NIPEC

EVIDENCING CARE:
IMPROVING RECORD KEEPING PRACTICE

A GUIDE ON

MANDATORY REQUIREMENTS

INVESTORS IN PEOPLE

Acknowledgements

Northern Ireland Practice and Education Council (NIPEC) would like to thank all the nursing and midwifery registrants who assisted in the development of this guidance during the Regional Record Keeping Initiative.

Purpose

The purpose of this guide is to assist nurses and midwives in improving their record keeping practice. The aim is to build on the record keeping advice and guidance from the Nursing and Midwifery Council (NMC, 2009) and, therefore, this guide should be read in conjunction with the NMC Guidance.

The NMC (2009) principles of good record keeping state that records must be:

Factual ⇒ What is recorded is truthful and based on fact

Consistent ⇒ What is recorded is reliable and dependable

Accurately documented ⇒ What is recorded is clearly written – dated, timed and signed

In a logical sequence ⇒ What is recorded is understandable and written at the time of occurrence (contemporaneous)

Introduction

To ensure accurate record keeping, it is vital that nurses and midwives adhere to the principles that have been outlined in the NMC 2009 Guidance in relation to:

Content and Style (NMC Principles 1, 4, 6, 7, 8, 9, 33)
Records should be written in a way that enables the reader to build a picture of why the person has come into contact with the health and social services, and what has been the care and treatment. There must be written evidence of the plan of management regarding the care and treatment; how care and treatment were implemented, evaluated and what was the outcome.

Patient Identification (NMC Principles 1,17, 23, 27)
Patient records should be written in such a way that the identity of the person for whom the record is being kept is evident throughout the document. The **person's name and record number or addressograph label should appear on every page of the relevant record.**

Author (NMC Principles 1, 2)
Records should be written in a way that makes clear who has written the entry. Nurses and midwives must sign entries using their name in full (not solely initials). They must also identify their position and status for example, Staff Nurse/Staff Midwife.

Point in Time (NMC Principles 1, 3, 4, 6, 7,)
The record should be dated and timed using the **24hour clock – day/month/year** format. **For example - 14:00hrs 24/06/2009.**

This should also normally be recorded in chronological order, for example in order of when the care/treatment/intervention happened. Late entries are acceptable, provided that they are clearly documented showing when they happened, and including a signature, time and date.

Permanent marker (NMC Principle 14)
Records should be written in **black ink** to facilitate photocopying.

Complete records (NMC Principles 6, 32, 33)
All sections of the record must be completed. If however, there is a section that is not relevant to a particular person, then **"not applicable"** must be recorded.

For example :–

Medication History	If the patient is not taking any medication "not applicable" needs to be recorded

Alterations (NMC Principle 10)
No record should ever be deleted, scored out (so that it is not legible) or covered up using, for example, any type of correction fluid.

Errors (NMC Principle 11)
Any alterations or errors must be dated, timed and signed, while ensuring that the original entry can still be clearly read. Errors must be bracketed and have a single line drawn through them, so that the original entry is still legible.

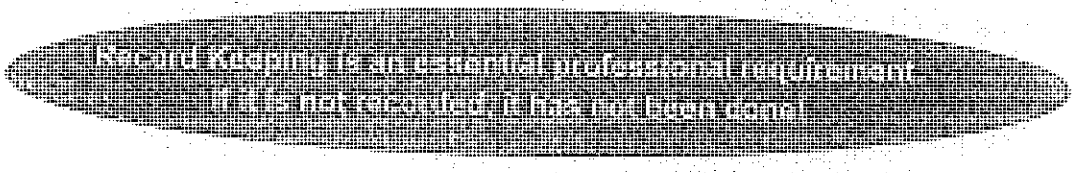
For example:

14:00hrs 01/04/09 error J Bloggs S/N
Mrs Another attended X-Ray Dept for (~~Chest X-Ray~~) Barium Enema.

J. Bloggs Staff Nurse

Legal Aspects (All NMC Principles)
A person's health and social care records are legal documents. These include all clinical observations sheets, drug kardexes, records of other professionals and nursing and midwifery records. They will all be used as evidence in legal cases and in the investigations of complaints. Nurses and midwives have a legal, as well as professional, duty of care to ensure they keep accurate, clear and legible records.

Nurses and midwives must ensure that their record keeping is sufficiently detailed to demonstrate that they have **discharged their duty of care.** An evidence-based care plan and regular progress reports form the backbone to this detail (Griffith and Tengnah, 2008).



Jargon and Abbreviations (NMC Principle 5)
The temptation to use jargon and abbreviations as a form of professional shorthand is compelling, especially for busy nurses and midwives. However, the risk of mis-communication increases dramatically and their use is, therefore, not good practice, unless there is an acceptable approved Trust policy. The use of these can be confusing and misleading to:

- Patients
- Peers
- Advocates
- Investigators
- Solicitors
- Families
- Health Professionals
- Complaints Officers
- Regulators

Table 1 demonstrates examples of good and unacceptable record keeping practices. Please take careful note of the areas highlighted.

Time and date using the 24hr format

GOOD PRACTICE

Table 1

Wrong time format

UNACCEPTABLE PRACTICE

Initials only

UNACCEPTABLE PRACTICE

1/01/09 - 16:30hrs

Mrs A attended X-Ray today at 14:00hrs for barium enema. Returned to the ward at 16:00hrs with no ill effects and has understood the procedure. Observations recorded on return, within normal limits for Mrs A. The report of the barium enema will be received from x-ray tomorrow. Mrs A states she feels comfortable no pain relief required at present

A. Green Staff/Nurse

4pm At x-ray depart today for ba enema – fine on return

AG

21/4/09 - 12.10 hrs Community visit Day 6 post delivery. Maternal observations checked within normal parameters, neonatal observations checked and within normal parameters. Discussed with Anne (Mother) agreed date for next planned visit, Friday 24/06/09. Contact number given.

B. Brown Staff/Midwife

Mother and baby both well review in 2 days

No Date, Time, Signature

'both well' Not enough information

UNACCEPTABLE PRACTICE

Name signed in full, identifying post or position

GOOD PRACTICE

Communicating with People and their Families

The quality of a nurse's or midwife's record keeping should be such that it demonstrates that the continuity of care is person-centred and that the person family/carer are always supported and included in decisions about care and treatment (NMC Principles 12,13). It is also essential that the views and comments of the person, or his/her family, regarding any aspect of care and treatment are included using quotation marks (Griffith and Tengnah, 2008).

This is evident when the records include:

- The views and observations of the person and his/her family members in relation to the assessment of the persons physical, psychological and social well-being
- The planning and provision of care which demonstrates that it was discussed and understood by the person and his/her family when appropriate
- Identification of next of kin and the agreed family member/carer to whom information for other family members is provided.

Table 2 demonstrates further examples of good and unacceptable record keeping practices in relation to communicating with the person and his/her family.

Table 2

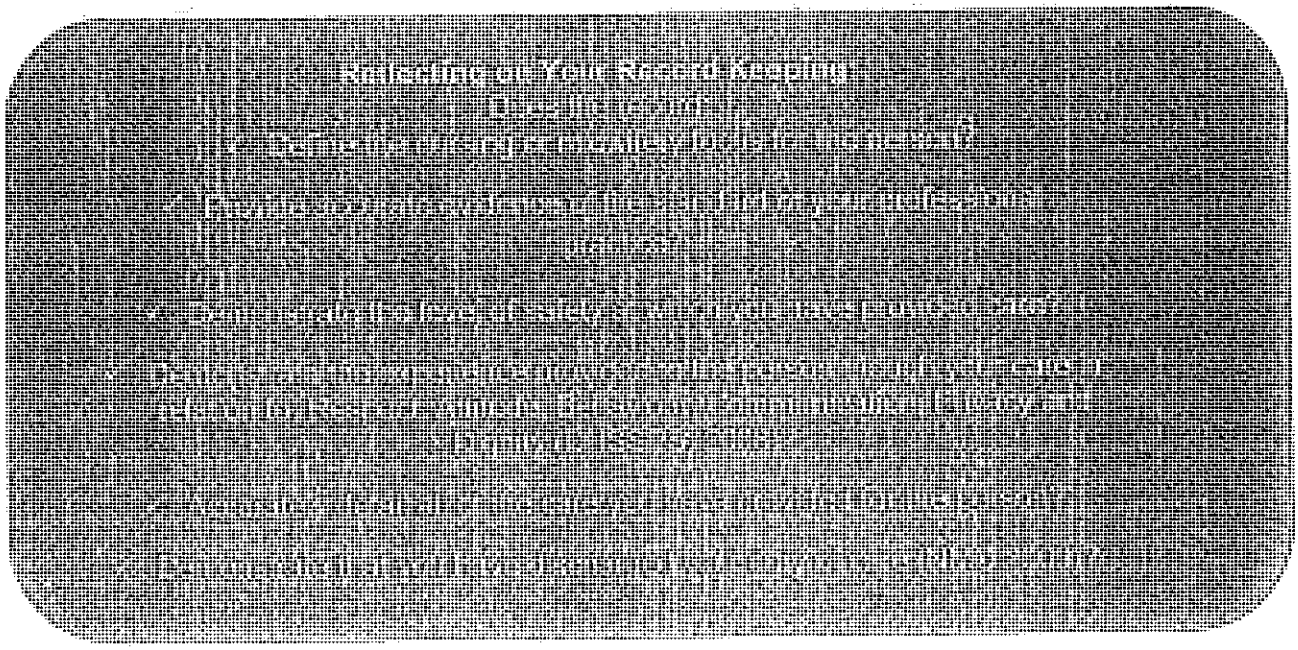
12:00hrs 01/01/2009
Mr B was admitted today for a .....procedure tomorrow accompanied by his wife. The procedure was explained to them both and on questioning they both confirmed that they "understood and were happy" with the plan of management for Mr B's treatment. Consent to procedure was discussed signed and witnessed. Orientation to the ward was explained to them both, hospital information leaflets on infection control and visiting times were given.
Doctor W. informed of admission
C.Smith Staff Nurse

