
- Obtaining peer input to determine your strengths and areas for improvement
- Developing your learning goals

Part B: developing and maintaining a learning plan to meet your learning goals

If randomly selected you participate in components 2 and 3

Component 2: Practice Assessment

- Submit your learning plan to the college
- Participate in specified assessments

Component 3: Peer Assessment

A college assigned peer assessor will:

- Review your learning plan and practice assessment results
- Make recommendations to the QA Committee

The QA Committee will then decide if you are requires to participate in remedial activities.

COLLEGE OF NURSES OF ONTARIO QUALITY ASSURANCE (2014)

Component One – Self-Assessment

Self-Assessment is a self-directed, two-part process that results in a Learning Plan. You must participate in this component.

Part A: Practice Reflection

Determining your strengths and areas you need to improve by reflecting on your practice and obtaining peer input will help you to continually improve your competence as a nurse. Peer input builds on practice reflection by providing greater awareness of your strengths and opportunities for learning. Use the results of Practice Reflection to create your learning goals.

Part B: Developing and maintaining a Learning Plan to meet your learning goals

The results of Practice Reflection will form the basis of your Learning Plan. Your Learning Plan is a record of your ongoing participation in activities that help maintain your competence as a nurse. The plan outlines how you relate practice standards to your nursing practice. It articulates learning goals based on your Practice Reflection, and the activities you will undertake to achieve those goals.

The College expects you to continually update your Learning Plan and to keep each Learning Plan for two years.

Component Two - Practics Assessment

Each year, the College randomly selects nurses to participate in Practice Assessment, which includes a review of the nurse's completed Learning Plan and other specified assessments (such as objective multiple-choice tests based on selected practice documents).

Members become eligible for Practice Assessment after two years of registration. Members of the General and Transitional Class will be randomly selected to participate in practice assessment; once selected, the member will be exempt for 10 years.

Component Three – Peer Assessment

All nurses whom are randomly selected to participate in Component Two – Practice Review will have their Learning Plan and assessment results reviewed by a peer assessor. The College of Nurses of Ontario's Quality Assurance (QA) Committee then reviews the peer assessor's report and can recommend or direct the nurse to complete follow-up activities like completing learning modules on CNO's website.

Nurses who have successfully completed the process must continue to maintain and update their Learning Plan on an ongoing basis.

This is an excellent schematic that represents the key elements of quality assurance. In reviewing the nursing literature, the College of Registered Nurses British Columbia (CRNBC, 2013) developed this illustration that one may find helpful when thinking about QA!

A picture is worth a thousand words.

FEEDBACK

- Think about feedback from clients or peers
- Take time each year to ask others
- Validate and adjust your goals

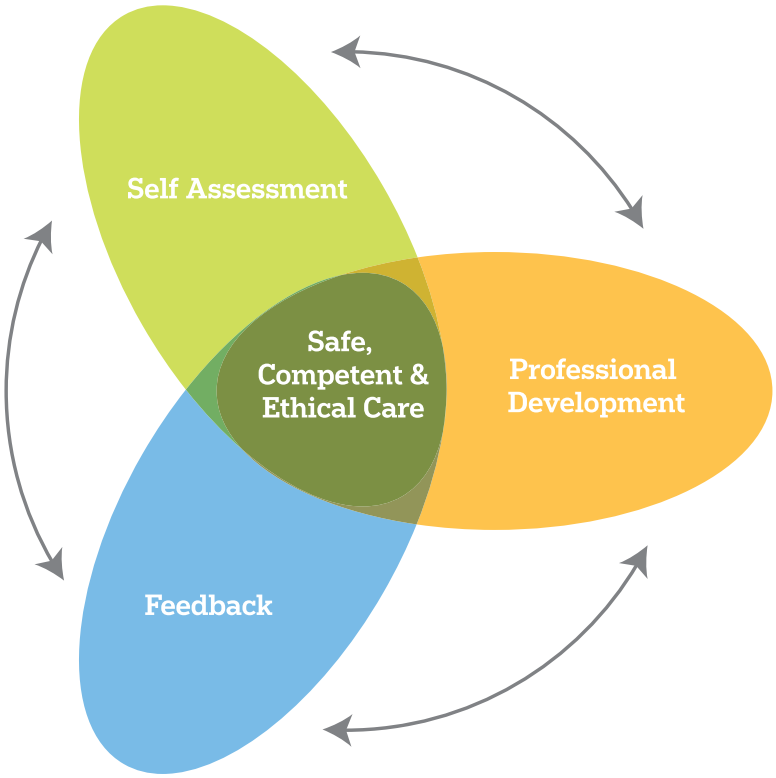
SELF ASSESSMENT

- Reflect on day to day practice
- Where can you develop and grow professionally?

PROFESSIONAL DEVELOPMENT

- What areas did you identify in you self-assessment and feedback?
- Be specific about your learning needs and goals.

(CRNBC, 20013)



SEIU Healthcare created the two (2) following self assessment tools for you to review your practice as it relates to Documentation (2008) and Restraints (2009)

DOCUMENTATION (2008) – ACCOUNTABLE NURSING PRACTICE!

Practice Standards set out requirements related to specific aspects of nurses' practice. They link with other standards, policies and bylaws of the College of Nurses of Ontario and all legislation relevant to nursing practice.

The College of Nurses of Ontario's Professional standards requires nurses to document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes. Documentation is any written or electronically generated information about a client that describes the care or service provided to that client – it is an integral part of nursing practice.

Nursing documentation is a critical component of safe and ethical nursing practice. Effective documentation allows nurses and other health care providers to communicate about both the care provided to a client and the client's responses to that care.

For nurses, documentation is a means of demonstrating the knowledge, judgment and critical thinking nurses use each and every day in nursing practice. By recording one's assessment, planning, implementation and evaluation of client care needs, documentation also conveys the nurse's contribution to care. Simultaneously, documentation is used to demonstrate accountability and to meet legislative requirements.

Documentation serves three purposes:
1) It facilitates communication;

2) It promotes safe and appropriate nursing care; and

3) It meets professional and legal standards.

Communication
Through documentation, nurses communicate to the interprofessional health care team their nursing assessment and nursing diagnoses of a client's condition, the plan of care, and nursing interventions enacted by the nurse.

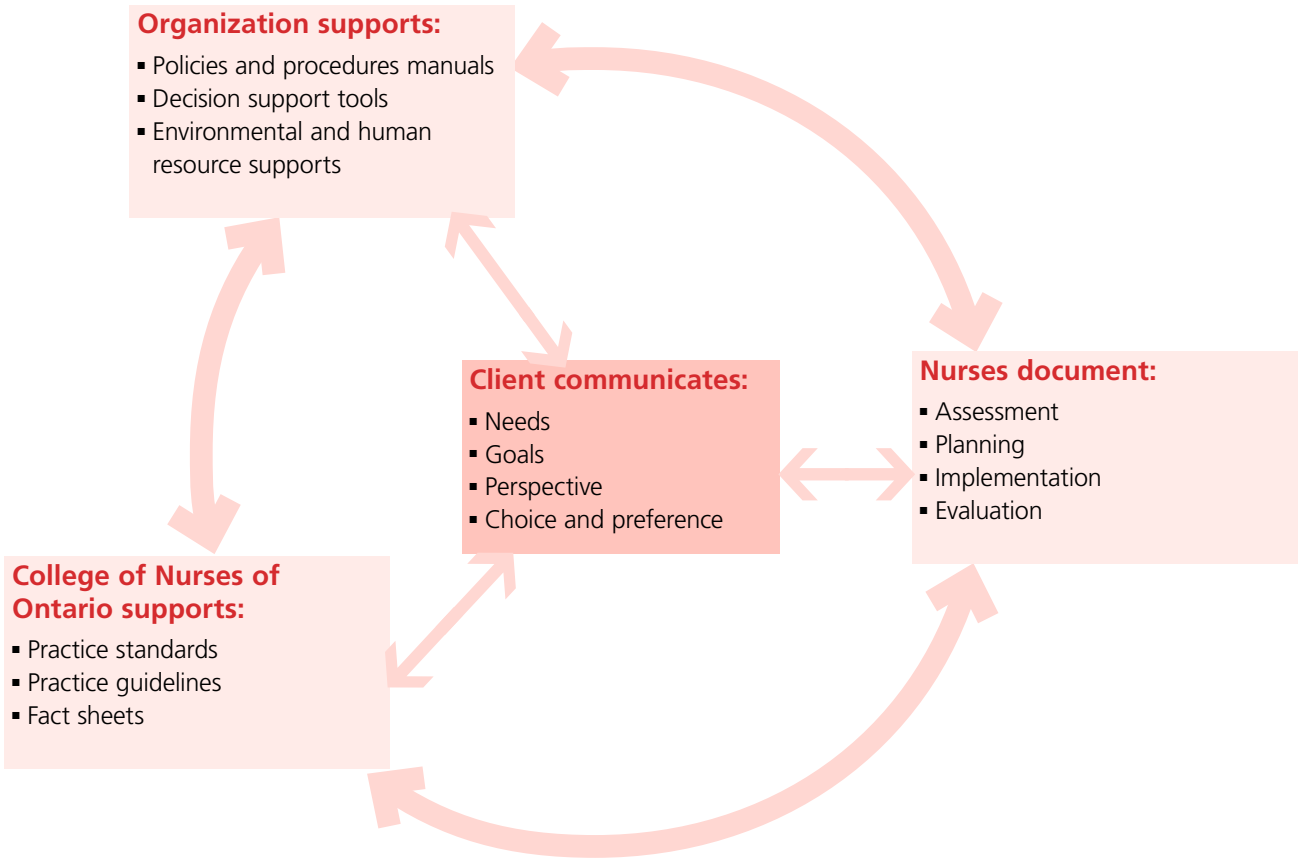
Safe and appropriate nursing care
When nurses document the care they provide, other members of the interprofessional health care team are able to review the documentation and plan their own contributions to safe and appropriate care. Documentation also provides valuable data for nursing research and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

