A DOCUMENTATION GUIDE FOR NURSES
and Health Professionals

2nd edition

Charting with Clarity

Mireille Guillemette, RN

Preface by Jean-Pierre Ménard, Ad.E.

PREFACE

I had the pleasure of reading Ms. Mireille Guillemette's work on documentation in medical records. This guide explores the evolution of record-keeping practices from the adoption of the Act Respecting Health Services and Social Services to the present day.

The healthcare sector is evolving at an astonishing pace, whether in terms of population, scientific advances or legal responsibilities, significantly increasing the accountability of all professionals involved.

In fact, the pace of work in healthcare today is much different than in previous decades.

This makes it all the more important to emphasize the importance of all actions taken by healthcare professionals and the urgency of finding ways to ensure that patients' records thoroughly and accurately reflect the care provided.

This guide provides essential support for the healthcare professionals who are required to write concise, high-quality, and unambiguous notes. It provides a framework for writing notes to meet the growing demands of all of those directly or indirectly involved in healthcare. It is both a contribution to nursing education and a valuable reference for all professionals.

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RECORDING NOTES:
AN OBLIGATION

1. RECORDING NOTES: AN OBLIGATION

Medical records are required by law. The record note is the basic element. Courts have given notes the status of overwhelming evidence on the nature of the professional work carried out in institutions. In the event of a dispute, the simple presentation of a record note can sometimes suffice, without the need to call the author of the note as a witness. Unless, of course, it is shown to be false or to contain incorrect facts. And in cases where the author's testimony is contradicted by the content of the note, the record note has more credibility with the courts. That's why it's so important to have a well-written, factual note, written as early as possible and contemporary with the events. The purpose of documentation is to follow the evolution of the patient's condition and the interventions that have an impact - in short, the stages of the care process. This communication ensures continuity of care and puts the patient at the centre of the team. When done correctly, this communication also protects the caregiver.

Nursing documentation plays a critical role in protecting patients and providing quality care. By recording physical and mental status assessments, professional assumptions and clinical impressions, and interventions in an accurate and organized manner, nurses can ensure continuous monitoring of the patient's health status and quickly identify any significant changes. In addition, chart notes facilitate interprofessional communication, enabling effective coordination of care among members of the healthcare team. This ensures optimal continuity of care, demonstrates vigilant monitoring, and reduces the risk of harm to the patient. Ultimately, complete and accurate documentation contributes to the safety, quality, and efficiency of healthcare.

The legal nature of notes is specified in numerous laws governing the profession. All institutions are subject to the provisions of the Act respecting Health Services and Social Services (AHSSS) and the Act respecting Access to Documents Held by Public Bodies and the Protection of Personal Information (AADHPBPPI). These laws provide most of the major legal guidelines for the keeping of medical records. Professional orders establish standards of practice to protect the public.

15. Make a decision on the use of isolation measures as part of the application of the Act respecting Health Services and Social Services and the Act respecting Health Services and Social Services for Cree Native Persons.
16. Assess mental disorders, with the exception of mental retardation, if the nurse has the university degree and clinical experience in psychiatric nursing care required under a regulation made in accordance with paragraph g of section 14 of the Nurses Act.
17. Assess a child not yet admissible to preschool education who shows signs of developmental delay, in order to determine the adjustment and rehabilitation services required.

Professional Code, Chapter C-26.

The assessment and clinical decision making involved in the nurse's reserved activities must be reflected in the progress notes. The nurse must demonstrate that the choice of interventions is based on sound evidence. Their credibility and professional responsibility are at stake. The Québec nursing professional order (OIIQ) has several reminders to this effect in its documents.

"The documentation of care is a professional responsibility inherent in the practice of nursing. It is one of the means of ensuring continuity of care and, by the same token, contributes to the safety of care. If the nursing care documentation produced by the nurse is found to be irrelevant, incomplete, difficult to obtain, unsustainable or absent, the risk of harm to the client is increased."

Nursing Care Documentation, Standard of Practice, OIIQ, 2023.

- Supporting the person and their loved ones;
- Developing a partnership with the patient while respecting his or her abilities.

