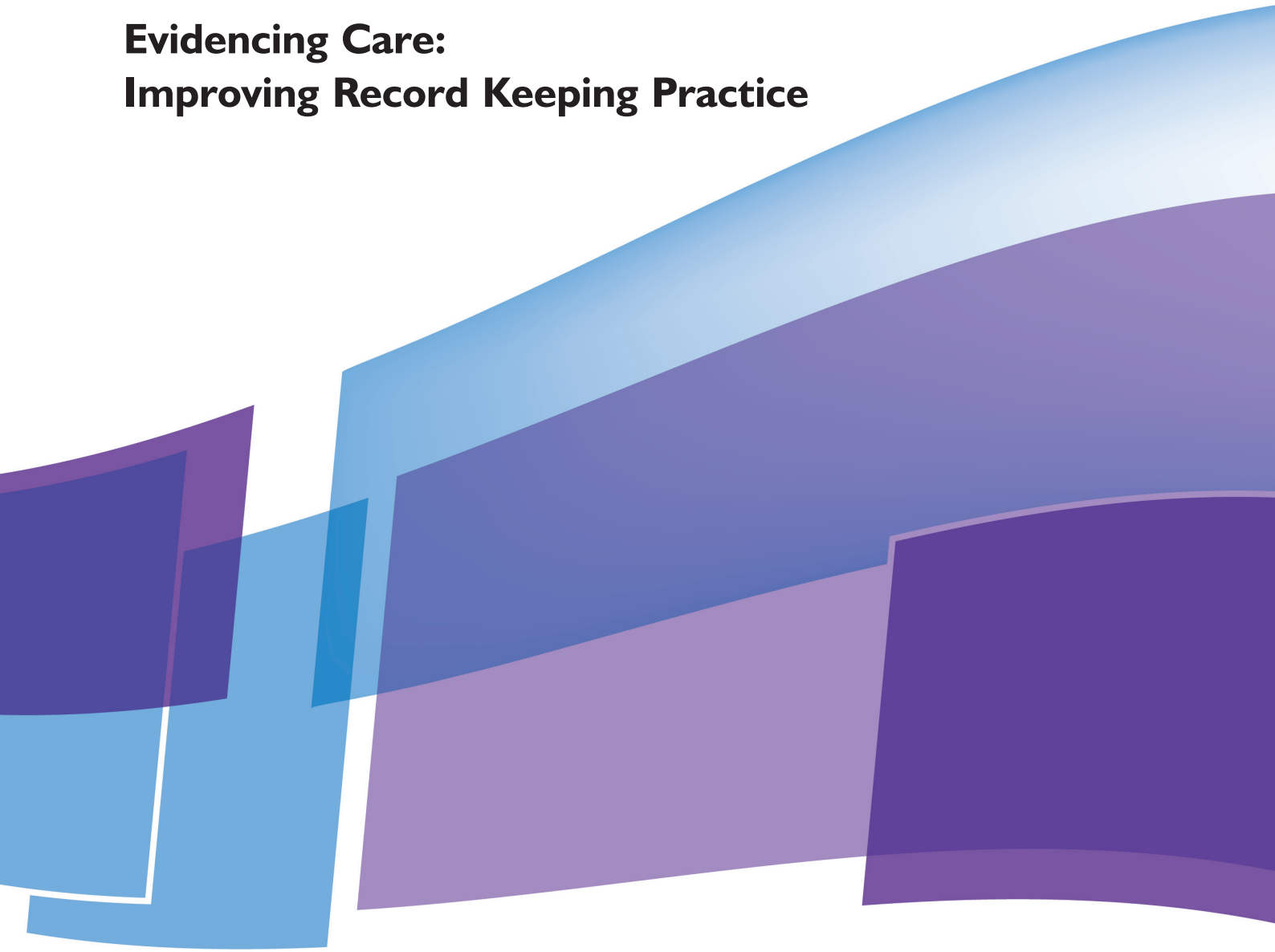
NIPEC

Evidencing Care:
Improving Record Keeping Practice



INVESTORS IN PEOPLE

Acknowledgements

Northern Ireland Practice and Education Council (NIPEC) would like to thank the nursing and midwifery registrants who assisted in the development of this guidance during workshops and the Regional Record Keeping Initiative.