Professional and Legal Standards
Documentation is a comprehensive record of care provided to a client. It demonstrates whether or not a nurse has applied nursing knowledge, skills, judgment and critical thinking according to the College of Nurses of Ontario's Standards of Practice. Documentation is generally accepted as evidence in legal proceedings. It establishes the facts and circumstances related to the care given and assists nurses in recalling details in a specific situation should the need arise.

A practice environment that has the necessary systems, supports and policies in place to enable nurses to document appropriately is fundamental to safe client care. This practice standard sets out requirements for nurses about documenting client care on paper or electronically. Nurses must advocate on behalf of safe, ethical and legal nursing practice for policies and procedures in their practice setting that reflect our standards of practice as espoused by the College of Nurses of Ontario.

Documentation can be paper, electronic or audio/visual. Examples of documentationinclude: flow sheets, Kardex, checklists, narrative nursing notes, monitoring strips, video or audio tape, and photographs.

Documentation Interrelationships (CNO, 2009)



Results of above inter-relationships

Complete documentation that demonstrates:

- Communication
- Accountability
- Legislative requirements

PRINCIPLES OF DOCUMENTATION

The Documentation, Revised 2008 practice standard is divided into three standard statements that describe the broad practice principles of documentation. These principles are:

- Communication;
- Accountability; and
- Security.

Although the requirements for documentation will vary depending on the client population and workplace policies, the general principles can be applied to every practice setting and to every type of nursing care. As self-regulated professionals, nurses must reflect on their role in improving their practice settings. They should advocate for quality documentation practices in their workplace that support the application of the practice standard.

Communication

The most important purpose of documentation is to communicate a client's health information. Documentation provides accurate, relevant, timely and comprehensive information concerning the needs of the client, and the care and services provided by the nurse. Communicating a client's health information to other members of the interprofessional team enables consistency and continuity in client care.

Documentation should include both subjective and objective data. Subjective data includes statements and feedback from a client. For example, a client may describe his pain to you by saying, "I feel a strong shooting pain while standing, but it goes away when I'm sitting. "

When documenting subjective data, provide accurate examples of what the client said using quotation marks to identify her or his comments. Objective data is data that can be observed, such as "client was screaming," or measured, such as the heart rate is 72 beats per minute or temperature was 39. 7 degrees Celsius. Objectivity means documenting facts without distortion of personal feelings, prejudice or interpretations.

For example, you may document the objective fact that a client's temperature is 38 degrees and the subjective information that the client reports: "I am feeling warm and dizzy. "

Another aspect of communication is to include a clearly identifiable signature, including designation, on all documentation.

Use of your initials is acceptable if there is a master list that provides your full signature, designation and initials.

Your designation will be either RN, RPN or NP.

Other degrees or certificates may be included with your signature depending on your workplace's policy, but they are not required by the College.

Nurses have an obligation to ensure that their documentation is captured in the permanent health care record. If you are using temporary hard copy documents, such as Kardex, shift reports or communication books, you must ensure that relevant information is transferred to the permanent record in either electronic or hard copy format as soon as possible.

When information about a client's health is obtained from a third party, for example, family members, nurses have to use their clinical judgment to decide if the information is relevant to the client's current status and likely to have an impact on the client's care.

You need to be aware of legislative requirements and organizational policies to help you decide what documentation is required. If you are unsure of what is relevant to document, discuss it with members of the team.

Accountability

Accountability means being responsible for your actions and the consequences of your actions.

Documentation demonstrates a nurse's accountability and determines responsibility. It answers the question: Who did what and when?

The standard statement for accountability in the Documentation, Revised 2008 practice document states: Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete. (CNO, 2008).

Nurses are accountable for recording information in a timely manner.

You should document information during care or as soon as possible after the care is provided. This enhances the accuracy of each entry and the overall credibility of the record.

Sometimes a practice setting or location may pose barriers that prevent the nurse from being able to document during or directly after an event. For example, a nurse assisting a client with skills development in the community may not be able to document the care until she is back in the office.

It is an expectation that nurses document as soon as reasonably possible, given the situation and the environment.

Regardless of the barrier or delays you may face, it is important that you never document care before it is given. For example, you should not complete a flow sheet about care you are going to provide until after the care has been provided, no matter how predictable you think the outcome is likely to be.

When you document, include the date and time of the documentation, as well as the date and time care was provided. Documentation should be in chronological order. Refer to your workplace policy regarding how to document a late entry.

Documentation should be completed by the individual who provided the care or observed the event. For example, you shouldn't document care provided by a personal support worker.

An exception is made in an emergency situation. For example, during a cardiac arrest, one nurse may be designated as the recorder to document the care provided by a number of other health care professionals. When acting as a designated recorder, identify the other health care professionals involved in relation to the care they provide. For example, the documentation should specify activities such as "Dr. Smith administered epinephrine 0. 5 mL and intubated the client..."

When correcting an error, a nurse is required to ensure that the original content of the documentation is maintained. The correction and the content that was changed should be identified, and the entry must be signed.

For example, if you record an incorrect date, it should remain visible as documented, even after you add the correct date to the record.

Also, you cannot delete, alter or modify in any way another individual's documentation.

All nurses are expected to be aware of legislation that may impact on documentation practices in their setting. Examples include the Mental Health Act, the Long -Term Care Homes Act, the Occupational Health and Safety Act and the Health Protection and Promotion Act. Current legislation is available on e-laws, a database of Ontario legislation and regulations.

Security

When clients entrust their personal information to an interprofessional health care team member or facility, it is essential that the confidentiality of that information is safeguarded and shared only as necessary in serving the interests of the client. Nurses are accountable for the security of their clients' personal information. Security relates to the access, sharing, storage, retrieval and transmission of client information.

A primary piece of legislation that impacts security and documentation is the Personal Health Information Protection Act, 2004. Known as PHIPA, this act outlines the legal collection, use and disclosure of personal health information.

As a Nurse, you have a responsibility to understand how PHIPA impacts your practice. The College's Confidentiality and Privacy – Personal Health Information practice document outlines legislation related to a nurse's obligation to maintain the confidentiality and privacy of client health information.

In keeping with the requirements of PHIPA, and to meet the College's security standard, nurses must only access client information for the clients within their care. For example, if a neighbor is hospitalized at your workplace, you have no authority to access or look at your neighbor's health care record.

PHIPA also requires that nurses take steps to ensure the safe storage of personal health information. This includes using physical security, such as locked filing cabinets, and technological security, such as passwords.

For example, if you are using a portable device, such as a memory stick, to store personal health information about clients, the information should be strongly encrypted. Whenever possible, all personal identifiers should be removed.

More and more, technology is used to communicate with clients and the interprofessional health care team. While technology offers many advantages for documentation, it also comes with serious risks, including breaching confidentiality. You must be aware of your obligation to protect client confidentiality. For example, if you use email to communicate with a client regarding his care, you must ensure that the email system is secure.

