Documentation: Professional Practice Series

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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 ensures the public of their commitment to safe, competent, and compassionate, ethical care by regulating and enhancing the profession of practical nursing.

Acknowledgements

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Documentation

The Association of New Brunswick Licensed Practical Nurses (the Association) is the regulatory body for licensed practical nurses (LPNs) in New Brunswick. The Association's mandate is to protect the public by promoting the provision of safe, competent, ethical and compassionate nursing care. The Association establishes and enforces requirements for entry into the profession, Standards of Practice, Code of Ethics, development and implementation of a Continuing Competence Program and polices, and interpretive documents to support the practice of practical nursing.

Using this document

Guidelines are documents that outline the licensed practical nurse's accountability in specific practice contexts. They reflect relevant legislation and are designed to help licensed practical nurses understand their responsibilities and legal obligations in order to make safe and ethical nursing decisions.

This document is intended to provide licensed practical nurses (LPNs) with guidelines to describe the expectations for nursing documentation in all practice settings, regardless of the method or storage of that documentation. These guidelines will assist the LPNs to meet the standards of practice as they relate to documentation. This, as with all Association documents, can be used with ANBLPN Standards of Practice, Code of Ethics and all applicable practice guidelines or position statements found on www.anblpn.ca .

Defining Documentation

Documentation is the written (or electronic) and legal recording of the interventions that concern the client which includes a sequence of processes. Documentation is established with a personal record of the client which forms the base of information on the status of their health care needs, (Ioanna, Stiliani and Vasiliki, 2007) or describes the status of the client or the care/services given to a client (Perry and Potter, 2010).

The Essentials of Quality Nursing Documentation

High-quality documentation enhances efficient individualized care (Jefferies, Johnson & Griffiths, 2010; Potter and Perry, 2010) and contains six essential characteristics. Table 1 below outlines the essentials of quality nursing documentation with examples. These essential characteristics of quality nursing documentation apply to every type of documentation in every practice setting (CRNNS, 2012).

Table 1

Essential Characteristics of Nursing Documentation	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 and the client's perception of their needs.
2. Accurate and relevant.	Clear and easy to understand information that contain details that have importance to the client, and/or variances in the client response(s) to care.
3. Complete (including nursing actions and client responses).	Information that sufficiently describes the clients care needs, nursing interventions (including teaching and support) and expected outcomes.
4. Current and contemporaneous.	Information that is up to date and that has been recorded during or as soon after the intervention or interaction occurred.
5. Organized, logical and sequential.	Information in a reasonable chronological manner so that nursing decisions, actions and client responses to actions (repeat as necessary) are evident.
6. Compliant with standards and other legal requirements.	Information is reflective of the delivery of safe, competent, ethical and compassionate nursing care and consistent with standards of practice, employer policies and provincial or federal legislation.

The Purpose of Nursing Documentation

The basic purpose of nursing documentation is the creation of a *data base or health record* of a client's experience with the health care system, (Ioanna, Stiliani & Vasiliki, 2007; Beach and Oates, 2014; Prideaux, 2011). Nursing documentation is a tool that demonstrates what the practical nurse does for/with the client (Jefferies, Johnson & Griffiths, 2010) and is one part of the broader interprofessional documentation that forms the client's health record. The health record is made up of a number of interprofessional tools and documentation that provides evidence of the care, treatment or service a client receives, (Beach and Oates, 2014). Table 2 outlines the purpose of documentation and why quality nursing documentation is important.

Table 2

Purpose of Documentation	Why Quality Nursing Documentation is Important
1. Communication among healthcare providers	Quality documentation supports the exchange of pertinent client information among the interprofessional care team, (Prideaux, 2011).
2. Care planning and continuity of care	The plan of care is established through quality documentation and supports the continued delivery of client care by the right care provider with the right skill set, (CNO, 2008).
3. Accountability	Quality documentation establishes the practical nurses' accountability for the delivery of safe, competent, ethical and compassionate care, (CRNNS, 2012; CNO, 2008).
4. Satisfies legal requirements	Quality documentation can be used as evidence in a court of law or a professional conduct hearing (CRNNS, 2012).
5. Quality assurance	Quality of services (CRNNS, 2012) or organizations (Ioanna, Stiliani & Vasiliki, 2007) can be evaluated through the analysis of quality documentation.
6. Funding and resource management	The allocation of resources, workload measurement and fiscal utilization can be determined through the analysis of quality documentations, (Potter and Perry, 2010).
7. Research	Quality documentation can be a valuable source of elements for nursing research, (Ioanna, Stiliani & Vasiliki, 2007).

