Standards for person centred nursing and midwifery record keeping practice
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.

The following standard statements and indicators do not currently provide direct guidance regarding the countersignature of entries made to the person centred nursing assessment and plan of care document by Health Care Support Work staff. At the time of launch a regional approach is being discussed and will be included in a future updated version of this publication.
A part of the work plan of the Recording Care Project Phase 1, 2011-2013 was the intended production of a regional policy for record keeping practice in nursing and midwifery. This part of the Strand 1 work was anticipated to coincide with the production of standards for record keeping practice in nursing and midwifery by the Nursing and Midwifery Council (NMC), due December 2012. It became clear in March 2012 that the NMC were intending to stand down this area of work following the Strategic Review of the NMC by the Council for Healthcare Regulatory Excellence. At that point, following debate, the Steering Group of the Project took a decision supported by the Acting Chief Nurse, Executive Directors of Nursing and Chief Executive, NIPEC, to produce 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.

It is acknowledged that much of the content of the standards document aligns with the NMC Record Keeping: Guidance for nurses and midwives, 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, NMC Information on Delegation, Health and Social Care Trust Records management policies, and other organisational policies related to record keeping practice, including local protocols.
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
- 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.

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, 9, 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.


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.

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, 9, 10 (page 11).
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 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 strikethrough, must be recorded in the original document.

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. Should be countersigned by a registered nurse/midwife.

5 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.

6 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 their actions and decisions. The nurse or midwife remains accountable, however, for the overall management of the person in their care.
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.

References: 4, 9, 10, 11 (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 nurses and midwives, nursing and midwifery students and other unregistered 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 unregistered 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.

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


