Western Health and Social Care Trust

Policy for Patient/Client Nursing & Midwifery Assessment and Recording Care

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Western Health and Social Care Trust

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Table of Contents

1.0 Introduction..... 4

2.0 Scope of the Policy..... 5

3.0 Purpose..... 5

4.0 Implementation of Policy..... 6

5.0 Person Centred Approaches..... 6

6.0 Content..... 7

7.0 Presentation..... 7

8.0 Governance..... 8

9.0 Nursing Assessment Booklets..... 9

10.0 Electronic Records..... 10

11.0 Patient held Records..... 10

12.0 Access to Records..... 11

13.0 Key Performance Indicators 11

14.0 Diaries and Patient/client Information..... 11

15.0 Duplicate Records..... 12

16.0 References..... 12

1.0 Introduction

Accurate record keeping is fundamental to the delivery of safe and effective person-centred care.

It is the professional responsibility of every registered nurse and midwife within the Western Health and Social Care Trust (WHSCT) to ensure records provide a clear and accurate account which evidences all aspects of patient/client care. Records both written and electronic must indicate a person-centred approach. The quality of the records documented can be reflective of the standard of care provided. Efficient record keeping also facilitates effective communication within the nursing and midwifery team.

Nursing and Midwifery Council (NMC) The Code (2018) point 10, highlights the requirement of all nurses and midwives to ***'keep clear and accurate records relevant to practice'.***

Care which has been agreed with the patient/client evidences shared decision making and enables partnership working. Department of Health Co-production guide. (2018)

The four Chief Nursing Officers, supported by the NMC, advocate Nurses and Midwives who provide *'**individualised care and services evidenced though support for personal choices and increased involvement in decision making about planned care or services,'*** demonstrate professionalism in practice. (Enabling professionalism in nursing and midwifery practice 2017)

The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) issued standards for person centred nursing and midwifery practice in 2017. These standards underpin this policy.

www.nipec.hscni.net/recordkeeping/standards

The standards specify that all staff who deliver care must have the knowledge, skills and confidence to record the details of care in the patient/client record. The content and style of the record must be of sufficient quality to protect the patient/client and the nurse or midwife from harm caused by missed or duplicated care.

The practitioner must be able to explain and justify the content of the record even after the active episode of care has finished. All entries must have information about what you have done, why you have done it, and ways in which you are protecting patient/client safety.

Serious case reviews and public enquiries, within healthcare, have highlighted the quality of clinical records. In the review of the *Care of Older People in Acute Hospitals,* (March 2015) the Regulation and Quality Improvement Authority (RQIA) identified it was evident nurses record keeping did not always adhere to the NMC and/or NIPEC guidelines. The review reported that frequently care records failed to demonstrate that safe and effective care was being delivered. The Francis report (2013) also identified poor quality record keeping being connected to the standard of patient/client care provided.

2.0 Scope of the Policy

This policy is applicable to all nursing and midwifery staff within WHSCT who record care for patient/clients. The policy compliments and is to be read in conjunction with the following policies and standards;

1. Nursing and Midwifery Council (NMC) 2018. The Code *Professional standards of practice and behaviour for nurses and midwives and nursing associates.*
2. Northern Ireland Practice Education Council (NIPEC) 2016. *Principle Standards for the use of Abbreviations within Health and Social Care settings*.
3. NIPEC 2017. *Standards for person centred nursing and midwifery record keeping practice.*
4. NIPEC. 2019. *Deciding to Delegate. A Decision Support Framework for Nursing and Midwifery.*
5. Royal College of Nursing. (RCN) 2017. *Delegating record keeping and countersigning records.*
6. WHSCT Data Protection and Confidentiality Policy. 2018
7. WHSCT Records Management Policy. 2018

3.0 Purpose

The purpose of this policy is to provide clear guidance on the required standard of record keeping for all registered nurses and midwives within WHSCT. Records that are completed to a high standard demonstrate that care has been planned and delivered in an organised and consistent manner. Clear record-keeping illustrates that the nurse or midwife is practicing in a skilled and safe way. Poor record-keeping is essentially poor communication and can put both staff and patient/client at risk.

