

The Northern Ireland Practice and Education Council for Nursing and Midwifery

Standards for person centred nursing and midwifery record keeping practice

Principles found in the Nursing and Midwifery Council (NMC) Code (2015):

Partnership

2.1 'work in partnership with people'

Contemporaneous

10.1 'records at the time or as soon as possible after the event'

Accurate and Attributed

10.3 - 10.4 'clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation'

Communicate Clearly

7.1 'use terms that people in your care, colleagues and the public can understand'

Contents

Background and context 4

Scope of the standards 5

Standard statements

Person centred approaches 6

Content 7

Presentation 8

Governance 10

References and evidence base 11

It should be noted that the term 'patient/client' or 'person' refers to all individuals receiving care and treatment within any health and social care setting, or organisation engaged in care provision, such as the independent and voluntary sectors. This includes: women, children, adults, and those people with mental health needs or learning disabilities.

Background and context

The Recording Care Project Phase 1, 2011-2013 supported the production of standards for record keeping practice in nursing and midwifery in Northern Ireland, led and coordinated by NIPEC.

The standards document was drafted and offered to members of the project groups for comment. This also included comment from the Royal College of Nursing (RCN). Following this period of review, the standards document was then offered for a period of consultation to the public and professions, via the NIPEC website. The final document was launched by the Chief Nursing Officer in November 2013 and adopted for use in Northern Ireland across all nursing and midwifery practice settings.

In April 2016 a group of representatives from all care settings in the five health and Social Care Trusts was convened. The document was reviewed in conjunction with the Evidencing Care: Improving Record Keeping Practice (2010) guidance for record keeping practice. The outcome led to a decision that the Evidencing Care: Improving Record Keeping Practice (2010) should be removed from circulation and the standards document updated.

It is acknowledged that much of the content of the standards document aligns with *The Code, Professional standards of practice and behaviour for nurses and midwives*¹, the rationale being that it is important to ensure that best evidence indicated by the regulator continues to be at the forefront of practice.

These standards should also be read in conjunction with the NMC Code, particularly section 10, A record Keeping Practice Framework for Health Care Support Workers (2016), Health and Social Care Trust Records management policies, and other organisational policies related to record keeping practice, including local protocols.

Reference: 9, 11. (Page 11).

¹ Nursing and Midwifery Council. (2015). *The Code: Professional standards of practice and behaviour for nurses and midwives*. London, NMC

Scope of the standards

The scope of these standards is to include all forms of records that nurses, midwives, nursing or midwifery students and Health Care Support Work staff (HCSW) aligned to the family of nursing and midwifery will make. Where nursing or midwifery students or HCSW staff make entries to care records, they do so under the delegated authority of a registered nurse or midwife.

The type or format of record of care that nurses and midwives keep may vary, for example electronic or hard copy; however, the standards required for good record keeping practice apply to all types of records, regardless of format including:

- All types of handwritten clinical records, including multi-professional records
- All types of electronic clinical records, including multi-professional records
- Emails/texts
- letters to and from other health professionals
- laboratory reports
- printouts from monitoring equipment
- incident reports and statements

Good record keeping is an **integral part** of nursing and midwifery **practice** and is an essential component of safe, effective and person centred care provision. There are four standards set out under the following themes:

Person Centred Approaches

Content

Presentation

Governance

The standards are outlined within four statements which are then expanded into a series of key performance indicators against which compliance can be measured.

Each standard statement refers to records made by nurses and midwives. Where a task has been delegated to an unregistered member of staff which includes a record keeping component, these standards must be applied appropriately.

Person centred approaches

Patient/client records must demonstrate patient/client/carer involvement in the patient/client journey from admission to discharge from the service.

Key Performance Indicators

Entries to patient/client records:

1. Must demonstrate the involvement of the person for whom care is being provided or where appropriate, and with the person's consent, the involvement of his/her carer in the record keeping process.
2. Must demonstrate that the needs and preferences of the person for whom care is being provided, where appropriate, have been included in the record keeping process.
3. Must demonstrate that appropriate consent for care/treatment has been sought from the patient/client.
4. Must be written in a way which can be easily understood by the person for whom care is being provided.