2019 Outlook on the Practice of Nursing, OIIQ, Chap. 1, Foundations of the Nursing Profession, p. 7..

1.5 CONFIDENTIALITY, PROFESSIONAL SECRECY AND ACCESS TO RECORDS

The Québec Charter of Human Rights and Freedoms (sections 4 and 5) states that everyone has an inalienable right to respect for his or her reputation and private life. A patient's medical record is therefore confidential and no one may have access to it without the patient's consent or that of a person representing the patient.

It is therefore imperative that all information contained in the medical record be treated with respect and rigour to avoid any disclosure to unauthorized third parties. Even if all those involved in a patient's care have access to the record, only the information necessary for the specific episode of care may be viewed.

The information contained in the medical record belongs to the patient.

With confidentiality comes the rule of professional secrecy. Confidentiality is a right that belongs to the patient, and the person who receives the patient's confidences has an obligation never to reveal or divulge personal information contained in a medical record. Any employee who is not a member of a professional order must respect confidentiality and privacy. Professional secrecy may be lifted only with the patient's consent or by court order.

Professional Code, section 60.4. 2017-05-30

If professional secrecy is to be lifted, a record must be kept of all the **reasons and details** that led to the decision.

1. The reasons supporting the decision to communicate the information, including the identity of the person who caused the nurse to communicate the information and the identity of the person or group of persons exposed to the danger.
2. The elements of the communication including the date and time of the communication, the content of the communication, the mode of communication used and the identity of the person to whom the communication was made

Code of Ethics of Nurses in Québec, section 31.1.

Without cause, all information in the medical record is confidential and protected by professional secrecy. Consulting a medical record, whether paper or computerized, to satisfy a curiosity is strictly prohibited.

Always refer to the code of ethics of your professional order regarding confidential information and professional secrecy.

It's important to remember that a professional's access to medical records must never be used for **personal** purposes! The same applies to access to databases via computer connections. A record is consulted only for **professional** purposes. Curiosity, requests from relatives and even consulting one's own medical record are therefore prohibited.

Finally, the health professional cannot invoke professional secrecy to avoid a disciplinary investigation. Since professional orders are obliged to verify the competence of their members, this gives them the right to inspect or investigate the practice of a professional who is the subject of a complaint. The professional may never invoke professional secrecy to refuse to provide information requested by the syndic of their order.

It is forbidden to take **photographs** (of wounds, stools, bleedings, record notes, results appearing on patients' vital signs devices, selfies in a health centre, etc.). Unfortunately, this is a very common problem in healthcare environments.

2

WHAT MUST BE RECORDED
AND REPORTED

2. WHAT MUST BE RECORDED

"What is written shall be deemed to have been done, and what is not written shall be deemed not to have been done."

This statement is often found in the jurisprudence of courts and ethics committees that have had to judge professional acts. It's a reminder that the note is essential to attest to the credibility and quality of a service. A rigorous, clear note that respects the treatment plan serves everyone, including the judiciary. Quality clinical content lends credibility both professionally and judicially. This should not obscure the fact that **we write only what is relevant**. Evidence is easier to establish when the record is rigorously documented. However, proof that an act has been carried out can also be confirmed in other ways, for example by interviewing the nursing staff.

During individual inspections, the OIIQ finds that too much data is entered and that the essentials are lost. There's no point in writing down generalities such as a nursing routine or the details of a technique if they are followed to the letter. The note must be concise, so avoid all those unnecessary words that make you lose sight of the nature and coherence of the interventions. The note should be limited to precise and relevant elements. The best way to achieve this is to place the patient at the centre of the note.

There's no need to note, for example, that a site was disinfected before an injection, a detail that is part of the care protocol. The injection, and its effect on the patient's health, is the care. Therefore, what is documented and signed is the injection.

Continuity of care must be provided at all times. This means that the information needed for safe patient follow-up is communicated to the right person at the right time. This ensures that the care provided is safe and tailored to the patient's needs. All of this information is contained in the chart notes.

Sending an end-of shift report is part of the routine of care and therefore does not need to be recorded. What is communicated in the report should already be documented in the patient's file. It is important to distinguish between sending an end-of-shift report and ensuring continuity of care.