This record demonstrates a logical sequence of events. GOOD PRACTICE

12:00hrs Mr B admitted as arranged for procedure tomorrow. Dr informed.
CS

Not enough information
No evidence of the person or family involvement
Not dated or signed properly

UNACCEPTABLE PRACTICE



This guide on **Mandatory Requirements** is part of a suite of resources, developed by NIPEC, to promote good record keeping practice. Supplementary papers demonstrating examples of good and unacceptable record keeping practices that include, **Admission and Risk Assessment, Care Planning and Discharge** are accessible via the NIPEC website www.nipec.hscni.net

References

Department of Health Social Services and Public Safety (2008). *Improving the Patient and Client experience.* Belfast: DHSSPS.

Department of Health Social Services and Public Safety (2009). *Code of Practice on Protecting the Confidentiality of Service User Information.* Belfast: DHSSPS.

Griffith, R. and Tengnah, C (2008). *Law and professional issues in nursing.* London: Learning Matters Ltd.

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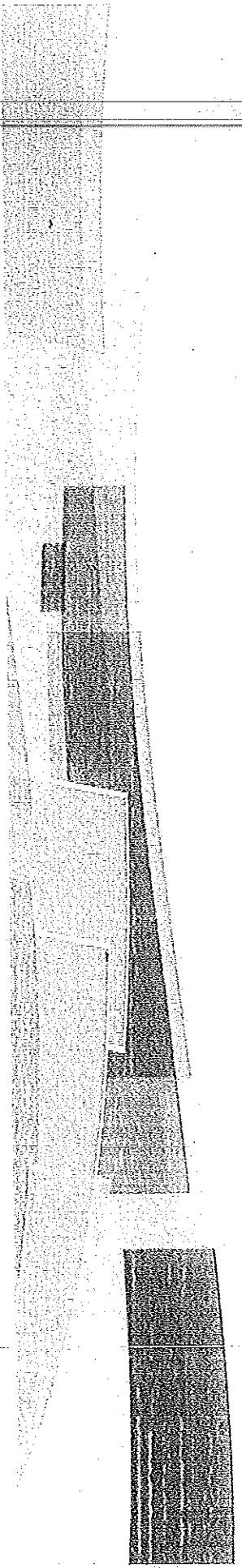

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JUNE 2010

NIPEC

EVIDENCING CARE:
IMPROVING RECORD KEEPING PRACTICE

A GUIDE ON

ADMISSION & RISK ASSESSMENT

SECTION 1

INVESTORS IN PEOPLE

Acknowledgements

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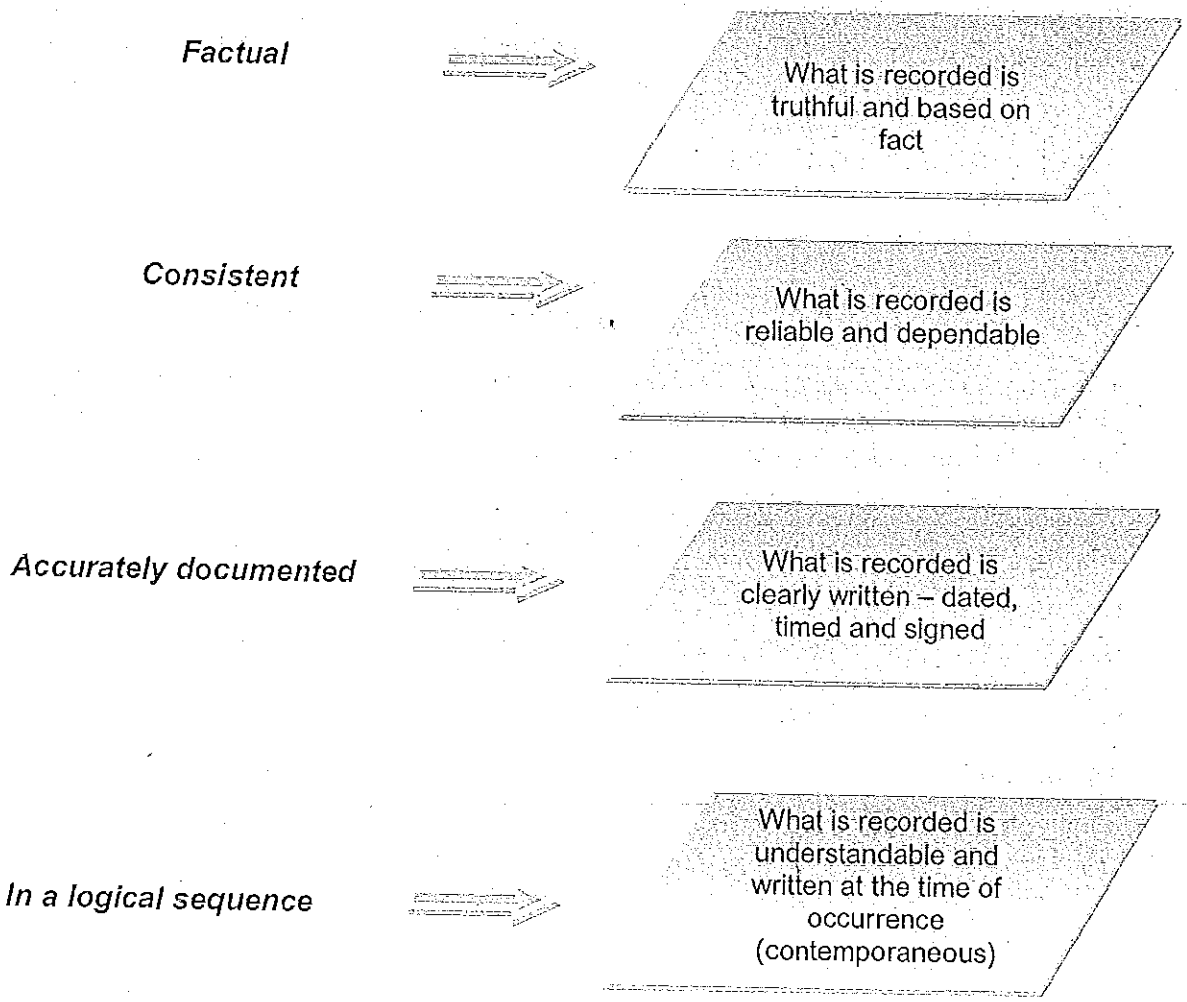
Purpose

The purpose of this guide is to assist nurses and midwives in improving their record keeping practice. This supplementary paper will concentrate on the admission and risk assessment process. The examples within focus on acute adult care, they however will demonstrate the requirement of good record keeping practice that can be interpreted to all fields of practice.

The aim is to build on the record keeping advice and guidance from the Nursing and Midwifery Council (NMC, 2009), and therefore this guide should be read in conjunction with the NMC Guidance.

The NMC (2009) principles of good record keeping state that records must be:



Introduction

To ensure accurate record keeping during the admission and risk assessment process, it is vital that the nurses and midwives adhere to the following:

Content and Style (NMC Principles 1, 4, 6, 7, 8, 9, 33)
Records should be written in a way that enables the reader to build a picture of why the person has been admitted to a health and social services facility. There must be written evidence that the admission form and any risk assessments have been completed.

Patient Identification (NMC Principles 1,17, 23, 27)
Records should be written in such a way that it is obvious to the reader that the identity of the person for whom the record is being kept is evident throughout the document. The person's name and record number or addressograph label should appear on every loose page of the relevant record. If a care pathway booklet is used then the person's name and record number should be on every section.

Author (NMC Principles 1, 2)
There must be evidence that admitting practitioner have signed all entries using name in full (not solely initials). They must identify their position, for example, Staff Nurse/Staff Midwife. In some areas, a register may be used that includes the names of all staff, along with their signatures. In those areas using care pathways, there is usually a 'sign in' sheet for staff to print their names on, with their usual signatures.

Point in Time (NMC Principles 1, 3, 4, 6, 7)
The admission assessment record should be dated and timed using the **24 hour clock – day/month/year** format. **For example - 14:00hrs 24/06/2009.**

It is of vital importance that the date and time of admission have been recorded. Late entries are acceptable, provided that they are clearly documented, showing when they happened including a signature, time and date.

Permanent marker (NMC Principle 14)
All records should be written in **black ink** to facilitate photocopying.

