A Record Keeping Practice Framework for Nursing Assistants

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Having the ability to record correctly is an important aspect of maintaining high quality Nursing/Midwifery documentation. This Framework sets out clearly the position in Northern Ireland regarding the record keeping practice of Nursing Assistant staff under the delegated authority of a nurse or midwife within a HSC Trust care setting.

The principles outlined within this framework apply to all record keeping practice, however, some tasks, for example, recording on 'bed end' charts such as fluid balance charts[1], may be assessed as a separate activity related to the delegated task. This could be via learning and development gained through Vocational Recognised Qualifications (VRQ).

Practice Statements

The framework applies to both new and existing Nursing Assistant staff.

Currently, any nursing assistant staff who records in nursing or midwifery records requires countersignature of the Nurse/Midwife who has delegated the task. This framework is composed of a number of practice statements which, once achieved, provide assurance that a nursing assistant [2] has the level of ability to keep records without supervision and countersignature (**Appendix A, page 4**).

Following achievement, annual appraisal and supervision processes should include a review of the practice of nursing assistant staff against the statements in the framework within HSC organisational policy and processes to assure on-going ability to record.

Whilst Nurses/Midwives are accountable for their decision to delegate tasks, the nursing assistant must be assured of his/her knowledge and skill to complete any task before accepting it.

It should also be noted that this document should be read in conjunction with the job descriptions and regional code[3] of practice for nursing assistant staff in Northern Ireland. For further information about delegation of care activities go to:

http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Code-A5-FINAL.pdf

Delegation section 11.1-11.3

New Nursing Assistant Staff

The framework process for new members of staff is as follows:

1. Following completion of the organisational initial induction programme, the person, along with his/her identified supervisor who must be a registered Nurse/Midwife, completes the assessment grid using the assessment scale provided.
2. The nursing assistant in collaboration with the registered Nurse/Midwife agrees an action plan to acquire the relevant knowledge, skill and behaviours that are needed

[1] Band 2 and 3 staff may engage in a range of such activities that have a component of record keeping assessed within the competence to complete the task.
[2] Nursing Assistant for the purposes of this document refer to staff at band 3 who report directly to a Registered Nurse or Registered Midwife.
[3] https://www.health-ni.gov.uk/publications/standards-nursing-assistants-and-associated-resources

defined through the assessment process. Activities that might assist in learning and development include:

- Reading a current journal article about record keeping practice
- Writing a reflective account about an area related to record keeping practice
- Shadowing those completing records who have been deemed able to do so on their own
- Accessing the resources online in the NIPEC Improving Record Keeping website for registered Nursing/Midwifery staff
- Engaging in supervision[4] or review of record keeping practice related to the staff member to support learning and development.

3. The staff member works through his/her plan gathering evidence to present back to the registered Nurse/Midwife acting as a supervisor.
4. Whilst the staff member is working through the learning and development needs, all records must be countersigned by the delegating registered Nurse/Midwife.
5. Countersignature in this context is evidence that the record has been reviewed and discussed. It is ***not*** a witness to the contact or treatment given however registrants are advised that they remain professionally accountable for the appropriateness of the delegation to pre-registration students and other unregistered staff.

   If the conditions for appropriate delegation have been met and an aspect of care is delegated, the delegatee becomes accountable for his/her actions and decisions. The Nurse/Midwife remains accountable, however, for the overall management of the person in their care.
6. The development of knowledge and skills should be completed up to and not exceeding a six month period after the end of the induction programme. It is the responsibility of the supervising registered Nurse/Midwife review progress with the nursing assistant at the midpoint of the learning activities. The purpose of this review is to support learning and development, providing opportunity to plan further activities, if required, which will help successful completion.
7. In the event that circumstances arise which prevent completion within this timeframe e.g. a period of illness, agreement should be negotiated with the supervising Nurse/Midwife and recorded in the individual's action plan for extension, with the approval of the relevant line manager.
8. Following achievement of the learning and development action plan and demonstration of ability for all indicators, the practice statements can be signed off by the registered Nurse/Midwife supervising the nursing assistant.
9. Where a practice statement cannot be signed off due to non-achievement, normal HSC Trust capability processes will apply.

[4] *Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice, and enhance service-user protection, quality and safety of care. NIPEC 2006. For Further information regarding the review of clinical Supervision and other projects, please go to: www.nipecdf.org*

Existing Nursing Assistant Staff

The process for assurance of ability related to record keeping practice for existing members of staff is as follows:

1. Review of record keeping practice should take place on an annual basis through existing annual review/supervision mechanisms[5].
2. It is recommended that there is a review of the individual's record keeping practice against the practice audit tool described at Appendix A, page 4 of this document as part of existing HSC development review processes.
3. Evidence of record keeping practice, e.g. a written record containing the practice of the individual and audits of practice which demonstrate compliance with the *Person Centre Standards for Nursing and Midwifery Record Keeping Practice*[6] may also be presented within this annual review to assure the reviewer of on-going ability.
4. Where the practice of a member of staff falls below the standard required, an action plan should be agreed to address any identified learning and development needs, through assessment against the practice framework used for new staff. The action plan related to the learning and development required should be completed within a period of up to and not exceeding a six weeks.
5. Compliance with this framework will provide assurance to the Executive Directors of Nursing of on-going competence related to record keeping practice of nursing assistant staff.