Unnecessary words to avoid / Suggestions for essential information

✘	✔
1. End-of-shift report given	Dr. Côté advised of shortness of breath and weakness.
2. Report given	Nurse advised of 1st dose of opioid administered at 15:40 and monitoring scheduled for 16:10.
3. First round	08:10 Awake, alert.
4. Last round	15:40 No new symptoms.

A user's record contains all kinds of documents. All these documents relate to the different steps of clinical monitoring. They include assessment reports, intervention plans, progress notes, photographs, monitoring documents, results of paraclinical examinations, observation and parameter grids, the therapeutic nursing plan, and medication administration records. It is a set of data relevant to clinical follow-up. The information contained in these documents should not be repeated in the medical record.

The progress note should provide an overview of all documents. The following are some of the elements that should be monitored and prioritized in the progress note:

First, we note a **fact**. A note is a fact if whoever reads it understands, sees, feels, and hears exactly the same thing as the author of the note. We write facts, not suppositions. We can never stress enough the uselessness and inappropriateness of writing judgments and interpretations about the patient's state of health. **A note should be an observation, not an interpretation.**

An **observation** is:

- An event that has occurred;
- A situation that is happening or has happened;
- An observable, measurable, quantifiable phenomenon;
- A new fact.

Notes sometimes contain vague terms such as "nothing special," "stable," or "no change." These are too general to be acceptable. A note must contain new facts based on both objective and subjective data obtained from the patient.

Objective, because they are collected by measuring instruments or by observed findings.

Subjective, because they are based on the patient's responses, what they say and how they feel.

Examples of objective data: Signs

- Vital signs
- Neurological signs
- Physical examination findings (inspection, palpation, percussion, auscultation)
- Test results

Examples of subjective data: Symptoms

- Reports feeling tight and short of breath with the slightest exertion
- Reports no other respiratory symptoms
- Reports abdominal pain

Ideally, both types of data, objective and subjective, should be included in the note.

Example of a subjective data entry

DATE	NOTES AND SIGNATURES
2025-11-25	06:40 Reports: headache and blurred vision.
This note will also contain interventions, including physical examination, results, follow-up and signature.	

Example of a note with subjective and objective data

DATE	NOTES AND SIGNATURES
2025-11-25	14:20 Reports: difficulty breathing on inspiration and shortness of breath on slight exertion.
	Does not report any cough, expectoration, orthopnea or LE edema.
	Says he feels this sensation all the time.
	Physical Examination
	INSPECTION
	Alert, attentive. Resp. 24/min, regular, superficial, abdominal. Pale facies.
	Capillary refill 4 seconds. Saturation 94%.
	AUSCULTATION
	No retractions or cough on examination. Crackles in the right and left lower lobes.
Interventions, results, signature, and title will complete this note.	

The note always follows the treatment. Therefore, it should be written **in the present or past tense**. A note should **never** be written before the treatment. Avoid trying to act quickly by writing down a medication in advance to be administered later. If the medication is forgotten or refused, the note would not only be wrong, it would also be an ethical error.

Examples of observations to note

Anamnesis:

- Signs and symptoms present;
- Changes in behaviour (especially in geriatrics), either improvement or deterioration;
- Changes in level of consciousness;
- Loss of autonomy (especially in geriatrics);
- Identification of risk factors;
- Physical examination findings;
- Clinical monitoring data and changes in vital signs;
- Absence of specific signs and symptoms;
- The person's participation in their episode of care;
- The presence and involvement of family and friends.

Forget generalities such as "**call bell within reach**" or "**eat well**" that reflect professional work that is not within the nurse's scope of practice. These generalities include the common error of recording an element of routine rather than an element of assessment or care. What's more, these generalities are **open to interpretation**. In short, notes that are too general are of no use to the care team.

4.4 CLARITY AND CONCISION

A **clear and concise** note leaves no room for interpretation. It states what the person working with the patient has seen, heard, felt and measured.

Vague or unnecessary language is the opposite of **clarity**. Notes should never contain superfluous elements lest the essential be drowned in a sea of words. There is no point in writing **patient** or **user** in the note if the form already identifies the person. The same applies to an expression such as "**on my arrival**": the date and time are more useful, precise and uninterpretable information.