Complete records (NMC Principles 6, 9, 32, 33)
All sections of the admission assessment record **MUST** be completed. If however, there is a section that is not relevant to a particular person, then a record stating why it is not relevant needs to be written.

For example –

Allergies	if the patient does not have any known allergies then this must be recorded as: **No Known Allergies**

Alterations (NMC Principle 10)
No record should ever be deleted, scored out (so that it is not legible) or covered up using, for example, any type of correction fluid.

Errors (NMC Principle 11)
Any alterations to, or errors in the admission record must be dated, timed and signed, while ensuring that the original entry can still be clearly read. Errors must be bracketed and have a single line drawn through them, so that the original entry is still legible.

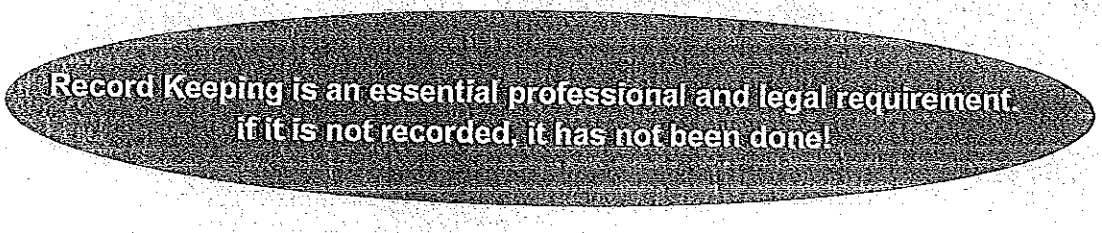
For example:

14:00hrs 01/04/09 error J Bloggs S/N
Mrs Brown admitted for ~~(Chest X-Ray)~~ Barium Enema, booked for 02/04/09

J.Bloggs. Staff Nurse

Legal Aspects (All NMC Principles)
A person's health and social care records are legal documents. These include **all clinical observations sheets, admission assessment sheets, drug kardexes, records from other professionals and all nursing and midwifery records.** They will all be used as evidence in legal cases and in the investigations of complaints. Nurses and midwives have a legal, as well as professional duty of care to ensure that they keep accurate, clear and legible records.

Nurses and midwives must ensure that their record keeping is sufficiently detailed to show that they have **discharged their duty of care.**



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The temptation to use jargon and abbreviations as a form of professional shorthand is compelling, especially for busy nurses and midwives. The risk of miscommunication increases dramatically and their use is, therefore, not good practice, unless there is an acceptable, approved Trust policy.The use of any jargon and /or abbreviations can be confusing and misleading to:

- Patients
- Peers
- Advocates
- Investigators
- Solicitors
- Families
- Health Professionals
- Complaints Officers
- Regulators

The following pages demonstrate examples of both good and unacceptable record keeping practices in relation to sections of the admission assessment process for adult nursing. Please take careful note of the areas highlighted.

Evidence of reason for admission
Evidence of person and family involvement
All parts of this section of admission form completed

GOOD PRACTICE

Surname: Green

Forename: James

Preferred name: James

GOOD PRACTICE

Correct date and time format

Time & Date of Admission: 15:30hrs 12/12/09

Mode of arrival: Ambulance accompanied by wife

Reason for Admission:
Dehydration, vomiting, abdominal pain for past 72 hrs

Diagnosis:
Possible Gastric Intestinal Infection

Patient aware of reason for admission:
Yes understands he has been admitted to investigate 'stomach problems'

Temp: 37.5c Pulse: 88beats per minute
Blood pressure: 150/90mmHg

Relatives aware of reason for admission:
Yes Mrs Green states she understands reason for husband's admission to investigate 'stomach problems'

Occupation: Retired Postman
Date of Birth: 20/2/1930
Age: 79yrs
Religion: Presbyterian
(Wishes to see hospital Chaplin)
Date: 12/12/09

Community Resources on Admission: Not Applicable
1.
2.
3.

Valuables: Cash – 5 x £10 notes – given to wife to take home
Dentures: Top and Bottom (present)
Spectacles: Reading glasses only – (with patient)
Hearing Aid: None
Other: Nothing to declare

Mobility: Able to walk any length of distance with the aid of walking stick
Height: – 5ft 6 ins
Weight: – 75Kgs

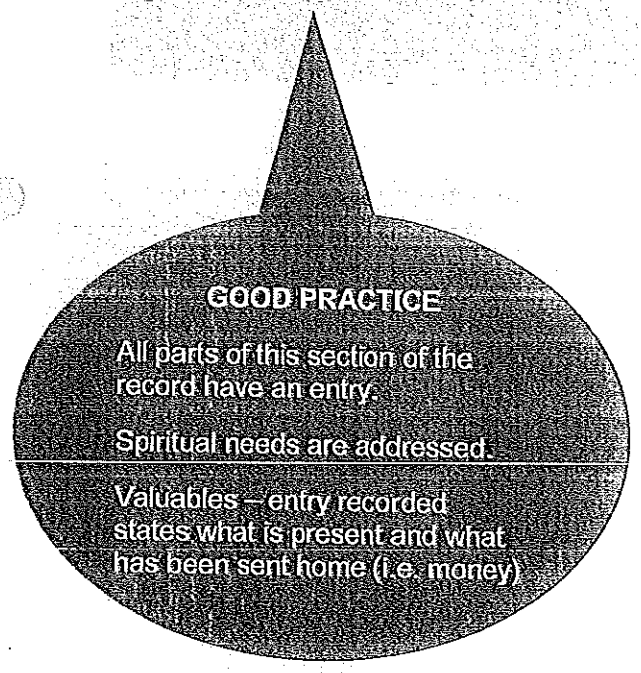
General Practitioner: Dr Black
Address: Black Group Practice, Belfast Road, Belfast
Telephone Number: 90 876543

Urinary Habits:
Bowel Habits:

Urinalysis:

Patient's Name: James Green

Consultant: Dr Brown
Ward: Medical C Ward



No record relating to urinary or bowel habits.
No urinalysis

This section of the assessment form is not completed properly

UNCCEPTABLE PRACTICE

Investigations/Referrals:

Date/Time		Signature
12/12/09 16:00Hrs	Mid Stream Specium Urine	M. Jones Staff Nurse
12/12/09 17:00Hrs	Blood Cultures	M. Jones Staff Nurse
12/12/09 16:00hrs	Chest X-ray requested	M. Jones Staff Nurse
12/12/09 16:30Hrs	Chaplin Referral	M. Jones Staff Nurse

GOOD PRACTICE

Signed in full stating post/position

GOOD PRACTICE

Completed admission forms must be signed, dated and timed correctly.
Patient hospital number must be recorded on every page especially if they are loose pages

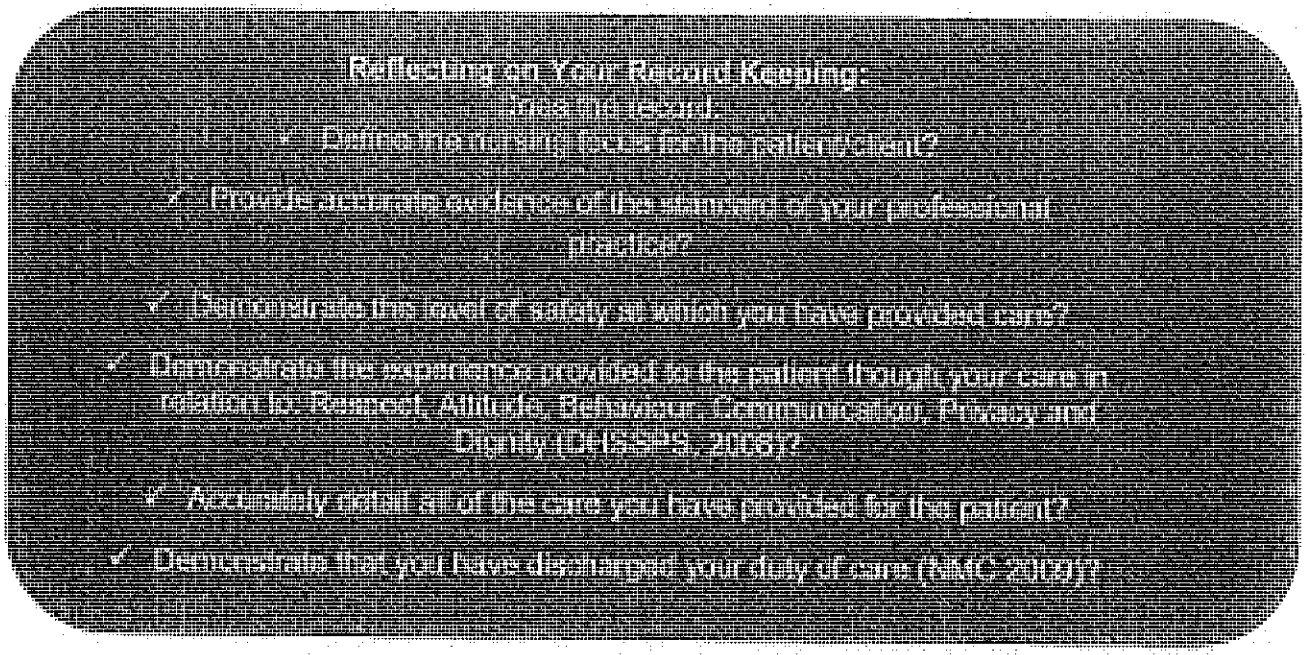
Signature: M. Jones Staff Nurse
(MARY JONES)
Date/Time: 12/12/09 - 17:00hrs
Hospital Number: 2345/09

There are many different formats of admission assessment forms. These examples demonstrate the importance of completing the form correctly, ensuring that all areas have an entry. If a particular area of the form is not relevant to a patient, then **'not applicable'** needs to be recorded.

