From: Anne Mills with track changes as per 7th January following review by CNO

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DATE: 2 November 2012

To: Angela McLernon

PROJECTS INITIATED BY THE OFFICE OF THE CHIEF NURSE TO IMPROVE RECORD KEEPING PRACTICE (situation report October 2012)

Introduction

The purpose of this paper is to provide a situation report of developments of ongoing projects that have been initiated by the Office of the Chief Nurse to ensure sustained improvement in the quality of registrant's record keeping practices in Northern Ireland, and to consider the next steps for future proofing practice in the Digital Era.

Background

Since 2003 a number of public inquiries, including the Hyponatraemia inquiry and the C.Difficile inquiry in Northern Trust have highlighted issues relating to poor standards of record keeping by health professionals which has influenced the quality of patient/client experience and care. Themes arising from recommendations include incomplete records, information not recorded on admission, discharge and during episodes of care. There has also been lack of evidence of patient and carer engagement.

Since 2003 the Office of the Chief Nurse has given direction, instructed and commissioned NIPEC to take forward various projects to assist in the development of practice in record keeping in accordance with the Nursing and Midwifery Council Guidance for Record Keeping Practice.

This paper will outline the time line of the projects to date and will consider the context of evidencing and recording care in the future, and what steps need to be taken to future proof practice, to ensure the continuous improvement in the quality of registrant's input to patient records in electronic format.

Timeline of CNO Initiated Projects to Improve Record Keeping Practice

- **2003-2005: Northern Ireland Essence of Care Project (NIPEC)**

This project identified benchmarks of best practice within a number of important patient centred areas. The aim of the project was to develop and test the Essence of Care benchmarks in Northern Ireland. **Record Keeping** was identified as one of the nine core and essential aspects of care that impact on patients. There were 16 HPSS Trusts, 5 Nursing Homes, Marie Curie and Prison Nursing Service who took part aiming to improve the patients experience across various sectors of health care.

The Project Evaluation Report and the Essence of Care Review are attached at **Appendix 1**

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- **2008-2010: Regional Record Keeping Initiative (RRK1) (NIPEC)**

In August 2008 CNO met with nurse leaders to discuss approaches to take to improve the quality of registrant's record keeping. This led to CNO commissioning NIPEC to support a regional approach to enhance record keeping in nursing and midwifery practice. The overall aim of this project was to develop a suite of web based tools which are easily accessible by registrants to use to facilitate self assessment and learning for improvement in record keeping.

The web based tool went live in December 2010 and is accessible to all nurses and midwives in Northern Ireland.

The tools are attached at **Appendix 2;**

-Evidencing Care: Improving Record Keeping practice
-A Guide on Mandatory Requirements
-A Guide on Admission and Risk Assessment
-A Guide on Care Planning
-A Guide to Discharge Planning
-Audit Tool

A copy of the full report published in June 2010 is attached at **Appendix 3**

A copy of the Literature Review is attached at **Appendix 4**

A diagrammatic representation of the time-line of NIPEC RRK projects is attached at Appendix **5**

- **2009: Publication of eHealth in Northern Ireland (RCN, Centre for Connected Health)**

This project was supported by CNO and taken forward by the RCN and the Centre for Connected Health. The final report made key recommendations for the future of nursing practice in relation to ICT.

A copy of this report is available at **Appendix 6**

http://www.rcn.org.uk/__data/assets/pdf_file/0009/333729/E-HEALTH_BROCHURE.pdf

- **December 2010: Letter to Dame Deirdre Hine**

Dame Deirdre Hine wrote to Martin Bradley CNO in November 2010 in her role as Chair of the Inquiry into the C. Difficile outbreak in Northern Trust with regards Nursing Records. CNO responded to Dame Deidre in December 2010 outlining the NIPEC RRK1 project, and attached copies of the suite of Tools and Final Report to her.

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A copy of the letter (DH1/10/204376) is attached at **Appendix 7**

- **February 2011: CNO Department Initiatives to Support the Nursing and Midwifery Contribution to Wider DHSSPS Policy Initiatives for IP&C.**

Martin Bradley prepared a paper for discussion with executive nurses which outlined a range of CNO led initiatives taken forward to support the wider policy context for infection prevention and control.

