NIPEC
Northern Ireland Practice & Education Council

Standards for **Person-centred Nursing and Midwifery Documentation**

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1.0 BACKGROUND AND CONTEXT

Good documentation, defined by the Nursing and Midwifery Council through The Code as clear and accurate records relevant to practice, is an integral component of a nurse or a midwife's role. It maintains safety, helps support effective communication and evidences decision making, professional judgement and care within professional practice.

Health and Social Care (HSC) organisations in Northern Ireland (NI), including the Independent and Primary Care sectors are now working within a digital environment, using digital systems such as encompass, EMIS and others, to document and plan care. It is therefore important to set standards that apply to digital documentation.

In 2022 the **'All-Ireland Nursing & Midwifery Digital Health Capability Framework'** was launched to provide support and guidance for colleagues and employers through the required digital skills and knowledge journey. The Framework recognises that:

- "Health and care professionals have a critical role in the capture, creation and recording of increasingly large quantities of clinical and health and care data".
- "Health and care professionals play a crucial role in the capture of complete, timely and accurate data".
- "Health and care professionals play a pivotal role in ensuring the accessibility, reliability, privacy, security and timeliness of data within health and care environments".
- Digital exchanges of "information provides the key to safe, quality health and care delivery and supported evidenced based activities".
- "Health and care professionals use information to develop, extend and support evidence-based care in critical decision making".

This document, hereafter referred to as the 'Standards' presents the revised version of the 'Standards for person centred nursing and midwifery record keeping practice' (2016). These Standards are developed in accordance with the legal obligations as outlined within the **Disability Discrimination Act (NI) (1995)**.

The Standards apply to both written and digital formats of documentation and follow guidance from **NHS England**. The Standards should be read in conjunction with Nursing and Midwifery Council's 'The Code; Professional standards of practice and behaviour for nurses, midwives and nursing associates', hereafter referred to as 'The Code' and organisational Records Management policies.

In addition, Nursing Assistants should read these standards alongside the **Standards for Nursing Assistants (2018)** and Maternity Support Workers should read these Standards alongside the **Standards for Maternity Support Workers**.

The Standards, reflect the ethos of the Person-Centred Framework (McCance and McCormack, 2021[1]), in which the mode and delivery of care is synonymous of the unique needs, preferences and values of individuals within Health and Social Care settings. This in turn is reflective within documentation.

For the purpose of clarity, the following definitions should be adopted when reviewing and applying the Standards:

1.1 A PERSON

A Person is anyone receiving care from a nurse, midwife or those aligned to the family of nursing and midwifery as outlined in the following section 'Scope of The Standards: Who do The Standards apply to?'

The Person may be receiving care in any care setting including:

- A hospital.
- In their residence.
- A care home including residential and nursing home.
- A sheltered dwelling.

General consent is a fundamental principle that ensures autonomy and right to make informed decisions about a person's healthcare. For the purposes of this document, it is assumed that any reference to "a Person" refers to a patient, client, or service user and is inclusive of the principle of general consent for care and treatment.

1 McCance T & McCormack B (2021) The Person-centred Practice Framework. In McCormack B, McCance T, Bulley C, Brown D, McMillan A & Martin S (Editors) (2021) *Fundamentals of Person-Centred Healthcare Practice*, pp.23-32. Oxford, Wiley-Blackwell

In addition, it is recognised that consent should be sought from a Person for a family member, carer and/or advocate to be included in conversations regarding their care and/or treatment. This may differ when a Person has been assessed as lacking in capacity to make a decision regarding specific treatment and will require a best interest approach. Each employing organisation will have relevant policies and procedures relating to this area of practice.

1.2 A PERSON'S RECORD

Section 205 of the **Data Protection Act 2018** defines a health record as a record which:

- Consists of data concerning health.
- Has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to who, the data relates.

1.3 DOCUMENTATION

An overarching term for any and all communication or records, both formal and informal, involving the Person receiving care, some of which are listed in the upcoming section 2.2.

