

# Documentation Practice Guideline

2017



COLLEGE OF  
LICENSED PRACTICAL NURSES  
OF NEWFOUNDLAND AND LABRADOR  
LPNS - A PRACTICAL APPROACH TO QUALITY CARE



The College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL), in accordance with the *Licensed Practical Nurses Act (2005)*, has the legislated responsibility for regulating the practice of Licensed Practical Nurses (LPNs) in Newfoundland and Labrador.

The mandate of the CLPNNL is to protect the public by ensuring the provision of safe, competent, ethical, and compassionate nursing care.

## USING THIS DOCUMENT

Practice guidelines outline the LPN's accountability in specific practice contexts. These guidelines reflect relevant legislation and are designed to assist LPNs to understand their responsibilities and legal obligations. This practice guideline will describe the CLPNNL's expectations for LPNs throughout the documentation process in all practice settings, regardless of the method of documentation. LPNs must also be familiar with, and follow their employer's documentation policies, standards and protocols.

Documentation is evidence of care provided. It is a vital component of safe, ethical and effective nursing practice, in any practice context or setting. LPNs are accountable to document and responsible to know what to include in their documentation. Through documentation, LPNs communicate observations, decisions, actions, and outcomes.

## GUIDING PRINCIPLES

LPNs are accountable and responsible to adhere to the following statements and principles as outlined in the CLPNNL's Standards of Practice and Code of Ethics.

**Standard 1:10** – LPNs have a responsibility to maintain documentation and reporting according to established legislation, regulations, laws and employer policies.

**Standard 3:5** and **Standard 4:7** – LPNs must document and or communicate care and information in a respectful, timely, open and honest manner to clients, caregivers, and co-workers.

**Principle 5.1** – LPNs demonstrate honesty, integrity and trustworthiness in all interactions when documenting.

**Principle 5.3** – LPNs accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which LPNs are accountable.

**The same guideline principles and documentation standards apply whether the documentation is in written or electronic format.**



## WHY DOCUMENT?

Regardless of the method (paper, electronic, audio or visual) documentation is completed for the following reasons:

1. *To facilitate communication between care providers*

Documentation contributes to the seamless continuity of care between health care providers. It provides current, accurate, and comprehensive information of a client's condition, as well as the care and services provided to the client. LPNs communicate to other health professionals their assessments, interventions, and outcomes of client care. Health care providers within the client's circle of care are able to assess the client's needs with the help of this documentation.

2. *To communicate the plan of care*

Where there is precise documentation, health care professionals are able to identify interventions that have been successful and unsuccessful with client care.

3. *To demonstrate accountability*

LPNs are accountable and responsible for documenting the care they provide. Documentation demonstrates that the LPN has applied nursing knowledge, skill, and judgment according to the CLPNNL's Standards of Practice, as well as provided safe, competent and ethical nursing care that is consistent with the Code of Ethics. As the client's complexity and care needs increase, the amount and frequency of documentation will also increase.

4. *To meet legal requirements*

Documentation should provide a chronological record of events which demonstrates evidence of safe, competent and ethical nursing care. It shows that the LPN met the standards of care and that nursing actions were reasonable, prudent and completed in a timely manner. A client's healthcare record may be used as evidence in legal proceedings such as lawsuits, coroner's inquests, and disciplinary hearings; therefore, it is vital that an accurate record of client care be maintained (CLPNA 2011). In a court of law, the client's health record serves as a legal record of the care or service provided (CLPNM, 2011). The courts may use this information to reconstruct events, establish timelines and to resolve conflicts in testimony.

5. *To promote quality assurance*

Documentation promotes quality improvement and helps manage risks. As both a quality improvement and risk management mechanism, agencies may examine healthcare records to evaluate the care and services provided, and plan improvements. Agencies utilize the information contained in the healthcare record to evaluate outcomes, identify and manage risks, and promote client safety (ARNNL, 2010).



## WHO SHOULD DOCUMENT

### Persons with Firsthand Knowledge

LPNs must only document what they have firsthand knowledge of (for example, a LPN documents a dressing change they provided to a client). A LPN should never document the work of others. There may be situations when two LPNs are actively providing care to a client (for example, a complex dressing that requires two nursing staff). In this particular setting, the LPN assigned to the client would be the LPN who provides the documentation as the second LPN would be assisting.

