

## Guideline: Documentation, 2026

**The purpose of this guideline is to provide guidance on legally prudent, professional clinical documentation and written communication. This guideline applies to both paper and electronic records and includes handwritten clinical notes, emails, text messages, and letters to and from other health professionals as well as initial client assessments, care plans, birth plans, photographs and observation charts and other clinical documentation.**

NZNO, as a bicultural partner to Te Tiriti o Waitangi, acts to ensure the obligations of active protection are upheld and honoured through supporting ways that are culturally specific to enhancing and empowering identity. NZNO is an organisation that seeks to improve the health status of all people in Aotearoa New Zealand, through participation in health and social policy development. We share the intent of the Ministry of Health's definition of equity which equally applies to NZNO work across professional, industrial and member activities. Further ensuring standards of cultural safety through adopting culturally appropriate approaches that recognise Māori as tāngata whenua, and acknowledge the diversity of all cultural needs, and guarantees positive equitable outcomes.

### Introduction

Nursing documentation is a legal record of patient/ client care. It is essential for good clinical communication and a core requirement of the Nursing Council of New Zealand (NCNZ) and Midwifery Council of New Zealand (MCNZ) competencies for scope of practice. Good documentation helps to protect the welfare of patients/ clients by promoting:

- High standards of clinical care.
- Continuity of care.
- Better communication and dissemination of information between members of the multidisciplinary care team.
- An accurate account of treatment, care planning and delivery.
- The ability to detect problems, such as changes in the patient's/ client's condition, at an early stage.

(Collins, Cato et al. 2013).

This guideline is not intended to replace Employer policies/ guidelines, which must be adhered to. This is intended to be used alongside local guidelines and also the NCNZ competencies standards for practice for Registered Nurses (RNs) (2024), Enrolled Nurses (ENs) (2025) and Nurse Practitioners (NPs) (2017) and the Midwifery Council of NZ Standards and Competencies for entry to the register of midwives (2021). Health care assistants (HCAs) may also be required by an employer to complete documentation in clinical notes and must be well-prepared to undertake this task under the direction and delegation of a regulated health professional (Ministry of Health, 2016).

It is recommended this document is read in conjunction with the following:

- [Office of the Privacy Commissioner | Health Information Privacy Code 2020](#)
- Ngā paerewa Health and disability services standard - [Standards New Zealand](#)

**NZNO Practice Guideline: Documentation, 2026**

Tōpūtanga Tapuhi Kaitiaki o Aotearoa: The New Zealand Nurses Organisation

[www.nzno.org.nz](http://www.nzno.org.nz)

- HDC Code of Health and Disability Services Consumer Rights (1996), in particular Right 4.2. - [Code of Health and Disability Services Consumers' Rights — Health & Disability Commissioner](#)
- MCNZ Competencies for entry to the Register of Midwives -
- NCNZ Competencies Standards of Competence for Registered Nurses.
- NCNZ Competencies for the Nurse Practitioner Scope of Practice.
- NCNZ Competencies Standards of Competence for Enrolled Nurses.
- NCNZ Guidelines Social Media and Electronic Communication.
- NZNO Guidelines:
  - Incident /Adverse Event Reporting.
  - Privacy, Confidentiality and Consent in Professional Development Activities.
  - Standing Orders.
  - Delegation of care by a registered nurse to a health care assistant.
  - Guideline for nurses on the administration of medicines, in particular the section on verbal and telephone medicine orders.

### **NZNO members must be familiar with their local policies/ guidelines for documentation.**

When documenting in the clinical record, many people may read the notes you have written. This could include:

- All health professionals who are involved in the planning, implementation and evaluation of care – from the time of admission through to discharge.
- Student health professionals and their educators by agreement.
- Researchers, quality assurance and accreditation personnel who are involved in studying and reviewing standards of care (complaints, adverse/sentinel events/ infection control practices).
- The recipient of care and/or their family whānau.
- External bodies in the case of an investigation e.g. NCNZ, MCNZ, Accident Compensation Corporation (ACC), Health and Disability Commissioner (HDC), Health Practitioners Disciplinary Tribunal (HDPT) or the Coroner.

Documenting all relevant information ensures others know what you observed and what nursing interventions you took. Documentation must show evidence of clinical judgement and escalation/referral as appropriate and documenting evaluation of the care provided. If care is not recorded, then it is assumed the care was not given.

Documentation should also include care that could not be given and the reason why, so that it does not get overlooked. When addressing ethical dilemmas in care delivery, health professionals are advised to document steps/care intentionally not taken and the rationale for the decision e.g. it may further endanger the safety of the individual.