The illustrations within this document focus mainly on acute adult care. However, they demonstrate the professional requirement of all nurses and midwives to maintain good record keeping practice.

Purpose

The purpose of this guide is to assist nurses and midwives in improving their record keeping practice. The aim is to build on the record keeping advice and guidance from the Nursing and Midwifery Council (NMC, 2009) and, therefore, this guide should be read in conjunction with the NMC Guidance.

The NMC (2009) principles of good record keeping state that records must be:

Factual

What is recorded is truthful and based on fact

Consistent

What is recorded is reliable and dependable

Accurately documented

What is recorded is clearly written – dated, timed and signed

In a logical sequence

What is recorded is understandable and written at the time of occurrence (contemporaneous)

Introduction

To ensure accurate and good record keeping, it is vital that nurses and midwives adhere to the principles that have been outlined in the NMC 2009 guidance in relation to the following **Mandatory Requirements.**

Patient Identification (NMC Principles 1,17, 23, 27)

Patient records should be written in such a way that the identity of the person for whom the record is being kept is evident throughout the document. **The person's name and record number or addressograph label should appear on every page of the relevant record.**

Author (NMC Principles 1, 2)

Records should be written in a way that makes clear who has written the entry. Nurses and midwives must sign entries using their name in full (not solely initials). They must also identify their position and status for example, Staff Nurse/Staff Midwife.

Point in Time (NMC Principles 1, 3, 4, 6, 7,)

The record should be dated and timed using the **24hour clock – day/month/year** format. **For example - 14:00hrs 24/06/2009.**

This should also normally be recorded in chronological order, for example in order of when the care/treatment/intervention happened. Late entries are acceptable, provided that they are clearly documented showing when they happened, and including a signature, time and date.

Permanent Marker (NMC Principle 14)

Records should be written in black ink to facilitate photocopying.

Complete Record (NMC Principles 6, 32, 33)

All sections of the record must be completed. If, however, there is a section that is not relevant to a particular person, then "not applicable" must be recorded.

For example:

Medication History If the patient is not taking any medication "not applicable" needs to be recorded

Alterations (NMC Principle 10)

No record should ever be deleted, scored out (so that it is not legible) or covered up using, for example, any type of correction fluid.

Errors (NMC Principle 11)

Any alterations or errors must be dated, timed and signed, while ensuring that the original entry can still be clearly read. Errors must be bracketed and have a single line drawn through them, so that the original entry is still legible.

For example:

14:00hrs 01/04/09 error J Bloggs S/N
Mrs Another attended X-Ray Dept for (~~Chest X Ray~~) Barium Enema.
J.Bloggs, Staff Nurse

Legal Aspects (All NMC Principles)

A person's health and social care records are legal documents. These include all clinical observations sheets, drug kardexes, records of other professionals and nursing and midwifery records. They will all be used as evidence in legal cases and in the investigations of complaints. Nurses and midwives have a legal, as well as professional, duty of care to ensure they keep accurate, clear and legible records.

Nurses and midwives must ensure that their record keeping is sufficiently detailed to demonstrate that they have discharged their duty of care. An evidence-based care plan and regular progress reports form the backbone to this detail (Griffith and Tengnah, 2008).

RECORD KEEPING IS AN ESSENTIAL PROFESSIONAL REQUIREMENT. IF IT IS NOT RECORDED, IT HAS NOT BEEN DONE!

Jargon and Abbreviations (NMC Principle 5)

The temptation to use jargon and abbreviations as a form of professional shorthand is compelling, especially for busy nurses and midwives. However, the risk of mis-communication increases dramatically and their use is, therefore, not good practice, unless there is an acceptable approved Trust policy. The use of these can be confusing and misleading to:

- Patients
- Peers
- Advocates
- Investigators
- Solicitors
- Families
- Health Professionals
- Complaints Officers
- Regulators.

Table 1 illustrates examples of good and unacceptable record keeping practices.
Please take careful note of the areas highlighted.