Risk Assessments
Part of the admission procedure should include the assessment of risk, which may have a bearing on the patient's care and treatment whilst in hospital. It is important and good practice to complete these correctly, ensuring that they are **dated, timed and signed properly.**

Example of Risk Assessments that may be in use are:

- MUST (Malnutritional Universal Screening Tool)
- BRADEN Score (Predicting Pressure Sore Risk)
- Manual Handling
- Early Warning Score or Modified Early Warning Score
- Infection Control
- Falls Assessment



This section demonstrates examples of good and unacceptable record keeping practice during ***Admission and Risk Assessment*** and is part of a suite, of resources developed by NIPEC. This paper along with those on, ***Care Planning and Discharge*** should be read in conjunction with the ***Mandatory Requirements*** guide that is accessible via the NIPEC website www.nipec.hscni.net

References

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A GUIDE ON

CARE PLANNING

SECTION 2

INVESTORS IN PEOPLE

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Purpose

The purpose of this guide is to assist nurses and midwives in improving their record keeping practice. This supplementary paper concentrates on the record keeping of planned care. The examples within focus on acute adult care, however they demonstrate the requirement of good record keeping practice that can be interpreted to all fields of practice.

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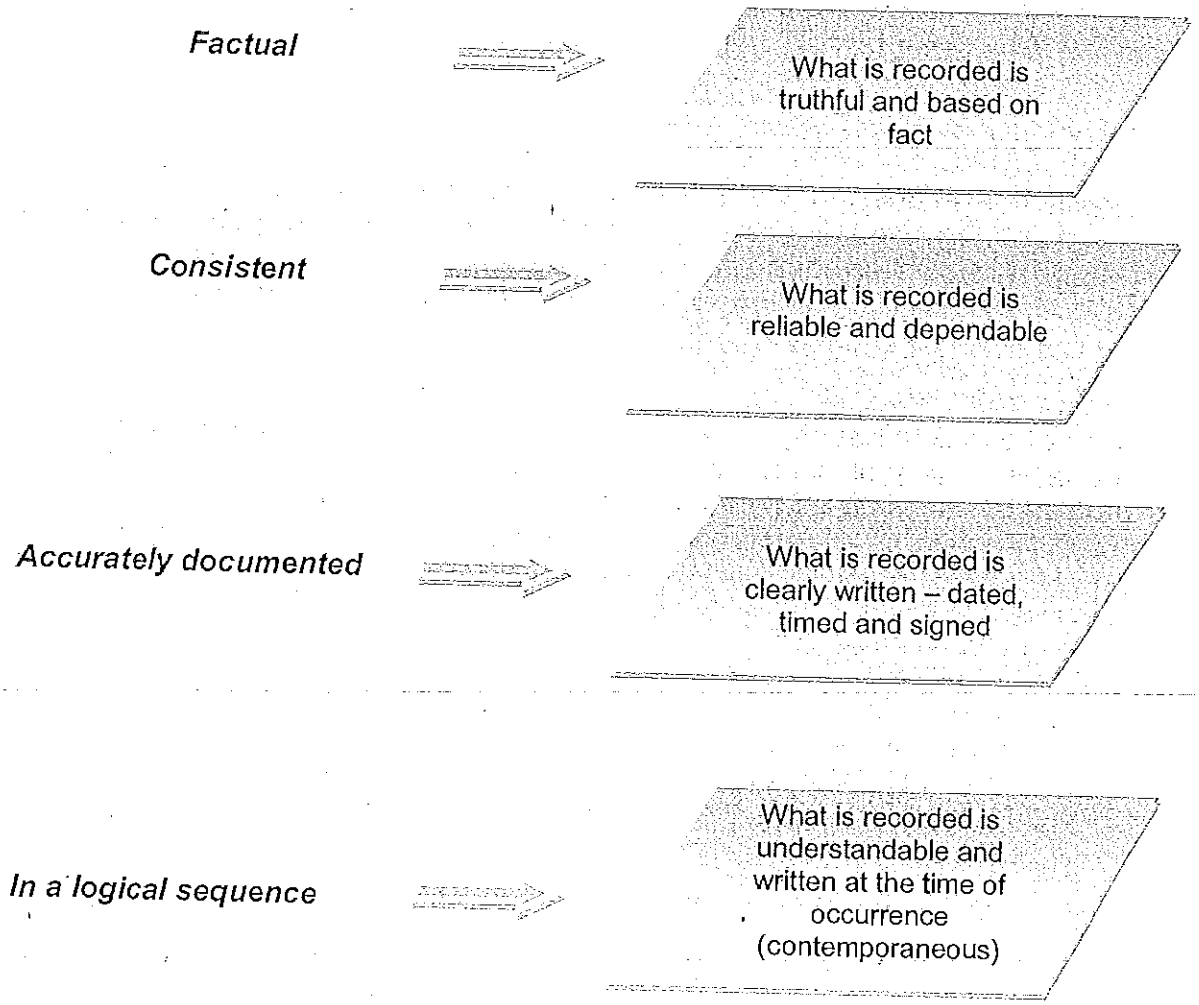

Introduction

Planning and documenting care is an essential part of nursing and midwifery practices. A clear and accurate record of the planned, delivered and evaluated care, can demonstrate that it is person-centred to meet the needs. Records should reflect the person centred approach and follow the principles contained in the NMC guidance.

Content and Style (NMC Principles 1,4,6,7,8,9,33)
Records should be written in a way that enables the reader to build a picture of why the person has been admitted to a health and social care facility. That means that the reader should be able to gather from the record:

- the person's care need
- the identified desired outcomes
- the nursing/midwifery interventions
- how these have been evaluated and reviewed

The written record of the planned care must be person-centred, and is crucial in monitoring progress and communicating concerns.

Patient Identification (NMC Principles 1,17,23,27)
Records should be written in such a way that it is obvious to the reader that the *identity of the person* for whom the record is being kept is evident throughout the document. The person's name and record number or addressograph label should appear on every loose page of the relevant record. If a care pathway booklet is used then the person's name and record number should be on every section.

Author (NMC Principles 1,2)
It must be evident that any nurse or midwife who records an entry has signed her or his name in full (not solely initials).The practitioner must also identify position or post held, for example, Staff Nurse/Staff Midwife. In some areas, a register may be used that includes the names of all of staff printed along with their signatures. In those areas using care pathways, there is usually a 'sign in' sheet for staff to print their names on with their usual signatures.

Point in Time (NMC Principles 1,3,4,6,7,)
As with all recorded entries, they should be dated and timed using the **24 hour clock – day/month/year** format. **For example - 14:00hrs 24/06/2009.**
It is of vital importance that the date and time of all planned care has been recorded. Late entries are acceptable, provided that they are clearly documented, showing when they happened and including a signature, time and date.

Permanent marker (NMC Principle 14)
All entries in records should be written in **black ink** to facilitate photocopying.

Complete records (NMC Principles 6, 9, 32, 33)
All sections of the individualised care plan that includes the patient's health and social care need and planned care **MUST** be completed.

Alterations (NMC Principle 10)
No record should ever be deleted, scored out (so that it is not legible) or covered up using, for example, any type of correction fluid.

Errors (NMC Principle 11)
Any alterations to or errors in either the person's care needs or planned care must be dated, timed and signed, while ensuring that the original entry can still be clearly read. Errors must be bracketed and have a single line drawn through them, so that the original entry is still legible.

For example -

14:00hrs 01/04/09 error J Bloggs S/N

Mrs Brown admitted for ~~(Chest X-Ray)~~ Barium Enema, booked for 02/04/09

J.Bloggs. Staff Nurse

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Admission Summary

The following tables demonstrate examples of good record keeping practices in relation to sections of the care planning process. Please take careful note of the areas highlighted.

In the example shown in Table 1 the practitioner's entries clearly identify:

- reason why the person has come into hospital,
- were he was admitted from
- a recent past history.

GOOD PRACTICE
First entry signed correctly

TABLE 1

Date/Time	Admission Summary	Signature
24/06/09 15:30 Hrs	Mr Green is a 68 year old man admitted to ward X from Accident & Emergency dept following an ambulance call out. He was found collapsed at the bottom of the stairs at home by his wife. Mr Green is orientated in time, place and person and states he is aware he has been brought and admitted to hospital following his collapse, he did not hit his head at any stage. Past Medical History – no other medical history of note to date. Not taking any medication currently. Initial Baseline Assessment of Mr Green Braden Score 18 – skin intact no obvious signs of abrasions or bruising, Mr Green has needed assistance with personal hygiene over the last two days Falls Assessment – Completed see assessment sheet Blood results from Accident & Emergency reveals haemoglobin of 7.0 g/d litre, examined by Dr Black who has prescribed two units of packed cells for transfusion. Full blood picture to be assessed post blood transfusion. Chest X-ray – reveals Mr Green has upper lobe pneumonia, commenced on antibiotic orally (see medicine kardex) Oxygen therapy prescribed at 2 litres per minute at 24% via nasal specula as required. Mr Green and his wife (accompanied) understand the reason for his admission. Trust advice leaflets given regarding infection control practices and visiting.	Sara Smith Staff Nurse

GOOD PRACTICE
Date and timed correctly

GOOD PRACTICE
This is an example of a clear admission history, giving a baseline assessment and initial treatment. It is evident that the person and his family are included.