Clients and their substitute decision-makers are entitled to access, inspect and obtain a copy of the information in their health record. Nurses must facilitate their clients' right to access health care information.

PHIPA provides conditions under which a client can be denied access to their own personal health information; for example, when access would cause harm to the client or a third party. If you are unsure of a person's authority to access their record, you can review PHIPA or contact the Information and Privacy Commissioner of Ontario.

To meet client care needs, nurses share client information with the health care team. Nurses should ensure that clients understand that confidential information will be shared with team members.

To share information outside the circle of care, such as with an insurance company, you must obtain informed consent from the client or their substitute decision-maker.

However, there are situations in which nurses have a legal obligation to disclose client information to a third party without prior consent from the client. For example, you are required to report child abuse and comply with search warrants during criminal investigations.

Transferring, retaining and disposing of health records can present security issues.

The requirements for the retention of health records may vary depending on the practice setting. You need to be aware of the legislation and organizational policies that stipulate the requirement for the retention of records in your workplace.

When documents are no longer necessary, it is essential to ensure confidentiality is maintained in the process of destroying or transferring the documents. For example, nurses often create worksheets to assist them with organizing their care of their assigned clients. These worksheets often contain confidential client information, such as name, medication, treatments and diagnosis. When the worksheets are no longer needed, they must be disposed of in a way that ensures client confidentiality is maintained, such as by shredding.

Applying the Principles of Documentation to Practice

It is your professional responsibility to familiarize yourself with your practice setting's policies on documentation and follow them, including policies on documenting verbal and telephone orders, and completing incident reports.

Document on the designated agency forms and ensure each form clearly identifies the client. Use only agency-approved abbreviations. Realize that various charting systems (e. g. , flow sheets, clinical pathways) are acceptable if they enable nurses to meet this practice standard.

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

1. in an emergency, such as a cardiac arrest when you are designated as recorder, document the care provided by other health professionals;
2. record a verbal order when circumstances require doing so; and
3. in cases where agency policy does not allow auxiliary staff to document on the health record, record what client information was reported to you and by whom.

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. The converse is also true. If it is not documented, it is questionable if it was really done.

Document any advocacy you undertake on the client's behalf. Understand that incident reports are for quality improvement purposes. Keep them separate from the health record and do not make any reference to an incident report in the client's health record.

PRACTICE STANDARD

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Documentation, Revised 2008

Table of Contents

Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their roles, job description or areas of practice.

— College of Nurses of Ontario

Introduction

Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client[1] health record. Documentation — whether paper, electronic, audio or visual — is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client.

This practice standard explains the regulatory and legislative requirements for nursing documentation. To help nurses[2] understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each statement is followed by corresponding indicators that outline a nurse's accountability when documenting and provide guidance on applying the standard statements to a particular practice environment.

To further support nurses in applying the standards, the document also includes appendices containing important supplementary information and a list of suggested readings. Appendix A provides strategies for nursing professionals — including nurses, researchers, educators and nurse employers — to support quality documentation practices in their work settings. Appendix B includes a sampling of provincial and federal legislation governing nursing documentation, and Appendix C references general resources on electronic documentation.

Why Document?

Nursing documentation:

- reflects the client's perspective, identifies the caregiver and promotes continuity of care by allowing other partners in care to access the information;
- communicates to all health care providers the plan of care,[3] the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions;
- is an integral component of interprofessional documentation within the client record;
- demonstrates the nurse's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history; and
- demonstrates that the nurse has applied within the therapeutic nurse-client relationship[4] the nursing knowledge, skill and judgment required by professional standards regulations.

Whether documenting for individual clients, or for groups or communities, the documentation should provide a clear picture of:

- the needs or goals of the client or group;
- the nurse's actions based on the needs assessment; and
- the outcomes and evaluation of those actions.

Data from documentation has many purposes:

- It can be used to evaluate professional practice as part of quality improvement processes.
- It can be used to determine the care and services a

[1] In this document, a client may be an individual, family, group or community.

[2] In this document, nurse refers to Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[3] In this document, the term plan of care may refer to treatment plan, care plan, care map, service plan, case management, mental health assessment plan, resident assessment forms, or other terms organizations use.

[4] For more information, refer to the College's *Therapeutic Nurse-Client Relationship, Revised 2006* practice standard at **www.cno.org/publications**.

client required or that were provided.
- Nurses can review outcome information to reflect on their practice and identify knowledge gaps that can form the basis of learning plans.
- In nursing research, documentation is used to assess nursing interventions and evaluate client outcomes, identify care and documentation issues and advance evidence-based practice.

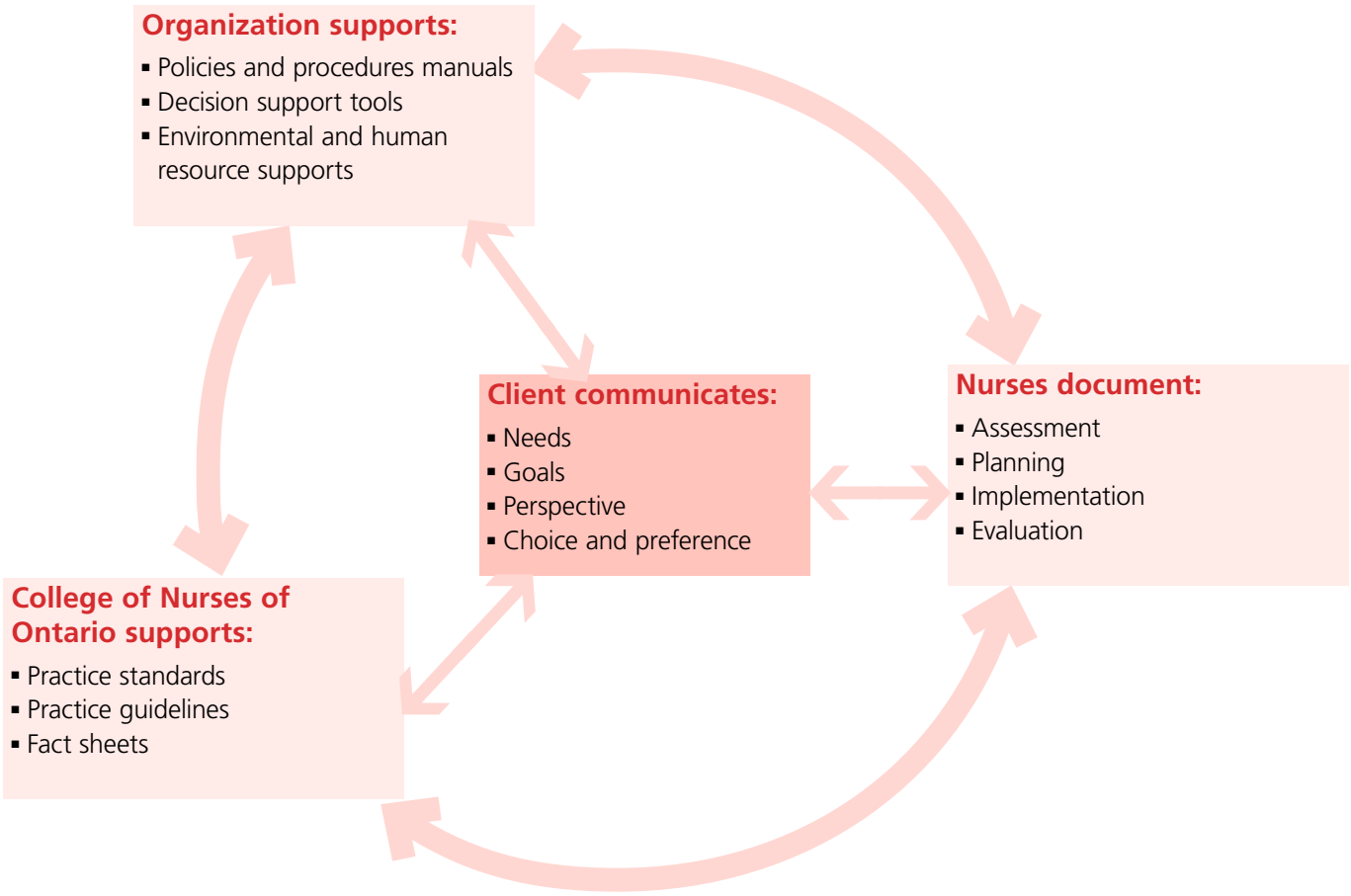
Nurses are required to make and keep records of their professional practice. As regulated health care professionals, nurses are accountable for ensuring that their documentation is accurate and meets the College's practice standards. Failing to keep records as required, falsifying a record, signing or issuing a document that the member knows includes a false or misleading statement, and giving information about a client without consent, all constitute professional misconduct under the *Nursing Act, 1991*. Nursing documentation may be accessed in College investigations and other legal proceedings.