GOOD PRACTICE
Time and date using the 24hr format

UNACCEPTABLE PRACTICE
Wrong time format

UNACCEPTABLE PRACTICE
Initials only

Table 1

1/01/09 - 16:30hrs Mrs A attended X-Ray today at 14:00hrs for barium enema. Returned to the ward at 16:00hrs with no ill effects and has understood the procedure. Observations recorded on return, within normal limits for Mrs A. The report of the barium enema will be received from X-Ray tomorrow. Mrs A states she feels comfortable, no pain relief required at present. A. Green Staff/Nurse	4pm At X-Ray depart today for ba enema – fine on return AG
21/4/09 - 12.10hrs Community visit Day 6 post delivery. Maternal observations checked within normal parameters, neonatal observations checked and within normal parameters. Discussed with Anne (Mother) agreed date for next planned visit, Friday 24/06/09. Contact number given. B. Brown Staff/Midwife	Mother and baby both well. Review in 2 days

UNACCEPTABLE PRACTICE
No Date
No Time
No Signature
'both well'
Not enough information

GOOD PRACTICE
Name signed in full... Identifying post or position

Communicating with People and their Families

The quality of a nurse's or midwife's record keeping should be such that it demonstrates the continuity of care is person-centred and that the person's family/carer are always supported and included in decisions about care and treatment (NMC Principles 12,13). It is also essential that the views and comments of the person, or his/her family, regarding any aspect of care and treatment are included using quotation marks (Griffith and Tengnah, 2008).

This is evident when the records include:

- the views and observations of the person and his/her family members in relation to the assessment of the persons physical, psychological and social well-being
- the planning and provision of care which demonstrates that it was discussed and understood by the person and his/her family when appropriate
- identification of next of kin and the agreed family member/carer to whom information for other family members is provided.

Table 2 illustrates further examples of good and unacceptable record keeping practices in relation to communicating with the person and his/her family.

Table 2

12:00hrs 01/01/2009
Mr B was admitted today for a ..... procedure tomorrow accompanied by his wife. The procedure was explained to them both and on questioning they both confirmed that they "understood and were happy" with the plan of management for Mr B's treatment.

Consent to procedure was discussed signed for and witnessed.

Orientation to the ward was explained to them both, hospital information leaflets on infection control and visiting times were given.

Doctor W. informed of admission

C.Smith Staff Nurse

12:00hrs Mr B admitted as arranged for procedure tomorrow. Dr informed.

CS

✔ GOOD PRACTICE

Evidence that the person and relative were involved with the care planned

✔ GOOD PRACTICE

This record demonstrates a logical sequence of events

✘ UNACCEPTABLE PRACTICE

Not enough information
No evidence of the person or family involvement
Not dated or signed properly

The following sections of this guidance will concentrate on the different segments of the patient/client record relating to:

- Admission and Risk Assessment (Section 1)
- Care Planning (Section 2)
- Discharge Process (Section 3).

Section 1 – Admission and Risk Assessment

To ensure accurate record keeping during the admission and risk-assessment process, it is vital that the nurses and midwives adhere to the following.

Content and Style (NMC Principles 1, 4, 6, 7, 8, 9, 33)
Records should be written in a way that enables the reader to build a picture of why the person has been admitted to a health and social services facility. There must be written evidence that the admission form and any risk assessments have been completed.

The following tables outline illustrations to demonstrate examples of both good and unacceptable record keeping practices of the admission and risk-assessment process for adult nursing. Please take careful note of the areas highlighted.

Table 3

Surname: Green

Forename: James

Preferred name: James

Time & Date of Admission: 15:30hrs 12/12/09

Mode of arrival: Ambulance; accompanied by wife

Reason for Admission: Dehydration, vomiting, abdominal pain for past 72 hrs

Diagnosis: Possible gastric intestinal infection

Patient aware of reason for admission: Yes, understands he has been admitted to investigate 'stomach problems'

Temp: 37.5c Pulse: 88beats per minute Blood pressure: 150/90mmHg

Relatives aware of reason for admission: Yes, Mrs Green states she understands reason for husband's admission to investigate 'stomach problems'

✔ GOOD PRACTICE

Correct date and time format

✔ GOOD PRACTICE

Evidence of reason for admission
Evidence of person and family involvement
All parts of this section of admission form completed

Table 4

Occupation: Retired Postman

Date of Birth: 20/2/1930

Age: 79yrs

Religion: Presbyterian
(wishes to see hospital Chaplin)

Date: 12/12/09

Valuables: Cash – 5 x £10 notes – given to wife to take home

Dentures: Top and Bottom (present)

Spectacles: Reading glasses only – (with patient)

Hearing Aid: None

Other: Nothing to declare

General Practitioner: Dr Black

Address: Black Group Practice,
Belfast Road, Belfast

Telephone Number: 90876543

Patient's Name: James Green

Community Resources
on Admission: Not Applicable
1.
2.
3.