2.0 SCOPE OF THE STANDARDS

2.1 WHO DO THE STANDARDS APPLY TO?

The Standards included in this document apply to documentation across all nursing and midwifery services in Northern Ireland completed by;

- Nurses
- Midwives
- Pre-registration Nursing and Midwifery Students
- Nursing Assistants
- Health Care Workers
- Senior Nursing Assistants; and
- Maternity Support Workers aligned to the family of nursing and midwifery.

These Standards apply to nursing and midwifery students, nursing assistants, senior nursing assistants and midwifery support workers as applicable under the direction and supervision (delegated authority) of a registered nurse or midwife[2]. It is important to note, that the delegator remains accountable for the person receiving care, the decision to delegate and the overall management of practice. Further, delegatee documentation must be reviewed throughout the delivery of person-centred care.

In regards to entries made by pre-registration nursing or midwifery students, these must be reviewed and countersigned by a registered nurse/midwife, as appropriate. However, it is recognised that countersignature does not confirm that the delegator witnessed the contact or treatment given by the delegate.

2.2 WHAT DO THE STANDARDS APPLY TO?

The type or format of documentation that nurses and midwives use will vary depending on their practice environment and may include;

- Handwritten Patient/Client records.
- Electronic Patient/Client records.
- Emails.
- SMS/MMS and the use of messaging applications.
- Letters to and from other health professionals.
- Clinical Reports.
- Statement Writing.
- Incident reports, complaint responses and related documentation.

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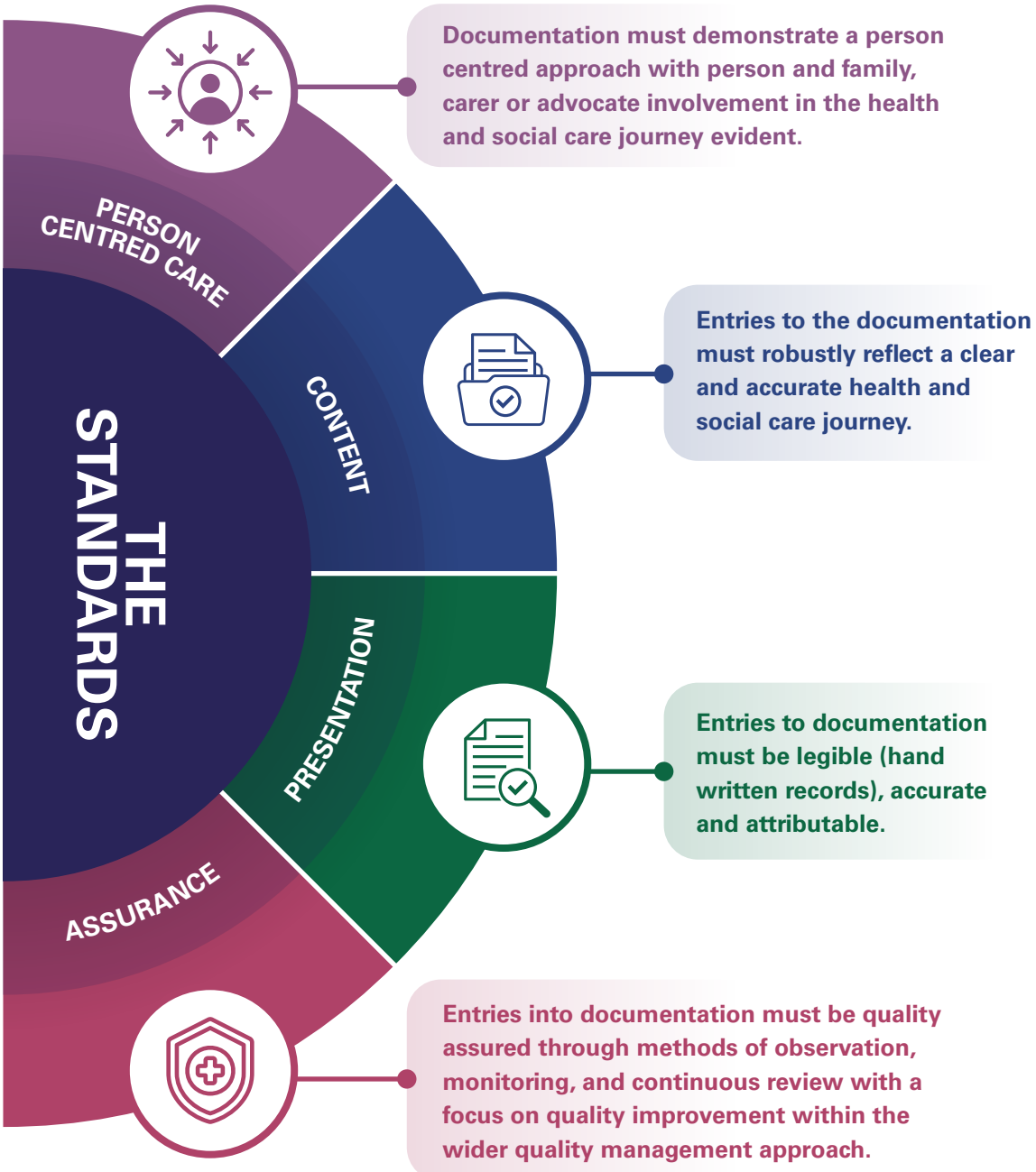
2.3 HOW ARE THE STANDARDS APPLIED?

