Documentation

Documentation is the process of creating a permanent record to monitor the care and progress of a patient/client for the purpose of legal record and communication to other care providers. Documentation identifies the caregiver and communicates the plan of care, assessment and interventions necessary based on client's history and effectiveness. Documentation demonstrates commitment to providing safe, effective, and ethical care showing accountability for professional practice by meeting the professional standards of practice.

SALPN Regulatory Bylaws provide the following:

> 20. All members shall ensure that they work within their educational preparation, level of competence and scope of practice and comply with the standards of practice set out in the *Standards of Practice for Licensed Practical Nurses* approved and adopted by Canadian regulatory agencies as of April 1, 2013.
>
> 21. All members shall conduct themselves in an honorable and ethical manner, upholding the values of truth, honesty, and trustworthiness, and shall observe the standards of conduct set out in the *Code of Ethics for Licensed Practical Nurses in Canada* approved and adopted by Canadian Regulatory Agencies as of April 1, 2013.

Therefore the Licensed Practical Nurse is accountable to enure:

- Documentation must provide clear information inclusive of all aspects of the nursing process: assessment, planning, implementation, and evaluation.
- Documentation must indicate the use of critical thinking and inquiry by linking all steps of the nursing process.
- LPNs are accountable to ensure documentation is accurate, timely, and encompasses all components the practitioner has provided or participated in.
- LPNs are accountable to practise within facility or health region policies regarding client confidentiality, sharing, retention, and disposal of information collected.
- LPNs are accountable for their documentation as it not only provides a written record of care, but serves as a legal document for law suits, coroner's inquest, and disciplinary hearings.
- Information documented not only communicates patient information to other providers, but can be evaluated to identify trends, challenges, risks in patient care.
- Unsafe situations must be documented appropriately.
- LPNs documentation must support a collaborative and communicative environment.
- Documentation serves as a tool to assist and support the health care team to achieve safe, ethical, and complete care.

Guidelines to Documentation

- Document in permanent ink in a clear and legible manner.
- Documentation must be accurate and honest.
- Avoid the use of generalizations, slangs, euphemisms and biased comments.

- Identify when an entry is a subjective comment.
- Make entries as soon as possible.
- Entries shall be in chronological order.
- Entries are to be timed with the 24hr clock.
- Late entries shall be indicated per agency policy.
- The next available space is to be used. Any lapse in space should be filled with a line of ink.
- Any corrections must ensure the original documentation remains visible, usually indicated with a strikethrough line, the word "void", and initials. No eraser or obliterating agents are to be used.
- Never delete, alter or modify anyone else's documentation.
- Documentation is to be completed by the person who performed nursing care, unless in a situation (ie:code) and a recorder has been designated
- If a situation warrants a co-signer those signing must have witnessed or have been involved in the care of process.
- If recording and warranted, the writer may create a roster of those present and clearly indicate who is administering care.
- Documentation is to include both subjective and objective data.
- Minimize duplications within the patient chart as much as possible.
- Document significant communication with the patient, family, or other care professionals.
- Complete documentation with a full signature and professional designation. Initials are appropriate if full signature exists on a facility master signature sheet.
- Electronic signatures must be password protected.
- Use only agency approved abbreviations.
- Document on relevant agency forms identifying the client on all sides of the document.

Formats

- Paper documents
- Electronic Records
- Audio Visual Recording
- Electronic Mail
- Faxes

Tools (may include, but not limited to)

- Nurses notes
- Care plans
- Kardexes
- Worksheets
- Flowsheets
- Monitoring strips
- Checklists

- Images
- Incident report
- Order
- Shift reports

Documentation Methods

Narrative Charting

Narrative charting is the most traditional approach whereby interventions and client responses are written in paragraph format and recorded in chronological order. The nursing process is often used as the organizing framework. Narrative notes may stand alone or be used in combination with other documentation.

SOAP Charting

The SOAP format focuses on specific client problems. The clients current problems are identified and listed on the nursing care plan. There is an optional addition to the SOAP format – SoapIER that focuses on outcomes and evaluation. Recording is organized under the following headings:

S = subjective data
O = objective data
A = assessment
P = plan
I = intervention
E = evaluation
R = revision

Focus Charting

Focus charting is a system that requires LPNs to document according to one or more identified focuses that reflect the clients concerns or health needs (e.g., symptom, behavior, or event) These focuses form the basis of the care plan and are determined during assessment. Recording is organized under the following headings:

D = data (subjective or objective)
A = action
R = response
P = plan

PIE Charting

This format uses a problem oriented approach and is based on the nursing process. The PIE system consists of a 24-hour daily assessment flow sheet. Quite often, standardized or individual care plans needs to be used in conjunction with PIE charting.

P = problems
I = interventions
E = evaluations

Charting by Exception

Charting by exception is a charting system for LPNs to document only those particulars or observations about the client that fall outside expected limits or established plans of care. It assumes all observations fall within expected limits or all care standards have been met with the normal expected response unless the care giver has documented otherwise. To be effective, all components of the charting by exception system must be effectively utilized e.g., flow sheets, care plans and protocols. When charting by exception:

- a baseline for the client must be established
- all procedures performed including medication administration, vital signs, and area specific required observations must be documented
- any changes in condition must be documented
- if you are unsure whether something is an exception, document it

References

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