Mobility: Able to walk any length of distance with the aid of walking stick

Height: 5ft 6ins

Weight: 75Kgs

Urinary Habits:

Bowel Habits:

Urinalysis

Consultant: Dr Brown

Ward: Medical C Ward

✔ GOOD PRACTICE

All parts of this section of the record have an entry.
Spiritual needs are addressed.
Valuables – entry recorded states what is present and what has been sent home (i.e. money)

✘ UNACCEPTABLE PRACTICE

No record relating to urinary or bowel habits.
No urinalysis
This section of the assessment form is not completed properly

GOOD PRACTICE

Signed in full stating post/position

Table 5

Date/Time	Investigations/Referrals:	Signature
12/12/09 16:00Hrs	Mid Stream Specimum Urine	M. Jones Staff Nurse
12/12/09 17:00Hrs	Blood Cultures	M. Jones Staff Nurse
12/12/09 16:00hrs	Chest X-ray requested	M. Jones Staff Nurse
12/12/09 16:30Hrs	Chaplin Referral	M. Jones Staff Nurse

GOOD PRACTICE

Completed admission forms must be signed, dated and timed correctly. Patient hospital number must be recorded on every page especially if they are loose pages

Signature: M. Jones Staff Nurse (MARY JONES)
Date/Time: 12/12/09 - 17:00hrs
Hospital Number: 2345/09

Risk Assessments

Part of the admission procedure should include the assessment of risk, which may have a bearing on the patient's care and treatment whilst in hospital. It is important and good practice to complete these correctly, ensuring that they are dated, timed and signed properly.

Example of Risk Assessments that may be in use are:

- MUST (Malnutritional Universal Screening Tool)
- BRADEN Score (Predicting Pressure Sore Risk)
- Manual Handling
- Early Warning Score or Modified Early Warning Score
- Infection Control
- Falls Assessment.

Section 2 – Care Planning

To ensure clear and accurate record keeping of the care that has been planned, delivered and evaluated, it is vital that nurses and midwives adhere to the following.

Content and Style (NMC Principles 1,4,6,7,8,9,33)

Good record keeping can demonstrate person-centred care that meets the person's needs. These records should be written in a way that enables the reader to build a picture of why the person has been admitted to a health and social care facility. Therefore the reader should be able to gather from the record what is the:

- person's care needs
- identified desired outcomes
- nursing/midwifery interventions
- evaluation and review of the person care.

The written record of the planned care must be person-centred, and is crucial in monitoring progress and evaluation of care and communicating concerns.

Admission Summary

The following tables demonstrate examples of good record keeping practices in relation to sections of the care planning process. Please take careful note of the areas highlighted.

In the example shown in Table 6 the practitioner's entries clearly identify:

- reasons why the person has come into hospital
- where he was admitted from
- a recent history.

GOOD PRACTICE

Date and timed correctly

Table 6

Date/Time	Admission Summary	Signature
24/06/09 15:30 Hrs	Mr Green is a 68 year old man admitted to ward x from Accident & Emergency dept following an ambulance call out. He was found collapsed at the bottom of the stairs at home by his wife. Mr Green is orientated in time, place and person and states he is aware he has been brought and admitted to hospital following his collapse. He did not hit his head at any stage. Past Medical History – no other medical history of note to date. Not taking any medication currently. Initial Baseline Assessment of Mr Green Braden Score 18 - skin intact, no obvious signs of abrasions or bruising. Mr Green has needed assistance with personal hygiene over the last two days. Falls Assessment – Completed, see assessment sheet. Blood results from Accident & Emergency reveals haemoglobin of 7.0 g/d litre, examined by Dr Black, who has prescribed two units of packed cells for transfusion. Full blood picture to be assessed post blood transfusion. Chest X-ray – reveals Mr Green has upper lobe pneumonia, commenced on antibiotic orally (see medicine kardex). Oxygen therapy prescribed at 2 litres per minute at 24% via nasal specula as required. Mr Green and his wife (accompanied) understand the reason for his admission. Trust advice leaflets given regarding infection control practices and visiting.	Sara Smith Staff Nurse

GOOD PRACTICE

This is an example of a clear admission history, giving a baseline assessment and initial treatment. It is evident that the person and his family are included

The admission/assessment summary identifies that Mr Green has a number of needs that require prescribed treatment and a number of nursing interventions. Please note that there is evidence that both the patient and his family member understand the reason for admission. Please take careful note that the entry is **timed, dated and signed.**

The Care Plan and Progress Report

The example in Table 7 will demonstrate:

- the first identified need for Mr Green following the initial assessment
- what the desired outcomes should be
- the nursing care/ actions or interventions that will be applied to achieve the goal
- the frequency with which evaluation of the interventions should be recorded.