### Third Party Documentation

Third Party documentation is when the LPN documents in the client's record care that they did not provide themselves. Generally, this is not acceptable practice. However in certain situations, third party documentation is appropriate; for example: (1) The LPN receives information from a family member or other health care provider who is not authorized to document in the client's record; or, (2) The LPN is assigned to be the designated recorder during an emergency situation.

- *Designated Recorder* - During a code, while other health care providers are administering medications, providing CPR, inserting IV's, etc., the LPN may be assigned as the designated recorder to document a record of events in sequence with staff names and designations. The LPN must refer to agency specific policies regarding the role of designated recorder.
- It may be necessary for the LPN to document care that was provided by others or events that were witnessed by others; for example: (1) A housekeeper may have witnessed a client put candy in their mouth which led to the client choking; or, (2) A family member may be actively involved in caring for their loved one by providing direct care. In these situations, it would be acceptable practice for the LPN to document in the client's record the care provided by the family, or the events witnessed by another individual. The LPN should ensure that the documentation clearly indicates that the information is from another source. The LPN must document the source of the information, including who witnessed the event and/or the names of family members who provided the care.

### Co-Signing

Co-signing is a second or confirming signature of a witnessed event or activity; for example, the LPN may be required to co-sign in a variety of situations such as telephone orders, telephone consents, discarding of a narcotic, counting of narcotics, and client identification for a blood transfusion. Co-signing implies shared accountability. It is imperative that the person co-signing actually witnessed or participated in the event. LPNs must never co-sign for something they were not part of (ARNNL, 2010).

### Countersigning

Countersigning is a confirming signature on a previously signed document, a blind signature which is not witnessed; for example, signing your name and designation after reviewing the chart to determine that the physicians' medical orders were accurately transcribed (CLPNA, 2014). Countersigning does not imply that the second person provided the service; it does imply that the person approved or verified that the service or record was completed (ARNNL, 2010).



## WHAT TO DOCUMENT

A Licensed Practical Nurse must maintain documentation that is:

- ***clear, concise, factual, objective, accurate, truthful, confidential and client-centered***
  - Documentation is always about the client and never the staff member writing the note;
  - Use appropriate language when documenting on a client's health care record;
  - Document factual information. Do not document judgmental conclusions regarding a client; rather, information documented should be supported with evidence and supportive data. For example: (1) If a client had a fall the LPN would chart that the client was found on the floor; (2) If a client came into the emergency department smelling of alcohol, the LPN would not make the assumption that the client was intoxicated. The LPN's appropriate charting would be that the client presented to the emergency department smelling of alcohol, with slurred speech and staggered ambulation;
  - Chart subjective data in the client's chart using the client's exact words in quotation. When a LPN asks a client how they are feeling today, the client may respond by saying, "I feel great today."
- ***reflective of the care provided, and the client's response to that care***
  - Documentation reflects the nursing process and demonstrates that the LPN has fulfilled their duty of care. It supports accountability by including the assessment data, interventions and the nursing evaluation of care (ARNNL 2010). The LPN evaluates the care they have provided, whether the effects of a medication or positioning of a client. This information assists the client's healthcare team to identify the needs of the client, the planning of care for the client, and what best practice will be for the client.
    - **Consultation**

If the LPN contacts another healthcare professional regarding client care, it is important that the LPN document this consultation in the client's health care record. This documentation should include the date, time, name of person contacted, the conversation details, as well as the LPN's signature. It is important that the LPN understand their expectations within employer policies regarding this type of documentation.
    - **Education**

When a LPN provides education or information to a client and/or client's family, the LPN is responsible to ensure that the information is understood. The LPN must document the method of education used – verbal, electronic, literature, etc., the education provided, as well as the client's response to this education.



## HOW TO DOCUMENT

LPNs are accountable and responsible to follow both documentation best practices as well as employer/agency policies. The following are important points to remember when documenting:

➤ **Legibility**

- If paper charting, writing should be neat and in black or blue ink.

➤ **Use correct spelling**

- Spelling errors should be avoided as they may lead to misinterpretation of information.

➤ **Avoid blank spaces**

- Do not leave blank lines/spaces between entries (information can be added to the documentation by others).

➤ **Use accurate and accepted abbreviations and symbols**

- Use only agency approved abbreviations and symbols or avoid them all together.

➤ **Do not modify or delete information that is recorded on the health record**

➤ **Correct documentation errors according to best practices and following agency policy**

- The original documentation must remain clearly visible.
- Do not use white-out or other correction tools.
- To correct an error in a paper-based system, cross through the word(s) with a single line, and insert your initials, along with the date and time the correction was made. Then enter the correct information.