Rationale:

People have a right to expect that they will be equal partners, wherever possible, in the compilation of the record of their nursing or midwifery care and treatment. The nursing or midwifery record should reflect a collaborative approach to care planning and delivery, and provide a mechanism for recording informed consent to care provided. This aspect is highlighted in section 2.1 – 2.5 of the NMC Code.

Through patient/client participation in record keeping, clarification of how the person wishes to be treated and cared for is formed, reflecting his/her needs and wishes.

Where a person is unable to express his/her wishes in relation to treatment choices due to issues of cognitive impairment or lack of capacity, the registrant will act in the best interests of the individual and reflect such action in the record.

Through patient/client participation in record keeping, important information for improving the quality of the care giving process may be received.

References: 3, 4, 7, 10 (page 11).

Content

Entries to records must demonstrate accurate, contemporaneous, factual record keeping practice in relation to the patient/client journey from admission to discharge from the service.

Key Performance Indicators

Entries to patient/client records:

1. Must be accurate, factual and must not include jargon, meaningless phrases or text-style abbreviated language.
2. Must identify the date and time in 24 hour format. This must be in real time and chronological order, and be as close to the actual time of the event as possible.
3. Must demonstrate details of all assessments, risk assessments, plans of care and reviews undertaken, and provide clear evidence of the arrangements made throughout a person's journey from admission to discharge from the service.
4. Must identify dates and times for the evaluation of the plan of care.
5. Must demonstrate that review of the plan of care has been carried out.
6. Must demonstrate evaluation of care and treatment.
7. Must demonstrate that discharge planning, where appropriate, has commenced at the time a person enters a care setting.

Rationale:

Good record keeping is essential to the provision of safe, effective person centred care. This practice requirement is presented in the NMC Code. Specifically, section 3 and 10.

Principle Standards for the use of Abbreviations within Health and Social Care settings can be found at reference 10.

An individualised plan of care should be established by a nurse/midwife based on the specific needs of the person, which includes nursing/midwifery diagnosis, interventions and outcomes.

Applying a content standard will ensure that the nursing/midwifery record demonstrates a chronological journey from admission to discharge from a care setting. This will enable other members of the health care team to follow the plan of care and treatment effectively.

References: 4, 5, 8, 10, 11 (page 11).

Presentation

All entries to patient/client records are legible, accurate and attributable.

Key Performance Indicators

Entries to patient/client records:

1. (Written entries) must be made in black ink and in legible handwriting.
2. Must be signed or contain a unique staff identifier in the case of electronic records. In the case of written records, the person's name and job title must be printed alongside the first entry, for example, on a document signature recognition register.
3. Made in error must be identified with a single line strike through, and the name, job title, signature of the nurse/midwife making the record, with the date and time of strike through, must be recorded in the original document².
4. Made as an alteration or addition should be identified by the name, job title, and signature of the nurse/midwife recording the alteration or addition, and the date and time of alteration/addition.
5. Must be made in records with a clearly identified unique patient number on each separate element.

Entries to patient/client records made by pre-registration nursing or midwifery students:

6. Must be countersigned by a registered nurse/midwife³.

Entries to patient/client records made by Health Care Support Workers (HCSW):

7. Must be countersigned by a registered nurse/midwife if the HCSW framework has not been undertaken or has not successfully been completed.

² The only exception to this standard is when recording an error relating to a Controlled Drug Register. The DHSSPS 2012 Regional Policy document: *Safer Management of Controlled Drugs* states that errors within a controlled drug register should be bracketed signed and countersigned by registered nurses/midwives.

³ 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 non-registered staff.

If the conditions for appropriate delegation have been met and a task or duty has been delegated, the delegatee becomes accountable for his/her actions and decisions. The nurse or midwife remains accountable, however, for the overall management of the person in their care.

Presentation *(continued)*

Rationale:

It is important that nursing and midwifery records are presented in a format that is easily understood and recognisable to all health care staff.

Significant quality improvement in record keeping practice can be achieved through the ability to identify and attribute record keeping practice to individual registrants.

Currently, HSC Trust organisations include the mandatory use of black ink in many of their policy arrangements for record keeping across the professions and disciplines.