The admission/assessment summary (Table 1) identifies that Mr Green has a number of needs that require prescribed treatment and a number of nursing interventions. Please note that there is evidence that both the patient and his family member understand the reason for admission. Please take careful note that the entry is **timed, dated and signed.**

The Care Plan and Progress Report

The example in **Table 2** identifies:

- the first identified need for Mr Green following the initial assessment
- what the desired outcomes should be
- the nursing care/ actions or interventions that will be applied to achieve the goal
- the frequency with which evaluation of the interventions should be recorded.

Table 2 Example of the Care Plan and Progress Report

Date/Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discon'd	Sign
24/06/09 15:40Hrs	1.Mr Green requires transfusion of blood due to Haemoglobin of 7.0g/d litre	To raise Mr Green's Haemoglobin levels to 11-15g/d litre by administering blood transfusion as prescribed by Doctor.	A. Monitor and record temperature, pulse and blood pressure as per hospital policy for blood transfusion.	As required		
			B. Observe patient hourly for any signs of reaction (rash/rigors) to blood transfusion	Hourly		
			C. Observe intravenous site for signs of infection/irritation.	Twice daily		S. Smit. S/N
			D. If any of the above reactions occur – inform Doctor.	25/04/09		
			E. Monitor haemoglobin level 24hrs post transfusion	Twice daily		
			F. Ensure Mr Green is positioned comfortably, call bell at hand	Daily		
			G. Assist at meal times if required	Totals twice in 24hrs		
			H. Record accurate Fluid Balance chart			

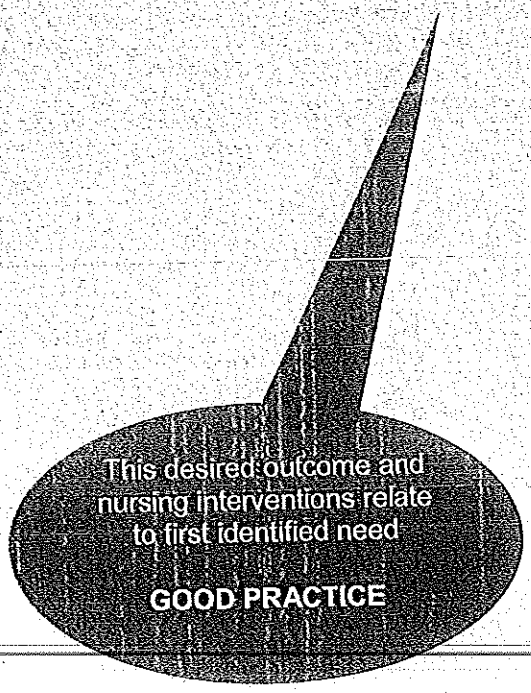
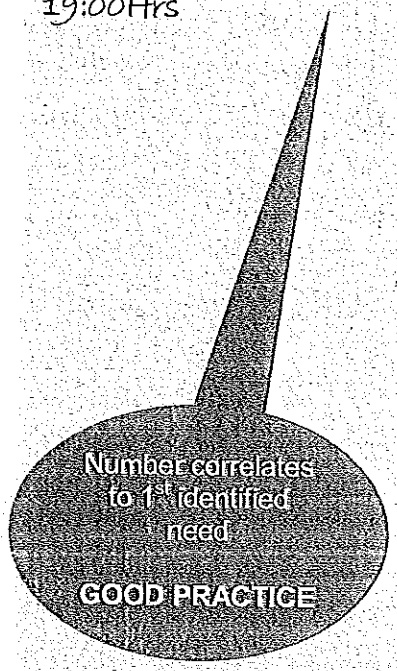
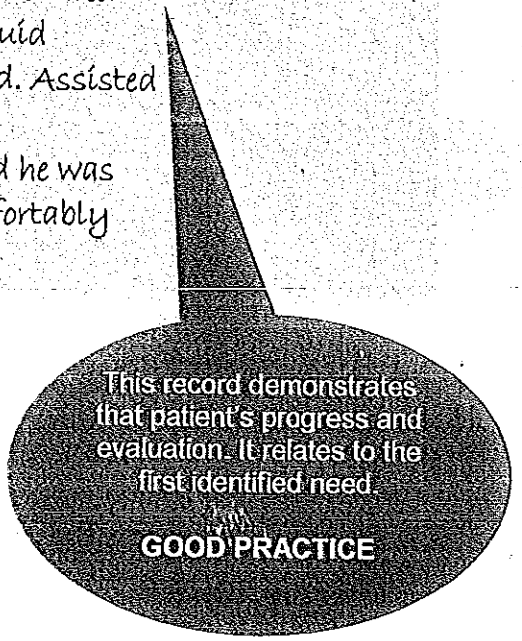


Table 3 demonstrates the progress report of this first need, providing evidence of how the patient is progressing towards each of the outcomes set. There is also evidence that the patient has been involved in evaluating the goals.

Table 3

Date/Time	Personal needs	Daily progress report	Signature
25/06/09 19:00Hrs	1	Explanation given and verbal consent agreed with Mr Green to administer blood transfusion via intravenous cannula Blood Transfusion 1st Unit completed at 21:15hrs – 2nd unit commenced at 21:30 hrs– no reaction noted. Clinical Observations (temperature, pulse, blood pressure) recorded hourly– as per hospital policy. IV Cannula is secure, no reaction noted. Mr Green feels well after 1st unit, informed that a repeat blood sample to be taken in morning. Fluid balance recorded. Assisted with meals. Mr Green stated he was positioned comfortably when asked.	S. Smith S/N





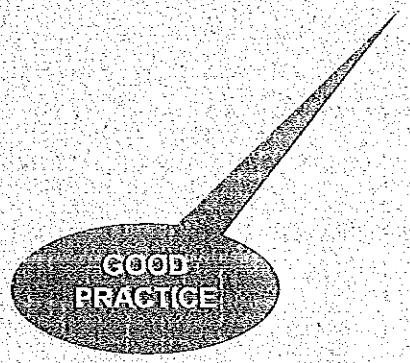
The Care Plan and Progress Report

The example in **Table 4** identifies:

- the second need of Mr Green, following the initial assessment
- what the desired outcomes should be
- the nursing interventions that will be applied to achieve the desired outcomes.

Table 4 Example of the care plan and progress report

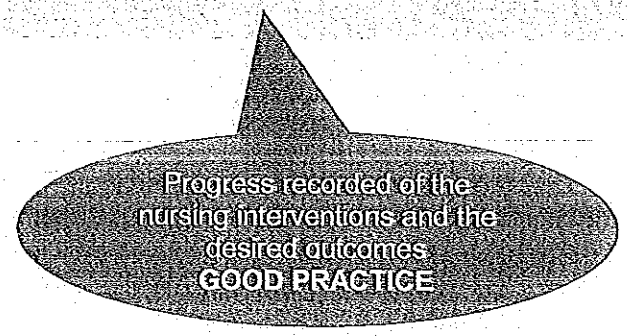
Date/Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discont'd	Sign
24/06/09 15:40Hrs	2. Mr Green is Short of Breathe due to pneumonia and low haemoglobin	To relieve Mr Green's breathing problems before discharge to home	a. Monitor respirations and oxygen saturations due to patient having pneumonia.	4 hourly		
			b. Apply oxygen if required as prescribed by Doctor	6 hourly		
			c. Administer antibiotics as prescribed			
			d. Reposition in upright position for full lung capacity.	4 hourly 4 hourly		
			e. Monitor for signs of shortness of breath	4 hourly		
			f. Encourage patient to do breathing exercises			S. Smith S/N
			g. Refer to physio			



The example in **Table 4a** demonstrates the progress report of patient's second need providing evidence of how the patient is progressing towards each of the desired outcomes set. There is also evidence that the patient has been involved in evaluating the outcomes.

Table 4a

Date/Time	Personal need	Daily progress report	Signature
24/06/09 15:40Hrs	2.	Oxygen Saturations recorded, averaging 85-90, oxygen therapy not required. Nursed in the upright position. Mr Green states he is breathing easier and able to ease himself to sit up in the bed. Antibiotic therapy administered as prescribed Chest Physio assessment planned tomorrow.	S. Smith S/N



The Care Plan and Progress Report

The example in **Table 5** identifies:

- the third need of Mr Green, following the initial assessment
- what the desired outcomes should be
- the nursing interventions that will be applied to achieve the desired outcomes.

The example then demonstrates the progress of this third need providing evidence of how Mr Green is progressing towards each of the desired outcomes set. There is also evidence that he has been involved in evaluating the desired outcomes.

