Appendix 9

REGIONAL RECORD KEEPING INITIATIVE

Update on Developments and Progress April 2010-April 2011

Accessed at DH1/12/274329

NIPEC

Regional Record Keeping Initiative

Update on Developments and Progress

April 2010 – April 2011

DH1/12/274182

Introduction

The purpose of this paper is to outline the ongoing progress by the Northern Ireland Practice and Education Council (NIPEC) and the five Health and Social Care Trusts, since the completion of the Regional Record Keeping Initiative (RRKI) in April 2010. The developments are to assist in the maintenance of continuous and sustained improvements in record keeping practices in Northern Ireland.

INVESTORS IN PEOPLE

Background

The aim of the RRKI (Mar. '09 – Apr. '10) was to develop tools for registered nurses to facilitate improvement in record keeping. The agreed focus was a development of practice/quality improvement methodology in acute adult care, the tools and resources produced supporting significant improvement in the standard of nursing record keeping in five HSC Trust acute medical wards. During the Initiative, an electronic audit tool was developed from a range of record keeping quality resources and tested over 8 months within each of the five HSC Trust medical wards who volunteered to be part of the RRKI. The final report of the RRKI can be accessed at;
http://www.nipec.hscni.net/pw_recordkeeping.htm

Progress and Developments

Since the completion of the RRKI all of the key stakeholders have been involved in a number of developments to assist in maintaining continuous and sustainable improvement in record keeping practice in the acute adult nursing care settings. The following sections outline what has been happening in each of the five HSC Trusts and NIPEC since April 2010.

NIPEC

NIPEC has developed and refined a mini website which was created to support registrants in achieving improvements to their record keeping practices. The site is a resource for the HSC Trust's to support them during the implementation phase of the Improvement Methodologies developed during the RRKI.

There are five sections accessed through the Tab Menu of this website, they are;

1. **NIPEC Guidance** – contains a set of illustrated guides based on the principles within the Nursing and Midwifery Council (NMC) Recordkeeping: Guidance for nurses and midwives (2009).
2. **Improving Individual Practice** - contains a range of learning and development activities to help individual registrants improve his or her record keeping practice.
3. **Learning and Development** - a framework to assist registrants in assessing and planning their own learning and development requirements.

4. Improving Team Practice – a range of activities to support a team who want to improve their record keeping.
5. Audit Tool - This section provides access to an online electronic audit tool which will assist in identifying the areas of record keeping practice which need improvement. Access to this audit tool is password protected. Governance Leads for Nursing in each Trust have been issued with unique usernames and passwords. This section has been built with the facility to obtain instant results. The audit tool is also available to download for manual usage.

The NIPEC Improving Record Keeping Practice site is accessible through NIPEC main website at http://www.nipec.hscni.net/recordkeeping/. The site has been accessible since August 2010 with the online audit tool available from January 2011.

In addition, NIPEC has been invited to a number of the Trust's raising awareness of the tools and resources developed through the RRKI to a range of nursing levels.

Belfast Health and Social Care Trust (BHSCT)

BHSCT developed a new documentation record following the results of the baseline and subsequent audits during the testing phases of the RRKI. The aim of the development of this new documentation record was to demonstrate the unique contribution of nursing to patients/clients by to effectively promoting and improving communication between patients, nurses and other multi disciplinary members and to reduce variability in the documentation in use across the four acute sites.

The objectives of the new documentation record are to:

- Develop a standardised format for recording nursing assessment and care plan documentation
- Improve patient safety
- Raise staff awareness of professional and legal issues
- Encourage more effective time management by decreasing duplication
- Review the current nursing documentation templates
- Review evidence-based practice
- Identify examples of 'best practice' across the in-patient legacy sites (exclusions: mental health & learning disability, paediatrics, & midwifery services)
- Establish the model of care that will be used across the Trust

The BHSCT plans to develop (in first instance) a standardised care plan to be used across the Trust that will set out individual patient needs and describe the planning, implementation and evaluation of the impact of nursing interventions. In addition there will be the development of a Trust policy to provide guidance for nurses in the documentation of care delivered. This will also include a training plan for implementation of the documentation that will be supported by sustained improvement through continuous audit.

Although BHSCT commenced the changes of the new document the other four Trusts through the Nursing Governance Leads have collaboratively agreed and supported its

development. This is viewed as a framework for continuous service development that focuses on the delivering person-centred nursing care through effective record keeping practices. Additionally, it is an assurance framework reflecting that good governance arrangements in record keeping are embedded within each HSC Trust.
The new documentation has some final stages to undergo before its completion and implementation into the BHSC Trust. It will be launched in June 2011 with introduction on the Mater and Musgrave sites followed by the Belfast City Hospital in July 2011 and Royal Victoria Hospital sites in August 2011, with full implementation by September 2011.