What, How Much and When to Document

Licensed practical nurses are expected to document first-hand knowledge (the LPN documenting is the same LPN who provided the care) in a manner that is consistent with their Standards of Practice, employer policy and provincial and federal legislation. Each LPN is accountable to be aware of and understand these elements and document appropriately within them.

What to Document

LPNs are expected to document enough client information so that continuity of care is maintained. Often, healthcare providers have defined continuity of care solely as the *same* care provider providing care to the same client. However, in this context, continuity of care means the client receives consistent care from other healthcare providers who have the necessary knowledge, skill and judgment to provide the level of care required. Clear, concise and accurate documentation supports continuity of care, (Beach and Oates, 2014).

Nursing documentation must be more than a list of interventions performed by the LPN. Documentation must be comprehensive enough to present a continuous account of the clients' experience. It must also demonstrate how the LPN understands the clients condition and how they have dealt with problems that may be evident. It is especially important to document variances or changes in the client's condition, (Jefferies, Johnson & Griffiths 2010). Regardless of

the technology (paper-based or electronic) or methodology (documentation format), documentation should provide a clear picture of: the needs of the client; the LPNs individual actions based on the ongoing assessment of the client, and; the outcomes and evaluation (including re-evaluation as necessary) of those actions, (CNO, 2008). LPNs are advised to document about the client's condition and care in a way that explains why decisions about that care were made, (Jefferies, Johnson & Griffiths 2010).

How to Document

Documentation is an important aspect of the care LPNs provide to clients. This is supported by numerous studies citing its positive impact on outcomes (Collins et al., 2013); however, it is often devalued by practical nurses in favour of hands on care (Prideaux, 2011). The lack of respect for documentation exists despite its necessity outlined in nursing research, Standards of Practice, agency policy and legislation. Failure to meet the Standards of Practice or comply with agency policy puts the client at risk and may be considered professional misconduct. Documentation is not optional.

Documentation formats vary widely. LPNs should have a clear understanding of their agency's policy concerning documentation in their practice setting. Regardless of the format, it is important to understand that with a move towards collaborative care, all health care professionals must adopt a style of documentation that suits this approach. LPNs should document with the understanding that records may be viewed by other team members who do not share their professional knowledge base, (Blair and Smith, 2012) following four principles: (adapted from Beach and Oates (2014) and Orwell (1962):

1. Stick to the facts and relevant information;
2. Use simple and concise words;
3. Write in concise sentences, and;
4. Avoid jargon, abbreviations (unless approved), inappropriate language, slang, generalizations or biases.

When to Document

To ensure that all nursing documentation is an accurate reflection of the client's condition and care, LPNs should record events contemporaneously or as soon as they occur, (Beach and Oates, 2014: Jefferies, Johnson & Griffiths 2010). Documenting chronologically is important because it enhances the clarity of communication among healthcare providers. It provides a logical account of the nature of the care that has been provided and the assessment or evaluation data that was used in the decision-making process. Documentation of an event should never be completed before the event has taken place, (CRNNS, 2012).

The intensity (frequency and amount) of documentation is based on the agency policies and the status of the client, (CRNNS, 2012). As client complexity or variability increases, so does the amount of, and need for documentation, (CRNBC, 2013). It is of importance to note that although agency policy may indicate the minimum documentation requirements, it is reasonable to expect

that LPNs document more frequently and with greater detail than outlined in policy, when the client's needs become more complex, (Collins et al., 2013). Table 3 below demonstrates the relationship between client complexity, documentation and employer policy.

Table 3*

Client Needs	Predictable	Varying	Complex
Intensity of Documentation	Routine	Frequent	Very Frequent
Documentation Processes	Outlined by employer policy		

*Adapted from CRNBC, 2013

Collaboration with other Health Care Professionals

There is a current trend toward interdisciplinary practice. Creating interdisciplinary communication and documentation is crucial in developing a strong interdisciplinary practice (Harper, 2007). This way of documenting is intended to eliminate duplication, enhance efficient use of time and enrich client outcomes through team collaboration. Collaborative documentation enables healthcare professionals of all disciplines to share the same documentation tools. Examples of such tools are clinical pathways which reflect interdisciplinary care and integrated, interdisciplinary patient progress notes.