Good documentation is integral to quality professional practice and is an essential component of safe, effective and person-centred care provision. The Standards set out associated Best Practice Principles of Documentation, which are summarised below;



Each Standard includes a "Statement of Understanding" which expands into a series of Best Practice Principles that can be used to support the development of an audit tool to measure compliance. Each Standard concludes with reference/ alignment to the Code.

3.0 PERSON-CENTRED CARE

Documentation must demonstrate a person-centred approach in the health and social care journey. To support the application of person-centred care there are processes within the Person-Centred Framework significant to documentation practices.

3.1 BEST PRACTICE PRINCIPLES

Digital and/or written entries to the Person's documentation must:

1. Demonstrate the involvement of the Person reflecting their beliefs and values; their needs and preferences including adaptive communication needs.
2. Demonstrate inclusive language, that can be easily understood by the Person.
3. Demonstrate the provision of holistic care.
4. Evidence a discussion has taken place to aid understanding of the options for care and/or treatment, ensuring the Person receiving care has had the opportunity to consider the right option for them.
5. Must provide evidence that those receiving and providing care are working collaboratively.

3.2 PERSON-CENTRED CARE RATIONALE

- A collaborative, holistic approach to care planning and delivery, should provide a mechanism for recording informed consent to care with recognition that there is a requirement to facilitate reasonable adjustments when and where required.
- A Person cannot be at the centre of their care if they cannot understand what their assessment, plan of care and evaluation is within their documentation.
- Through the Person's participation in documentation, clarification of how they wish to be cared for and treated is formed, reflecting their needs and wishes.
- Shared decision making is only achieved when a Person receiving and those providing care and/or treatment work jointly to make the best treatment and care decisions for each individual.

How Person Centred Care links with The Code

Prioritise People	Treat people as individuals and uphold their dignity. Encourage and empower people to share in decisions about their treatment and care.
Preserve Safety	Be open and candid.

4.0 CONTENT

Entries to the Person's documentation must reflect a clear and accurate health and social care journey.

4.1 BEST PRACTICE PRINCIPLES

Digital and/or written entries to the Person's documentation must:

1. Clearly identify the date and time, in 24 hour format, the entry was made. All entries should be as close to the actual time of the care, treatment or event as possible.
2. Be legible, accurate and a factual account of the Person's journey through health and social care. Digital systems may support devices which facilitate entries of voice notes or to automatically transfer recorded data such as vital signs or patient/client recorded information. If such devices are approved and used, it is the responsibility of the recorder of care to ensure the entry is accurate and suitable.
3. Not include jargon, meaningless phrases, text-style abbreviated language or personal opinion.
4. Documentation must include:

    - Person-centred processes.
    - Identification of risks and completion of risk assessment tools.
    - Assessments.
    - Individualised plans of care and subsequent evaluations.
    - Communication with the Person.
    - Communication with members of the multidisciplinary team.

