# Documentation Guidelines

## Definition

The International Board of Lactation Consultant Examiners (IBLCE) defines clinical documentation as the written, typed or electronic record of information about a client or client group, which details the care provided. Client health records may be paper or electronic records such as electronic records, faxes, e-mails, audio or video recordings as well as pictures and diagrams. The record communicates observations, assessment, plan, interventions, evaluation, outcome and follow-up. Documentation has the potential to be admitted into legal proceedings.

## Underpinning Principles

The underpinning principles of clinical documentation are in line with local/state/province/federal laws. All documentation must be:

- Accurate, clear, comprehensive and concise
- Contemporaneous
- Documented by the clinician him/herself
- Dated, timed, and signed
- Legible and permanent
- Accepted abbreviations to the organization and/or legal requirements

And include:

- Maintained to ensure client confidentiality and security of the record
- Only corrections of one’s own mistake by using acceptable techniques and/or manner

International Board Certified Lactation Consultants (IBCLCs) are accountable for the care they provide and therefore their documentation of clinical events, this is enshrined in the Code of Ethics and Standards of Practice.

It is important to note that poor documentation can provide the foundation for a disciplinary complaint against an IBCLC and could lead to disciplinary action.

**References**

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