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 of the contact;
- name(s) and designation (e.g., R. Smith, MD) of the people involved in the collaboration;
- information provided to or by healthcare providers;
- responses from healthcare providers;
- orders/interventions resulting from the collaboration;
- the agreed upon plan of action, and;
- anticipated outcomes.

It is important to remember that in New Brunswick, LPNs practice autonomously within a collaborative relationship with other care providers (namely the registered nurse). It is reasonable to suggest the increase in the intensity of client documentation is reflective of the increase in intensity of the consultation/collaboration between the LPN and registered nurse (RN). All practical nurses should recognize a disruption in care delivery is a signal to re-evaluate the care assignment when the frequency of consultation with RN is increased.

Guidelines for 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.

Guidelines	Rationale	Correct Actions
1. There must be sufficient client identifiers (e.g., name, record number) on *each* page of nursing documentation.	Appropriate client identification on each page decreases the risk of confusion and ensures continuity of care.	Apply client identifiers (sticker, imprint or hand write) to each page of nursing documentation.
2. Documentation must be legibly written in non-erasable ink.	Legible handwriting decreases the risk of confusion and ensures accurate communication of information. Pencil and erasable ink may be altered after the fact by other care providers.	Write or print in a legible manner using ink. Follow agency policy with regard to colour of ink and/or use of felt-tipped or fountain pens.
3. Entries must be dated, timed and include the name and designation of the practical nurse.	Time dating entries ensures the correct sequence of events is recorded. Signatures ensure lines of accountability are clear.	Documenting as events occur, ensuring the date and time are accurate. Use first initial, last name and nursing designation (N. Smith, LPN) after each entry. May use non-nursing credentials, after the nursing designation and approved designations. (P. Hill, LPN, BA). *Follow agency policy with regards to the use of initials.*
4. Record all relevant facts as statements. Avoid referring to self as 'writer'.	Documentation must be factual, accurate and objectives and from the perspective of the LPN. Adding 'writer noted' is redundant because the entry is signed by the practical nurse who is documenting it.	Be certain entry is accurate and complete. Do not document speculations or assumptions. The documentation should clearly show the needs of the client, the actions of the practical nurse and the outcomes or interventions.
5. Use only terminology or abbreviations approved by the agency or practice setting.	Unapproved terminology or abbreviations could result in misinterpretation and put the client at risk.	Follow your agency policy with regard to use of abbreviations. Go to IMSP-Canada https://www.ismp-canada.org/

		for a list of **DO NOT USE** abbreviations.
6. Understand the terminology used in documentation.	Using terminology that is unfamiliar increases the risk in gaps in communication among care providers.	Use only language that is familiar and understood.
7. Avoid using generalized or empty phrases such as 'had a good day' or 'status unchanged'.	Such information is too generalized and has no context because specific assessment data is missing (i.e., how does the practical nurse know the status is unchanged?).	Use complete concise descriptions of care or nursing actions and/or findings.
8. Document only own actions.	Doing otherwise may blur the lines of accountability.	Documenting for another care provider is generally not advised; however, in an emergency situation (such as a Code Blue) this may be warranted. The Association advises against agency processes that require the LPN to document for other care providers as a matter of ongoing day-to-day processes because of the risk to both the clients and care providers. LPNs acting as leaders, should engage their employers in conversations about creating documentation policy and process that is grounded in best practices to ensure a quality practice environment.
9. Correct all documentation errors promptly.	Errors in recording can lead to errors in treatment.	Be sure information is correct. ~~Draw a line through incorrect entries~~, note it as "mistaken entry" initial and correct. Follow agency policy with regard to correcting mistaken entries. Never use correction fluid, stickers or felt pens to obliterate error.
10. Avoid critical comments about clients, care provided by others or employer.	This is unprofessional and inappropriate.	Document only objective data. If there are issues with the practice of other care providers, address them directly with the person.

