Documentation- Frequently Asked Questions

The Association of New Brunswick Licensed Practical Nurses is the regulatory body for Licensed Practical Nurses (LPNs) in New Brunswick. Our mandate is protection of the public by promoting the provision of safe, competent, ethical, and compassionate care by its registrants.

Please refer to ANBLPN practice guideline Documentation to review our publication in full.

Do LPNs document on a client's care plan?

As per the ANBLPN practice guideline, The Nursing Care Plan, LPNs are involved in *all aspects of the development of the care plan* in collaboration with the RN. LPNs may document their assessment findings to develop and/or modify the care plan within their individual competence.

My shift was extremely busy, we were short staffed, and I did not have time to complete my documentation. Can I just provide the information verbally to the next shift?

Documentation by nursing professionals is a critical component of care and equally as valuable as clinical care. You must document all care that you have provided, including any consultations that you have done, in a factual and timely manner regardless of how busy you are. It is when it is busiest that documentation can be most crucial. **Documenting for someone else may be acceptable in emergency situations only**- like in the event of a Code Blue. Refer to facility policies and your standards of practice when you have questions regarding best practice and practice guidelines.

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Am I required to document any client consultations that I have done?

It is important to document the facts in client health records. *In cases where consultations are made due to a concern about a specific client, a notation of the consultation is made in the progress (practical nurses') notes*. The notation should include the reason for the consultation, the name and designation of whom you consulted with, and the outcome of the conversation. If the call is not returned in a reasonable time, note your next action (e.g., made another call, called another care provider, notified your supervisor) *and* the actions you have taken to manage the situation you were seeking consultation for. If you are 'going off-shift' and the call was not returned or answered before you leave, make a notation in the record that you have passed the information on to the oncoming care provider.

What are the legal implications of documentation?

According to the Canadian Nurses Protective Society (2020), timely and accurate documentation could be your best defense if you are ever faced with a complaint or legal proceedings. During legal proceedings it is the client's chart that is often used as evidence to support a nursing professionals defense. The documentation of your actions will help determine if you acted in a reasonable and prudent way OR if you failed to meet the standards of care of a reasonable and prudent nurse.

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How do I manage mistaken entry/errors and changes or additions?

Inaccuracies in documentation can result in inappropriate care decisions and client injury. Errors must be corrected according to agency policy. The content in question must remain clearly visible or retrievable so that the purpose and content of the correction is clearly understood. If an error occurs in paper-based documentation, do not make entries between lines, do not remove anything (e.g., monitor strips, lab reports, requisitions, checklists), and do not erase or use correction products, stickers or felt pens to hide or obliterate an error. Agency policy should guide LPNs to the accepted means of correcting errors. An accepted practice to correct an error in a paper-based system is to cross through the word(s) with a single line, above the line write "mistaken entry" and insert your initials, along with the date and time the correction was made and enter the correct information. Never remove pages. Failing to correct an error appropriately (according to agency policy) or correcting or modifying another's documentation may be interpreted as falsification of a record. Falsifying records is professional misconduct.

If I forget to sign for a medication, is it considered a medication error or a documentation error?

Failing to sign for a medication is considered both a medication and a documentation error. Referring to your Standards of Practice will help you understand why.

What records are self-employed practical nurses required to keep?

Self-employed practical nurses must have a documentation system in place to reflect the client care provided. What is recorded will depend on the type of service provided but must reflect the plan of care and ongoing assessment and evaluations. Forms should address nursing assessments, plans, interventions, and client outcomes. Follow this link to refer to the ANBLPN guidelines for self-employed LPNs. Also, a personal time log indicating hours practiced is recommended to ensure the LPN can justify practice hours in the event of an audit.

Who owns the health record, and can clients access their own records?

The agency or self-employed LPN in which the client's health record is kept is the legal owner of the record as a piece of physical or electronic property. The information in the record, however, belongs to the client. Clients have the right to access their records and to protection of their privacy with respect to the access, storage, retrieval, and transmittal of the records. The rights of clients and obligations of public agencies are outlined in the *Freedom of Information and Privacy Act* and are often summarized in agency policies. Client consent for disclosure of this information to agency staff for purposes related to care and treatment is implied upon admission, unless there is a specific exception established by law such as the *Personal Health Information Act*, or agency policy. If clients wish to access their health record, they may submit a written request as per the *Freedom of Information and Privacy Act*. LPNs should refer to their workplace policies regarding processes to follow when clients request access to their health record.

January 2022

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Association of New Brunswick Licensed Practical Nurses
L'Association des Infirmier(ère)s Auxiliaires Autorisé(e)s du Nouveau-Brunswick

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Reference: Canadian Nurses Protective Society (2020). InfoLAW: *Quality Documentation: Your Best Defense.* Retrieved from: https://cnps.ca/article/infolaw-qualitydocumentation/