

Practice Education Guidelines for BC Documentation by Students

GL#4-4

Practice Guideline

November 17, 2008

All students are required to document their care and service according to:

- Receiving Agency documentation* standards
- Statutory Regulations
- Professional Standards for Practice
- Legal principles (based on Canadian common law court decisions)

Guideline Details

Staff supervising students maintain responsibility for the care of the patient. As such, staff or faculty supervising students must review the student's documentation* and identify, follow up, document, and sign any discrepancies in the patient record in a timely manner.

Note: Some disciplines have specific requirements for co-signing student documentation.

The principles of documentation remain the same whether traditional or electronically generated documentation methods are used. Students are accountable for safeguarding the confidentiality of patient information regardless of which documentation method is used. (refer to [Practice Education Guideline – Confidentiality](#)). Students are to use only Receiving Agency approved abbreviations to represent their discipline and/or Placing Agency.

Paper based Documentation

Signature:

- For Students: include approved method for indicating 'student' followed by Placing Agency name.
Example: *Given Name, Surname, Student (Discipline), Placing Agency*
- For Students in a post-basic education program: use approved current professional designation* abbreviation followed by Placing Agency name.
Example: *Given Name, Surname, Discipline, Placing Agency*
- For Faculty: use approved professional designation* abbreviation followed by Placing Agency name.
Example: *Given Name, Surname, Discipline, Placing Agency*
- Provide a sample signature, if required, on the chart signature record for each patient.

Signature Record/Sheet:

- Print given name, surname
- Designation/Discipline
- Provide sample signature
- Provide sample initials
- Record date sample was provided
Example: *Given Name, Surname, Student (Discipline), Placing Agency, Signature, Initials, Date*

Electronic based Documentation

Electronic signatures are generated automatically when the student logs into the system using a password. Students must use their own user ID and access code.

Staff **should never allow** students to use a staff access code to document in an electronic health record.

No one should document on behalf of another unless it is clearly identified as being third party documentation (usually only done in unusual or emergency situations). (refer to [Practice Education Guideline – Confidentiality](#))

Co-Signing Student Documentation

College of Physiotherapy of BC: requires professional co-signature to all physiotherapy student entries.

Professions requiring some degree of co-signing for their students: Audiology, Dietetics and Clinical Nutrition, Medicine, Occupational Therapy, Recreational Therapy, Respiratory Therapy, Social Work, and Speech & Language Pathology. (see Rationale)

Co-signing is required in Receiving Agencies for a number of procedures and activities that are not necessarily related to one of the two parties being a student. (e.g. wasting of a narcotic, hanging a blood product, transcribing of orders).

Instead of co-signing student documentation, the student's supervisor may write something similar to *"I have read the above (discipline) student note and I have independently performed my own examination of the patient. I agree with the assessment and plans as they now stand"*. If the student's supervisor does not agree with the assessment, analysis, or care plan for the patient, the supervisor must take corrective action and document an addendum indicating this.

Roles & Responsibilities

Supervising Faculty or Staff:

- complete the signature record if required
- follow the documentation standards of the Receiving Agency
- use only abbreviations listed in Receiving Agency policy
- review student documentation to ensure accuracy
- use professional judgement in the determining the correct level of supervision required with documentation
- when co-signing, know the reason for the co-signature
- if one disagrees with or has concerns about the assessment, analysis, or care plan documented, follow up must occur and may include corrective action
- facilitate timely training on electronic system
- ensure students receive personal access code
- use only the username and password issued

Students:

- follow the documentation standards of the Receiving Agency
- use only abbreviations listed in Receiving Agency policy

- complete the signature record if required
- take training on electronic documentation systems if required
- use only the username and password issued (refer to [Practice Education Guideline – Confidentiality](#))

Receiving Agency:

- have a standard/policy in place that articulates the expectations for student signature (eg. abbreviations for professions/disciplines and for post-secondary education institutions)
- have clear written expectations for co-signatures (who, what, when and why)
- have a process for students and faculty to obtain training and timely access to the Receiving Agency computer network and specific electronic documentation programs

Consequences of Non-compliance

Inadequate or incomplete documentation may be considered evidence of unsafe or insufficient care by the student, the supervising staff, and/or faculty. In the event of an incident or legal action, what was documented is the evidence of what occurred or did not occur regardless of what actually happened. Inadequate or incomplete documentation also impacts what care may or may not be provided by others.

Use of abbreviations that are not recognized/approved within the Receiving Agency may jeopardize the outcome of any legal action.

In the event of an incident or legal action, individuals are not easily tracked down if not properly identified by their signature and designation.