The diagram on page 5 illustrates the inter-relationships supporting nurses in the provision of safe, effective and ethical care.

The Inter-relationships that support clients through documentation

This diagram illustrates how the nursing profession, the organizational environment and the self-regulatory framework within which nurses practise work together to support the client to obtain and/or maintain optimal functioning.

- The College's fact sheets, practice standards and guidelines support nurses in the provision of safe, ethical and effective care.
- Nursing organizations support nurses with policies, procedures and decision support tools.
- As self-regulated professionals, they are accountable to the practice standards that the College sets.



Results of above inter-relationships

Complete documentation that demonstrates:

- Communication
- Accountability
- Legislative requirements

Standard Statements and Indicators

Documentation, Revised 2008 includes three standard statements and corresponding indicators that describe a nurse's accountabilities when documenting.

- The standard statements describe broad principles that guide nursing practice.
- The indicators can help nurses apply the standard statements to their particular practice environment.

Communication

Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client's needs, the nurse's interventions and the client's outcomes.

Indicators

A nurse meets the standard by:

a) ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;
b) documenting both objective and subjective[5] data;
c) ensuring that the plan of care is clear, current, relevant and individualized to meet the client's needs and wishes;
d) minimizing duplication of information in the health record;
e) documenting significant communication with family members/significant others,[6] substitute decision-makers and other care providers;
f) ensuring that relevant client care information kept in temporary hard copy documents (such as kardex, shift reports or communication books) is captured in the permanent health record. For example, if the electronic system is unavailable, the nurse must ensure that information captured in temporary documents is entered in the electronic system when it becomes available again;
g) providing a full signature or initials, and professional designation (RPN, RPN[Temp], RN, RN[Temp] or NP) with all documentation;
h) providing full signature, initials and designation on a master list when initialling documentation;
i) ensuring that hand-written documentation is legible and completed in permanent ink;
j) using abbreviations and symbols appropriately by ensuring that each has a distinct interpretation and appears in a list with full explanations approved by the organization or practice setting;
k) documenting advice, care or services provided to an individual within a group, groups, communities or populations (for example, group education sessions);
l) documenting the nursing care provided when using information and telecommunication technologies[7] (for example, providing telephone advice);
m) documenting informed consent[8] when the nurse initiates[9] a treatment or intervention authorized in legislation; and
n) advocating for clear documentation policies and procedures that are consistent with the College's practice standards.

[5] Documentation should reflect a nurse's observations and should not include unfounded conclusions, value judgments or labelling.

[6] Significant other may include, but is not limited to, the person the client identifies as being the most important in his or her life. Examples include spouse, partner, parent, child, sibling or friend.

[7] For more information, refer to the College's *Telepractice* practice guideline at **www.cno.org/publications**.

[8] For more information, refer to the College's *Consent* practice guideline at **www.cno.org/publications**.

[9] For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at **www.cno.org/publications**.

Accountability

Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

Indicators

A nurse meets the standard by:

a) documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;
b) documenting the date and time that care was provided and when it was recorded;
c) documenting in chronological order;
d) indicating when an entry is late as defined by organizational policies;
e) documenting at the next available entry space, and not leaving empty lines for another person to add documentation (when using paper documentation forms). If there are empty lines, the nurse should draw a line from the end of the entry to the signature. When using an electronic system, the nurse should refrain from leaving a space in a free-flow text box;
f) correcting errors while ensuring that the original information remains visible/retrievable;
g) never deleting, altering or modifying anyone else's documentation;
h) enabling a client to add his or her information to the health record when there is a disagreement regarding care;[10]
i) documenting when information for a specific time frame has been lost or cannot be recalled;
j) indicating clearly when an entry is replacing lost information;
k) ensuring that documentation is completed by the individual who performed the action or observed the event, except when there is a designated recorder, who must sign and indicate the circumstances (for example, a code situation, or instances when an electronic system has technical difficulties and someone else enters the information when the system becomes available again);
l) clearly identifying the individual performing the assessment and/or intervention when documenting; and
m) advocating at the nurse's facility for clear documentation policies and procedures that are consistent with the College's standards.

[10] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

Security

Nurses safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with the standard(s) and legislation.

Indicators

A nurse meets the standard by:

a) ensuring that relevant client care information is captured in a permanent record;
b) maintaining confidentiality of client health information,[11] including passwords or information required to access the client health record;
c) understanding and adhering to policies, standards and legislation related to confidentiality;
d) accessing only information for which the nurse has a professional need to provide care;
e) maintaining the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, using initials when quoting a client's roommate);
f) facilitating the rights of the client or substitute decision-maker to access, inspect and obtain a copy of the health record, unless there is a compelling reason not to do so (for example, if disclosure could result in a risk of serious harm to the treatment or recovery of an individual);[12]
g) obtaining informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care;[13]
h) using a secure method such as a secure line for fax or e-mail to transmit client health information (for example, making sure the fax machine is not available to the public);
i) retaining health records for the period the organization's policy and legislation stipulates when required by the nurse's role (for example, in independent practice);
j) ensuring the secure and confidential destruction of temporary documents that are no longer in use; and
k) advocating for clear documentation policies and procedures that are consistent with the College's standards.

[11] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[12] For more information, refer to the Ontario Information and Privacy Commissioner's website at www.ipc.on.ca.

[13] For more information, refer to the College's *Confidentiality and Privacy—Personal Health Information* practice guideline at **www.cno.org/publications**.

Appendix A: Supporting Documentation Practices

All nurses — including employers who are nurses, researchers and educators — must demonstrate the knowledge, skill, judgment and attitude required of regulated health professionals. They must also reflect on their role in improving their practice settings, and advocate for quality nursing care practices.

Strategies that nurses in all roles can use to support documentation practices that meet the College's *Documentation, Revised 2008* practice standard include:

- facilitating nursing staff involvement in choosing, implementing and evaluating the documentation system as well as the policies and procedures and risk management systems related to documentation;
- providing access to appropriate, reliable and available documentation equipment, and to IT support;
- providing access to documentation equipment that meets ergonomic standards;
- ensuring policies are available and reflect the documentation standards to guide practice (for example, having explicit assessment norms and standards of care for charting by exception);
- ensuring that staff orientation includes documentation systems and relevant policies and procedures;
- ensuring that effective mechanisms are in place to help nurses apply the organization's documentation policies;
- supporting nurses' development of information and knowledge management competencies, and designing continual quality improvement activities related to effective documentation;
- developing performance management processes that provide opportunities to improve documentation;
- providing adequate time to document appropriately and review prior documentation;
- identifying and acknowledging nursing excellence in staff documentation;
- having an available and open management structure (for example, "management walkabouts" that focus on documentation issues or trends); and
- providing opportunities to explore or promote team building as it relates to documentation practices.

Appendix B: Nursing Documentation Legislation References

The following list contains a sampling of federal and provincial legislation that may affect nursing documentation. The legislation was in force at the time this document was published.

Federal Legislation

To obtain copies of current federal legislation, contact the Government of Canada Inquiry Centre at 1 800 O Canada (1 800 622-6232) or visit the Department of Justice website at www.laws.justice.gc.ca/en.

Access to Information Act, 1985

Personal Information Protection and Electronic Documents Act, 2000

Privacy Act, 1985

Provincial Legislation

To obtain copies of current Ontario legislation, contact Publications Ontario at 1 800 668-9938 or visit the Ontario Statutes and Regulations website at www.e-laws.gov.on.ca.

Charitable Institutions Act, 1990

Child and Family Services Act, 1990

Coroners Act, 1990

Freedom of Information and Protection of Privacy Act, 1990

Health Care Consent Act, 1996

Health Protection and Promotion Act, 1990

Homes for the Aged and Rest Homes Act, 1990

Mental Health Act, 1990

Municipal Freedom of Information and Protection of Privacy Act, 1990

Nursing Act, 1991

Nursing Homes Act, 1990

Occupational Health and Safety Act, 1990

Personal Health Information Protection Act, 2004

Public Hospitals Act, 1990

Quality of Care Information Protection Act, 2004

Regulated Health Professions Act, 1991

Appendix C: Electronic Documentation Resources

Below are some general resources related to electronic documentation.