A copy of the Briefing Paper (DH1/11/28163) is attached at **Appendix 8**

- **2010-11: Update on Developments Report (NIPEC)**

In December 2010 CNO commissioned NIPEC to continue this work and support the project board chaired by Alan Finn executive nurse in Western Trust to take forward a strategy for the continuous improvement in the standards of nursing and midwifery record keeping.

A copy of the Update on Developments Report is attached at **Appendix 9**

- **2011 Regional Record Keeping Initiative Bid (RRK2) (NIPEC)**

In 2011 a bid for professional officers, one for each Trust was developed by the steering group and put forward to the PHA. The bid was successful and project officers were appointed in each Trust to take forward and facilitate improvements in record keeping. On-going audit with the RRK1 audit tool demonstrated a 34% improvement in record keeping practice in the areas audited.

A copy of the bid is attached at **Appendix 10**

- **December 2011: Attendance at DoH Leadership for Informed Practice (LIP) Workshops**

Three senior nurses from policy, service and academia attended the LIP programme in December 2011. LIP is a three day programme which introduces senior nurses to the Innovation Theory and Leadership Behaviours that are considered to drive Innovation and Informatics in practice. The programme is now closed.

An outline of LIP is attached at **Appendix 11**

- **March 2012: Masterclass with Dr Susan Hamer Nurse for (LIP)**

In March 2012 Dr Susan Hamer gave a Masterclass as part of an evening Seminar to senior nurses, policy leads and programme leads from the Centre for Connected Health on the big ticket items in relation to Innovation, Informatics and Technology in practice.

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Claire Buchner Nurse Lecturer from QUB gave an update on Informatics in practice and talked about her experience on the LIP programme. Eddie Ritson from the CCHSC gave an update on the progress for the development of Tele-health and Tele-care in Northern Ireland. Alan Corry Finn chair of the Recording Care Steering Group chaired the event and Glynis Henry CEO of NIPEC gave the closing remarks.

A copy of the programme (DH1/12/82752) is attached at **Appendix 12**

- **May 2012: Letter from Alan Corry-Finn to CNO and Executive Nurses.**

Alan Corry-Finn sent a letter to CNO and Executive DoNs outlining a proposal, that the Recording Care Project should include the development of a set of high level standards for Record Keeping Practice to be hosted and managed by NIPEC.

A copy of the letter is attached at **Appendix 13**

- **September 2012: Steering Group Progress Report Strands 1 and 2**

Steering group progress reports were produced using a traffic light system to identify progress.

Strand 1 activities are around Standards Development, Documentation and Evaluation.
Strand 2 activities are around Improvement Methodology and Evaluation.
A copy of Strand 1 activity is attached at **Appendix 14**
A copy of Strand 2 activity is attached at **Appendix 15**

- **October 2012: Recording Care: Evidencing Safe and Effective Care Proposals for Future Funding Arrangements of Professional Officers HSC Trusts.**

The recording care steering group have prepared an update and briefing paper in which proposals are made for further funding of the professional officers in each Trust to carry on the role of recording care practice development facilitators.

A copy of the proposal is attached at **Appendix 16**

- **October 2012: Record Keeping Inventory of Document/Information Sent/Provided to DHSSPSNI-Nursing Officer Anne Mills**

NIPEC forwarded a copy time-line of documents forwarded to Anne Mills Nursing Officer with regards the Record Keeping project. To note that no formal minutes were taken of the meeting on 26th July. This was an informal stock-take meeting. Anne Mills has met with Angela Drury on two other occasions for update meetings with regards RRK Project.

Anne Mills was unable to attend regular meetings of the group due to clashes of diary priorities or Private Office work or Annual Leave. On each occasion Anne Mills checked if other NOs could attend. Denise Boulter attended the initial meetings, however due to staff numbers and other pressures other NOs have been unable to support attendance at group meetings.