Too much data is often documented in progress notes. If the data is not useful for understanding, you will get lost in it and risk distracting your attention from the essential elements.

Avoid imprecise and open to interpretation terms ✘	Replace with ✔
In bed upon my arrival.	08:40 Awake and alert.
Startling all the time.	Hyperalert.
Shifting eyes, difficulty following a conversation.	Inattentive.
Confused.	Changes in mental state, level of consciousness, alertness.
Disoriented ×3.	Disoriented to time and place. Memory impaired, does not recognize me.
Vomiting ~~profusely~~.	Projectile vomiting with streaks of blood.

Eats well.	Give details about autonomy, tastes, amounts, etc.
Large ~~amount~~ of greenish secretions.	Productive cough. Greenish sputum.
Restless.	Specify whether restlessness is verbal or physical, describe behaviour.
No voiced complaints.	Pain well controlled with current interventions **OR** No new symptoms.
Catheter drains well.	Urinary catheter drains 500 ml of dark yellow urine with whitish deposits.
Cooperates well.	06:45 I talk to her about cars. IV right forearm. Calm for duration of treatment x 10 minutes (for a patient who often refuses treatment).

✘ **Example of a note that is imprecise and open to interpretation**

DATE	NOTES ET SIGNATURES
2025-11-25	Respiration 24/min. **Significant** rales. **Bed rest in the morning**.

✔ **Example of precise information**

DATE	NOTES ET SIGNATURES
2025-11-25	09:40 Abdominal respiration 24/min, deep, regular amplitude.
	Rales 3/3 Victoria scale. Calm, no indrawing.
This note will also include any teaching or non-pharmacological interventions, outcome and signature.	

Confused is the vaguest of terms. It is often used to describe a mental state. It should be **banned**. It is one of those catch-all words with as many definitions and explanations as there are people who use it.

The note should be clear and specify the **mental state, behaviour, autonomy or signs and symptoms of delirium. Forget** the term "**confused**". **Mental state** assessment, with all its components, is described in **Chapter 5**.

Another commonly used term to avoid is "**seems**". There are no circumstances that justify its use. Comments such as "seems", "appears to be", "looks like" are far too imprecise to be useful. In fact, they can cause serious confusion. This is the case when a person appears to be asleep. To avoid confusion with a person **who is dying but appears to be asleep, we will instead enter observed data such as respiratory rate**.

The case has happened before and was the subject of a coroner's inquest.

In July 2018, Mr. René, who had been admitted with a urinary tract infection, died in the hospital a few hours after being admitted. Coroner Yvon Garneau investigated this sad death. He said he found a major flaw in "communication between the different professionals, as well as ambiguity about the roles and responsibilities of each." "It is a whole series of gestures, words and **notes that are not in the file, or are in the file, but in a confused way**," adds Yvon Garneau. At 1 a.m., the nurse's note says: "right lateral decubitus, eyes closed, seems to be sleeping." At 1:50 a.m., the staff noticed that he was no longer breathing. The patient had unsuccessfully requested his BiPAP machine several times during the evening to control his sleep apnea.

Example of a note for a new symptom

DATE	NOTES ET SIGNATURES
2025-11-25	08:45 Reports mouth pain and metallic taste.
	Physical Examination
	Dry mucosa, cracked tongue, pink gums. No lesions.
	TNP adjusted. M. Thibault, RN

5.1 ASSESSMENT OF THE PHYSICAL CONDITION OF A SYMPTOMATIC PERSON

An assessment is necessary whenever a new symptom suggests a deterioration in health. The clinical examination must include an **anamnesis** using the PQRSTU and a **physical examination** (inspection, palpation, percussion, auscultation).

To ensure that the note can be read **easily and quickly** by the care team, it is advisable to:

- Highlight sections by using capital letters or underlining them;
- Do not draw a line at the end of a line to make the content easier to read.

Voyer, P., Willcocks, K., L'examen clinique de l'aîné, 3rd edition ERPI, 2024.

