NHS Professionals

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CG2 – Record Keeping Guidelines

Introduction

Record-keeping is an integral part of Nursing, Midwifery and Allied Health Professionals' practice and is essential to the provision of safe and effective care.

Health professionals must keep clear, accurate and timely records of the care they provide to their patients to support communication, continuity and decision making. It is not an added extra and should be completed in a timely manner, as close to the time that care was delivered as possible (RCN 2017).

Records include anything that refers to the care of the patient and any record can be called as evidence as part of:

1. Coroners' inquests or criminal proceedings
2. Nursing & Midwifery Council's Fitness to Practice Committee hearings
3. Trust Investigation Panels
4. NHS Professionals' disciplinary investigations

The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. Good record keeping shows how decisions related to patient care were made while poor record keeping increases the risk of harm when making decisions.

NHS Professionals Flexible Workers must comply with information governance and Data Protection policies in every NHS organisation where they work assignments to ensure that patient personal information is dealt with legally, securely and effectively to deliver the best possible care

Scope

This guidance applies to both paper and electronic records and includes handwritten clinical notes, emails and letters to and from other health professionals as well as care plans, birth plans and observation charts etc.

This guidance applies to all flexible workers on assignments for NHS Professionals in any healthcare setting including Acute, Mental Health and Community NHS Trusts.

It is not intended to replace local Trust policies/guidelines, which must always be adhered to.

NHS Professionals flexible workers must ensure they are familiar with local Trust documentation.

NHS Professionals flexible workers must comply with information governance and Data Protection policies and procedures to ensure that patient personal information is dealt with legally, securely, efficiently and effectively to deliver the best possible care.

For Registered Nurses, Midwives and Health Visitors this guidance is intended to be used alongside The Code Professionals standards of practice and behaviour for nurses and midwives (NMC 2015).

For Allied Health Professionals the guidance is intended to be used alongside the Health and Care Professions Council Standards of conduct, performance and ethics (HCPC 2018)

Guidelines

1.1 Health care professionals have a duty to keep up to date with, and adhere to, relevant legislation, case law and national and local policies relating to information and record keeping

1.2 Handwriting must be legible and written in blank ink to enable legible photocopying or scanning of documents if required.

1.3 Records must be accurate and written in such a way that the meaning is clear.

1.4 Records must demonstrate a full account of the assessment made and the care planned and provided and actions taken including information shared with other health professionals.

1.5 All entries in a record must be dated (to include date/ month/ year), timed accurately and signed.

1.6 All entries in a record must be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient/ client

1.7 All entries in a record must be recorded, wherever possible, with the involvement of the patient/ client or their carer and written in language that the patient can understand.

1.8 Records must demonstrate any risks identified and/ or problems that have arisen and the action taken to rectify them.

1.9 First entries on each page of the record must include the printed name and signature of the person recording the information.

1.10 Abbreviations, jargon, meaningless phrases or offensive statements must not be included in any records.

1.11 In the event of an error being made, entries must be corrected by striking the error through with one line, and applying the author's initial, time and date, by the correction. The original entry should still be read clearly. Errors must not be amended using white correction fluid, scribbling out or writing over the original.

1.12 Records must never be falsified.

1.13 Health care professionals must develop communication and information sharing skills as accurate records are relied on at key communication points, especially during handover, referral and in shared care.

1.14 Legal requirements and local policies regarding confidentiality of patient records must always be followed

1.15 Care records and information concerning people must not be left accessible or in public places.

1.15 Health care professionals remain professionally accountable for ensuring that any duties delegated to non-registered practitioners are undertaken to a reasonable standard and records made by pre-registration nurses/midwives or care support workers are countersigned

2. Guidance for Non-Registered flexible workers

2.1 Entries may be made to patients' records in line with local Trust policy

2.2 Entries in a patient's record must be to the standard outlined above

2.3 Supervision and countersigning of care records completed by non-registered flexible workers must take place until the worker is deemed competent

3. Electronic records

3.1.1 The principles of confidentiality of information apply to computer and faxed records as they do with all other records.

3.2 Staff must log out of electronic record systems when not in use (DH 2010)

3.3 Registered Nurses, Midwives and Allied Health Professionals are professionally accountable for ensuring that they are aware of and know how to use information systems and tools available in their area of practice.

3.4 Registered Nurses, Midwives and Allied Health Professionals are accountable for any entry they make to a computer held record and must ensure that any entry made is clearly identifiable in accordance with local Trust policy.

3.5 If a staff member does not have a smartcard or authorised access to the electronic system then the Registered Nurse in charge must record the name of the person that has provided the care.

3.6 The sharing of passwords or smartcards on electronic systems is prohibited

3.7 Staff members must never access a patient's record unless they are authorised to do so.

4. References

RCN (2017) Record Keeping and Countersigning Records Guidance
https://www.rcn.org.uk/professional-development/publications/pub-006134
Accessed 02/02/2018

NMC (2015) The Code Professionals standards of practice and behaviour for nurses and midwives
http://www.nmc.org.uk/standards/code/read-the-code-online/
Accessed 02/02/2018

HCPC (2018) Standards of conduct, performance and ethics
http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/Access
Accessed 02/02/2016

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3	March 2010	Document reviewed and updated	Karen Barraclough, Senior Nurse
4	November 2012	Document reviewed and updated	Karen Barraclough, Senior Nurse
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