Canada Health Infoway *Canada Health Infoway: Establishing Electronic Health Records for Canadians* www.infoway-inforoute.ca

Canadian Institute for Health Information *CIHI - Canadian Institute for Health Information* www.cihi.ca

E-Health Ontario www.ehealthontario.ca

Health Canada *Electronic Health Record* www.hc-sc.gc.ca

Registered Nurses Association of Ontario *Nursing and E-health Initiative* www.rnao.org

Suggested Reading List

Ammenwerth, E., Mansmann, U., Iller, C., & Eichstadter, R. (2003). Factors affecting and affected by user acceptance of computer-based nursing documentation: Results of a two-year study. *Journal of the American Medical Informatics Association*, *10*(1), 69-84.

Cheevakasemsook, A., Chapman, Y., Francis, K., & Davies, C. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice*, *12*(6), 366-374.

Hebert, M. (2000). A national education strategy to develop nursing informatics competencies. *Canadian Journal of Nursing Leadership*, *13*(2), 11-14.

Kossman, S.P., & Scheidenhelm, S.L. (2008). Nurses' perceptions of the impact of electronic health records on work and patient outcomes. *CIN: Computers, Informatics, Nursing*, *26*(2), 69-77.

Langowski, C. (2005). The times they are a changing: Effects of online nursing documentation systems. *Quality Management in Health Care*, *14*(2), 121-125.

Lee, T. (2006). Nurses' perceptions of their documentation experiences in a computerized nursing care planning system. *Journal of Clinical Nursing*, *15*(11), 1376-1382.

Nagle, L.M., & Catford, P. (2008). Toward a model of successful electronic health record adoption. *Electronic Healthcare*, *7*(1), 84-91.

Oroviogoicoechea, C., Elliott, B., & Watson, R. (2008). Review: Evaluating information systems in nursing. *Journal of Clinical Nursing*, *17*(5), 567-575.

Saletnik, L.A., Niedlinger, M.K., & Wilson, M. (2008). Nursing resource considerations for implementing an electronic documentation system. *AORN Journal*, *87*(3), 585-596.

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June 2009
41001
2009-05

STANDARD WORK FOR THE REGISTERED PRACTICAL NURSE (RPN/RN) DOCUMENTATION STANDARD (CNO, 2008)

Standard work is a nurses' professional accountability to know their roles and their responsibilities as it applies to meeting the Documentation Standards (2008) as espoused by the College of Nurses of Ontario (CNO). Each RPN/RN has standard work at every level when providing quality and safe patient/client centred care. By applying the College of Nurses of Ontario Documentation Standards (2008), the process of standard work becomes part of nurses' accountability and professional practice.

Standard Work	Completed	Incomplete
1. Communication – ensures documentation represents an accurate, clear & comprehensive picture of clients needs, nursing interventions and the client's outcomes.		
Ensures documentation is a complete record of nursing care provided including all aspects of the Nursing Process, assessment, planning, intervention (both independent & collaborative) and evaluation		
Documents both objective & subjective data – does NOT reflect unfounded conclusions, value judgments or labelling		
Ensures the plan of care is clear, current, relevant and reflects individualized clients needs &wishes		
Minimize the duplication of information in health record (ie. , if documented on flow sheet no need to document elsewhere)		
Documenting significant communication with family members/significant others, substitute decision makers & other health care providers		
Ensures all relevant client care information kept in "temporary" hard copy documents (ie. , kardex, communication books, shift reports) is captured in the permanent health record.		
Provides a full signature or initials, and professional designation (RPN/RN) with all documentation		
Provides a full signature, initials & professional designation (RPN/RN) on a master list when initialling documentation		
Use practice setting approved abbreviations and symbols		
Documents advice, care or services provided to an individual within a group, communities or groups		
Documents nursing care provided when using information & telecommunication like telephone advice		
Documents informed consent when the RPN initiates a treatment or intervention authorized in legislation		
Advocates for clear documentation policies in your practice setting reflecting CNO's Documentation Standards		

2. Accountability – Nurses are accountable for ensuring their documentation of client care is accurate, timely & complete		
Documents in a timely manner & completes documentation during or as soon as possible after care or event		
Documents date & time care was provided and time documentation was recorded		
Documents in a chronological order		
Documents late entries according to practice setting policies		
Documents in the next available space – do NOT leave empty lines – if empty lines draw a line across		
Correct errors while ensuring original information remains visible/retrievable		
Never delete/modify or alter anyone else's documentation		
Enabling a client to enter his/her information in health record if a disagreement regarding care occurs		
Documenting when information for a specific time frame has been lost or cannot be recalled		
Ensure documentation is completed by the individual who performed the action, observed the event EXCEPT when there is a designated recorder ie. , code situation		
Clearly identify the individual performing the assessment and/or intervention when documenting		
3. Security – Nurses safeguard client health information by maintaining confidentiality & act in accordance with information retention and destruction policies & procedures		
Ensures all relevant client care information is documented in a permanent record		
Maintains confidentiality of client information including passwords needed to access client information		
Understands & adheres to policies, standards & legislation related to confidentiality		
Accesses only information nurse has a professional need to provide care		
Maintaining confidentiality of other clients by using initials when referring to another client in a health record		
Facilitate the rights of a client or substitute decision maker to access, inspect or obtain a copy of health record		
Obtaining informed consent from client/SDM to use or disclose information to others outside circle of care		
Using a secure method such as a secure fax line or email to transmit health information		
Retaining health records for the period your practice setting policies stipulate		
Ensuring secure & confidential destruction of temporary documents that are no longer in use		

LINKING COLLEGE OF NURSES OF ONTARIO (CNO) SEVEN (7) PROFESSIONAL NURSING STANDARDS (2002) WITH THE CNO DOCUMENTATION STANDARDS (2008)

1. **Accountability.** Provide and facilitate the best documentation based on client care provided: communicate an accurate , clear and comprehensive reflection of the client's needs, your nursing interventions & the clients outcomes based on your interventions; communicates to all health care providers the plan of care, the assessment, the interventions based on the client's history and the effectiveness of those outcomes. Nurses are required to make & keep records of their professional practice; nurses are accountable for ensuring their documentation is accurate & meets CNO's practice standards.
2. **Continuing Competence.** Improve your knowledge: by completing the CNO Documentation Learning Modules www. cno. org , review as needed and yearly ; review your practice settings policies & procedures; stay abreast with updates from CNO by searching the CNO Website and reading the quarterly CNO Standard; attend in services when offered and be involved with your practice settings nursing practice meetings to advocate for policy changes reflecting CNO's Documentation Standards (2006).
3. **Ethics.** Protect yourself and your client by ensuring you document in a timely manner. Nursing documentation demonstrates nurses' commitment to providing safe, effective & ethical care by showing accountability for professional practice & the care the client receives, & transferring knowledge about client's health history
4. **Knowledge.** Acquire the knowledge of CNO Documentation Standards: instructional learning modules from CNO; appropriate documentation tools & forms; practice setting policies and procedures (abbreviations). Review CNO Standard
5. **Knowledge Application.** Apply the knowledge: documenting in a timely, non-judgmental & factual manner, documenting chronologically, correcting errors accordingly, documentation is completed by the individual who performed the action or observed the event; documenting objective & subjective information
6. **Leadership.** Demonstrate nursing leadership: role model proper documentation principles; role model proper use documentation standards; share knowledge with other health care providers, coach and mentor colleagues if gaps in their documentation, active involvement in committees to ensure documentation standards reflect CNO standards, become a documentation champion within your practice setting. Provide education/ health teaching to colleagues on nursing documentation and or provide current literature on nursing documentation. Ensure orientation includes documentation systems and relevant policies and procedures. Provide adequate time and support for documentation.
7. **Relationships.** Maintain professional and/or therapeutic relationships: nursing documentation demonstrates that the RPN has within the therapeutic nurse client relationship the nursing knowledge, skill and judgment required by CNO's professional standards; share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the documentation standards.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the CNO Documentation Standards

Signature: _____ Date: _____

Developed by: Donna Rothwell, RN, BScN, MN Wharton Fellow, SEIU Healthcare January 2014

RESTRAINTS (2009) – SAFE NURSING PRACTICE!

The Ministry of Health and Long-Term Care passed the Patient Restraints Minimization Act in 2001. The Act sets out when to use restraints on clients and emphasizes the minimal use of restraints. The College's Restraints practice standard is consistent with the Act and encourages documentation, nurse education, policy development, client consent and regularly reviewing the need for a restraint.

