CG2 – Record Keeping Guidelines

Introduction

Record-keeping is an integral part of Nursing, Midwifery and Allied Health Professionals’ practice and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow (NMC 2009).

Records include anything that makes reference to the care of the patient and any record can be called as evidence as part of:

1. Coroners’ inquests or criminal proceedings
2. Nursing & Midwifery Council’s Fitness to Practice Committee.
3. Trust Investigation Panels
4. NHS Professionals’ disciplinary investigations

The approach to record keeping that courts of law adopt tends to be that ‘if it is not recorded, it has not been done’. Good record keeping helps to improve accountability and shows how decisions related to patient care were made (NMC 2009).

A number of common problems with record-keeping have been identified (Dimond 2005, HSC, 2003-2004). These are:

- Absence of clarity e.g. the meaning of ‘Had a good day’ and ‘slept well’ is not clear
- Failure to record action taken when a problem is identified, e.g. ‘is suffering increasing pain’ then no record of action taken
- Missing information, e.g. administration of a drug not documented
- Spelling mistakes, e.g. error in name resulting in wrong diagnosis
- Inaccurate records, e.g. changing a dressing or giving medication, when in fact the patient had not received the recorded treatment (leading to a nurse being removed from the Register)
- Failure to document conversations
- Failure to document care given
- Failure to document special needs
- Failure to record telephone calls, e.g. on risk of suicide
- Failures in communication between healthcare professionals
- Too much jargon
- Patient identification, e.g. entry of information on an identity band, clinical documentation and failure to transfer patient details on continuation sheets

Scope

This guidance applies to both paper and electronic records and includes handwritten clinical notes, emails and letters to and from other health professionals as well as care plans, birth plans and observation charts etc.
This guidance applies to all flexible workers on assignments for NHS Professionals in any healthcare setting including Acute, Primary Care & Community NHS Trusts. It is not intended to replace local NHS policies/guidelines, which must be adhered to. NHS Professionals flexible workers must be familiar with local Trust documentation. For Registered Nurses, Midwives and Health Visitors the guidance is intended to be used alongside and not replace Nursing & Midwifery Council guidelines (NMC 2009)

For Allied Health Professionals it is also intended to be used alongside and not replace the Health Professionals Councils Standards. (HPC 2008)

Guidelines

1.1 Health care professionals have a duty to keep up to date with, and adhere to, relevant legislation, case law and national and local policies relating to information and record keeping (NMC 2009).

1.2 Handwriting must be legible and written in blank ink to enable legible photocopying or scanning of documents if required.

1.3 Records must be accurate and written in such a way that the meaning is clear (NMC 2009) (HPC 2008).

1.4 Records must demonstrate a full account of the assessment made and the care planned and provided and actions taken including information shared with other health professionals.

1.5 All entries in a record must be dated (to include date/ month/ year), timed accurately and signed.

1.6 All entries in a record must be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient/ client.

1.7 All entries in a record must be recorded, wherever possible, with the involvement of the patient/ client or their carer and written in language that the patient can understand.

1.8 Records must demonstrate any risks identified and/ or problems that have arisen and the action taken to rectify them (NMC 2009)

1.9 First entries on each page of the record must include the printed name and signature of the person recording the information.

1.10 Abbreviations, jargon, meaningless phrases or offensive statements must not be included in any records.

1.11 In the event of an error being made, entries must be corrected by striking the error through with one line, and applying the author’s initial, time and date, by the correction. The original entry should still be read clearly. Errors must not be amended using white correction fluid, scribbling out or writing over the original.

1.12 Records must never be falsified
1.13 Health care professionals must develop communication and information sharing skills as accurate records are relied on at key communication points, especially during handover, referral and in shared care.

1.14 Legal requirements and local policies regarding confidentiality of patient records must be followed at all times.

1.15 Health care professionals remain professionally accountable for ensuring that any duties delegated to non-registered practitioners are undertaken to a reasonable standard and records made by pre-registration nurses/midwives or care support workers are countersigned (NMC 2005) (HPC 2008).

2. Guidance for Non-Registered flexible workers

2.1 Entries may be made to patients’ records in line with local Trust policy.

2.2 Entries to a patient’s record must be to the standard outlined above and where applicable countersigned.

3. Electronic records

3.1 The principles of confidentiality of information apply to computer and faxed records as they do with all other records.

3.2 Registered Nurses, Midwives and Allied Health Professionals are professionally accountable for ensuring that they are aware of and know how to use information systems and tools available in their area of practice.

3.3 Registered Nurses, Midwives and Allied Health Professionals are accountable for any entry they make to a computer held record and must ensure that any entry made is clearly identifiable in accordance with local Trust policy.

4. References


VERSION HISTORY – CG2

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