ALPP
THE ACADEMY OF
Lactation Policy
and Practice

Documentation Guidelines

For Certified Lactation Counselors® (CLC®)

Preamble:

- The goal is to promote health, meet the needs of the family, and provide safe, competent lactation care that is accurately documented and a collaborative part of the health care team.
- Critical thinking is an important skill of the Certified Lactation Counselor. The CLC must use evidence based interventions and document these interventions.

Guidelines:

Documentation is a key element in communication to promote continuity of care. The Certified Lactation Counselor can be an integral part of the health care team. Proper documentation is imperative and can impact the care of the mother and baby. It is important to accurately document. Documentation must be factual, accurate, current (timely), organized, and compliant with standards (Potter & Perry, 2010). Documentation can also assist quality improvement research teams to accurately assess patient care/outcomes.

Notes may contain (but are not limited to):

- Identification of the parent/baby.
- Documentation about education on specific areas of concern to the mother.
- Assessments of breastfeeding specifically including before and after weights (when necessary/possible), pain, and breast/nipple soreness.
- Breastfeeding assessment tool data (such as the Lactation Assessment Tool, LAT) and lactation statistics (e.g. time of first initiation of breastfeeding, if skin to skin was immediate and continuous after birth, if baby breastfed in first hour, exclusive breastfeeding, etc.).
- Documentation for supplementation (who ordered the supplement, what was supplemented, reason for supplement and delivery method of supplement).
- Observations and assessment of the mother and baby dyad.
- Lactation counseling notes (addressing the mother's concerns and appropriate evidence based information that addresses the mother's concerns).
- Development and implementation of a care plan.
- Plan for follow-up or additional services (and reevaluation of the plan).

- Progress notes (including unusual observations, descriptions of concerns and changes noted, and evidence of notification of others within the health care team and referrals as needed).

Expectations:

- Documentation of client care must adhere to laws pertaining to the privacy of health care information. Paper copies of records or electronic forms must be protected.
- Corrections to mistakes must follow employer/institution's policy for corrections.
- Only do what you are qualified to do. Stay within your scope of practice and document with the same language (be descriptive but not diagnostic).
- Never chart before providing care.
- Date and time all entries.
- Sign all entries.
- Do not use abbreviations (except for ones that are accepted by employer/institution).
- Entries must be legible.
- Use correct biological terms.
- Use objective, clear, and specific language that is inclusive and non-discriminatory.
- Documentation could be written by hand (legibly in pen, never pencil) or by electronic means.

Lack of documentation or untruthful documentation is a violation of the Academy of Lactation Policy & Practice Code of Ethics.

Perry, A. G., & Potter, P. A. (2010). Clinical nursing skills & techniques. St. Louis, Mo: Mosby/Elsevier.