Note:

The application of the **PACE framework** is required in certain care settings; however, it can be applied across all of health and social care. It is evidence based with person-centredness considered through the Person's journey in care. The four core aspects are; the Person; Assessment; Plans of Care and Evaluation.

It is recognised that whilst applicable, the PACE Framework is not used in all care settings and other frameworks are available.

4.2 CONTENT RATIONALE

- Contemporaneous record keeping ensures accuracy to documentation. Applying a consistent standard will ensure that nursing/midwifery documentation demonstrates the Person's chronological journey in health and social care. This will enable other members of the health and social care team to follow the plan of care and/or treatment effectively.
- Accurate documentation supports safe, effective and quality delivery of care
- Copying and pasting of documentation is discouraged in digital records. If there is intention to document someone else's words verbatim, it should be quoted and easily distinguished through the use of speech marks. This excludes the functionality in SMART digital tools where data may be re-used for specific and relevant purposes.
- Clear and accurate documentation of care given, is a key component of **enabling professionalism within nursing and midwifery practice**.
- An individualised plan of care should be established by a nurse/midwife based on the specific needs of the Person and should include nursing/midwifery interventions and outcomes.

How Content links with The Code

Practise Effectively	Communicate effectively, keeping clear and accurate records Use terms that people in your care, colleagues and the public can understand

5.0 PRESENTATION

Entries to health and social care documentation must be legible (hand written records), traceable, accurate and attributable.

5.1 BEST PRACTICE PRINCIPLES

Digital and/or written entries to the Person's documentation:

1. Must include the Person's name, date of birth and unique identifier on each element/page of paper documentation.
2. Must be legible and made in black ink for written documentation and black font used for digital documentation.
3. Must be signed and the nurse/midwife's name and job title must be printed alongside the first entry, for example, on a document signature recognition register. In the case of digital documentation, the entry must be uniquely identifiable as to who made the entry, therefore a system must be logged onto with an individuals own login details.
4. Must identify an error with a single line strike through with the date and time of strikethrough documented. The name, job title, signature or unique staff identifier of the nurse/midwife must also be recorded.
5. Made as an alteration or addition must be identified by the name, job title, and signature or unique staff identifier of the nurse or midwife (in the case of digital documentation) recording the alteration or addition, alongside the date and time of alteration/addition.
6. The only exception to this standard is when recording an error relating to a Controlled Drug Register. **The DHSSPS 2013 Regional Policy** document: The Safer Management of Controlled Drugs states that errors within a controlled drug register should be bracketed signed and countersigned by registered nurses or midwives.

5.2 PRESENTATION RATIONALE

- In order to deliver safe, effective and quality care, it is important to be able to review all documentation for every Person across health and social care.
- It is widely recognised that the use of black ink across professions and disciplines to document hand written records is the expected standards.

- Traceability of documentation is critical to ensure safe practice by nurses and midwives. Additionally, significant quality improvement in record keeping practice can be achieved through the ability to identify and attribute documentation to individual registrants.
- It is important that nursing and midwifery records are presented in a format that is legible, easily understood and recognisable to all health and social care staff, ensuring consistency in approach across all care settings.

How Presentation links with The Code

Practise Effectively	Keep clear and accurate records relevant to your practice Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

6.0 ASSURANCE

Entries into health and social care documentation must be quality assured through methods of observation, audit and monitoring.

6.1 BEST PRACTICE PRINCIPLES

Must ensure that:

1. Confidentiality, security and data protection is maintained at all times during the provision and management of care. All staff must adhere to **Data Protection and GDPR Legislation**.
2. Log in credentials for digital systems are user specific for the purposes of safety, quality and traceability and must not be shared.
3. To mitigate the risk of entries on digital systems being made under the incorrect user, logging out is mandatory when leaving any device unattended.
4. Those who hold more than one role within health and social care, vigilance must be maintained when logging into digital systems to ensure documentation is being completed under the correct job role and work context.
5. Nurses and midwives only access records of a Person for whom they are caring for directly, or connected to reasonable use for the purpose of their job role.
6. Care is taken when accessing documentation, maintaining confidentiality and protecting records from those who do not have permission to view.
7. Where digital systems have adopted artificial intelligence (AI), measures must be in place to ensure these are used appropriately and in keeping with organisational policies/procedures and professional ethics.

