Documentation

Practice Guideline

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ANBLPN | AIAANB

Association of New Brunswick Licensed Practical Nurses

L'Association des Infirmier(ère)s Auxiliaires Autorisé(e)s du Nouveau-Brunswick

Mission

The Association of New Brunswick Licensed Practical Nurses (ANBLPN) is the regulatory authority for Licensed Practical Nurses (LPN) in New Brunswick. ANBLPNs mandate is protection of the public by promoting the provision of safe, competent, ethical, and compassionate care. ANBLPN sets, monitors, and enforces practical nurse education, registration, and professional conduct. ANBLPN creates Standards of Practice, establishes a Code of Ethics, and develops and implements a Continuing Competence Program. Additionally, ANBLPN publishes documents to support the practice of LPNs in New Brunswick.

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DOCUMENT PURPOSE:

This document was developed to help Licensed Practical Nurses (LPN) understand their responsibilities, legal obligations, and expected standards of practices to make safe and ethical nursing decisions across all practice environments.

WHAT IS DOCUMENTATION?

Documentation is a required nursing action that produces a written and/or electronic account of pertinent client data, nursing decisions and interventions, and client responses in a client's health record (Perry, Potter, Stockert & Hall 2017). It is an integral part of safe, competent, compassionate, and ethical nursing practice and is not optional. Documentation is equally as valuable as direct client care and is an essential component of nursing practice.

All LPNs are expected to meet their Standards of Practice in relation to documentation to ensure their actions meet those of a prudent and reasonable health care professional. According to the Canadian Nurses Protective Society (CNPS, 2020) documenting in the client's chart assures that health care professionals:

Documentation is not just 'paperwork'; documentation IS client care.

- Record relevant client information to ensure the client receives the best and most personalized care;
- Communicate in writing to other healthcare providers, to promote the continuity of care; and
- Show accountability for providing safe, competent, compassionate, and ethical care.

All LPNs have a legal obligation to meet their documentation standards. It is important to understand that your documentation in client health records can be used during legal proceedings and LPNs must document with this knowledge in mind.

Standard 1, Indicator 1.9:
LPNs document and report according to established legislation, regulations, laws, and employer policies.

THE ESSENTIALS OF QUALITY NURSING DOCUMENTATION

According to Potter and Perry (2019), high-quality documentation contains several essential characteristics such as:

- Following facility policies and legal requirements for documentation and correction of errors;
- Documenting as promptly and prudently as possible at the time of the event (never before);
- Correcting all errors promptly and never leaving blank spaces;
- Documenting only your actions unless in rare urgent situations (i.e., Code Blue);
- Avoiding critical comments or generalized phrases (such as "had a good day" or "status unchanged"); and
- Documenting the date and time for all entries, avoiding any pre-charting, and signing each separate entry with your full name and designation.

The following table outlines some essentials of quality nursing documentation and applies to all types of documentation across all practice settings (NSCN, 2022).

	Example
Nursing documentation should be:	**Nursing documentation should contain:**
1. Factual, objective and client centered.	Descriptive, objective information based on first-hand knowledge and the practical nurse's assessment (objective and subjective information collected as well as any collaboration/consultation that has occurred).
2. Accurate, timely and relevant.	Clear and easy to understand information that contains important details about the client's ongoing condition and care given. Documentation is completed during or as soon after the intervention or interaction occurred.
3. Complete (including consultations, nursing actions, client responses and reassessment).	Information that best describes the client's care needs, nursing interventions (including teaching and support), expected outcomes, and ongoing assessment. *<u>According to SARNA 2021, this should contain the five following elements:</u>* *• A clear and concise statement of the client's status (physical, psychological, and spiritual),* *• All relevant assessment data (including client and family comments as appropriate),* *• All ongoing monitoring and communications,* *• The care provided to the client including interventions (treatments, advocacy, counseling, consultation, client, and family teaching) and,* *• Evaluation of the care provided, including the client's response and any impact for discharge planning.*
4. Organized, logical and sequential.	Information recorded in a chronological manner to show nursing decisions, actions/interventions, and client responses/ongoing assessments and care provided are evident. Documenting events in chronological order is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications regarding the care provided, the assessment data, and outcomes or evaluations of that care (including client responses).
5. Compliant with standards and other legal requirements.	Information is reflective of the delivery of nursing care that is consistent with the LPN standards of practice, employer policies, and provincial or federal legislation.

LEGALLY SOUND NURSING DOCUMENTATION

The health record is the legal document for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards.

Documentation is the single most important piece of evidence used to support your practice.

Nursing documentation serves as the necessary legal proof that appropriate health care was provided. As such, nursing professionals must keep in mind that:

- The client record is a legal document that can be used as evidence in a court of law or in a professional conduct proceeding;
- Courts rely on documentation as evidence of what was, or was not, done;
- Courts may use the client record to reconstruct events, establish dates and times, refresh an LPNs memory, and verify/or resolve conflicts in testimony; and
- Inadequate or poor documentation can undermine or destroy your defense in a lawsuit (CNPS, 2020).