Rationale

Receiving Agencies are continually implementing new electronic systems. Recognizing that students may not be in the practice education setting for long periods and it is hard to get students trained on electronic systems in a timely manner, it might be tempting to find ways to ‘work around’ these challenges. Standards of practice for documentation may be negatively impacted as a result. For example, a student types up patient care documentation in a WORD document and then the supervising staff cuts and pastes that documentation into the electronic record and signs it off. The supervising staff member has ‘worked around’ the principles of documentation. Documentation should only occur from first-hand knowledge and only for the care provided directly by the individual. “Investigations into complaints about care will look at and use the patient/client documents and records as evidence, so high quality record keeping is essential.”¹ Users of an electronic system need to be aware that when they log on to the system, they have generated their electronic signature. Any documentation under that electronic signature is attributed to that user. Hence, in the event of legal action, that user is deemed the one with direct knowledge of the care or service given.

¹ Parkinson, J. & Brooker, C. (May 2004). *Everyday English for International Nurses: A Guide to Working in the UK*, Chapter 4: Nursing Documentation, record keeping, and written communication. Churchill Livingstone, UK. Page 38.

There is no recognized standard format for how students sign off their documentation. Some professions have clearly defined how students of that profession are to sign. Generally, the “student” designation of the title is first and foremost to ensure a well-informed public as well as quick recognition of who documented.

Co-signing entries of students or other care providers is not a standard of practice for all professions. When the intent or purpose of co-signing is poorly defined, it can blur accountability. Co-signature can be a method of:

- demonstrating evidence of professional accountability and judgement on level of supervision and/or
- confirming accuracy of documentation and/or
- agreeing that care or service was valid, relevant and suitable.

Even when there is an expectation of co-signature, it is not clear as to when or how soon after the documentation should the co-signature be done. The key is recognizing one’s accountability, exercising good judgement, and recording adequately.² To ensure that accountability remains clear, it is important that the reasons for co-signing are well-defined and communicated to everyone involved.³

Definitions

Documentation: Any written or electronically generated information about a client that describes the care or service provided to that client.⁴ A fundamental communication tool that reflects the patient’s perspective on her/his health and well-being, the care provided, the effect of care, and the continuity of care.⁵

Professional Designation: recognized, regulated, or reserved professional title (i.e. MD, RN, LPN), or non-regulated profession job title (i.e. RCA, RA). This is not an educational credential.

References

Board of Registration for Social Workers in B.C. (July 2006). Code Of Ethics and Standards Of Practice: General. Vancouver, BC. Retrieved on October 6, 2006 from http://www.brsw.bc.ca/resources_links/practice_standards/adoption.htm.

² Professional Practice. (2006). Practice Guideline: Professions that Require Professional Preceptors Co-Sign Student Clinical Documentation. Vancouver Coastal Health.

³ College of Nurses of Ontario. (2004). Practice Standard: Documentation. Toronto, Ontario. Pub. No. 41001 page 10.

⁴ College of Registered Nurses of BC. (Dec. 2005). Practice Standard for Registered Nurses and Nurse Practitioners: Documentation. Vancouver, BC. Pub. No. 334.

⁵ College of Nurses of Ontario. (2004). Practice Standard: Documentation. Toronto, Ontario. Pub. No. 41001 page 3.

College of Nurses of Ontario. (2004). Practice Standard: Documentation. Toronto, Ontario. Pub. No. 41001. Retrieved on October 13, 2006 from http://www.cno.org/docs/prac/41001_documentation.pdf.

College of Registered Nurses of BC. (Dec. 2005). Practice Standard for Registered Nurses and Nurse Practitioners: Documentation. Vancouver, BC. Pub. No. 334. Retrieved on October 13, 2006 from <http://www.crnbc.ca/downloads/334.pdf>.

Ibid. (January, 2003) Nurse to Nurse Book: Nursing Documentation. Vancouver, BC. Pub. No. 151. Retrieved on October 13, 2006 from <http://www.crnbc.ca/downloads/151.pdf>.

College of Physiotherapists of Ontario. (September 1998). Guideline: Supervision of Physiotherapy Students. Toronto, Ontario. Retrieved on September 1, 2006 from http://www.collegept.org/college/content/pdf/en/Supervision_of_Physiotherapy_Students.pdf

Learning & Career Development. (February 2006) Student Practice Education Policy and Procedure DRAFT. Vancouver Coastal Health Authority, Vancouver, BC.

Interior Health Authority. (February 2006). Administrative Policy Manual - AU1000 Student Placements (Clinical & Practice Education). Kelowna, BC.

Parkinson, J. & Brooker, C. (May 2004). Everyday English for International Nurses: A Guide to Working in the UK, Chapter 4: Nursing Documentation, record keeping, and written communication. Churchill Livingstone, UK. Retrieved on October 6, 2006 from <http://www.intl.elsevierhealth.com/catalogue/title.cfm?ISBN=0443073996>.

Professional Practice. (2006). Practice Guideline: Professions that Require Professional Preceptors Co-Sign Student Clinical Documentation. Vancouver Coastal Health.