Digital efficiency tools, are those which are designed to streamline critical workflows, reduce digital documentation burdens and support healthcare professionals in their daily tasks. As a result, they standardise communication while personalising patient records, saving time, whilst maintaining consistent and thorough documentation.

6.2 AUDIT

Documentation practice is an integral part of nursing and midwifery and there should be an Audit Programme within organisations, to assure the standard of documentation practice and identify any areas where improvements must be made.

6.3 ASSURANCE RATIONALE

- The use of digital efficiency tools such as Macros along with the use of AI must not replace the application of clinical/professional judgement. The person completing the record retains responsibility for accuracy and documentation that reflects person-centred care
- Documentation using digital efficiency tools to record care within digital systems must be monitored to ensure personalised and accurate records are completed for the Person's journey in health and social care.
- Auditing documentation standards is a method for continuous quality improvement, focusing on improvement rather than just compliance can lead to better outcomes and a more efficient health and care system[3].

How Assurance links with The Code

Prioritise People	Be accountable for your decisions to delegate tasks and duties to other people. Respect people's right to privacy and confidentiality
Promote professionalism and trust	Identify priorities... to make sure that the quality of care... is maintained and improved, putting the needs of those receiving care or services first.

3 Roberts, C, Smith, R. Improving Nursing records with audit. *Nursing Standard 7, 51, 37-39.*

APPENDIX A: A SUMMARY OF THE STANDARDS FOR PERSON-CENTRED NURSING AND MIDWIFERY DOCUMENTATION

	Statement	Best Practice Indicators	Rationale for Indicator	Application to The Code
Person-Centred Care	Documentation must demonstrate a person-centred approach in the health and social care journey. To support the application of person-centred care there are processes within the Person-Centred Framework significant to documentation practices.	Documentation must demonstrate the person's: 1. Involvement 2. Needs and Preferences 3. Inclusive language 4. Holistic care 5. Consent	✓ Equality ✓ Participation ✓ Agreement/ Best interests ✓ Understanding of care	**Prioritise People** — Treat people as individuals and uphold their dignity. Encourage and empower people to share in decisions about their treatment and care. **Preserve Safety** — Be open and candid.
Content	Entries to the Person's documentation must reflect a clear and accurate health and social care journey.	Documentation must be: 1. Contemporaneous 2. Accurate and factual 3. Clear 4. Demonstrate holistic recording of care	✓ Ensures accuracy ✓ Safe, effective and quality care ✓ Professionalism ✓ Individualised care based on specific needs	**Practise Effectively** — Communicate effectively, keeping clear and accurate records Use terms that people in your care, colleagues and the public can understand
Presentation	Entries to health and social care documentation must be legible (hand written records), traceable, accurate and attributable.	Documentation must: 1. Contain a Person's unique identifier 2. Be in black ink/legible (hand written records) 3. Be attributable 4. Contain clear tracing of errors, alterations and additions, when required	✓ Demonstration of the Person's health and social care journey ✓ Application of the appropriate standard to handwritten records ✓ Ensure completion of traceable documentation/ application of quality improvement approach ✓ To ensure understanding of the Person's documentation through application of a consistent format	**Practise Effectively** — Keep clear and accurate records relevant to your practice Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
Assurance	Entries into health and social care documentation must be quality assured through methods of observation, audit and monitoring.	Documentation must be considered in the context of: 1. Use of devices and systems 2. Audit	✓ Demonstrate confidentiality/ data protection, recording care within the correct job role/work context in systems and AI developments ✓ Ensure personalised and accurate documentation is completed ✓ Rolling audit is a method for continuous quality improvement for record keeping	**Prioritise People** — Be accountable for your decisions to delegate tasks and duties to other people. Respect people's right to privacy and confidentiality **Promote professionalism and trust** — Identify priorities... to make sure that the quality of care... is maintained and improved, putting the needs of those receiving care or services first.