Restraints can be chemical, physical or environmental measures used to control the physical or behavioral activities of a client or part of the client's body. An example of a chemical restraint is a psychoactive medication. A physical restraint could be a fixed table or bed rail. A locked unit is an example of an environmental restraint.

There are a number of common myths about the use of restraints. Some nurses and other health care providers believe that the use of restraints can protect clients from injuries and falls; control abusive or disruptive behaviors; and reduce negative outcomes. In fact, research has shown that the use of restraints can increase the incidence of falls and skin tears, increase agitation and disruptive behavior, and increase incontinence and muscle atrophy. The use of restraints can also decrease the dignity of the client.

The decision to use a restraint on a client, and a nurse's accountability in that decision, is often complex.

By applying the decision process for deciding to use a restraint, nurses can provide the best possible client-centered care. The process can help you decide whether to use a restraint or try alternative interventions. Nurses must assess the client's needs first and then the need for a restraint. If it's determined that a restraint is necessary, nurses need to develop a plan for the client's care, implement the use of a restraint and evaluate the restraint's effectiveness.

The first step is to assess whether restraining a client is the most appropriate intervention. A thorough assessment may identify factors that are contributing to the client's behavior; for example, consider the client's health status and medications. As well, environmental factors, such as a high level of noise, can cause stress and agitation in some clients.

After exhausting alternative interventions and determining that a restraint is required, choose the least restrictive

form of restraint. The less restrictive the restraint, the less invasive it is for the client. For example, it's less invasive to allow a client to walk around in a secure unit than it is to restrain the client to a chair. Before using a restraint, discuss with the health care team the options and risks associated with different types of restraints. Nurses should obtain client consent to use a restraint, except in emergency situations in which there is a serious threat of harm to the client or others.

After you have obtained consent, develop an individualized plan of care with the client, the client's family and the multidisciplinary health care team. Once the restraint is applied, evaluate its effectiveness and whether there's a continued need for the restraint. One must follow their practice settings policies and procedures related to ongoing assessments and the frequency of such assessments.

Documentation is key in terms of your discussions with the client and family and your nursing assessments.

PRACTICE STANDARD

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Restraints

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THE STANDARD OF CARE.

OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.

Restraints Pub. No. 41043

ISBN 1-894557-46-8

First published March 2000 as *A Guide on the Use of Restraints* (ISBN 0-921127-71-5)
Reprinted October 2000, Revised for Web June 2003, January 2004, Reprinted December 2005, May 2008. Updated June 2009.

Additional copies of this booklet may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Ontario at 1 800 387-5526.

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www.cno.org

Ce fascicule existe en français sous le titre : *La contention*, nº 51043

Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— College of Nurses of Ontario

Introduction

The purpose of this document is to help nurses[1] understand their responsibilities and make decisions regarding the use of restraints. Restraints, whether physical, environmental or chemical, are a controversial measure used to restrict the movement or control the behaviour of a client.

Reasons for using restraints include protecting clients from injury, maintaining treatment and controlling disruptive behaviour. According to *Prevention of Falls and Fall Injuries in the Older Adult* (2002, Nursing Best Practice Guideline, Registered Nurses Association of Ontario), several studies have found that restraints actually increase the severity of falls and can increase confusion, muscle atrophy, chronic constipation, incontinence, loss of bone mass and decubitus ulcers. Restraint use is also linked to emotional distress, including loss of dignity and independence, dehumanization, increased agitation and depression. In severe cases, clients have been seriously injured or have died after becoming trapped in a restraint, such as a bed rail. Coroners' inquests in North America have cited the use of restraints as the cause of numerous deaths due to strangulation. There are no studies that demonstrate that the use of restraints results in increased client safety.

When and how restraints are used is also a legal issue. In 2001, the Ontario government passed Bill 85, the *Patient Restraints Minimization Act*. The Act regulates when and how restraints may be used and addresses the principle of minimal restraint on clients. The Act is consistent with this document, the College of Nurses of Ontario's (CNO's) *Restraints* practice standard. It includes components such as staff training, reassessment, record keeping, client consent, policy development relating to restraint use and alternative methods.

Many facilities in Ontario use a least restraint philosophy. This philosophy acknowledges that the quality of life for each client, with the preservation of dignity, is the value guiding the practice of health care practitioners, including nurses.[2] CNO supports this in all settings where nurses practise.

Nurses believe strongly in the right of clients to make their own decisions regarding care. When the client is not competent, the substitute decision-maker is expected to make the same decision the client would have made if he/she were competent. Nurses, as client advocates, are responsible for ensuring that the client has received information and has been a partner in planning and consenting to the proposed plan of care. Nurses respect client wishes even when those wishes carry risk.

Increasing numbers of facilities are reporting success in achieving the goal of restraint-free care. Changes in institutional policies have led to the development of educational programs and assessment tools that assist care providers in finding alternatives to restraints. The programs have offered nurses a process for identifying precipitating behaviour and have encouraged implementation of policies of least restraint.[3] Quality practice settings effectively support nurses in achieving the goal of restraint reduction. The use of restraints is an intervention of last resort and is based on meeting the needs of the client.

[1] In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[2] Ontario Hospital Association. *Position Paper on the Use of Restraints.* Toronto: Author, 1993.

[3] England, W., Godkin, D., & Onyskiw, J. *Outcomes of Physical Restraint Reduction Programs for Elderly Residents in Long Term Care — A Systematic Overview.* Alberta Professional Council of Licensed Practical Nurses, 1997.

What are Restraints?

Restraints are physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body. Physical restraints limit a client's movement. Physical restraints include a table fixed to a chair or a bed rail that cannot be opened by the client. Environmental restraints control a client's mobility. Examples include a secure unit or garden, seclusion or a time-out room. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement.

What is considered a restraint may vary by practice setting. For example, a nurse working in a correctional facility cares for an entire population of clients who are restrained by the environment. In a paediatric setting, nurses typically do not view the use of cribs as a form of restraint. CNO acknowledges that nurses are in the best position to determine appropriate definitions of restraint for their specific practice settings.

Assumptions

Professional judgment is integral to decision-making and includes organizing data, giving it meaning and coming to a conclusion.

1. ***Nursing interventions promote well-being and prevent harm.*** Nurses respect the dignity of the individual and advocate for an environment that promotes a client's quality of life.

2. ***A least restraint policy does not mean that nurses are required to accept abuse.***

3. ***Nurses involve clients or substitute decision-makers in planning.*** It is important for the nurse to develop a plan of care with the client and the client's family. The health care team, which includes the client, discusses the proposed interventions to identify the client's therapeutic needs and to facilitate the client's short-term and long-term goals. To assist decision-making, nurses provide education for clients or their substitute decision-makers, including information about least restraint practices and the right to refuse proposed interventions.

4. ***Consent is essential to nursing interventions.*** Clients have the right to make decisions regarding their care and treatment. The nurse informs the client or substitute decision-maker of any proposed intervention and alternative measures available. Nurses cannot use any form of restraint without client consent, except in an emergency situation in which there is a serious threat of harm to the individual or others, and all other measures have been unsuccessful. Emergency situations are time-limited. Once the situation is no longer critical, client consent is required. (For more information on these issues, see CNO's *Ethics* practice standard and *Consent* practice guideline.)

5. ***Restraint reduction is an interprofessional process.*** Nurses collaborate with other members of the health care team, including the client or substitute decision-maker, in assessing, planning and evaluating client care to eliminate restraint use. Nurses share knowledge about the risks of restraint use with the interprofessional team.

Policy Direction: Least Restraint

Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint. This requires assessment and analysis of what is causing the behaviour. Most behaviour has meaning. When the reason for the behaviour is identified, interventions can be planned to resolve whatever difficulty the client is having that contributes to the consideration of restraint use. For example, if a client has poor balance or is frequently falling, an intervention, such as providing the client a walker, can be developed to help protect the client's safety while allowing freedom of mobility. A policy of least restraint indicates that other interventions have been considered and/or implemented to address the behaviour that is interfering with client safety.

CNO endorses the least restraint approach. Nurses need to assess and implement alternative measures

before using any form of restraint. When restraint is required, the least restrictive form of restraint to meet the client's needs should be used.

Quality Practice Settings

Organizations that are committed to achieving quality practice settings create and maintain supports for professional nursing practice. These supports include:

1. Fostering excellent nursing practice and safe client care. Practice settings that support a policy of least restraint provide a safe workplace for staff and clients.