1. Anamnesis (Data collection using the PQRSTU memory aid)

Example of an anamnesis note

DATE	NOTES ET SIGNATURES
2025-12-04	07:40 Pain left lower extremity.
	P: Provoke: bad position last night. Palliate: nothing.
	Q: Burning pain 6/10. Effect: limping.
	R: Left leg from ankle to knee.
	S: None.
	T: Constant since waking at about 05:00.
	U: Don't know.
	Redness to left lower leg.
	Nurse notified STAT. *Julia Castillo. LPN*

2. Physical examination (inspection, palpation, percussion, auscultation)

The data collected verbally during the anamnesis must be confirmed by the various measuring instruments and recognized assessment techniques.

- Instruments for measuring vital signs.
- Accepted inspection, palpation, percussion and auscultation techniques.

- Clinical examination memory cards
- Pulmonary-auscultation.
- Abdominal-examination.

The results must provide a complete and accurate assessment of the functions and organs examined.

The first stage of the physical examination is the inspection. Whether the situation is acute, i.e., a new symptom, or a follow-up, the first element to be assessed is the mental state.

Mental status includes, at a minimum, the level of consciousness and alertness.

Level of consciousness

- Alert
- Hyper-alert
- Lethargic
- Stuporous
- Comatose

Level of attention

- Attentive
- Inattentive

Clinical tools exist for these cases where subjective data cannot be collected.

More than 50 tools are available. Depending on the evidence, certain tools are prioritized. Clinical judgment allows the nurse to use the most appropriate validated tool according to age, development, cognitive status, care setting, etc.

- PACSLAC (**P**ain **A**ssessment **C**hecklist for **S**eniors with **L**imited **A**bility to **C**ommunicate)
- BPI (**B**rief **P**ain **I**nventory)
- PAINAD (**P**ain Assessment in **A**dvanced **D**ementia)
- EVENDOL (Behavioural Pain Scale for children ages 0-7 years, French: **Év**aluation/**En**fant/**Do**uleur)
- NIPS (**N**eonatal **I**nfant **P**ain **S**cale)
- FLACC Scale (**F**ace, **L**egs, **A**ctivity, **C**ry, **C**onsolability)

Example of a note

DATE	NOTES ET SIGNATURES
2025-01-04	07:20 Mother reports that her baby has been "different" for the past 30 minutes.
	Pain 5/15 EVENDOL scale.
This note is to be followed by vital signs, nonpharmacologic and pharmacologic interventions, results, and signature.	

Example of Chronic Pain

DATE	NOTES ET SIGNATURES
2025-10-13	14:00 Reason for consultation: Chronic back pain.
	Anamnesis
	BPI completed for last 24 h. Classifies most severe pain as 7/10 and least severe pain as 3/10.
	No improvement in relief noted.
	Impact: Sleep and couple's life affected.
	Smokes cannabis 5 to 7 times a day.
	Patient's goal: To be able to walk his dog 2 times a day.
	Understands that he should aim for 50% relief, not 100%.
	Intervention: Teaching of mental imagery technique.
	Result: Doesn't think he has enough imagination and concentration, but agrees to try 1 time a day for 5 days.
	14:35 Email sent to Dr. Mercier regarding patient's request to increase medication.
	Follow-up is planned in 6 days. Murielle Jean-Louis, RN

Criterion 1: State of panic	- Terror; - Agitation; - Severe Anxiety.
Criterion 2: Any of the following three situations:	- Sudden severe respiratory distress; - Unbearable pain (sudden onset or rapid increase); - Massive bleeding.

Reference: INESSS, National Medical Protocol No. 888020, August 2020.

Clinical signs of distress must be clearly noted in the record. The three medications listed in the distress protocol should be signed off on the Medication Administration Record (MAR). The note must also indicate the monitoring and outcome of the intervention. **When administering a distress protocol, the following should be noted:**

- Description of the panic state according to Criterion 1;
- Presence of signs and symptoms according to Criterion 2 (respiratory distress, unbearable pain, massive bleeding);
- Interventions performed, medications signed for;
- Name of physician notified;
- Monitoring performed;
- information and instructions given to relatives;
- Effectiveness at 10 and 20 minutes;
- Monitoring of side effects.