## **Documentation Frameworks**

There are many different documentation frameworks to guide nursing documentation in use across New Zealand (NZ). Four commonly used documentation methods in NZ- SBARR, Focus charting, SOAP/SOAPIER and Narrative documentation are described below.

### **ISBAR**

The SBARR is a communication framework used to create a structured and standardised communication format between health care workers. It is commonly used within DHBs alongside Early Warning Systems (EWS). It is particularly useful for reporting changes in a patient's/ client's status and / or deterioration between health care services or shifts.

## ISBAR:

- I = Identify - refers to the people involved in the communication.
- S = Situation - what is going on with the client/ patient (Chest pain, nausea, etc...).
- B = Background - client's/ patient's presenting complaint, relevant past medical history and brief summary of background.
- A = Assessment - Vital signs, any outside normal parameters, your clinical impression, severity of client/ patient and clinical concerns.
- R = Recommendation - suggestions of what action is to be taken, how urgent and when action needs to be taken.

(EBSCO, 2025)

**Note: A further 'R' can be added, in an acute situation this can stand for: Read back - verify any direction given and confirm orders to minimize errors, or Review - what has been the effect of the action/ intervention (Picmonic, 2025).**

## Focus Charting

Focus charting identifies specific concerns determined during the assessment e.g. a focus may reflect:

- A client/ patient concern, such as decreased urinary output.
- A change in a client's/ patient's condition, such as disorientation to time, place and person.
- A significant event in the client's/ patient's care, such as surgery.

The client/ patient care is then organised under the headings of:

- Data: Subjective/ objective information as supporting evidence of the client/ patient status.
- Action: Completed or planned nursing interventions based on the nurse's assessment of the client's/ patient's status.
- Response: Evaluation of the impact of the interventions.

Flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations such as personal care, vital signs, intake and output, etc. Information recorded on flow sheets or checklists does not then need to be repeated in the progress notes (College of Registered Nurses of British Columbia, 2025). However, they still are part of the client's clinical record and should be kept with all clinical notes.

## SOAP / SOAP I E (R) Charting

SOAP/ SOAP I E (R) charting is a problem-oriented approach which includes the following:

- S = subjective data (e.g. how does the client/ patient feel?)
- O = objective data (e.g. results of the physical exam, relevant vital signs)
- A = assessment (e.g. what is the client's/ patient status?)
- P = plan (e.g. does the plan stay the same? is a change needed?)
- I = intervention (e.g. what occurred? what did the nurse do?)
- E = evaluation (e.g. what is the client outcome following the intervention?)
- R = revision (e.g. what changes are needed to the care plan?)

Similar to focus charting, flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations (College of Registered Nurses of British Columbia, 2025).

## Narrative Charting

Narrative charting is a method whereby nursing interventions and the impact of these on client/ patient outcomes are documented in chronological order over a specific time period.

Information is recorded in the progress notes, often without a framework. This framework does not necessarily provide the rationale or evaluation for a particular action or task.

The “Literature suggests that no matter what documentation framework is used nurses require continuing education related to documentation in order to improve and maintain standards” (Blair & Smith 2012, pp. 163).

## Documentation Why and What?

Whether documenting for individual clients/ patients, or for groups or communities nursing documentation should:

- Be factual, objective, consistent and accurate.
- Be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient or client including standard care and out of the ordinary care.
- Be written clearly and in a way that the text cannot be erased.
- Be written in a manner that any alterations or additions are dated, timed and signed so the original entry can still be read clearly.
- Be accurately dated, timed and signed, with the signature printed alongside the first entry.
- Avoid inclusion of abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements.
- Be readable on any photocopies- ideally written in black ink.
- Have a unique identifier on both sides of every page (NHI, Date of Birth)

In addition, records should:

- Be written, wherever possible, with the involvement of the patient/ client or their carer.
  - Be written in terms that the patient/ client can understand.
  - Be consecutive- numbering pages can be of assistance.
  - Identify problems that have arisen and the action taken to rectify them.
  - Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/ or inaction.
  - Cross reference vital observations, fluid balance charts etc. rather than repeating the information already available in the client's/ patient's notes.
- (Beach & Oates, 2014; Doncliff, 2015; Jefferies et al., 2010).