2. Involving nurses in the development of a least restraint policy, including identifying specific resources to support nurses in achieving restraint-free environments.

3. Providing resources that include appropriate staffing levels, tools to identify clients at risk of restraint and an environment that's supportive of alternatives to the use of restraints.

4. Providing staff education about the assessment, planning, implementation, support and evaluation of least restraint practices and client rights.

5. Implementing mechanisms to evaluate the impact of staff education and the need for continued support or alternative strategies to assist staff in implementing a least restraint policy.

Nursing Responsibilities

There are a number of activities that should be carried out to provide quality care for clients. These activities are as follows:

- understanding the client's behaviour. This is essential for accurately determining the need for restraints. A thorough nursing assessment identifies factors that lead to difficult behaviour, for which a restraint may be considered. The assessment includes individual factors, such as the client's health status, strengths, abilities and medications, as well as environmental factors such as noise level;
- developing an individualized plan of care to meet client goals, such as increased safety or decreased agitation;
- collaborating with other members of the health care team in developing and implementing the plan of care. For example, physiotherapists can aid in assessing and treating gait disturbances to reduce the need for restraints. The confused client may benefit from occupational therapy to implement environmental interventions that aid in orientation. Problem-solving occurs, in part, through collaboration with other team members, including the client and the family;
- evaluating the plan of care and making changes if it is not effective. It may take several attempts to determine the best plan to avoid the use of a restraint;
- using least restrictive restraints. If attempts to modify or eliminate the risk factors have not been successful and a restraint is required, the nurse uses the least restrictive measure following consultation with the client or substitute decision-maker. Examples of least restrictive measures include using a secure ward for a wandering client rather than using a chair restraint, and using partial side rails rather than full side rails;
- discussing with the client or substitute decision-maker the options and associated risks of using a restraint to enable the client to make an informed decision. For example, a chemical restraint may be considered for a confused client who is pulling out her nasogastric tube. Given information about the options available, the family may choose to provide additional attendant care rather than a chemical restraint that could increase falls and confusion. The nurse needs to understand her/his values and be cautious of not interfering with decision-making. Clients will, at times, prefer to endure safety risks rather than be restrained;
- being aware of individual agency policies regarding the use of restraints. In some settings, a physician's order may be required prior to the use of restraints. In other settings, it is a nursing decision;
- regularly reviewing the continued use of restraints. When caring for a client who is restrained by physical, environmental or chemical

means, the nurse is accountable for reviewing the continued use of restraints on an ongoing basis. The nurse is responsible for identifying any new client needs that may arise from the use of the restraints;
- being aware that restraint use, when required, is a short-term or temporary solution — never a planned long-term intervention. The exception to this may be the use of an environmental restraint; and
- documenting the assessment of the client, interventions to eliminate the need for restraint, discussions with the client or substitute decision-maker, the results of ongoing evaluation and revisions to the plan of care.

Case Studies

Scenario

Mary has been a resident at a restraint-free long-term care facility for five years. When she first arrived, Mary experienced frequent falls due to difficulties with balance. Through assessment, the staff determined that Mary was likely to attempt to ambulate independently when she was bored or had to go to the bathroom. An interprofessional team developed a plan of care that included toileting Mary every two hours, providing her with a low bed with one side rail to assist her to balance when sitting, installing a special seat on her wheelchair and developing recreational activities that provided stimulation and prevented boredom.

Mary has had ongoing difficulty with a leg ulcer, and her physicians arranged for skin grafting at a local hospital. It was expected that Mary would be at the hospital for about seven days to receive post-operative intravenous therapy. The staff at the facility were concerned that Mary's poor balance would result in falls while in hospital and that the use of restraints might be considered. Adding to their concern was the knowledge that immobilization contributed to muscle wasting and that Mary's ability to ambulate on return to their facility might be impaired to the degree that she would require an alternative level of care.

Discussion

The concerns about Mary's hospitalization prompted staff to plan proactively. Before Mary was admitted to hospital, a care-planning meeting was held by telephone with key hospital nursing staff, the family and the nurse manager of the long-term care facility. Mary's current plan of care was shared with the hospital nursing staff.

Because of the meeting, the hospital staff were able to follow the long-term care facility's plan of care, except for the recreational activity. To prevent falls related to boredom, and in anticipation that medication for pain might further increase Mary's difficulty with balance, the family devised a visiting schedule that allowed them to be with Mary and participate in her care. The hospital admitted Mary to a room close to the nurses' station and used an alarm that signalled when Mary attempted to get out of bed. The hospital physiotherapy department provided assisted exercises to maintain Mary's leg strength while she was less mobile.

A post-operative infection delayed Mary's discharge, but after two weeks she returned to the facility and to her pre-hospital admission routine. Despite post-operative confusion, Mary sustained no falls while in hospital, and due to the proactive planning of staff and family, the use of restraints was not included in her plan of care.

Scenario

A nurse in a long-term care facility is admitting a client who has been transferred from a local hospital. The facility has a least restraint policy and for the past year has used no restraints. It has a risk assessment protocol used on admission to help staff determine an appropriate plan of care that identifies behaviours that may lead to restraint use. Since implementing a least restraint policy, the facility has found that falls have not increased. The falls that have occurred have resulted in significantly less injury. Additionally, the incidents of skin breakdown declined by 50 per cent.

The family is insisting that their mother be restrained to protect her safety. They tell the nurse that if they do not restrain their mother and she falls, they will initiate legal action.

Discussion

This situation, like many involving the use of restraints, is an ethical dilemma. While nurses respect client choice, limits do exist. As explained in CNO's *Ethics* practice standard, client choice might be limited by policies that promote health or by the resources available in a particular situation. When clients request nurses to perform an act that may cause serious harm, nurses need to inform clients in a nonjudgmental manner of the potential risks and harm associated with the practice.

The nurse in this scenario needs to explore the implications of the request. The family believes that if no restraint is used, their mother's safety will be jeopardized. The nurse is able to provide education about the risks of restraint use and the alternatives available. If the family continues to request that restraints be used, the nurse respects the family's choice but needs to explain that because the facility has a no restraint policy, it does not have restraints available or the resources to use restraints safely. Knowing this information, the family can then make an informed decision about where to place their mother. Client and family needs are best met when these discussions occur before the admission takes place.

Scenario

Nancy is working in the emergency department of a community hospital when a client from the local correctional facility arrives for treatment of a large leg wound. The client is handcuffed and accompanied by two correctional workers. The nurse asks the workers to remove the handcuffs and respect the client's privacy while he is in the emergency department. Although she is able to assess and treat his leg wound with the handcuffs in place, Nancy is uncomfortable with the client's restricted ability to move.

Discussion

In this scenario, the decision to use restraints is made by the correctional facility, not by the nurse. The correctional facility has a least restraint policy and has determined that there is risk of harm to others if the client is not restrained and accompanied by correctional workers. Should the hand restraints interfere with the client receiving medical treatment, the nurse would need to discuss removing the restraints and alternative means of ensuring safety with the correctional workers. Nancy also needs to advocate within her facility for education on how to manage clients from correctional facilities and the types of restraints that may be used on these clients.

Scenario

Jody, a three-year-old, is intubated post-operatively on a ventilator following brain surgery. To prevent her from pulling out the endotracheal tube, her hands are restrained with mittens. Prior to the surgery, the need to use the mittens was explained to her parents and consent was obtained.

Discussion

This is an appropriate use of restraints that will be discontinued as soon as possible. To avoid frightening the child, the nurse arranged for the family to reassure Jody during the post-operative period. As well, using language Jody could understand, the nurse explained to her why she had to wear mittens. There are circumstances in which a nurse may need to restrain clients when they are not capable of understanding the necessity for the intervention. The nurse needs to consider these situations carefully and use the least restraint possible.

Resources

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STANDARD WORK FOR THE REGISTERED PRACTICAL NURSE (RPN/RN) DOCUMENTATION STANDARD (CNO, 2008)

Standard work is a nurses' professional accountability to know their roles and their responsibilities as it applies to meeting the Documentation Standards (2008) as espoused by the College of Nurses of Ontario (CNO). Each RPN/RN has standard work at every level when providing quality and safe patient/client centred care. By applying the College of Nurses of Ontario Documentation Standards (2008), the process of standard work becomes part of nurses' accountability and professional practice.