A copy of this is attached at **Appendix 17**

The Future Context of Record Keeping

The following definition is generally agreed to sum up the scope of the Health Informatics discipline as it is currently practised.

> "Health Informatics is the knowledge, skills and tools which enable information to be collected, managed, used and shared to support the delivery of healthcare and to promote health."

Informatics is no longer a subject to be taught separately in the curriculum but simply the way we do things. The challenge for the HSC is keeping up with the speed of change and new ways of doing things.

Clinical knowledge is increasing at a faster rate than ever and it is now not possible for health and social care professionals to keep all we need to know in our heads. We increasingly rely on web based information which is also accessible to patients and the public. The relationship with patients is changing to something where the power of knowledge is held as much by patients as by their clinicians. The new clinical role is now often about guidance and health coaching rather than focused on treatment.

It is clear that we need an infrastructure that allows us to transfer patient-related information efficiently and securely, and helps us to assess our performance so that we can continue to improve; this is essential to the delivery of a high quality service.

The requirement for information is a constant theme – information for those who are providing care, information for patients and the public to make choices about their care, information for clinicians and other care providers who wish to assess and improve their performance, and information for researchers, planners, managers and regulators to improve services. In meeting these needs maintaining the security of personal data is paramount.

Health Records in the Digital Age: Implications for Clinical Practice

Health records serve many purposes in the modern healthcare environment, but fundamentally they are the foundation of high quality, safe patient care. All clinical

practice increasingly relies upon the electronic storage and communication of patient records and electronic communication of records.

Currently primary care leads the way; however the deployment of new clinical systems in the hospital sector will increasingly impact on acute care and parallel the changes already occurring in General Practice.

Use of health records can be divided broadly into primary and secondary functions. The record's primary function is to support direct patient care by acting as the basis of evidence for individual clinicians, supporting clinical decision making and providing an important means of communication with colleagues and with the patient.

The record's secondary function is to provide a legal record of care given and act as a source of data to support clinical audit, research, resource allocation, performance monitoring, epidemiology and service planning.

The need to monitor and improve the quality and safety of clinical practice and services, along with widespread increasing expectations and the increasing costs of care mean the structure and content of the clinical record is becoming ever more important. Moreover the implementation of electronic patient records in the HSC will critically increase the importance and need for structured records.

Structure and content standards are essential for ensuring that clinical data can be stored reliably, retrieved and shared between information systems. They need to be based on professional consensus that reflects best clinical practice and should facilitate, not hinder, the process of writing, communicating, retrieving and interpreting clinical information, so that care is safer and more efficient.

Record keeping standards can be sub-divided into two categories: generic standards for good practice and specific standards to define the structure and content in specific clinical contexts. Above all, standards are needed so that records are structured appropriately and clinical information is recorded in the right place, and account needs to be taken when writing the record that patients are able to have access either through the conventional Subject Access Request and / or through contemporaneous electronic access.

The health record is essentially a record of a very partial clinician view of the transaction between patient and clinician. However, we are entering a time when patients will be able to enter their own data and the record will become a more shared enterprise. Patients will be able to see their full or partial record at will and, ideally, this will be the whole, accurate, contemporaneous record, available anywhere, any time. Consequently, it will be increasingly important that clinicians understand the implications of patients being able to access their own health records and are able to provide support.

Patients in future will be able to access their Summary Care Record using the Patient Portals secure website. Patient portals will provide alongside a range of online services that patients can use to help support, manage and co-ordinate their health and care.

Patients in Wales will be able to access their Individual Health Record (IHR), as well as order prescriptions and book appointments with their doctor, through the *My Health Online* secure website.

Other systems are also currently available in the UK to enable patients to see their full GP record online or through kiosks in the waiting room, or through a smartcard. Currently, 60% of practices in the UK can enable their patients to access their GP records online securely and for free. There are substantial benefits for practices and patients.

This is the future picture of the management of information and electronic clinical records. The future is here now and there is an urgent need to accelerate education and learning for all clinical staff to enable high quality care through good information management.

The language of record keeping is changing and we must embrace informatics with a sense of urgency.

ANNE MILLS
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