Table 5 Example of the care plan and progress report

Date/Time	Personal Need	Desired Outcomes	Nursing Interventions	Record of Frequency	Date Discontinued	Sign
24/06/09 15:40Hrs	3.Mr Green states he is unable to attend to attend to personal hygiene needs due to being "unsteady on his feet"	To assist and promote personal hygiene needs preparing Mr Green for discharge	a. Assist daily with personal hygiene at bathing/showering. b. Assess patient's difficulty attending to own needs c. Refer to Occupational Therapy for assessment d.Encourage patient as much as possible to attend to own needs	Daily Daily Daily		S. Smith S/N

Date/Time	Personal need	Daily progress report	Signature
24/06/09 15:40Hrs	3.	Mr Green up to the bath daily with assistance, steady while walking. Assisted with personal hygiene and promoted to attend to own needs. Informed that OT will assess ability States that he feels more confident attending to personal hygiene	S. Smith S/N

Progress recorded of the nursing interventions and the desired outcomes
GOOD PRACTICE

Please note all entries have been dated, timed and signed

Reflection

The previous examples have demonstrated good record keeping practice. The care plan identifies:

- the person's individual needs assessment
- what has to be achieved in terms of desired outcomes
- the nursing interventions
- evaluation of the interventions.

The records clearly indicate how often the evaluation of each of nursing interventions has to be performed. The desired outcomes and the nursing interventions are realistic, achievable, person-centred and evidence-based. The records demonstrate to the reader that it is evident the patient has been encouraged to be involved in the evaluation of the desired outcomes and nursing interventions set.

Incomplete record

Table 6 demonstrates an example of incomplete or inaccurate record providing little or no evidence of the planned care or care given. This type of record is not helpful in the following circumstances:

- Communicating the person's progress/deviations/problems to other professionals
- Communicating the person's progress/deviations/problems with the person and family or carers
- In the transfer of the person from one ward or one facility to another
- During the investigation of complaints/incidents/investigations.

Time of evaluation missing

UNACCEPTABLE PRACTICE

No signature

UNACCEPTABLE PRACTICE

Table 6 example of an incomplete record

Date/Time	Personal Needs	Daily progress report	Signature
25/06/09	1. Low Haemoglobin	Blood Transfusion – 2nd unit of packed cells in progress Hb in am. Fluid Balance recorded	
	2. SOB	Oxygen given	

Record of the entire person need incomplete,
Personal hygiene not recorded
Use of abbreviations
UNACCEPTABLE PRACTICE

No record of person's condition, clinical observations, or if he had any reaction to the blood transfusion.
No evaluation of his breathing problems
UNACCEPTABLE PRACTICE

Unacceptable Practice

The example in **Table 6** demonstrated that:

- There is no record of involvement of person or family/carer
- The record does not give a picture of the planned care or care given
- There is no record of the time when the 2nd unit of blood was commenced. (This could be a problem should a query arise)
- Entries not signed.

Conclusion

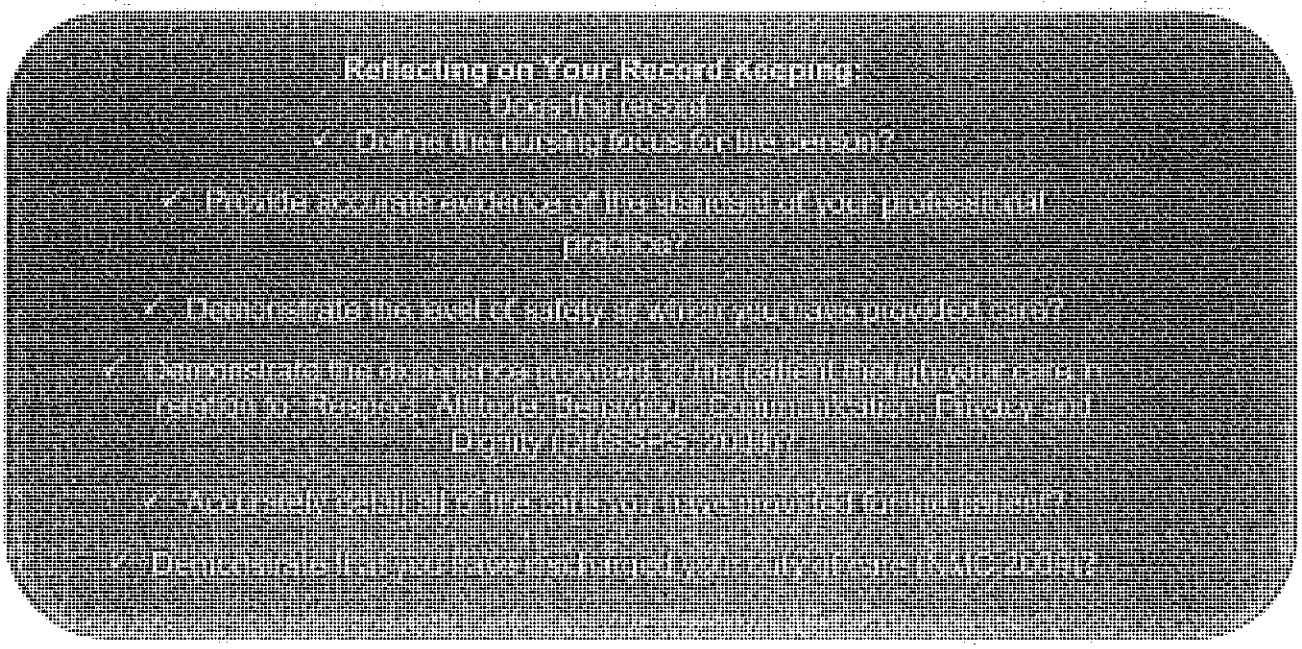
Within the five Health and Social Care Trusts in Northern Ireland, there are many different forms of care plans (that is, the written record). It is important, however that the planned care is well documented, to give the reader a complete picture of what the persons health needs are; it should also be clear what the desired outcomes are and what nursing interventions are planned to achieve those outcomes.

The examples in this guide are **only illustrations** to demonstrate the importance of completing the process correctly and to ensure that all areas of the care plan have an entry, which has been **dated, timed and signed.**

It is recognised that there are more complex issues that require extensive care planning / desired outcomes setting and nursing interventions.

Sufficiently detailed records demonstrate that the practitioner has discharged his or her duty of care. Evidence-based care planning and regularly evaluated progress reports form the backbone of this detail.

Nurses and midwives must be mindful that their records are the key communication tool between themselves and other professionals as they allow for continuity of care.



This paper demonstrates examples of good and unacceptable record keeping practice during ***Care Planning*** and is part of a suite, of resources developed by NIPEC. This paper along with those on, ***Admission and Risk Assessment and Discharge*** should be read in conjunction with the ***Mandatory Requirements*** guide that is accessible via the NIPEC website www.nipec.hscni.net

References

Barrett, D. Wilson, B. and Woollands, A. (2009) *Care Planning – a guide for nurses.* England: Pearson Education.

Department of Health Social Services and Public Safety (2008) *Improving the Patient and Client Experience.* Belfast: DHSSPS

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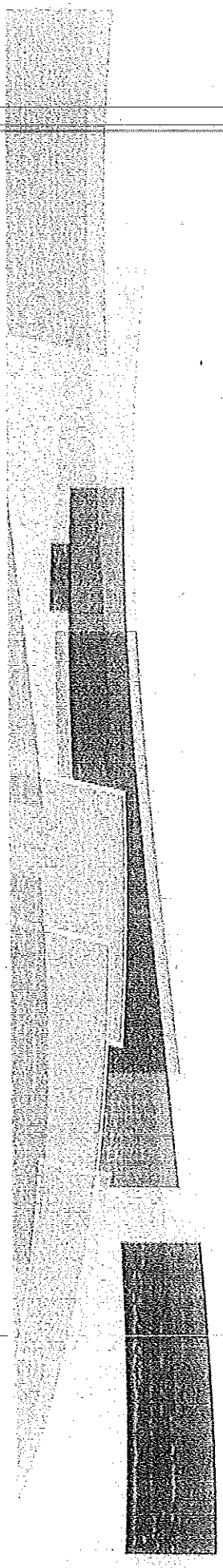