Table 7

Date/ Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discon'd	Sign
24/06/09 15:40Hrs	1. Mr Green requires transfusion of blood due to Haemoglobin of 7.0g/d litre	To raise Mr Green's Haemoglobin levels to 11-15g/d litre by administering blood transfusion as prescribed by Doctor.	A. Monitor and record temperature, pulse and blood pressure as per hospital policy for blood transfusion.	As required		S. Smith S/N
			B. Observe patient hourly for any signs of reaction (rash/rigors) to blood transfusion.	Hourly		
			C. Observe intravenous site for signs of infection/irritation.	Twice daily		
			D. If any of the above reactions occur – inform Doctor.			
			E. Monitor haemoglobin level 24hrs post transfusion.	25/04/09		
			F. Ensure Mr Green is positioned comfortably, call bell at hand.	Twice daily		
			G. Assist at meal times if required.	Daily		
			H. Record accurate Fluid Balance chart.	Totals twice in 24hrs		

GOOD PRACTICE

This desired outcome and nursing interventions relate to first identified need

Table 8 demonstrates the progress report of this first need, providing evidence of how the patient is progressing towards each of the outcomes set. There is also evidence that the patient has been involved in evaluating the goals.

Table 8

Date / Time	Personal Need	Daily Progress Report	Signature
25/06/09 19:00Hrs	1	Explanation given and verbal consent agreed with Mr Green to administer blood transfusion via intravenous cannula. Blood Transfusion 1st Unit completed at 21:15hrs – 2nd unit commenced at 21:30 hrs – no reaction noted. Clinical Observations (temperature, pulse, blood pressure) recorded hourly – as per hospital policy. IV Cannula is secure, no reaction noted. Mr Green feels well after 1st unit, informed that a repeat blood sample to be taken in morning. Fluid balance recorded. Assisted with meals. Mr Green stated he was positioned comfortably when asked.	S. Smith S/N

GOOD PRACTICE

Number correlates to 1st identified need

GOOD PRACTICE

This record demonstrates that patient's progress and evaluation. It relates to the first identified need

The Care Plan and Progress Report

The example in Table 9 will demonstrate:

- the second need of Mr Green, following the initial assessment
- what the desired outcomes should be
- the nursing interventions that will be applied to achieve the desired outcomes.

Table 9

Date/ Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discon'd	Sign
24/06/09 15:40Hrs	2. Mr Green is short of breath due to pneumonia and low haemoglobin	To relieve Mr Green's breathing problems before discharge to home	a. Monitor respirations and oxygen saturations due to patient having pneumonia.	4 hourly		S. Smith S/N
			b. Apply oxygen if required as prescribed by Doctor	6 hourly		
			c. Administer antibiotics as prescribed	4 hourly		
			d. Reposition in upright position for full lung capacity.	4 hourly		
			e. Monitor for signs of shortness of breath	4 hourly		
			f. Encourage patient to do breathing exercises			
			g. Refer to physio			

The example Table 10 demonstrates the progress report of patient's second need providing evidence of how the patient is progressing towards each of the desired outcomes set. There is also evidence that the patient has been involved in evaluating the outcomes.

Table 10

Date / Time	Personal Need	Daily Progress Report	Signature
24/06/09 15:40Hrs	2.	Oxygen saturations recorded, averaging 85-90, oxygen therapy not required. Nursed in the upright position. Mr Green states he is breathing easier and able to ease himself to sit up in the bed. Antibiotic therapy administered as prescribed Chest Physio assessment planned tomorrow.	S. Smith S/N

✔ GOOD PRACTICE

Progress recorded of the nursing interventions and the desired outcomes

The Care Plan and Progress Report

The example in Table 11 identifies:

- the third need of Mr Green, following the initial assessment
- what the desired outcomes should be
- the nursing interventions that will be applied to achieve the desired outcomes.

