



COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Policy

Documentation

Effective May 15, 2023



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:

[Code of Ethics for Licensed Practical Nurses in Canada](#)
[Competency Profile for Licensed Practical Nurses](#)
[Entry-Level Competencies for Licensed Practical Nurses](#)
[Medication Management](#)
[Professional Responsibility and Accountability](#)
[Standards of Practice for Licensed Practical Nurses in Canada](#)

This document is linked to related supportive documents:

[Confidentiality](#)
[Privacy Legislation in Alberta](#)

The legislative mandate of the College of Licensed Practical Nurses of Alberta (CLPNA) is to serve and protect the public by ensuring its registrants deliver safe, competent, and ethical nursing care. A Registrant Policy is a clear and concise statement outlining requirements and expected behaviours of regulated registrants.

Approval Date May 3, 2023
Approver Executive Officer,
 Professional Practice



INTRODUCTION The College of Licensed Practical Nurses of Alberta (CLPNA) has the authority under the *Health Professions Act* (HPA) to carry out its activities and govern registrants* in a manner that protects and serves the public interest.

Documentation is a critical component of nursing practice as it is one of the primary communication tools used by healthcare providers to share information, support continuity of care, promote a culture of safety, and serves as an indicator of clinical competence.

Documentation creates a record that includes but is not limited to the plan of care, the nursing process, interventions, health services provided, and client outcomes. This record of care can be electronic, paper based, or a combination of both, but will always be required regardless of the practice setting.

Accurate documentation in a timely manner provides necessary information to the healthcare team for planning and evaluating client care as well as for client research and quality improvement purposes. Documentation can be used as evidence in legal proceedings to show the timeline of events and what care was provided.

PURPOSE The purpose of this policy is to outline the professional regulatory expectations of Licensed Practical Nurses (LPNs) in producing clear, accurate, and detailed documentation. An employer may have additional requirements and expectations that LPNs must follow. This policy offers guidance on how to uphold best practices for documentation and highlights some of the legal implications and risks associated with poor documentation practices.

For information about medication specific documentation, please refer to the *Medication Management Policy*.

POLICY In accordance with the *Standards of Practice for Licensed Practical Nurses in Canada*, LPNs must:¹

Standard 1.9: Document and report according to established legislation, regulations, laws, and employer policies.

Standard 2.5: Collaborate in the development, review, and revision of the plan of care to address client needs and preferences, and to establish client centered goals.

Standard 2.10: Assess client and collaborate with the appropriate person(s) when client status is changed, new, or not as anticipated.

Standard 3.4: Provide relevant, timely, and accurate information to clients and healthcare team.

Professional Expectations

LPNs are required to have the knowledge and ability to document client care.² LPNs are responsible and accountable for documenting the nursing services they provide to their clients in accordance with legislation, regulatory expectations, and employer requirements. LPNs are legally and ethically obligated to maintain privacy and confidentiality of a client's personal health information when documenting. For more information about this topic please see CLPNA's documents on *Privacy Legislation in Alberta* and *Confidentiality*.

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

Different facilities or employers may use a variety of methods or procedures to document care. 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 all the following information:

* In this document, "registrant(s)" has the same meaning as "regulated member(s)" in the *Health Professions Act*.



- observations and assessments of the client
- what care was provided
- to whom care was provided
- health care provider who provided the care (name and designation), and when (date and time)
- why this care was provided
- relevant communication or attempts at communication (e.g., between LPN, client, client's family or substitute decision maker, and other healthcare providers including name and designation)
- the outcome or follow up of the care provided.

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

Ways 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.

Maintain documentation security: 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 client's health record should be disposed of promptly and appropriately. Do not leave any blank lines in your paper documentation as empty spaces leave room for information to be added after the fact.
- Take reasonable steps to maintain the security of any electronic documentation systems. For

example, use password protection and log off when you are not using your electronic documentation system etc.

- Employers may have specific requirements around documentation security that you must follow.

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.

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

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

Note late entries: If documentation is not done in a timely manner, it may be considered a 'late entry'. When a late entry is necessary, it must be labeled as late entry and entered as soon as reasonably possible. Late entries must accurately reflect the event or care provided. Follow any further employer requirements regarding late entries.

Document frequently: Documentation should occur throughout the delivery of care. 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 that has been provided to the client.

Avoid using abbreviations: The use of abbreviations is one of the most common causes of medication errors and creates confusion in documentation.³ If



abbreviations must be used, follow employer requirements and only use employer-approved abbreviations.

Document legibly: If no one can read what you write, your documentation may inaccurately reflect the care provided. Illegible handwriting or spelling mistakes can lead to misinterpretation or missing information, resulting in errors or client harm.

Don't delete or hide documentation errors: Incorrect information must always be corrected by the person who created the documentation entry and in a way that shows that the documentation was altered. All LPNs are accountable for their documentation including any changes they make. The LPN must follow employer requirements around correcting errors to ensure consistency in their documentation.

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

Legal Risks of Poor Documentation Practices

Clear, concise, and accurate documentation supports continuity of care. It is also the best defense in a legal proceeding as it is a record of the care provided. If something was not documented, it will be presumed 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 healthcare services were or were not provided. Your documentation serves as your evidence of the nursing care that you provided to a client.

Delayed documentation entries can lead to questions about credibility in a legal proceeding.

CONCLUSION The client's health record is the evidence of the care provided by the healthcare team and is the primary communication tool between team members. Documentation contributes to safe client care, quality practice environments, and supports a culture of safety within the healthcare system. LPNs are accountable to ensure their documentation accurately reflects the care they provided. 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.

The accurate, complete, and timely documentation of your nursing care is a critical part of client care.

If you have any questions, please contact the Professional Practice Team at [Ask CLPNA](#), or by phone at 780-484-8886 or 1-800-661-5877 (toll free in Alberta).



REFERENCES

¹ Canadian Council for Practical Nurse Regulators, *Standards of Practice for Licensed Practical Nurses in Canada* (2020), <https://www.clpna.com/governance/standards-code/>.

² College of Licensed Practical Nurses of Alberta, *Competency Profile for Licensed Practical Nurses* (2020), 40 <https://www.clpna.com/members/continuing-competency-program/competency-profile-for-lpns/>; Canadian Council for Practical Nurse Regulators, *Entry-Level Competencies for Licensed Practical Nurses* (2019) 6, <https://www.clpna.com/governance/practice-policy/>.

³ Institute for Safe Medication Practices (ISMP), *Reaffirming the “Do Not Use: Dangerous Abbreviations, Symbols, and Dose Designations” List*, 18, no.4, (2018), <https://ismpcanada.ca/bulletin/reaffirming-the-do-not-use-dangerous-abbreviations-symbols-and-dose-designations-list/>.