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JUNE 2010

NIPEC

EVIDENCING CARE:
IMPROVING RECORD KEEPING PRACTICE

A GUIDE TO

DISCHARGE PLANNING

SECTION 3

INVESTORS IN PEOPLE

Acknowledgements

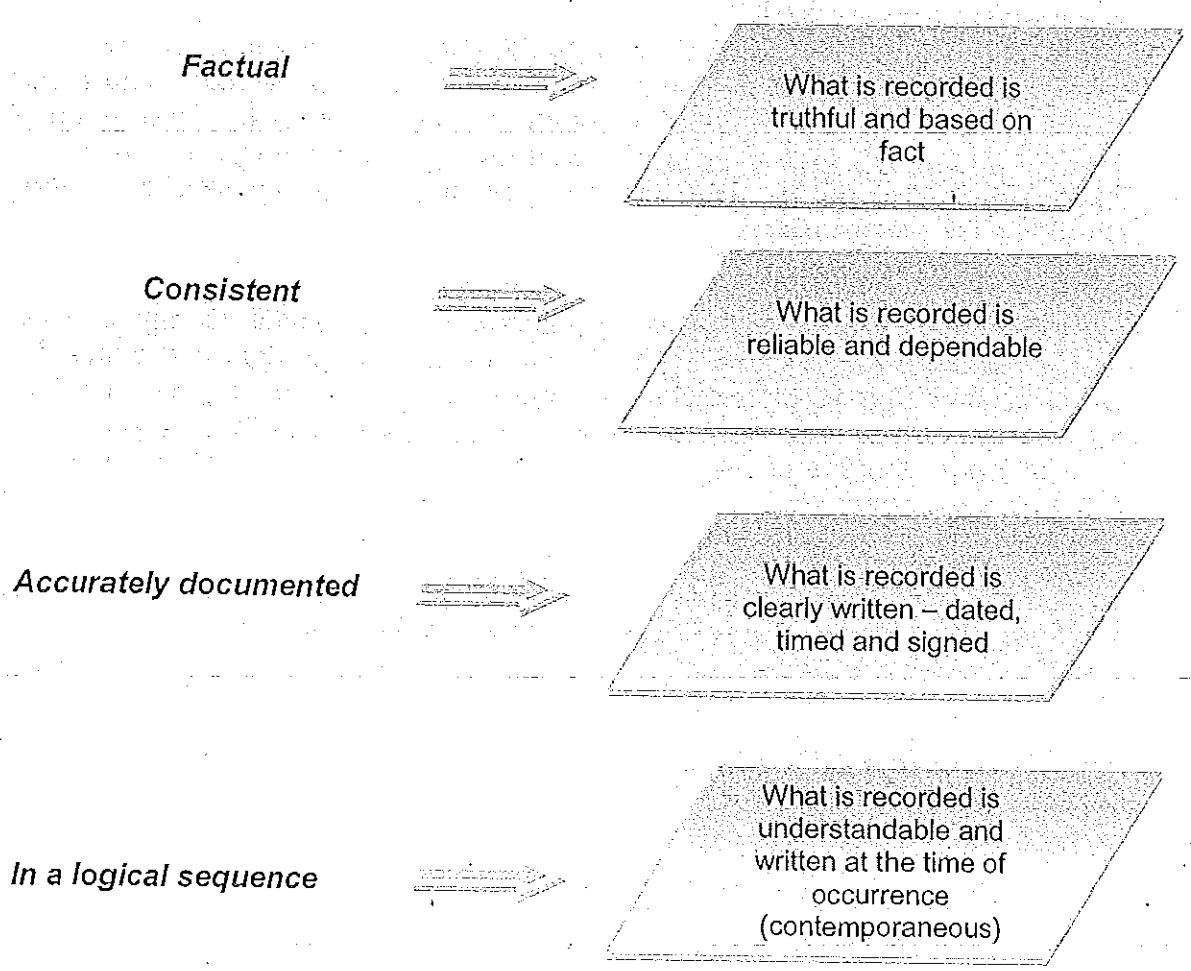
Northern Ireland Practice and Education Council (NIPEC) would like to thank all the nursing and midwifery registrants who assisted in the development of this guidance during the Regional Record Keeping Initiative.

Purpose

The purpose of this guidance is to assist nurses and midwives in improving their record keeping practice in relation to discharge planning. This supplementary paper concentrates on the discharge process. The examples within focus on acute adult care, however, they demonstrate the requirement of good record keeping practice that can be interpreted to all fields of practice.

The aim is to build on the record keeping advice and guidance from the Nursing and Midwifery Council (NMC; 2009) and, therefore, this guide should be read in conjunction with the Guidance.

The NMC (2009) principles of good record keeping state that records must be:



Introduction

Discharge planning is an accepted nursing and midwifery intervention aimed at the prevention of problems after discharge. The record component of the discharge process is an essential aspect of practice, as it serves as an effective communication tool to other health professionals. Records should reflect the person centred approach and follow the principles contained in the NMC's *Record Keeping: Guidance for nurses and midwives (*2009).

Content and Style (NMC Principles 1, 4, 6, 7, 8, 9, 33)
Records should be written in a way that enables the reader to build a picture that focuses on the person in relation to:

- treatment planned within 24hrs of admission
- identified desired outcomes
- nursing interventions
- evaluation and progress report of nursing interventions
- a documented expected date of discharge
- evidence of a planned discharge.

Patient Identification (NMC Principles 1, 17, 23, 27)
It should be obvious to the reader that the **identity of the person** for whom the record is being kept is evident throughout the document. The **person's name and record number or addressograph label should appear on every loose page of the relevant record including those used during the discharge process. If a care pathway booklet is used then the person's name and record number should be on every section.**

Author (NMC Principles 1, 2)
There must be evidence that admitting practitioners have signed all entries using name in full (not solely initials). They must identify their position and status, for example, Staff Nurse/Staff Midwife. In some areas, a register may be used that includes the names of all staff, along with their signatures. In those areas using care pathways, there is usually a 'sign in' sheet for staff to print their names on, with their usual signatures.

Point in Time (NMC Principles 1, 3, 4, 6, 7)
All record entries should include a date and time using the **24 hour clock, day/month/year** format. **For example - 14:00hrs 24/06/2009.**
Late entries are acceptable, provided that they are clearly documented showing when they happened and including a signature, time and date.

Permanent marker (NMC Principle 14)
All entries in records should be written in **black ink** to facilitate photocopying.

Complete records (NMC Principles 6, 9, 32, 33)
All sections of the person's record **MUST** be completed.

Alterations (NMC Principle 10)
No record should ever be deleted, scored out (so that it is not legible) or covered up using, for example, any type of correction fluid.
Errors (NMC Principle 11)
Any alterations or errors must be dated, timed and signed, while ensuring that the original entry can still be clearly read. Errors must have a single line drawn through them, so that the original entry is still legible.

For example:

14:00hrs 03/01/10 error J Bloggs S/N
Mrs Brown attending ~~(Chest X-Ray)~~ Physiotherapy Department for assessment of her stair walking/handling prior to discharge
J.Bloggs. Staff Nurse

Legal Aspects (All NMC Principles)
A person's health and social care records are legal documents. These include all clinical observations sheets, admission assessment sheets, care plans, drug kardexes, records from other professionals, all nursing and midwifery records. They will **all** be used as evidence in legal cases and in the investigation of complaints. Nurses and midwives have a legal, as well as professional, duty of care to ensure that they keep accurate, clear and legible records.
Nurses and midwives must ensure that their record keeping is sufficiently detailed to show that they have **discharged their duty of care.**

Record Keeping is an essential professional and legal requirement. If it is not recorded, it has not been done!

Jargon and Abbreviations (NMC Principle 5)
The temptation to use jargon and abbreviations as a form of professional shorthand is compelling, especially for busy nurses and midwives. The risk of miscommunication increases dramatically and their use is, therefore, not good practice, unless there is an acceptable, approved Trust policy.The use of any jargon and /or abbreviations can be confusing and misleading to:

- Patients
- Peers
- Advocates
- Investigators
- Solicitors
- Families
- Health Professionals
- Complaints Officers
- Regulators

Discharge Process

The care-treatment plan should be person-centred with an expected date of discharge predicted within 24 hours of admission-to a health care facility. Nurses and midwives should ensure that the person and family members are aware of the expected date of discharge from the time of admission. This is recognised as good practice and improves the person's experience, (Webber-Maybank 2009).

GOOD PRACTICE Expected date of discharge is recorded and evidence shows communication to the patient and family

Table 1 demonstrates an example of good record keeping practice as part of the admission assessment:

Surname: Green	**Address -** 123, Old Street, Anytown, Co Antrim **Telephone:** 02890654321	**Expected date for discharge** -20/12/09 Expected date of discharge given to Mr Green and his wife -they are happy with this and aware that the date will be reviewed **Date reviewed:** **Revised Date:**
Forename: James	**Reason for Admission:** Dehydration, vomiting, abdominal pain for past 72 hrs	**Discharge Planning** Mr Green is hoping to be discharged to his own home. Lives with his wife in a Bungalow type dwelling.
Preferred name: James	**Diagnosis:** Possible Gastro-Intestinal Infection	
Time & Date of Admission: 15:30hrs 12/12/09	**Patient aware of reason for admission:** Yes Mr Brown understands he has been admitted for investigations of 'stomach problems'	
Mode of arrival: Ambulance accompanied by wife	**Temp:** 37.5c **Pulse:** 88beats per min **Blood pressure:** 150/90mmHg	
Next of Kin: Wife **Address:** As above	**Relatives aware of reason for admission:** Yes Mrs Green states she understands reason for husbands admission is to 'investigate stomach problems'	S. Smith S/N

GOOD RECORD KEEPING PRACTICE Record of person's living conditions and if he lives alone or has company

Table 1

The expected date of discharge should be reviewed at regular intervals. If there is a change to this date, it must be entered into the patient's record and communicated to the relatives.

Fit for discharge

Person's are usually deemed 'fit for discharge' from hospital, when the physiological, social, functional, and psychological factors or indicators have been taken into account, usually following a multidisciplinary assessment (DH, 2004).