Western Health and Social Care Trust (WHSCT)

WHSCT have established a Trust Record Group comprising of staff from nursing, medical records and the Nurse Education and Development Consortium for North and West (NEDC). The purpose of this group is to lead on the review of nursing record keeping, project manage the implementation of the new regional nursing record tool and ensure that the audit and improvement programme is rolled out across the adult acute wards.

The Ward Sisters who had been involved in the RKKI presented their results to their peers in the Trust, demonstrating their improvement to date. In addition they gave an overview of the journey they have taken to improve their record keeping practice.

The Assistant Director of Nursing Governance has presented an overview of the initiative, the developed tools and resources and the WHSCT results at the Nursing Midwifery Governance Committee and has advised the Trust Safety and Governance Committee of the up and coming record keeping project.

Four values clarification workshops relating to record keeping have been held on two sites. The workshops also included a presentation of the Regional Record Keeping Initiative and the developed tools and resources.

Following the development of the NIPEC online audit tool, two of Senior Professional Officers gave a practical demonstration of the mini web-site for Improving Record Keeping Practices and how to access and use the audit tool to band 6 staff and above.

Southern Health and Social Care Trust (SHSCT)

SHSCT has implemented its own acute and non-acute adult nurse record keeping document which has been of assistance to the SHSCT Nursing Governance Leads in the rollout of the record keeping tools and resources post RRKI.

A number of areas self-nominated to be involved in the implementation of the improvement programme. These include five non-acute wards in the Older Person Primary Care who are completing the full improvement programme from the NIPEC Improving Record Keeping website.

In addition seven wards/facilities in the Mental Health and Disability Directorate are auditing and adapting the tools for improvement in the Mandatory requirements programme from the NIPEC Improving Record Keeping website.

At present the Acute Directorate did not feel that they had the time to engage in the rollout at this stage. The provision of a secondment for a Project Lead to support the process would assist in this process.

In summary, twelve wards throughout the SHSC Trust are currently engaged in implementing the improvement programme to improve record keeping in the Trust.

South Eastern Health and Social Care Trust

The SEHSC Trust has established a multiprofessional working group to standardise documentation throughout the Trust. This group has continued to meet over the past year to develop uniform systems for management of both record files and contents. The work of this group resulted in a draft multi-professional assessment and nursing care planning/evaluation document being developed. However due to the development and adaption of the regional documentation through the collaborative work with the Trust Governance Leads, the pilot of the SEHSC Trust documentation has been delayed.

The Trust has continued with its commissioned training on good record keeping provided for nursing through the BMC.

The SEHSC Trust previously used HQS Standard 48 Documentation Audit and this audit continued throughout the Trust until replaced in acute adult wards by the NIPEC on-line audit for record keeping in Jan 2011. The Trust has just completed two months of auditing record keeping practice using the NIPEC online tools and resources within the adult acute sector. At present the results are being analysed and the report will be issued in May 2011, alongside a proposal for disseminating the learning and rolling out of relevant improvement initiatives regarding the practice of record keeping across the adult acute wards.

Northern Health and Social Care Trust

The NHSCT plans to implement a standardised nursing assessment and care planning document to be used across adult in-patient services in the Trust that will set out individual patient needs and describe the planning, implementation and evaluation of the impact of nursing interventions. This work forms part of the 'Best Nursing Care' initiative currently being designed in the trust to contribute to a culture of person-centeredness and incorporating bespoke improvement plans for individual wards drawn from Releasing Time to Care and Transforming Care at the Bedside programmes of improvement. In addition there will be the development of a Trust policy to provide guidance for nurses in the documentation of care delivered. This will also include a training plan for implementation of the documentation that will be supported by sustained improvement through continuous audit.

Although BHSCT commenced the changes of the new nursing document the NHSCT has contributed to and supported its development, as a regional initiative. This is viewed as a framework for continuous service development that focuses on the delivering person-centered nursing care through effective record keeping practices.

Additionally, it is an assurance framework reflecting that good governance arrangements in record keeping are embedded.

The Deputy Director of Nursing has presented an overview of the initiative, the developed tools and resources and the NHSCT results at the Nursing Executive Team (NET). In addition, NIPEC Senior Professional Officers were invited to NET to demonstrate the use of the developed tools and resources from the RRKI, and its website. This was in preparation of the funded support for regional implementation of the improvement programme

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