Reference: INESSS, National Medical Protocol, Distress in Palliative Care, September 2019.

An individualized PRN Distress Protocol is prescribed for this person at the end of life

DATE	NOTES ET SIGNATURES
2025-11-04	05:00 Severe respiratory distress: RR 28/min., supraclavicular indrawing, cyanosis around the lips,
	bronchial embarrassment 3/3 on Victoria Scale. Foamy secretions from mouth.
	Terrified look. Constant arm movements.
	05:06 Distress protocol administered. Orderly at bedside. Dr. Chang coded on pager.
	Explains effects of medication to spouse. Says he understands and is relieved of the intervention.
	05:20 RR 22/min. Supraclavicular indrawing, pink colouration, bronchial embarrassment 2/3 on Victoria
	Scale. Calm, eyes closed.
	Calm between 05:30 and 07:00 with spouse at bedside. M. Beaumont, RN
The details of the 3 medications are signed on the Medication Administration Record (MAR).	

Example of non-administration

DATE	NOTES ET SIGNATURES
2025-11-02	16:35 Respiration 24/min. Rales 3/3 Victoria Scale. Comatose. PACSLAC: No signs of pain or distress.
	Interventions: ventilator directed to face, right lateral positioning, mouth care, soft music.
	Teaching given to her daughter Nicole. Charlène Louis, RN
Contraindications indicated in the national protocol: an unconscious person presenting an isolated clinical manifestation or a single refractory symptom not accompanied by a state of panic.	

7.3 HIGH-ALERT MEDICATIONS

According to the Québec Order of Pharmacists (QOP), the term "high-risk medication" encompasses medications that are prone to errors and may cause harm to the patient or the pharmaceutical assistant.

This includes medications that are:

- dangerous;
- with a high alert level;
- with a high risk of error;
- with a narrow therapeutic index.

For this reason, the brand name, generic name, and indication must be stated on the prescription. Independent double-checking is recommended for high-alert medications, as the risk of consequences is much higher in the event of an error.

The QOP also suggests taking into account the context of care. The risk is higher if you work in pediatrics, a private retirement home, or any care setting where you may be distracted during preparation and administration.

In the medication record, high-alert medications require greater vigilance in preparation and administration. The Institute for Safe Medication Practices Canada (ISMP) suggests steps to take when prescribing, storing, preparing, and administering these high-risk medications, which can cause serious patient harm if an error occurs. The list of high-risk medications is long. Some examples: oral hypoglycemics, heparin, insulin, opioids, pediatric drugs, or intravenous drugs. **See Appendix 8** for this list.

Independent double-checking is a procedure designed to reduce the risk of errors associated with these medications. In this procedure, two caregivers check the medication and dosage. It is suggested that both caregivers initial the Medication Administration Record (MAR).

Mireille Guillemette is a registered nurse with over 30 years' experience and has been a member of the OIIQ (Québec Nurses Order) since 1993. She has worked in various healthcare settings, including CLSCs and several hospitals, such as Sacré-Coeur Hospital in Montreal, as well as several CHSLDs (long-term care facilities).

She has also worked as a teacher, including a four-year period as an educational advisor. In 2013, she founded her own company, which specialises in accredited training. She travels throughout Quebec, offering continuing education based on best practices and current knowledge. The training courses she offers are accredited by several professional orders. She also works as a trainer for the Centre d'excellence du vieillissement de Québec (CEVQ), which is part of Laval University's integrated university health network. In 2019, she participated in an educational mission in Switzerland, training a team of professors and nurses to become mentors specialising in assessment and clinical intervention with seniors.

Also in 2019, Mireille Guillemette designed a guide to writing nursing documentation for the OIIAQ (Québec Registrered Practical Nurses Order), and gave talks on the subject at regional conferences throughout Québec.

This second edition has been enhanced with even more examples and digital content. Laws, standards, and regulations dictate the 'WHAT'. This guide will equip you with the 'HOW'. The guide she is presenting today is suitable for all healthcare professionals, especially nurses. It is designed for quick reference and to help you adapt your note writing to current standards.

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ISBN : 978-2-9818651-5-1
9 782981 865151