It is, therefore imperative that continuous assessment of the person's progress towards the goal of discharge, involving the person and family, is demonstrated in the daily progress and evaluation record.

Table 2 demonstrates, for example, that one of Mr Green's identified needs could have been that he was:

C. Mr Green states he is unable to attend to personal hygiene needs due to being "unsteady on his feet"

Table 2

Date/Time	Personal needs	Daily progress report	Signature
14/12/09 15:40Hrs	C. Mr Green states he is unable to attend to attend to personal hygiene needs due to being "unsteady on his feet"	Mr Green up to the bath daily with assistance, steady while walking. Assisted with personal hygiene and independence encouraged to attend to own needs. Informed that Occupational Therapy will assess on 15/12/09 Mr Greens ability to independently attend to own needs Mr Green states that he is beginning to feel more confident attending to his personal hygiene particularly as he lives in a bungalow and his bathroom is situated beside the bedroom	S. Smith S/N

GOOD RECORD KEEPING PRACTICE
Evidence of a progress and evaluation record of how Mr Green feels he has the ability to attend to own needs

Please take careful note that all of the entries are **timed, dated and signed.**

Information on discharge

It is **important that there is a record** of the information that has been conveyed and understood by person and their families before discharge, regarding:

- explanation and possible side effects of the medicines they are taking home
- a letter to be sent to the General Practitioner
- details of dates and times regarding follow-up appointments if required
- details of community/liaison/specialist nurses visits
- information leaflets about condition/procedures/treatment and follow-up care.

Information to other professionals

The following examples of information that should be recorded to inform other health professionals is evidenced by :

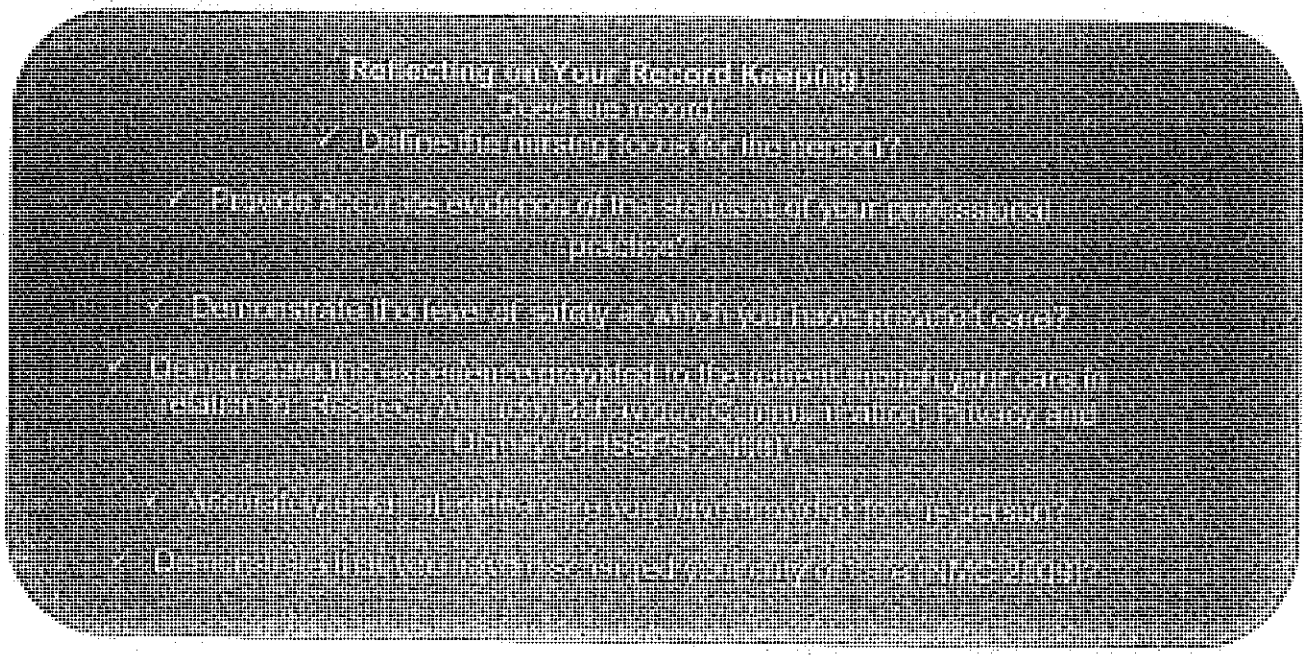
- the care, treatment and discharge arrangements having been discussed with the multidisciplinary/case management team
- a record of how the patient is progressing with the goals set
- the number and type of cannulae/lines removed
- what, if any, equipment or aids have been ordered or delivered to patient's home e.g oxygen/nebuliser
- the community liaison team being informed of discharge; this would include the General Practitioner
- the person's home conditions having been assessed
- whether transport is arranged or if someone is accompanying the person home
- address checked for discharge to appropriate setting.

Conclusion

The examples in this guide are **only illustrations** to demonstrate the importance of completing the discharge process correctly and to ensure that all areas have a recorded entry, which has been **dated, timed and signed.**

It is recognised that there can be more complex discharge arrangements that require extensive planning and recording.

Sufficiently detailed records show that the practitioner has discharged his or her duty of care. Nurses and midwives must, therefore be mindful that their records are the key communication tool between themselves and other professionals as they allow for continuity of care.



This paper demonstrates examples of good and unacceptable record keeping practice during ***Discharge Planning*** is part of a suite, of resources developed by NIPEC. This paper along with those on, ***Admission/ Risk Assessment and Care Planning*** should be read in conjunction with the ***Mandatory Requirements***, guide that is accessible via the NIPEC website www.nipec.hscni.net

References

Barrett, D. Wilson, B. and Woollands, A. (2009). *Care Planning – a guide for nurses*: Pearson, Harlow

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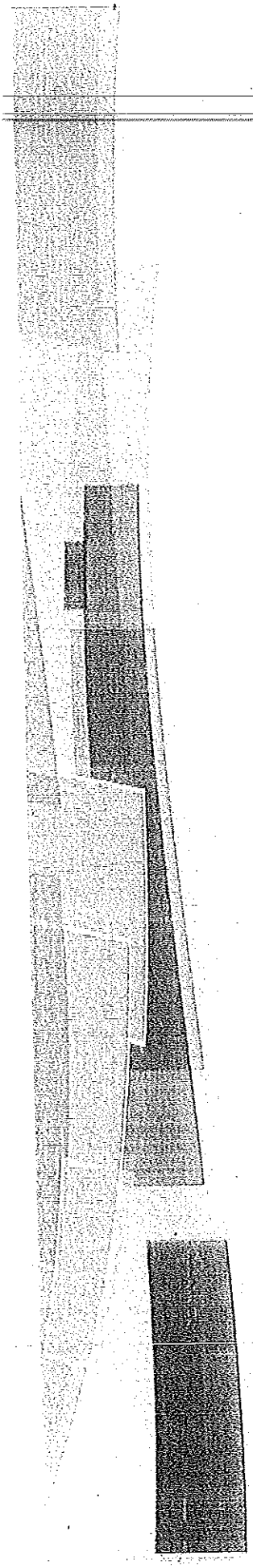
Webber-Maybank, R. (2009). Making effective use of predicted discharge dates to reduced the length of stay in hospital. *Nursing Times* 105 (15), p 12-13.



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JUNE 2010

NIPEC Northern Ireland Practice and Education Council for Nursing and Midwifery

Improving Record Keeping

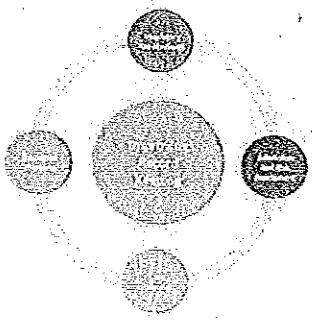
Improving Record Keeping - Audit

COMPLETE AUDIT

The Audit Tool should be used in conjunction with:

- the recommended practice, learning and development activities
- sections of the NIPEC Record Keeping Guidance

which make up the Practice Improvement Programme.



For guidance on how to complete full Programme, click here

You should decide whether you wish to carry out your audit using:

- Hard Copy; or
- Electronic Audit Tool

It is recommended that you use the **electronic audit tool** to carry out a complete audit

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Appendix 2

NIPEC RECORD KEEPING GUIDANCE

-Evidencing Care: Improving Record Keeping practice

http://www.nipec.hscni.net/recordkeeping/docs/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf

-A Guide on Mandatory Requirements

http://www.nipec.hscni.net/recordkeeping/docs/RecordKeepingGuidanceMandatoryRequirementsFinal.pdf

-A Guide on Admission and Risk Assessment

http://www.nipec.hscni.net/recordkeeping/docs/RecordKeepingGuidanceAdmissionandRiskFinal.pdf

-A Guide on Care Planning

http://www.nipec.hscni.net/recordkeeping/docs/RecordKeepingGuidanceCarePlanning.pdf

-A Guide to Discharge Planning

http://www.nipec.hscni.net/recordkeeping/docs/RecordKeepingGuidanceDischargeFinal.pdf

-Audit Tool

http://www.nipec.hscni.net/recordkeeping/audit6.html