11. Document collaboration or consultation with other care providers, include reason for consultation.	LPNs are required to consult with other care providers when clients' needs are changing or complex. Noting consultations (whether for support, guidance or clarity) indicates accountability for the delivery of safe care.	Clarity of an order: 'Called Dr. Smith to clarify analgesic order.' Support for decision making: 'BP 150/90. Discussed with A. Miller RN. PRN medication given.' Collaborative Assignment: 'Report received with collaborative partner S. Richard RN.' (See page 8)
12. Reference late or out of sequence entries with actual time the entry is recorded and the actual time the event took place.	Noting that an entry is late or out of sequence maintains accountability for actions and ensures the information is accurately recorded in the client records.	August 8th, 2014 - 2315 Late Entry: 'At 1730 today, client requested pain medication for headache. Stated pain scale was 8/10. Medication given at 1735'. Follow agency policy regarding late or out of sequence entries. (See Page 23)
13. Do not 'pre-chart' (documenting actions before they are taken).	Pre-charting is a risk prone practice that can lead to confusion about the care provided to a client. Lack of clarity can result in an untoward outcome for a client.	Document during or immediately after the performance of intervention. Care planning is the only exception.
14. Do not leave white space in the practical nurse's notes.	Another person could add incorrect information in the available space.	Chart consecutively, line by line and fill up empty space at the end of a line with a strikethrough or line----------D. Brown LPN.
15. Protect passwords used to access electronic health records.	This maintains security and client confidentiality.	Follow agency policy with regard to safety and security of client information when using an electronic health record.

Co-signing and Counter Signatures

Co-signing refers to a second or confirming signature on a witnessed event or activity (ARNNL, 2010). Co-signing entries made by other care providers is not a standard of practice and, when poorly defined, can blur accountability. If two practical nurses are involved in an assessment or the delivery of care, both practical nurses should document, according to agency policy. Agency policies should clearly describe how documentation should be completed when two practical nurses are required to be involved in an aspect of care. For example, if two practical nurses 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 practical nurse (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 actually witnessed or participated in the event (SRNA, 2011).

Counter signing is defined as a second signature on a previously signed document, such as a flow sheet. The counter signature is blind, meaning that the signer did not witness the activity of the first signature. It is believed that the counter signature evolved from a time when individual practitioners did not hold their own professional accountability and a counter signature was required as part of the assignment or delegation of work to others. Today, the counter signature process ('signing off' another flow-sheet, care plan, or charting) is no longer best practice, (CRNNS, 2012) because it blurs the lines of accountability.

Counter signatures may be appropriate in quality control processes such as 24-hour chart reviews or order transcription. In this case, countersigning does not imply the counter signer performed the action, but rather verified that the action was performed by another, (CRNNS, 2012).

As such, LPNs are not expected to 'counter sign' documents or entries into documents for other care providers, such as unregulated care providers (UCP). LPNs should be aware that when they engage in this practice they are assuming accountability for the activities, interventions and outcomes for which they have counter signed. If an agency wishes LPNs to counter-sign documents for the UCP, they are accountable to develop policy that clearly outlines the role of LPNs and the accountability they assume with the counter signature.

Incident Reports

Incident reports are also known as Occurrence or Adverse Event reports. The term Incident Report will be used in this document.

An incident is an event which is not consistent with the routine operations of the unit or of client care (Perry and Potter, 2010). Examples of incidents include falls, medication errors, needle stick injuries, or any circumstances that places clients or staff at risk of injury. Incidents that involve clients are generally recorded in two places; in the client's medical record and in an incident report. Incident reports are filed separately from the chart.

Documentation in the chart is used to ensure continuity in client care and should be accurate, concise, factual, unbiased and recorded by the person who witnessed the event. LPNs should avoid using the words "error", "incident" or "accident" in their documentation. It is recommended the LPN first document an incident in a concise and factual manner, in the health record to ensure continuity and completeness, and then complete an incident report in accordance with facility policies and procedures (Grant & Ashman, 1997).

The purpose of a health record and incident report differs. Therefore, for the sake of clarification, the LPN should avoid documenting "refer to incident report" in a client's health record. Incident reports are used by organizations for risk management, to track trends in systems and client care and to justify changes to policy, procedure and/or equipment. Information included in an incident

report is similar to the information included in a client's health record, however, the incident report also includes additional information with respect that may not be directly related to the care of the client. Agency policy should clearly describe processes necessary to complete an incident report.

Use of Technology

Technology may be used to support client documentation in a number of 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. These new ways of recording, delivering and receiving client information, however, pose significant challenges for practical nurses, particularly with respect to confidentiality and security of client information. It is important that practical nurses be supported by agencies in resolving these issues through clear policies and guidelines and ongoing education.

Electronic documentation

A client's electronic health record is a collection of the personal health information of a single individual, entered or accepted by health care providers, and stored electronically, under strict security. As with traditional or paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care. Entries are made by the provider providing the care 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 after the entry has been stored, agency policies provide direction as to how this should occur.

Agencies using electronic documentation should have policies to support its use, including (but not limited to):

- correcting documentation errors or 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;
- processes for documenting in agencies using a mix of electronic and paper methods;
- backing-up client information, and;
- documentation processes in the event of a system failure.