## Here are some ‘dos and don’ts’ to help you document accurately and effectively:

### DO

- Record date, time (24hr), signature and designation, e.g. RN, EN, HCA.
- Record in chronological order and complete the clinical notes at the time the care was given, or as soon as possible after this. Number pages.
- If amending an entry, include the amendment date and time as well as the time/ date the care was delivered.
- Record patient's comments – “patient/ client reports ...” or “Mr X states that...”
- Record/cross reference to observations and evaluations.

- Record patient care and their response to that care.
- Record incidents that occur and the actions taken in response to these – refer to NZNO Incident Reporting (NZNO, 2021).
- Accurately record details of medications given on medication chart and document any refused/ untoward administration by the client/ patient in their notes.
- Be aware of your organisation’s complaint policy and document all complaints/ communication (e.g. concerns, praise, requests or queries) from the client/ patient and their family/ whanau.
- Document all changes in conditions, your assessment and actions to address the changes.
- Sign and date any amendments. Include your designation, e.g. RN, EN, and HCA.
- Write legibly using permanent blue or black ink that can photocopy clearly if required (NB red and green ink copies poorly, so it is recommended you avoid using it).
- Write objectively. Be specific and factual.
- Use the correct terminology e.g. cyanosed instead of “blue”.

### DO NOT

- Rely on memory.
- Erase entries. If you make an error, strike it through so that the original can still be read. Sign and note the entry is an error. It is medico-legally inadvisable to use a “white out” product.
- Make assumptions or use subjective/ judgmental language.
- Leave blank spaces. It is advisable to strike through to the end of the line or through several lines if there is a small gap at the end of the page.
- Use abbreviations (be familiar with your organisation’s policy on this).
- Make entries on behalf of another health professional.
- Write additional information at a later date unless it is essential. Any information added retrospectively to the record must state that it is written retrospectively and include the date/ time of entry, the date/ time of the care and signature.
- Use generalisations, e.g. condition unchanged.

**Note: Health care assistants (HCAs), Student Nurses and/or caregivers cannot be made responsible for undertaking or documenting consumer assessments, care plans and evaluations.**

## Use of Technology

Many nurses and midwives are now regularly using information technology to record the planning, assessment, and delivery of care. If technology is used, the principles underlying documentation, access, storage, retrieval, and transmittal of information remain the same as for a paper-based system. It is important agencies have clear policies, guidelines, and on-going education to support their patients/ clients and nurses working with this technology.

### Electronic Documentation

A client’s/patient’s electronic health record is a collection of the individual’s personal health information, entered or accepted by health care providers, and stored electronically, under strict security. As with traditional or paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care (College of Registered Nurses of British Columbia, 2025).

Entries made and stored in an electronic health record are considered a permanent part of the record and may not be deleted. If corrections are required to the entry after the entry has been stored, agency policies will provide direction as to how this should occur. Most agencies using electronic documentation have policies and guidelines to support this including:

- Correcting documentation errors or making “late entries”.
- Preventing the deletion of information.
- Identifying changes and updates to the record.
- Protecting the confidentiality of client/ patient information.
- Maintaining the security of the system (passwords, virus protection, encryption, firewalls).
- Tracking unauthorised access to client/ patient information.
- Processes for documenting in agencies using a mix of electronic and paper methods.
- Backing-up client/ patient information.
- Alternate means of documentation in the event of a system failure.

NZNO recommends the following guidelines for nurses using electronic health records:

- Never reveal or allow anyone else access to your personal identification number, login or password. These are your electronic signature.
- Inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else.
- Change passwords at frequent and irregular intervals (as per your agencies policy) and choose passwords that are not easily deciphered.
- Log off when you are not using the system or when leaving the terminal.
- Maintain confidentiality of all information, including all print copies of information and retrieve printed information immediately.
- Shred any discarded print information containing client/ patient identification.
- Locate printers in secured areas away from public access. Use secure printing systems (that only issue the document when the person printing it is in attendance).
- Protect client/ patient information displayed on monitors (e.g. use of screen saver, location of monitor, use of privacy screens). Angle monitors away from public view.
- Only access client/ patient information which is required to provide nursing care for that client. You may not access information from any patient/ client for the purpose of your ongoing education (e.g. case review or exemplar) unless you have gained prior consent from the individual before doing so (NZNO, 2025).
- Ensure you have closed episodes of care on e-records, especially in circumstances where the client/ patient is not discharged. This ensures notes are not left open without a plan of care.
- Be very careful of pre-populated text especially when you are documenting something out of the norm. This text may not accurately reflect the care you provided or nursing assessment you undertook.

(New South Wales, 2025)

### Fax Transmission

Although electronic communication is becoming increasingly more common facsimile (fax) transmission remain a convenient and efficient method for communicating information between health care providers. Protection of client/ patient confidentiality is the most significant risk in fax transmission and special precautions are required when using this form of technology.



