Documentation

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INTRODUCTION

The College of Licensed Practical Nurses and Health Care Aides of Alberta (CLHA) has the **authority** under the *Health Professions Act* (HPA) to carry out its activities and **govern** Health Care Aides (HCAs)[1] in a manner that protects and serves the public interest.

Effective **documentation** is essential when providing **professional services**. Health professionals use documentation as a communication tool to share information, support **continuity of care**, and promote a **culture of safety**.

Documentation creates a record that includes the plan of care, care provided, client outcomes, and other details. This record of care can be electronic, paper-based, or a combination of both. An employer may also have **requirements** and expectations on documentation. The HCA must meet those requirements in addition to the ones outlined in this policy.

Accurate documentation needs to be completed as soon as possible. It provides necessary information to the healthcare team for planning and evaluating client care and improving the quality of care for clients. Documentation can be used for legal purposes to show the timeline of events, what care was provided, and the communication between team members that occurred.

Terms found in the glossary are **bolded** where they appear for the first time in this document.

PURPOSE

This policy describes the professional expectations of HCAs in producing clear, accurate, and detailed documentation. This document also outlines the importance of effective documentation, potential legal problems, and risks that may result from poor documentation.

For information about medication-specific documentation, please refer to the *Medication Assistance Policy*.

[1] In this document, "HCA(s)" has the same meaning as "regulated member(s)" in the *Health Professions Act.*

POLICY

The *Standards of Practice for Health Care Aides in Alberta* state HCAs must:[i]
Standard 1.6: report and document according to relevant legislation, **regulatory**, and employer requirements.
Standard 2.5: provide relevant, timely, and accurate information to clients, families, caregivers, and the healthcare team.

HCAs are professionally **responsible** and **accountable** for the care and services they provide no matter where they work.

Professional Expectations

HCAs are required to have the knowledge and ability to document client care. HCAs are responsible and accountable for documenting the professional services they provide to their clients following legislation, CLHA requirements, and employer requirements. HCAs are required by law to maintain the **privacy** and **confidentiality** of a client's personal and health information. For more information about this topic, see the CLHA's *Privacy Legislation in Alberta* interpretive document and *Confidentiality* practice guideline.

Different employers may use different methods to document care. Regardless of the method used, the documented client record (electronic or paper) should outline all the following information:

- what care was provided;
- who received the care;
- who provided the care (the HCA's name or initials and designation or protected title);
- when care was provided (date and time);
- why this care was provided;
- observations of the client;
- relevant communication or attempts at communication (e.g., between HCAs, the client, the client's family or **alternate decision maker**, and other healthcare providers, including their name and designation); and
- other relevant information.

The HCA must use their protected title as found in the HCA register. In general, HCAs should minimize the use of **abbreviation**s when documenting (see below). However, abbreviations are acceptable for protected titles (e.g. "HCA").

Documentation Principles

HCAs are expected to follow the documentation principles below in order to document effectively.

Be objective: Document facts only and avoid including assumptions, opinions, or accusations.

Be complete: Provide charting details of the care provided to the client that include any follow-up steps taken. For example, it is important to document the actions undertaken when a task performed by the HCA is unsuccessful. This includes actions such as contacting another healthcare professional for guidance or arranging follow-up consultations.

Be accurate: Document the correct details of the care provided to the client. This includes the date and time of the care the HCA provided and accurate details of the care that the HCA provided. Records should only include what the HCA observed, heard, or did. If the HCA's task involves documenting the actions of others, the HCA should clearly state in the documentation that they are recording other people's actions.

Maintain documentation security: HCAs are responsible for protecting client records in their care. This can be done by following these practices.

- Notes with client information that are not part of the client's health record must be disposed of as soon as possible in a secure and appropriate manner.
- Avoid leaving any blank lines in paper documentation, as these empty spaces can allow for the addition of information after the fact.
- Before sharing client information, verify that it is being sent to the correct person(s).
- Take steps to maintain the security of any electronic documentation systems. Use password protection. Log off when away from the system, when the system is not in use, etc. HCAs should create strong and unique passwords that are hard to guess. HCAs should not share passwords with others or save passwords on unauthorized platforms.
- Follow employer requirements regarding the access of client information by unauthorized persons.

Document legibly: Documentation must be written clearly to ensure that information in records is not difficult to read, missed, or misunderstood. These can result in errors or harm to the client.

*Document **chronologically**:* Document events in the order in which they happened. This makes the care timeline clear and helps to ensure good communication between co-workers.

Document in a timely manner: Documentation should be completed right after care is provided to ensure all healthcare team members are aware and to maintain the credibility of the information. If documentation is delayed, it must be marked as a "late entry" and filled out accurately and as soon as possible, following any specific employer guidelines on late entries.

Document frequently: The frequency of documentation will vary based on the client's needs and condition and employer requirements. For example, the frequency of documentation may increase as the complexity of the care increases or depending on the client's acuity. HCAs should be aware of these factors and document as frequently as necessary.