Table 11

Date/ Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discon'd	Sign
24/06/09 15:40Hrs	3.Mr Green states he is unable to attend to personal hygiene needs due to being "unsteady on his feet".	To assist and promote personal hygiene needs preparing Mr Green for discharge	a. Assist daily with personal hygiene at bathing/showering.	Daily		S. Smith S/N
			b. Assess patient's difficulty attending to own needs.	Daily		
			c. Refer to Occupational Therapy for assessment.	Daily		
			d.Encourage patient as much as possible to attend to own needs.			

The example in Table 12 then demonstrates the progress of this third need providing evidence of how Mr Green is progressing towards each of the desired outcomes set. There is also evidence that he has been involved in evaluating the desired outcomes.

Table 12

Date / Time	Personal Need	Daily Progress Report	Signature
24/06/09 15:40Hrs	3.	Mr Green up to the bath daily with assistance, steady while walking. Assisted with personal hygiene and promoted to attend to own needs. Informed that OT will assess ability. States that he feels more confident attending to personal hygiene	S. Smith S/N

GOOD PRACTICE

Progress recorded of the nursing interventions and the desired outcomes

Reflection

The previous examples have demonstrated good record keeping practice. The care plan identifies:

- the person's individual needs assessment
- what has to be achieved in terms of desired outcomes
- the nursing interventions
- evaluation of the interventions.

The records clearly indicate how often the evaluation of each of nursing interventions has to be performed. The desired outcomes and the nursing interventions are realistic, achievable, person-centred and evidence-based. The records demonstrate to the reader that it is evident the patient has been encouraged to be involved in the evaluation of the desired outcomes and nursing interventions set.

Incomplete record

Table 13 demonstrates an example of incomplete or inaccurate record providing little or no evidence of the planned care or care given. This type of record is not helpful in the following circumstances:

- communicating the person's progress/deviations/problems to other professionals
- communicating the person's progress/deviations/problems with the person and family or carers
- in the transfer of the person from one ward or one facility to another
- during the investigation of complaints/incidents/investigations.

Table 13

Date / Time	Personal Need	Daily Progress Report	Signature
25/06/09	1. Low Haemoglobin	Blood Transfusion – 2nd unit of packed cells in progress Hb in am. Fluid Balance recorded	
	2. SOB	Oxygen given	

UNACCEPTABLE PRACTICE

Record of the entire person need incomplete, Personal hygiene not recorded
Use of abbreviations

UNACCEPTABLE PRACTICE

No record of person's condition, clinical observations, or if he had any reaction to the blood transfusion.
No evaluation of his breathing problems

Unacceptable Practice

The example in Table 13 demonstrated that:

- there is no record of involvement of person or family/carer
- the record does not give a picture of the planned care or care given
- there is no record of the time when the 2nd unit of blood was commenced (this could present as a problem should a query arise)
- entries not signed.

Section 3 – Discharge Planning

Discharge planning is an accepted nursing and midwifery intervention aimed at the prevention of problems after discharge. The record component of the discharge process is an essential aspect of practice, as it serves as an effective communication tool for other health professionals. Records should reflect the person-centred approach and follow the principles contained in the NMC's Record Keeping: Guidance for nurses and midwives (2009).

Content and Style (NMC Principles 1, 4, 6, 7, 8, 9, 33)

Records should be written in a way that enables the reader to build a picture that focuses on the person in relation to:

- treatment planned within 24hrs of admission
- identified desired outcomes
- nursing interventions
- evaluation and progress report of nursing interventions
- a documented expected date of discharge
- evidence of a planned discharge.

Discharge Process

The care-treatment plan should be person-centred, with an expected date of discharge predicted within 24 hours of admission to a healthcare facility. Nurses and midwives should ensure that the person and family members are aware of the expected date of discharge from the time of admission. This is recognised as good practice and improves the person's experience (Webber-Maybank 2009).

The expected date of discharge should be reviewed at regular intervals. If there is a change to this date, it must be entered into the patient's record and communicated to the relatives.