The following guidelines were developed by the College of Registered Nurses of British Columbia (2025) and NZNO supports these for protecting patient/ client confidentiality when using fax technology:

- Locate the fax machine in a secure area away from the public.
- Check the fax numbers and/or fax “distribution lists” stored in the machine of the sender are up to date and correct prior to dialling.
- Carefully check activity reports to confirm successful transmission.
- Include cover sheet notifications indicating the information being transmitted is confidential.
- Request verification that, in the event of a misdirected fax, it will be confidentially and immediately destroyed without being read.
- Make a reasonable effort to ensure the fax will be retrieved immediately by the intended recipient or will be stored in a secure area until collected.
- Shred any discarded faxed information containing client/ patient identification.
- Client/ Patient information received or sent by fax is a form of documentation and is stored electronically or printed in hard copy and placed in the client’s/ patient’s health record. The fax is an exact copy of original documentation.
- Additional notations may be made on the faxed copy as long as these meet the agency standards for documentation and are appropriately dated and signed. Faxes are part of the client’s/ patients’ permanent record and, if relevant, can be subject to disclosure in legal proceedings. Faxed information should be written with this in mind.
- If a physician’s order is received by fax, nurses must use whatever means necessary to confirm the authenticity of the order.
- If your fax machine still uses thermal paper, thermal paper fades over time so a copy will need to be taken of the faxed message to preserve it.

### Electronic Mail and Text Messages

The use of e-mail and text messaging is becoming more widespread as a result of its speed, reliability, and convenience. These advantages also pose significant confidentiality, security and legal risks.

E-mail and/ or text messages should be viewed as like sending a postcard. It is not sealed and may be read by anyone. Although email messages on a local computer can be deleted, they are never deleted from the central server and can be retrieved.

When using text messages, a system needs to be set up so those messages can be captured and recorded in the patient’s electronic records.

NZNO recommends the following for protecting client/ patient confidentiality when using e-mail to transmit information:

- Obtain written consent from the client/ patient when transferring health information by e-mail.
- Check the e-mail address of the intended recipient(s) is correct prior to sending.
- Transmit e-mail using special security software (e.g. encryption, user verification or secure point-to-point connections).
- Ensure transmission and receipt of e-mail is to a unique e-mail address not a generic one e.g. info@....
- Never reveal or allow anyone else access to your password for e-mail.
- Include a confidentiality notification indicating the information being sent is confidential, the message is only to be read by the intended recipient and must not be copied or forwarded to anyone else.

- Never forward an e-mail received about a client/ patient without their written consent.
- Maintain confidentiality of all information, including that reproduced in hard copy.
- Similar to physicians' orders received by fax, if physicians' orders are received by e-mail, nurses must use whatever means necessary to confirm the authenticity of those orders.

It is important to note, e-mail messages are a form of client/ patient documentation and should be stored electronically or printed in hard copy and placed in the client's/ patient's health record. They are part of the client's permanent record and, if relevant, can be subject to disclosure in legal proceedings. E-mail messages should be written with this in mind.

If you are using a cell phone to communicate with patients/clients via text messaging, then this information must be captured in the clinical record. If you are needing to use a phone for patient contact, a work device should be provided so that you are not giving your personal cell phone number to clients/ patients. Photographs taken on a mobile device e.g. to document wound healing or to get a second opinion, also form part of the patient's/ client's record and should be transferred to that document. These photographs should not be on personal devices.

## Documentation and Investigations

Clinical notes (including care plans) are the "evidence" if there is an investigation into your practice. An investigation may be internal (Employer) or may be from the NCNZ or MCNZ, the office of the HDC, HPDT, ACC or the Coroner. For examples of the types of complaints that have been received about health professionals in the past two years visit [Health and Disability Commissioner — Te Toihau Hauora, Hauātanga — Health & Disability Commissioner](#).

Often investigations occur months or even several years after the event. Therefore, it is vitally important documentation is clear and detailed enough that you can recall, as clearly as possible, the event(s) months or possibly even years later. Documentation is the only way you can prove the care you gave met the clinical requirements of the patient/client.

If you are involved in an investigation, as a NZNO member you are entitled to our support – contact us as early as possible for information and advice. Seek advice from NZNO before you prepare a statement. If you are no longer an NZNO member but were at the time of the incident with which you now need help, please contact us.

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#### **Mission Statement**

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa New Zealand through participation in health and social policy development.

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