Minimize the use of abbreviations: Using abbreviations can lead to medication errors and can also create confusion.[ii] If abbreviations must be used, the HCA should follow employer requirements and only use employer-approved abbreviations.

Do not delete or hide documentation errors: If an error is made when documenting, the person who documented it is responsible for correcting the error. The correction must be made in a way that clearly shows that the documentation was altered. The HCA must follow employer requirements around correcting errors to ensure consistency in their documentation.

Avoid making personal notes: Anything written, including on client charts or elsewhere, can be used as evidence. Personal notes may need to be shown in **legal proceedings**. Additionally, to maintain confidentiality, always ensure that personal notes or self-reflections do not include information that can identify a client. For more information, please see the *Confidentiality* practice guideline.

Risks of Poor Documentation Practices

Clear, **concise,** and accurate documentation supports continuity of care and can be relied on as a record of the care provided in a legal proceeding. If something was not documented, it could be assumed that the care in question was not provided.

Poor documentation practices can lead to medical errors, poor client care, repeating or missing tasks, and unprofessional conduct charges against the HCA.

In the event of a legal proceeding, the client's health record may be used as evidence of what healthcare services were or were not provided. Effective documentation supports evidence of the care provided to a client by the HCA. If an HCA documents late, makes changes to documentation, or deletes documentation errors without clearly recording such actions, it may harm the credibility of the documentation.

CONCLUSION

The client's health record is evidence of care provided to the client and is the primary communication tool between team members. Documentation contributes to safe client care and safe practice environments. HCAs are accountable for ensuring their documentation accurately communicates the care they provided. It is a professional expectation and regulatory requirement for HCAs to follow the documentation principles to provide quality documentation.

Documents are updated frequently. For the most current version and access to related documents and resources, please visit the Knowledge Hub on clha.com.

If after reading this document you have any questions, please contact the CLHA's Professional Practice Team via practice@clha.com or by phone at 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

DEFINITIONS

Abbreviations: a shorter way of writing a word or phrase used in place of the whole word or phrase.

Accountable: the ability to explain why actions were taken or not for a job or task for which the HCA is responsible.

Alternate decision-maker: someone who is appointed to make certain decisions about the care of a client when the client cannot make those decisions themselves.

Authority: refers to the power or right to give orders, make decisions, and enforce obedience. It can also mean the appropriate person to give orders or make decisions. This could include supervisors, managers, employers, charge nurses, or educators.

Chronologically: arranging a group of things or events in the order they happened in time. It refers to presenting events in the sequence they occurred, from the earliest to the most recent.

Concise: short and clear, expressing what needs to be said without unnecessary words.

Confidentiality: the ethical duty to protect personal and health information about a client.

Continuity of care: when a client's experience of care is connected and well-organized through their entire care journey, from care provider to care provider, no matter in what facility or environment they may be accessing care.

Credibility: someone or something that can be believed or trusted.

Culture of safety: a way of working that promotes the safety, security, and well-being of clients, staff, and organization.

Documentation: material that provides official information or evidence or that serves as a record.

Govern: to lead, control, or manage an organization or group, often by creating rules and making decisions that guide their actions.

Legal proceeding: actions taken to settle an argument in a court of law.

Password protection: refers to a security method used to limit who can see information or use devices. It works by asking for a correct password before allowing entry. It keeps private or important data safe, making sure only authorized users can access that platform or device.

Privacy: the right of a client to have some control over how their personal information or personal health information is collected, used, accessed or disclosed.

Professional service: defined in the *Health Professions Act* as a service that falls within the practice of an HCA. This includes one or more of the following:

- assist and support activities of daily living to provide basic personal care and health services,
- assist in teaching a Health Care Aide certificate program approved by the council,
- participate in client education and promotion of client wellness across the lifespan,
- teach health care aide techniques and practices to practitioners in the workplace, and
- provide restricted activities provided by the regulation.

Regulatory requirements: rules and guidance documents made by a regulatory body, such as CLHA, that govern the practices of its regulated members. Some examples of regulatory documents include CLHA standards of practice, code of ethics, policies, and practice guidelines.

Responsible: duty to provide for the needs of a client following professional and legal standards.

Requirements: something that is needed.

Unauthorized: a person uses something without permission.

REFERENCES

[i] Canadian Council for Practical Nurse Regulators, *Standards of Practice for Licensed Practical Nurses in Canada* (2020), https://www.clpna.com/governance/standards-code/.
[ii] Institute for Safe Medication Practices (ISMP), *Reaffirming the "Do Not Use: Dangerous Abbreviations, Symbols, and Dose Designations" List,* 18, no.4, (2018), https://ismpcanada.ca/bulletin/reaffirming-the-do-not-use-dangerous-abbreviations-symbols-and-dose-designations-list/.