[5] *The NHS Knowledge and Skills Framework (NHS KSF) and the development review process*, Department of Health, October 2004, available from www.nhsemployers.org/agendaforchange has a core dimension of Communication within which record keeping can be reviewed.

[6] http://www.nipec.hscni.net/recordkeeping/docs/Standards%20for%20Nursing%20and%20Midwifery%20Record%20Keeping%20Practice.pdf

Appendix A - The Practice of Keeping Records for Nursing Assistants

The next page presents a set of short statements to test your knowledge and skills in the practice of record keeping. In discussion with your supervisor, who should be a registered nurse or midwife, look at each statement and test your knowledge and skill by reflecting on your practice. To complete this activity you should:

1. Use the grid page 5 – 6, to record 'achieved' or 'not achieved' against each practice statement.
2. When you have completed this exercise, look at the statements which you have scored as 'not achieved'. These are the areas in which you need to develop your knowledge and skills.
3. In discussion with your supervisor, plan learning and development activities that will help you achieve the knowledge and skills outlined in each practice statement. Much of your learning can be undertaken alongside your day-to-day working life. Those activities could include:
    - Reading a current journal article about record keeping practice
    - Shadowing those completing records who have been deemed able to do so on their own
    - Accessing the resources online in the NIPEC Improving Record Keeping website for registered nursing staff
    - Engaging in supervision or review of your record keeping to support learning and development
    - Writing a reflective account about an area related to record keeping practice
4. A written action plan of the activities have been agreed which will be part of your continuous development and existing HSC organisational processes. It is important that the completion date of your learning activity is recorded, along with any comments. This plan may be used as part of the evidence you need to meet requirements or for your annual review.

    The process of thinking about your practice (reflection) for the purpose of improving it, will benefit the people you care for as well as the other health care professionals you work with.

NURSING ASSISTANT: RECORD KEEPING PRACTICE

Practice Statements

Organisation: _____ **Name of Nursing Assistant (NA):** _____ **(To be completed within 6 months)**

Appraisal ☐ **Induction** ☐

	Date	Signature NA	Print Name	Signature Registered Nurse/Midwife	Print Name
Initial Assessment Date					
Midway Assessment Date					
Final Assessment Date					

Before using the practice statements the following knowledge awareness must be demonstrated and understood as this applies to practice. These must be signed off as achieved by both the member of staff and supervising registered Nurse/Midwife [please refer to xxxx HSC Trust Intranet]	**Achieved**	**Not Achieved**
Principles outlined in legal[7] and organisational policy standards for record keeping and delegated professional standards countained within the *Standards for Person-Centred Nursing and Midwifery Record Keeping Practice (2013)*[8].		
The rights of the people receiving care to confidentialityof information (in code 5.1-5.5), within the procedures and requirements of the Trust Policy and legal framework[6].		
The principles of organisation, storage and management of records in compliance with organisational policy.		
The principles under which information must be disclosed, with or without the permission of the person I am caring for		
The principles of requirement ro report back relevant information of importance to the registered nurse who has delegated the activity of care		
Record Keeping Practice Statements	**Achieved**	**Not**

[7] Legal and Professional frameworks include: Data Protection Act 1998, Freedom of Information Act 2000, Human Rights Act 1998.
[8] http://www.nipec.hscni.net/pub/Standards%20for%20Nursing%20and%20Midwifery%20Record%20Keeping%20Practice.pdf

			Achieved
1	I understand the purpose of record keeping: **e.g. I have had a discussion with my supervisor about the need to record factual timely information about the delegated care I have provided.**		
2	I gain permission from the nurse/midwife delegating the care activity to access records when needed for my work in line with work setting practices, policies and principles of data protection:		
3	I communicate with patients/ clients/ carers to support their understanding of what I have recorded about them and why: **e.g. There is a record of ongoing communication with the patient/client/carer**		
4	My record keeping practice reflects a factual timely record of the delegated care I have provided: **e.g. nursing assistant entry is dated, timed (24 hour format), signed legibly and in full, written in black ink, and designation clearly visible**		
5	I complete a factual record of care that I have provided and any problems arising: **e.g. the progress report records evidence of: actions and observations of the nursing assistant relevant to the delegated care activity; signs and symptoms that showed a change in condition; and the nurse/midwife this was reported to.**		
6	I record the preferences of people I care for, related to the delegated care activities I undertake, where possible: **e.g. record reflects the preferences of the person receiving care**		
7	I report to the delegating registered nurse/midwife accurate information related to signs and symptoms that might show a change in the condition of the person I am caring for: **e.g. a person has become unusually confused during a care activity. The nursing assistant reports immediately to the nurse/midwife delegating the activity and records this in the nursing/midwifery document.**		
8	I accurately record when I ask for permission/consent to undertake any of the activities I have been delegated, where relevant and appropriate: **e.g. there is a record of discussion with the patient/parent regarding obtaining consent for care were relevant /appropriate**		
9	I seek advice from a registered nurse when I require additional support related to my record keeping practice:		

Date	Statement Number	Action Needed	Review Date