Standard Work	Completed	Incomplete
1. Professional judgment is integral to decision-making and includes organizing data, giving it meaning and coming to a conclusion.		
Restraints are physical, chemical or environmental measures that are used to control the physical or behavioural activity of a person or a portion of his/her body. • **Physical restraints** limit a client's movement. Physical restraints include a fixed table to a chair or a bed rail that cannot be opened by the client. • **Environmental restraints** control a client's mobility. An example of such would be a locked unit. • **Chemical restraints** are any form of psychoactive medication used not to treat illness, but intentionally inhibit a behaviour. Nurses need to recognize key factors associated with the use of restraints and utilize their professional judgment at all times to ensure the safe delivery of care and positive patient outcomes.		
Nursing interventions promote well-being and prevent harm: a) Nurses respect the dignity of the client at all times b) Advocate for an environment that promotes a client's quality of life		
A least restraint policy does NOT mean that nurses are required to accept abuse.		
Nurses involve clients or substitute decision makers in planning: a) It is important to develop a plan of care with the client and client's family b) The health care team, which includes the client, discusses the proposed interventions to identify the client's therapeutic needs and to facilitate the client's short and long-term goals c) To assist decision making, nurses provide information and education for clients and their substitute decision makers, including information about least restraint practices and the right to refuse the proposed interventions		
Consent is essential to nursing interventions: a) Clients have the right to make decisions regarding their care and treatment b) The nurse informs the client or substitute decision maker of any proposed intervention and alternative measures available c) Nurses cannot use any form of restraint without client consent, except in an emergency situation in which there is a serious threat of harm to the individual or others, and all other measures were unsuccessful d) Once the situation is no longer critical, client consent is required		
Restraint reduction is an interprofessional process a) Nurses collaborate with other members of the interprofessional health care team including the client or substitute decision maker in assessing, planning and evaluating client care to eliminate restraint use. b) Nurses share their knowledge and expertise with the interprofessional team		

LINKING THE COLLEGE OF NURSES OF ONTARIO (CNO) SEVEN (7) PROFESSIONAL NURSING STANDARDS (2002) WITH THE RESTRAINTS STANDARD (2009)

1. **Accountability.** One of the most important components of client care is safe, effective and ethical nursing practice. As with any nursing intervention, a nurse must be able to use their nursing knowledge and judgment in their decision making in the use of restraints. Nurses are accountable to have knowledge, technical skills and good nursing judgment in the utilization of restraints. Nurses must continuously reflect on their practice and maintain their competence to assess the appropriateness of the use of restraints for their patients.
2. **Continuing Competence.** Improve your knowledge: by reviewing the Restraints practice standard (2009) available on the CNO website: www. cno. org. Review as needed and annually review your practice settings policies & procedures. Stay abreast with updates from CNO by searching the CNO Website and reading the quarterly CNO Standard; attend in services when offered and be involved in nursing practice meetings to advocate for policy changes reflecting the use of restraints. Keep current with legislation to ensure the use of least restraints.
3. **Ethics.** Protect yourself and your client by ensuring you continuously make effective ethical decisions about client care as it relates to the use of restraints in your nursing practice . It is an imperative for nurses to ensure ethical decisions are made in the best interest of safe, quality and effective client care.
4. **Knowledge.** Acquire the knowledge of CNO Restraints Standard (2009), appropriate plans of care and clear communication; practice setting policies and procedures. Review CNO Standard quarterly. Complete the self-directed learning module made available on the CNO website www. cno. org on Restraints.
5. **Knowledge Application.** Apply the knowledge: identify opportunities for improvement in the use of restraints supporting clients and substitute decision makers. Continuously seek opportunities to learn about new strategies to minimize the utilization of restraints to ensure quality, ethical and safeclient care.
6. **Leadership.** Demonstrate nursing leadership: role model critical thinking and problem solving skills to minimize the use of restraints for clients. Share knowledge with other health care providers, coach and mentor colleagues if one identifies gaps in understanding the intent behind the least restraint philosophy. Be active in committees to ensure restraints reflect CNO standards, become a champion within your practice setting related to the use of least restraints.
7. **Relationships.** Maintain professional and/or therapeutic relationships with colleagues to promote the philosophy of least restraints. Share your nursing knowledge, skill and judgment required by CNO's professional standards to avoid inappropriate use of restraints. Share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the restraint standard.

WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!

I am knowledgeable and aware of how my 7 Professional Nursing Standards apply to the CNO Documentation Standards

Signature: _____ Date: _____

Developed by: Donna Rothwell, RN, BScN, MN Wharton Fellow, SEIU Healthcare January 2014

Practice Reflection Worksheet (2014) – A SAMPLE

The following are key questions that you may consider when you reflect on your practice. The following illustrates an example of how you may document your reflective practice with the intent of developing the QA Program Learning Plan.

Describe an experience, event or change in your practice or practice setting that was significant toyou.

1. I was approached by my client's daughter that she wanted her mother restrained at night as she was worried she would fall out of bed and break her hip. I explained to her that we have a policy of least restraints. This has created conflict between me and the daughter.
2. I recently documented in the wrong patient's chart and I discarded my notes. My manager brought this to my attention and informed me that I did not meet the College of Nurses documentation standards.

Based on what you described above, what were your strengths and what were your areas of improvement?

1. I participated on the restraint committee developing our workplace policy following the legislation and standards. Along with other colleagues, we shared this at our staff meeting. I have worked hard with my clients and families to develop strategies not to use restraints on their loved one.
2. Since my documentation error I have learned more about the principles of documentation and how to correct errors. I want to share this with my colleagues.

What input have you received from your peers about your practice?

1. I am always trying to improve nursing practice.
2. I like to teach others and work well with nursing students.
3. I am a patient advocate and an effective communicator.

Based on your own reflection and input you received, what are your learning needs?

1. I need to complete the Documentation Learning module from the College of Nurses of Ontario (www. cno. org) to ensure I know all of my practice expectations to practice safely and competently.
2. I need to provide better education and more information to patients families to help them understand the risks and benefits of restraints.

QUALITY ASSURANCE PROGRAM LEARNING PLAN (2013)

Collection of Personal Information

The College of Nurses of Ontario (the College) collects the information in the Learning Plan for Practice Assessment under the general authority of the RegulatedHealth Professions Act, 1991, S. O. 1991, c. 18, the Nursing Act, 1991, S. O. 1991, c. 32, and its regulations, and the College's bylaws. The College collects the information for the purpose of assessing your continuing competence through its Quality Assurance Program. Appropriate measures are taken to safeguard the confidentiality of the personal information you provide, and all documents become the property of the College.

Name	
Registration Number	QA Year
Class	Current Practice Setting
Client Population	

Learning Needs

What learning needs did I identify through Practice Reflection?

1. To complete the Documentation Standard Learning module from CNO to ensure I practice safely and competently.
2. To complete the Restraints Learning module from CNO to develop a comprehensive understanding of restraints to develop a teaching tool for clients and families within my practice setting.

Learning Goal #1

What do I want to learn?

To complete the Documentation Standard Learning module from CNO to ensure I practice safely and competently.

Which practice document does my goal relate to?

Documentation Revised (2008).

Goal #1: Activities and Timeframes

How am I going to achieve my goal?

1. By June 30, I will complete the Documentation Learning Module on line.
2. I will read three (3) articles related to effective nursing documentation.
3. I will ask my manager to review my documentation of client care I provided and ask for feedback.
4. By September 30, I will ask my manager and educator to provide us with education on the importance of nursing documentation. I would like to recommend we have a legal expert come and present the legal aspects of documentation.
5. I will read the Standard from the College of Nurses of Ontario to ensure I am aware of changes to practice.

Learning Goal #2

What do I want to learn?

I will review current literature on the use of restraints in the elderly patient population and review the learning module on Restraints from CNO.

Which practice document does my goal relate to?

Restraints (2009)

Goal #2: Activities and Timeframes

How am I going to achieve my goal?

1. By June 30, I will have researched two (2) articles on the use of restraints.
2. Discuss the new policy and procedure that the organization has developed at a staff meeting in September.
3. By July 15, I will complete the CNO Learning Module on Restraints.
4. Ask our educator to provide education on the use of restraints by October 30.

How do my learning goals support my commitment to continuing competency? How does my learning relate to the competencies of my practice?

I am able to keep up to date and competent on effective documentation practice and develop strategies on how to teach clients and family members the risks and benefits associated with restraints. .

Evaluation of changes/outcomes to my practice

What did I learn? What impact has my Learning Plan had on my practice?

I have learned the importance through my error of ensuring I am aware of standard changes. The learning module helped me enhance my practice. I am much more confident with approaching colleagues when there is a practice issue.

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