## WHEN TO DOCUMENT

A Licensed Practical Nurse must maintain documentation that is:

- **entered in a chronological order of time and date** – All charting should be done in sequence of events. Charting begins with a date and time, body, and ends with the LPN's signature. The LPN should ask themselves, "When the client's chart is reviewed by the oncoming staff, will they understand the needs of this client?" The client's chart should clearly represent the sequence of events that occurred, including the assessments, interventions, and evaluations of the client.
- **entered as soon as possible into the clients record following care** – Documentation is never completed before care is provided. It is completed as soon as possible after care is provided. This enhances the accuracy of each entry and the overall credibility of the health record. LPNs must understand that the frequency of documentation increases as the client's complexity increases; for example, if the LPN is caring for a client whose condition deteriorates or status changes and requires increased nursing assessments or interventions, the frequency of documentation will also increase.
  - **late entry** - If a period of time has elapsed and charting was not completed due to unforeseen circumstances, (a client had a fall, or needed transportation to hospital, for instance) the LPN writes a late entry. The LPN is responsible to familiarize themselves with employer policies regarding late entry notes.



## ELECTRONIC DOCUMENTATION

The security and confidentiality of all electronically documented client information must be ensured. The following guidelines will contribute to safe guarding electronic client information:

- a) Never share your personal passcode or identifying information with anyone.
- b) Always log off when you step away from the terminal.
- c) Ensure monitors are situated so that client information cannot be viewed by others.
- d) Only access client information that you require in order to provide safe, effective care.
- e) To decrease the likelihood of inadvertently pasting incorrect information, avoid using the "copy and paste" feature.
- f) Ensure privacy when using a voice-activated feature.

## TYPES OF FORMATTING FOR DOCUMENTATION

The LPN must be aware of the accepted format of documentation at their place of employment. Employers should have policies to determine the appropriate format to use. Some examples of documentation formats include:

1. **Focus charting** – Focus charting requires the LPN to document in relation to a specific client concern or health need (e.g.: a symptom, event, activity). The statement is recorded using the following headings:
  - D)** Data (subjective or objective)
  - A)** Action (what it is the LPN did)
  - R)** Response (the client’s response to the care the LPN provided)
2. **Soap charting** – SOAP charting requires the LPN to document based on specific client problems as identified in the nursing care plan. This note is recorded using the following headings:
  - S)** Subjective data (what the client verbalizes s/he is feeling)
  - O)** Objective data (data that is observed or measured, e.g.: vital signs)
  - A)** Assessment (nursing diagnosis based on the data)
  - P)** Plan (what actions will be taken)
3. **Narrative charting** – The LPN writes a narrative note in the client’s chart. It includes information on interventions provided as well as the client’s response. Narrative charting follows a chronological order of events.
4. **PIE charting** – Pie charting focuses on client problems, interventions and evaluation. Problems are recorded using the following headings:
  - P)** Problem
  - I)** Intervention
  - E)** Evaluation
5. **Charting by exception** – Charting by exception requires that LPNs chart only abnormal findings or findings that fall outside the expected limits for a client. This means the LPN documents when there is a deviation from the client’s baseline and/or expected outcome. Charting by exception assumes that uncharted observations fall within the normal or expected pre-established baseline. This type of charting must be supported by employer policies, and include care plans and clinical protocols.

Documentation is not separate from care and it is not optional. It is an integral part of nursing practice (ARNNL, 2010). Documentation should be as important as the direct care that LPNs provide to clients. Skillful and mindful documentation will benefit the client for the best possible outcome.



## RESOURCES

Child, Youth, and Family Services Act (2004) - <http://www.cssd.gov.nl.ca/>

ISMP Canada - The Institute for Safe Medication Practices Canada - <https://www.ismp-canada.org/index.htm>

Personal Health Information Act (2008) - <http://www.health.gov.nl.ca/health/phia/>

The CLPNNL's Standards of Practice and Code of Ethics (2013) - <http://www.clpnnl.ca/images/standards.pdf>

The Licensed Practical Nurses Act of NL (2005) - <http://www.assembly.nl.ca/legislation/sr/statutes/l12-1.htm>

The Licensed Practical Nurses Regulations of NL (2011) - <http://www.assembly.nl.ca/legislation/sr/annualregs/2011/nr110002.htm>

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