The following table outlines basic guidelines to follow to ensure your documentation is legally sound:

Guidelines
1. There must be sufficient client identifiers (e.g., name, record number) on *each* page of nursing documentation.
2. Documentation must be legibly written in non-erasable ink.
3. Entries must be dated, timed, and include the name and designation of the practical nurse.
4. Record all relevant facts. Avoid referring to self as 'writer'.
5. Use only terminology or abbreviations approved by the agency or practice setting and recommended by ISPM (2018).
6. Understand the terminology used in documentation.
7. Avoid using generalized or empty phrases such as 'had a good day' or 'status unchanged'.
8. Document only your own actions.
9. Correct all documentation errors promptly by placing a line across the entry with your initials, date, and time of correction, and indicating it is an error.
10. Avoid critical or personal comments and opinions about clients, care provided by others or about the employer.
11. Document collaboration or consultation with other care providers, **include reason for consultation, the name and designation of whom you consulted with, and outcome of the consultation**. Make sure to ALWAYS avoid the following: "RN Aware" or "Will continue to monitor".
12. Reference late or out of sequence entries with the actual time the entry is recorded and the actual time the event took place.
13. Do not 'pre-chart' (documenting actions before they are taken).
14. Do not leave any white space in the notes. Put a line across the blank space and sign with your designation at the end of the line/note.
15. Protect passwords used to access electronic health records.

Follow this link to CNPS (Canadian Nurses Protective Society) to learn more about your legal obligations in documentation.

COLLABORATION AND CONSULTATION WITH OTHER HEALTH CARE PROFESSIONALS

In New Brunswick, LPNs practice autonomously and in collaboration with other health care professionals (most often the registered nurse). Documentation is reflective of the consultation/collaboration between the LPN and registered nurse (RN) or other health care professionals. LPNs should recognize that there is a need to re-evaluate the care assignment when the frequency of consultation with the RN is increased. When LPNs collaborate with members of the interdisciplinary team in the development and/or modification of the plan of care, the following should be documented:

- date and time the information was shared;
- full name(s) and designation of the person (s) involved in the collaboration;
- information provided, received and/or exchanged;
- responses from healthcare professionals;
- orders/interventions resulting from the collaboration; and
- the agreed upon plan of action, and ongoing evaluations.

CO-SIGNING AND COUNTER SIGNATURES

Legal and professional principles dictate that the LPN who provided client care should be the individual who documents in the client's health record. If the entry requires a co-signature, it should be completed according to agency policy. Agency policy related to the co-signing of entries should indicate the intent of a co-signature and in what circumstances co-signing is required (SRNA, 2021). For example, if two LPNs are required to hang a unit of packed-cells, and both must sign the health record, the intent of a co-signature should be clearly stated in policy. In this case, agency policy would likely indicate that the co-signature is confirmation that the LPN (co-signee) witnessed that the correct unit was given to the correct client. Co-signing implies shared accountability. It is imperative that the person co-signing witnessed or participated in the event (NSCN, 2022).

If an agency wishes LPNs to counter-sign documents for the unregulated care provider (UCP), they are accountable to develop policy that clearly outlines the role of LPNs and the accountability they assume with the counter signature.

ADVERSE EVENTS

At times, a client may experience an adverse event such as a fall, injury, an incorrect dosage of a medication, or a missed dose of a medication. Should an adverse event occur, the LPN shall objectively record the event and care provided following best practice for documentation. In addition, LPNs should avoid the use of the words; 'error', 'incident', or 'accident' when documenting***. Assumptions, conclusions, and judgements about the event should not be included in the documentation***.

Agency policy should be followed when completing incidents reports. Incident reports are generally separate from the client's health record, however the completed incident report following an adverse event should be included in the client's health record. Reporting of adverse events is important from a

quality improvement perspective as they can help identify issues that need to be addressed to support clients and staff (SARNA, 2021).

Adverse events that involve clients are generally recorded in two places:

1- the client's health record; and
2- the incident report itself (incident reports are filed separately from the chart).

The purpose of a health record and incident report differs therefore, the LPN should avoid documenting "refer to incident report" in a client's health record. Agency policy should clearly describe processes necessary to complete an incident report.

USE OF TECHNOLOGY

Technology may be used to support client documentation in several ways. If technology is used, the principles underlying documentation access, storage, retrieval, and transmittal of information *remain the same* as for a traditional, paper-based system. The emerging trend in the use of technology to record client information poses significant challenges for LPNs, particularly with respect to confidentiality and security of client information. It is important that LPNs be supported by agency policies and guidelines.

The use of technology for documentation poses significant challenges with respect to confidentiality. Employer policies should be put in place to support this practice.

Documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care. Entries are made under strict security by the care provider and not by other staff. 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, agency policies provide direction as to how this should occur.

Elements that should be part of these agency policies could include:

- documenting processes (including blending of electronic and paper base processes);
- correcting documentation errors and making "late entries";
- preventing the deletion of information;
- identifying changes and updates to the record;
- protecting the confidentiality of client information;
- maintaining the security of the system (passwords, virus protection, encryption, firewalls);
- tracking unauthorized access to client information;
- backing-up client information; and
- documenting in the event of a system failure.

The following are guidelines for LPNs using electronic documentation systems of health records:

Guidelines
Never reveal or allow anyone else access to your personal identification number or password.
Change passwords at frequent and regular intervals (as per agency policy); choose passwords that are not easily deciphered.
Inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else.
Log off when not using the system or when leaving the terminal.
Maintain confidentiality of all information, including all print copies of information.
Shred any discarded print information containing client identification.
Retrieve printed information immediately.
Protect client information displayed on monitors
Use only systems with secured access to record client information.

It is crucial to recognize that accessing client information for purposes other than providing nursing care is a breach of confidentiality and may be considered professional misconduct.

Facsimile (fax) transmission is a convenient and efficient method for communicating information between health care providers. Protection of client confidentiality is the most significant risk in fax transmission and special precautions are required when using this form of technology. Follow agency policies and procedures with every fax transmission. They are part of the clients' permanent record.

The following are some general guidelines for protecting client confidentiality when using fax technology to transmit client information:

Guidelines
Use fax machines in secured areas away from public access.
Make a reasonable effort to ensure that 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 identification.
Carefully check activity reports to confirm successful transmission.
Include a cover sheet with a Confidentiality Statement that identifies the fax document as confidential and instructs unintended recipients to immediately destroy the document without reading it.
Advocate for secure and confidential fax transmittal systems and policies.

The use of **e-mail or phone texting** by health care organizations and health care professionals is becoming more widespread because of its speed, reliability, convenience, and low cost. Unfortunately, the factors that make their use so advantageous also pose significant confidentiality, security, and legal risks. An e-mail or text is not sealed and may be read by anyone. Because their security and confidentiality cannot be guaranteed, it is not recommended as a method for transmission of health information.

If e-mail or text are the preferred option to meet client needs, the following guidelines can help LPNs protect client confidentiality:

Guidelines
Obtain client consent before transferring health information as dictated by policy.
Transmit information using special security software (e.g., encryption, user verification or secure point-to-point connections).
Never reveal or allow anyone else access to your password for e-mail or phone.
Check that the intended recipient(s) is correct prior to sending.
Ensure transmission and receipt of e-mail or text is to a unique e-mail or text address/number.
Maintain confidentiality of all information.
Use printers in secured areas away from public access and retrieve printed information promptly.
Include a confidentiality warning indicating that the information being sent is confidential and that the message is only to be read by the intended recipient and must not be copied or forwarded to anyone else.
Never forward any information received about a client without the client's written consent.
Advocate for secure and confidential systems and policies.

It is important to realize that e-mail and text messages are a form of client documentation and therefore they must be stored electronically or printed in hard copy, be appropriately labeled with the necessary client information, and are to be placed in the client's health record. As part of the client's permanent record, they can also be subject to disclosure in legal proceedings.

TELENURSING

While telenursing changes how nursing practice is conducted, it does not change the nature of nursing practice, or the nursing process that is foundational to the delivery of nursing care. Telenursing is subject to the same principles of client confidentiality as all other types of nursing care. Even if telenursing practice has been found to improve access to care, it also carries barriers to accessing, collecting, and interpreting information because the client is in a remote location (NANB, 2021). When deciding to engage in telenursing with a specific client, the LPN must carefully consider what is in the best interest of the client while adhering to all the ANBLPN Practice Guidelines.

Giving telephone advice (Telenursing) is not a new role for LPNs. What is new is the growing number of people who want ease of access to health care due to the constraints of the health care system and assistance with decision-making about how and when to use health care services. Agencies such as health units, hospitals, and clinics increasingly use telephone advice as an efficient, responsive, and cost-effective way to help people care for themselves or access health care services.

All documentation standards apply when engaged in telenursing. As telenursing is a unique practice area, you may also be required to document; the reason for providing services via technology, the type of technology being used, the location of the client, and any relevant privacy and security measures that are being used to protect client information.

For further information and guidance on this topic, please refer to ANBLPNs practice guideline: Telenursing

CONCLUSION

LPNs should recognize that the documentation of their nursing decisions and actions are as equally professionally and legally valuable as the direct care they provide to clients. Quality documentation is an important element of LPN practice and essential to positive client outcomes. Documentation is a a key component of meeting the Standards of Practice for LPNs in Canada.

For more information on documentation, please visit Documentation: Frequently Asked Questions.

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