



COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Policy

Documentation

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This document is linked to legislation:

[Health Professions Act](#)
[Licensed Practical Nurses Profession Regulation](#)

This document is linked to other documents that direct expectations of professional behaviour or requirements for practice:

[Standards of Practice](#)
[Code of Ethics](#)
[Competency Profile](#)
[Entry-Level Competencies](#)
[Professional Responsibility and Accountability](#)

This document is linked to related supportive documents:

[Confidentiality](#)

REVISIONS and UPDATES

Editorial Update December 2019

The legislative mandate of the College of Licensed Practical Nurses of Alberta (CLPNA) is to serve and protect the public by ensuring its members deliver safe, competent and ethical nursing care. A CLPNA Policy outlines requirements and expected behaviours that will be monitored and enforced.

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Approver	Council



INTRODUCTION Documentation creates a record of the care that has been planned and provided to clients by the health care team. This record of care can be electronic or paper-based and is most often a combination of both. Documentation is a critical component of nursing practice and is one of the primary communication tools used by health care providers to share information. Documentation is used as evidence in legal proceedings to show what care was provided.

High quality nursing documentation promotes effective communication between care providers, which facilitates continuity of care and contributes to the quality of care.¹ When the care provided is accurately documented in a timely manner, members of the care team are able to review the necessary information to plan and evaluate client care appropriately.

PURPOSE The purpose of this practice policy is to outline the CLPNA's expectations of LPNs around documentation. Additionally, this policy highlights some of the legal implications and risks associated with poor documentation practices.

POLICY In accordance with the *Standards of Practice for Licensed Practical Nurses in Canada*, LPNs must:²

Standard 1.10: Maintain documentation and reporting according to established legislation, regulations, laws and employer policies.

Standard 2.8: Collaborate in the development, review and revision of care plans to address client needs and preferences and to establish clear goals that are mutually agreed upon by the client and the health care team.

Standard 2.13: Modify and communicate to appropriate person changes to specific interventions based on the client's responses.

Standard 3.5: Provide relevant and timely information to clients and co-workers.

CLPNA Expectations

LPNs are required to have the knowledge and ability to document client care appropriately upon their entry to practice.³ LPNs are responsible and accountable for documenting the nursing services they provide to their clients in accordance with legislation, CLPNA expectations and employer policy.

The essential elements of effective and appropriate documentation include the time, date, and intervention, as well as the signature and designation of the health care provider.

Quality nursing documentation reflects the application of the nursing process including nursing assessment, nursing diagnosis, planning, implementation and evaluation.

Different facilities or employers may use a variety of methods or procedures to document care, but regardless of the method used, the fundamental expectation of documentation is that anyone reviewing a client's record (electronic or paper chart) must be able to determine the following information:

- 1. What care was provided,***
- 2. To whom it was provided,***
- 3. Who provided the care and when,***
- 4. Why this care was provided, and***
- 5. The evaluation of the care provided.***

This means that documentation must be accurate and complete, including all nursing assessments, interventions and evaluations. All documentation must be in the correct client's record and must include the care provider's name, designation and time the intervention was performed. Electronic documentation systems may often automatically provide some of this information.

Documentation by an LPN must be a complete record of the nursing care provided by that LPN.

If documentation is not done in a timely manner, it may be considered a 'late entry.' Employer policy around what constitutes a late entry and the



appropriate procedures to be followed when making a late entry can vary. However, the LPN must always note that it is a 'late entry' and include the date and time the care was provided as well as the date and time it was actually documented. The purpose of this expectation is to clarify the chronology of care.

Legal Risks of Poor Documentation Practices

Clear, concise and accurate documentation supports continuity of care and it is also the best defence in a legal proceeding. If something was not documented, it will be assumed that the care in question was not provided.

It can take years for a lawsuit to get to court; by the time it does, the people involved may not recall the facts with clarity or even recall the specific client. In these situations, the client's health record is extremely important in establishing what happened.

In the event of a court proceeding, the client's health record, including nursing documentation, is used as evidence of what health care services were or were not provided.

Delayed documentation entries can create negative inferences and questions about credibility in a legal proceeding. This is especially true if the time of the documentation is after the event or incident that led to the legal proceeding occurred.

Best Practices to Ensure Quality Documentation

Be objective: Stick to the facts and avoid assumptions, unfounded conclusions or accusations.