Table 14 demonstrates an example of good record keeping practice as part of the admission assessment. (please see over)

GOOD PRACTICE

Expected date of discharge is recorded and evidence shows communication to the patient and family

Table 14

Surname:
Green

Forename:
James

Preferred name:
James

Time & Date of Admission:
15:30hrs
12/12/09

Mode of arrival:
Ambulance; accompanied by wife

Next of Kin:
Wife

Address:
As above

Address:
123, Old Street, Anytown,
Co Antrim

Telephone: 028 9065 4321

Reason for Admission:
Dehydration, vomiting, abdominal pain for past 72 hrs

Diagnosis:
Possible gastro-intestinal infection

Patient aware of reason for admission:
Yes, Mr Brown understands he has been admitted for investigations of 'stomach problems'.

Temp: 37.5c

Pulse: 88beats per min

Blood pressure:
150/90mmHg

Relatives aware of reason for admission:
Yes, Mrs Green states she understands reason for husbands admission is to 'investigate stomach problems'

Expected date for discharge:
20/12/09
Expected date of discharge given to Mr Green and his wife. They are happy with this and aware that the date will be reviewed.

Date reviewed:

Revised Date:

Discharge Planning
Mr Green is hoping to be discharged to his own home. Lives with his wife in a bungalow-type dwelling.

S. Smith S/N

GOOD PRACTICE

Record of person's living conditions and if he lives alone or has company

Fit for discharge

Persons are usually deemed 'fit for discharge' from hospital when the physiological, social, functional, and psychological factors or indicators have been taken into account, usually following a multidisciplinary assessment (DH, 2004).

It is, therefore imperative that continuous assessment of the person's progress towards the goal of discharge, involving the person and family, is demonstrated in the daily progress and evaluation record.

Table 15 demonstrates, for example, that one of Mr Green's identified needs could have been that he was:

Table 15

Date / Time	Personal Need	Daily Progress Report	Signature
14/12/09 15:40Hrs	C. Mr Green states he is unable to attend to personal hygiene needs due to being "unsteady on his feet".	Mr Green up to the bath daily with assistance, steady while walking. Assisted with personal hygiene and independence; encouraged to attend to own needs. Informed that Occupational Therapy will assess on 15/12/09 Mr Greens ability to independently attend to own needs. Mr Green states that he is beginning to feel more confident attending to his personal hygiene particularly as he lives in a bungalow and his bathroom is situated beside the bedroom.	S. Smith S/N

GOOD PRACTICE

Evidence of a progress and evaluation record of how Mr Green feels he has the ability to attend to own needs

Please take careful note that all of the entries are timed, dated and signed.

Information on discharge

It is important that there is a record of the information that has been conveyed and understood by person and their families before discharge, regarding:

- explanation and possible side-effects of the medicines they are taking home
- a letter to be sent to the General Practitioner
- details of dates and times regarding follow-up appointments if required
- details of community/liaison/specialist nurses' visits
- information leaflets about condition/procedures/treatment and follow-up care.

Information to other professionals

The following examples of information that should be recorded to inform other health professionals is evidenced by:

- the care, treatment and discharge arrangements having been discussed with the multidisciplinary/case management team
- a record of how the patient is progressing with the goals set
- the number and type of cannulae/lines removed
- what, if any, equipment or aids have been ordered or delivered to patient's home, e.g oxygen/nebuliser
- the community liaison team being informed of discharge; this would include the General Practitioner
- the person's home conditions having been assessed
- whether transport is arranged or if someone is accompanying the person home
- address checked for discharge to appropriate setting.

Conclusion

The examples in this guide are only illustrations to demonstrate the importance of good record keeping and to ensure that all areas have been dated, timed and signed.

It is recognised that there can be more complex admission, risk assessment, care planning and discharge arrangements that require extensive preparation. However, the recording of such preparations is vitally important.

Sufficiently detailed records show that the practitioner has discharged his or her duty of care. Nurses and midwives must, therefore, be mindful that their records are the key communication tool between themselves and other professionals as they allow for continuity of care.

Reflecting on Your Record Keeping

Does the record:

- ✔ Define the nursing/midwifery care focus for the person?
- ✔ Provide accurate evidence of the standard of your professional practice?
- ✔ Demonstrate the level of safety at which you have provided care?
- ✔ Demonstrate the experience provided to the patient though your care in relation to: Respect, Attitude, Behaviour, Communication, Privacy and Dignity (DHSSPS, 2008)?
- ✔ Accurately detail all of the care you have provided for the person?
- ✔ Demonstrate that you have discharged your duty of care (NMC 2009)?

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