Record Keeping Reflective Exercise
Registered Bank Members

Bank Member:

CIMS (if applicable):

Introduction

NHS Professionals is committed to the continuous professional development and support of all Bank Members. This reflective exercise is aimed to provide you with a framework for development and reflection in your current practice.

Clear and accurate record keeping is an integral part of health care practice and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.

Examples of Sources of Evidence

In gathering evidence to support you through this exercise a wide variety of evidence can be used. Two examples are detailed below; add two further examples in the table below.

Reflective Accounts	In line with revalidation reflection is an essential tool for Registrants to utilise, to think systematically about the phases of an experience or activity, what has been learned and how this relates to your practice and the Code.
Discussion/Questioning	Sharing experiences with your peers and questioning practice can improve the quality of care delivered to patients

Record Keeping Exercise

Competency	Your Practice Experience
What is your understanding of the key principles of record keeping as outlined in the NMC Code (2018) or HCPC Standards of Conduct, Performance and Ethics (2016)	
In line with the Data Protection Act (DPA) and General Data Protection Regulations (GDPR) how do you ensure good record keeping in practice?	
Why are you responsible and accountable in maintaining accurate patient records and how do you maintain confidentiality of patient information?	
Why is it important to complete written records in black ink?	
Why is it important to produce legible, factual, and accurate patient records, that are written up as soon as possible after an intervention and are signed, dated, and timed, with a full printed name and job title against the first entry?	
Why is it important to use your own log-in details when completing electronic patient records, and to log-out immediately following the entry?	
How do you ensure that your patient records give a full account of assessments and evaluations of care provided? -What information would you record regarding the patient's condition, records of referrals and arrangements for continuing care?	
Why should you ensure that your patient records are unambiguous, contain no jargon or abbreviations, and that any alterations are dated, timed and signed, and remain legible?	
Why is it important that errors are corrected with a single line through the incorrect entry? What else should be included?	
Why should patient care records be kept secure and not left accessible, or shared unlawfully with anyone not directly involved in the patient's care?	

References

NHS Professionals Record Keeping Guidelines (NHSP 2021)
NMC The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC 2018)
http://www.nmc.org.uk/standards/code/read-the-code-online/
HCPC Standards of Conduct, Performance and Ethics (2016).
http://www.hcpc-uk.co.uk/ Data Protection Act (DPA 2018)
https://www.gov.uk/government/collections/data-protection-act-2018
General Data Protection Regulations (GDPR 2018)
https://www.gov.uk/government/collections/data-protection-act-2018