The NMC code (2015), section 11 presents standards attributed to delegation. Guidance relating to the practice of Health Care Support Work (HCSW) staff entries to patient/ client records can be found in 'A record keeping Practice Framework for Health Care Support Workers'. This includes requirements relating to countersignature under the delegated authority of a nurse or midwife within a HSC Trust setting.

References: 4, 9, 11, 12 (page 11).

Governance

Regular organisational audit must demonstrate compliance with the standards for record keeping practice for nursing and midwifery.

Key Performance Indicators

1. Executive Directors of Nursing must ensure that there is a robust audit programme of records made by registered nurses and midwives, nursing and midwifery students and other non-registered staff, to assure the standard of record keeping practice and identify any areas where improvements must be made.
2. The standard of record keeping practice must be an integral part of nursing and midwifery Key Performance Indicators and Patient Safety Improvement programmes within HSC Trust or organisational governance arrangements.

Rationale:

Processes should be in place to monitor the standard of record keeping practice for nurses and midwives including non-registered members of staff aligned to nursing and midwifery, and where appropriate, actions put in place to address areas identified for improvement.

Rolling audit against agreed standards has been cited as a method for continuous quality improvement for record keeping, particularly where audit carried the clear responsibility of learning through measurement, and not merely for use as a method of indicating quality.

There are 2 audit tools available – shortened NIPEC Online Audit Tool (NOAT) and longer version NOAT, both valid in all care settings within HSC Trust and Non Statutory organisations. For further information on the rolling improvement programme of work and related resources please go to: www.nipec.hscni.net

References: 1, 4, 6, 9, 10 (page 11).

References and evidence base

1. Cheevakasemook, A., Chapman, Y., Francis, K. and Davies, C. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice*. 12: (6), 366-374. Cited in: Griffiths, P., Debbage, S. and Smith, A. (2007). A comprehensive audit of nursing record keeping practice. *British Journal of Nursing*. 16, 21; 1324-1327.
2. Department of Health, Social Services and Public Safety. (2012). *Safer Management of Controlled Drugs: a guide to good practice in secondary care (Northern Ireland)*. Belfast, DHSSPS.
3. Florin, J., Ehrenberg, A., and Ehnfors, M. (2006). Patient participation in clinical decision making in nursing: a comparative study of nurses' and patients' perceptions. *Journal of Clinical Nursing*. 15, 1498-1508.
4. Northern Ireland Health and Social Care Trust Records Management Policies and Procedures.
5. Jansson, I., Philhamar, E. and Forsberg, A. (2011). Factors and Conditions that have an Impact in Relation to the Successful Implementation and Maintenance of Individual Care Plans. *World views on Evidence-Based Nursing*. 8(2):66-75.
6. Kalsen, R. (2007). Improving the nursing documentation: professional consciousness-raising in a Northern-Norwegian psychiatric hospital. *Journal of Psychiatric and Mental Health Nursing*. 14, (6), 573-577.
7. Kärkkäinen, O. and Eriksson, K. (2005). Recording the content of the caring process. *Journal of Nursing Management*. 13, 202-208.
8. McCloskey, R. (2006). Documentation: Challenges and recommendations specific to long-term care. *Canadian Nursing Home*. 17, (3), 4-9.
9. Northern Ireland Practice and Education Council. (2016). *A Record Keeping Practice Framework for Health Care Support Worker*. Belfast, NIPEC.
10. Northern Ireland Practice and Education Council. (2016). *Principle standards for the use of abbreviations within health and social care settings*. Belfast, NIPEC.
11. Nursing and Midwifery Council. (2015). *The Code: Professional standards of practice and behaviour for nurses and midwives*. London, NMC.
12. Thompson, D. and Wright, K. (2003). *Developing a Unified Patient Record: A Practical Guide*. Abingdon, Radcliffe Medical Press.



For further information, please contact:

NIPEC
Centre House, 79 Chichester Street,
BELFAST, BT1 4JE

Tel: 028 95361192

Document downloadable from the
NIPEC website: www.nipec.hscni.net

May 2017

Planned review date – September 2019

ISBN No: 978-1-903580-44-8