Guidelines for LPNs Using Electronic Health Records

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

Guidelines	Rationale
Never reveal or allow anyone else access to your personal identification number or password.	Sharing passwords is a risk prone activity because it allows others to access to client information under your name. LPNs that share their passwords, or do not take reasonable steps to protect their passwords may be held accountable for any activity in their name.
Change passwords at frequent and regular intervals (as per agency policy); choose passwords that are not easily deciphered.	Decreases the likelihood that you code can be used by others.
Inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else.	This will establish a timeline and help differentiate your entries from entries another care provider has added using your access information.
Log off when not using the system or when leaving the terminal.	Decreases the likelihood of an unintended breach of client confidentiality.
Maintain confidentiality of all information, including all print copies of information.	
Shred any discarded print information containing client identification.	
Locate shared printers in secured areas away from public access.	
Retrieve printed information immediately.	
Protect client information displayed on monitors (e.g., use of screen saver, location of monitor, use of privacy screens).	
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.

Fax Transmission

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.

Guidelines for LPNs Using Fax Technology to Transmit Client Information

The following are guidelines for protecting client confidentiality when using fax technology to transmit client information.

Guidelines	Rationale
Locate fax machines in secured areas away from public access.	Decreases the likelihood of an unintended breach of client confidentiality.
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.	Ensures that fax was sent and not sitting in the queue to be resent or accessed by someone else.
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.	This is a safeguard that make the unintended recipient accountable for any actions they may take with information incorrectly sent to them.
Advocate for secure and confidential fax transmittal systems and policies.	This is an important leadership action that contributes to the quality practice environments.

Client information received or sent by fax is a form of client documentation and is stored electronically or printed in hard copy, is appropriately labeled with the necessary client information and placed in the client's health record. Faxes are part of the client's permanent record and, if relevant, can be subject to disclosure in legal proceedings. If a physician's order is received by fax, LPNs are expected to use whatever means necessary to confirm the authenticity of the order.

Electronic Mail

The use of e-mail by health care organizations and health care professionals is becoming more widespread as a result of its speed, reliability, convenience and low cost. Unfortunately, the factors that make the use of e-mail so advantageous also pose significant confidentiality, security and legal risks.

E-mail can be likened to sending a postcard. It is not sealed, and may be read by anyone. Because the security and confidentiality of e-mail cannot be guaranteed, it is not recommended as a method for transmission of health information. Messages can easily be misdirected to or

intercepted by an unintended recipient. The information can then be read, forwarded and/or printed. Although messages on a local computer can be deleted, they are never deleted from the central server routing the message and can, in fact, be retrieved.

Guidelines for Protecting Confidentiality when using E-mail to Transmit Client Information

Having considered these risks and alternative ways to transmit health information, e-mail may be the preferred option to meet client needs in some cases. The following guidelines can help LPNs protect client confidentiality.

Guidelines	Rationale
Obtain client consent before transferring health information by e-mail as dictated by policy.	Even with safeguards, transmitting information by email has a higher risk. Client should be informed about the process and any potential risks.
Transmit e-mail using special security software (e.g., encryption, user verification or secure point-to-point connections).	Encryption safeguards against hacking and unauthorized persons from accessing client information.
Never reveal or allow anyone else access to your password for e-mail.	Sharing passwords is a risk prone activity because it allows other access to client information under your name. LPNs that share their passwords, or do not take reasonable steps to protect their passwords may be held accountable for any activity in their name.
Check that the e-mail address of the intended recipient(s) is correct prior to sending.	Decreases the likelihood of an unintended breach of client confidentiality.
Ensure transmission and receipt of e-mail is to a unique e-mail address.	
Maintain confidentiality of all information, including that reproduced in hard copy.	
Locate printers in secured areas away from public access.	
Retrieve printed information immediately.	
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.	This is a safeguard that makes the unintended recipients accountable for any actions they may take with information sent incorrectly to them.
Never forward an e-mail received about a client without the client's written consent.	Client must grant permission for their information to be shared with others and refer to local agency policies and procedures.
Advocate for secure and confidential e-mail systems and policies.	This is an important leadership action that contributes to the quality practice environments.