Be complete: Although it is important to be concise, you need to include enough detail so another care provider looking at the client record will have a clear understanding of the care that has been provided.

Be accurate: Record only what you saw, heard or did. In some situations (e.g., an emergency resuscitation or during surgery) one person may be designated to document (the recorder), while the other care provider performs the task. It is important to be clear in the documentation that you are recording other people's actions.

Avoid using abbreviations: According to the Health Quality Council of Alberta, the use of abbreviations is one of the most common causes of medication errors.⁴ If abbreviations must be used, take care to follow employer policy and only use employer-approved abbreviations.

Document all steps taken: Documentation must reflect the care provided, including any follow-up steps taken. For example, if attempts to contact the primary care physician were unsuccessful, documentation should include what you did about it or who you notified – such as whether you were able to contact the on-call resident.

Document chronologically: Documenting events in the order they occurred simplifies communication between providers and creates clarity in the timeline of care.

Never leave blank lines: Empty spaces leave room for information to be added after the fact.

Document contemporaneously: Since it is not always possible to document at the same time as the care is provided, this means that documentation must be completed as soon as possible after the care was provided. Delays between entries can result in another member of the care team being unaware of important information. Long delays can also call the credibility of the documented information into question.

Document more often as risk increases: The frequency of documentation should increase as the complexity of the care increases or if the client is at an increased risk of harm.

Never document in advance: The chart must be an accurate reflection of the care provided to the client. For example, if you document something that you intended to do but were interrupted or called away before you could do it, then that client's chart no longer accurately reflects the care provided.

Write Legibly: If no one can read what you write, your documentation may inaccurately reflect the care provided. Illegible writing can lead to



misinterpretation or negation of important and essential information, resulting in errors or patient harm.

Don't delete or white-out errors: Incorrect information must be corrected in a way that allows it to still be legible. Ensure you are familiar with any employer policy specific to correcting documentation errors.

Maintain Client Confidentiality: LPNs are legally and ethically obligated to maintain the confidentiality of a client's personal health information. LPNs must ensure proper care is taken to safeguard any personal assessment notes, cheat sheets or client assignment sheets. Notes with client information that are not part of the health record should be shredded at the end of your shift.

Avoid making personal notes: Anything you write (on the client chart or elsewhere) can be evidence. You could be required to produce your personal notes if they are deemed relevant to the legal proceeding. Additionally, to maintain confidentiality, always ensure that any personal notes or self-reflections do not include identifying information about a client.

CONCLUSION The client's health record is the evidence of the care provided by the care team and is the primary communication tool between team members. LPNs are accountable to ensure their documentation accurately reflects the care they provided.

Your documentation serves as your evidence of the nursing care that you provided to a client.

Accurate, complete and timely documentation promotes communication within a team. Effective communication between members of the care team can improve the quality of the care provided and minimize the potential for confusion or misinterpretation.

It is important to understand that the accurate, complete and timely documentation of your nursing care is equally as important as the care you provide to clients.

Providing quality documentation is an essential aspect of the care nurses provide to clients and is required in order to meet the LPN professional Standards of Practice and regulatory expectations.

REFERENCES

¹ Ning Wang, David Hailey and Ping Yu, "Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review," *Journal of Advanced Nursing* 67(9), (2011) 1858.

² Canadian Council for Practical Nurse Regulators, *Standards of Practice for Licensed Practical Nurses in Canada* (2013), https://www.clpna.com/wp-content/uploads/2013/02/doc_CCPNR_CLPNA_Standards_of_Practice.pdf.

³ College of Licensed Practical Nurses of Alberta, *Competency Profile for Licensed Practical Nurses* (2015), 36 https://www.clpna.com/wp-content/uploads/2013/02/doc_Competency_Profile_for_LPNS_3rd_Ed_2015_COMPLETE.pdf; Canadian Council for Practical Nurse Regulators, *Entry to Practice Competencies for Licensed Practical Nurses* (2013) 8, https://www.clpna.com/wp-content/uploads/2013/02/doc_CCPNR_CLPNA_Entry_to_Practice.pdf.

⁴ Health Quality Council of Alberta, *No Shortcuts to Patient Safety*, https://d10k7k7mywg42z.cloudfront.net/assets/53164c114f720a7954000017/No_Shortcuts_.pdf