It is important to realize that e-mail messages are a form of client documentation and are stored electronically or printed in hard copy, are appropriately labeled with the necessary client information and placed in the client's health record. E-mails are part of the client's permanent record and, if relevant, can be subject to disclosure in legal proceedings. E-mail messages are written with this in mind. LPNs are expected to use whatever means necessary to confirm the authenticity of the orders received via electronic mail. LPNs may not use their personal (non-work) email account to send or receive client information because of the risk of violation of confidentiality. They also may not accept prescriber orders via text messaging because of the risk in misinterpretation and difficulty validating authenticity or documenting.

Telenursing

Giving telephone advice is not a new role for LPNs. What is new is the growing number of people who want access to telephone "help lines" to assist their 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. Telenursing is subject to the same principles of client confidentiality as all other types of nursing care.

LPNs that provide telephone care are required to document the telephone interaction. Documentation may occur in a written form (e.g., log book or client record form) or via computer. Minimum documentation includes the following:

- date and time of the incoming call (including voice mail messages);
- date and time of returning the call;
- name, telephone number and age of the caller, if relevant (when anonymity is important, this information may be excluded), and;
- reason for the call, assessment findings, signs and symptoms described, specific protocol or decision tree used to manage the call (where applicable), advice or information given, any referrals made, agreement on next steps for the client and the required follow-up.

Sometimes clients seeking advice do not live in New Brunswick. LPNs can provide telephone follow-up/advice to client who lives outside New Brunswick in the following context:

- the client was initially assessed in person in New Brunswick by a care provider with the necessary knowledge, skills, judgment and authority to initiate a plan of care;
- the client has a well-established plan of care and is responding to the plan as expected;
- the LPN has the necessary knowledge, skill and judgment to engage in these practices;
- the employer has sufficient processes in place (human, reference, policy) to support this practice, and;
- the client currently lives in a Canadian province or territory.

The Association advises against providing telephone advice to clients; who do not permanently reside in a Canadian province or territory or; resides in Canada but is temporarily outside the country (such as on vacation).

Conclusion

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

Frequently Asked Questions about Documentation

Who owns the health record?

The agency or self-employed LPN in which the client's health record is compiled 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 a right of access to 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.

Is the information in the client's health record confidential?

Yes. Information in the health record is considered confidential. 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. Client consent is required if the contents of the health record are to be used for research or if any client information is to be transmitted outside the agency.

Do clients have access to their health record?

Yes. The Standards of Practice for LPNs in Canada, adopted by ANBLPN in 2013, require that in appropriate circumstances, LPNs may provide or assist clients to gain access to their health records. These standards are consistent with the Freedom of Information and Protection of Privacy Act whereby clients can submit written requests for access to their records or for information that might otherwise not normally be provided. Refer to agency policy as to the process to follow when clients request access to their health records.

How is client information contained in communication books and shift reports communicated?

Communication books and shift reports are not part of the legal health record. They are tools used to exchange information between care providers and alert them to information critical to their care of their clients. These tools are used to direct others to the health record where the pertinent information is recorded in detail. Relevant health information communicated by these tools *must* be documented in the health record.

Occasionally I will 'put a call into' another health care provider because I have questions about the client. Should I document that I have made these calls? Should I document that they have not been returned?

It is important to document facts in client health records. In cases where calls are made because of a concern about a specific client, a notation of these calls is made in the progress (practical nurses') notes. The notation should include the reason for your call and who you called. If the call is returned, note 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've taken to manage the situation you were calling about. If you

are 'going off-shift' and the call has not been returned before you leave, make a notation in the record that you have passed the information on to the oncoming care provider.

Should chart pages or entries be recopied?

Generally, chart pages or entries should not be recopied. Errors are corrected according to agency policy. Refer to your agency policy with regard to managing information/pages that has become difficult to read.

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. A generally 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.

To protect the integrity of the health record, changes or additions need to be carefully documented. Never remove pages. A client alternate decision maker, or another care provider, may request changes or additions to documentation. Consult agency policy for the appropriate process to manage this request.

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 considered professional misconduct.

How are late entries made?

Documentation should occur as soon as possible after an event has occurred. When it is not possible to document at the time of or immediately following an event, or if extensive time has elapsed, a late entry is required. Late entries must be clearly identified (e.g., "Late Entry or Addendum to Care"), and should be individually dated. They should reference the actual time recorded as well as the time when the care/event occurred. Employer policy should define how late entries (within same shift or extensive time has passed) are managed.

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

Self-employed practical nurses must have a documentation system. What is recorded will depend on the type of service offered. Forms can be simple and still address nursing assessment, plans, interventions and client outcomes. A time log indicating hours practiced is also recommended to ensure the LPN can justify practice hours in the event of an audit.

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