4.0 Implementation of Policy

The following NIPEC Standards for person centred nursing and midwifery record keeping practice (2017) highlight the requirements for record keeping. These standards are underpinned by the principals of the NMC Code (2018).

Good record keeping is an integral part of nursing and midwifery practice and is an essential component of safe, effective and person centred care provision. There are four standards set out under the following themes:

1. Person centred approaches
2. Content
3. Presentation
4. Governance

5.0 Person Centred Approaches

Patient/client records must demonstrate patient/client/carer involvement in the patient/client journey from admission to discharge from the service.

Key Performance Indicators

Entries to patient/client records:

1. Must demonstrate the involvement of the person for whom the care is being provided or where appropriate, and with the person's consent, the involvement of his/her carer, in the record keeping process.
2. Must demonstrate that the needs and preferences of the person for whom the care is being provided, where appropriate, have been included in the record keeping process.
3. Must demonstrate that the appropriate consent for care/treatment has been sought from the patient/client.
4. Must be written in a way which can be easily understood by the person for whom the care is being provided.

6.0 Content

Entries to records must demonstrate accurate, contemporaneous, factual record keeping practice in relation to the patient/client journey from admission to discharge from the service.

Key Performance Indicators

Entries to patient/client/client records:

1. Must be accurate, factual and must not include jargon, meaningless phrases or text-style abbreviated language.
2. Must identify the date and time in 24 hour format. This must be in real time and chronological order, and be as close to the actual time of the event as possible.
3. Must demonstrate details of all assessments, risk assessments, plans of care and reviews undertaken, and provide clear evidence of the arrangements made throughout the person's journey from admission to discharge from the service.
4. Must identify dates and times of the evaluation of the plan of care.
5. Must demonstrate that review of the plan of care has been carried out.
6. Must demonstrate evaluation of care and treatment.
7. Must demonstrate that discharge planning, where appropriate, has commenced at the time the person enters a care setting.

7.0 Presentation

All entries to patient/client records are legible, accurate and attributable.

Key Performance Indicators

Entries to patient/client/client records:

1. Written entries must be made in black ink and legible handwriting.
2. Must be signed or contain a unique staff identifier in the case of electronic records. In the case of written records, the person's name and job title must be printed alongside the first entry, for example, on a document signature recognition register.

3. Made in error must be identified with a single line strikethrough, and the name, job title, signature of the nurse/midwife making the record, with the date and time of strikethrough, must be recorded in the original document.
4. Made as an alteration or addition should be identified by the name, job title, and signature of the nurse/midwife recording the alteration or addition, and the date and time of the alteration/addition.
5. Must be made in records with a clearly identified unique patient/client number on each separate element.

Retrospective entries which need to be added to the record must be entered as the next chronological entry using the current date and time (24 hour clock) with reference made to the date and time to which it relates.

Entries to patient/client records made by pre-registration nursing or midwifery students:

6. Must be countersigned by a registered nurse/midwife.

Entries to patient/client records made by Health Care Support Workers (HCSW)

7. Must be countersigned by a registered nurse/midwife if the HCSW framework has not been undertaken or has not successfully been completed

8.0 Governance

Regular organisational audit must demonstrate compliance with the standards for record keeping practice for nursing and midwifery.

Key Performance Indicators

1. Executive Directors of Nursing must ensure that there is a robust audit programme of records made by nurses and midwives, nursing and midwifery students and other unregistered staff, to assure the standard of record keeping practice and identify any areas where improvements must be made.
2. The standard of record keeping must be an integral part of nursing and midwifery Key Performance Indicators and Patient Safety Improvement programmes within the WHSCT organisational governance arrangements.

9.0 Nursing and Midwifery Assessment Booklets

The assessment booklet selected by nursing staff will be determined by the patient/clients predicted length of hospital stay. Nursing assessment booklets within WHSCT include;

1. The Regional ***HSC Person-centred Nursing Assessment and Plan of Care*** *– Adult Inpatient Care Setting (April 2019)*
   This assessment booklet is selected for patients with length of stay more than 48 hours. An on-going Continuation/Evaluation of Nursing Care accompanies this booklet for patients with prolonged length of stay.
2. *Nursing Assessment and Plan of Care for Adults Admitted up to 48 hours only.*
   This assessment booklet is selected for patients with a length of stay up to 48 hours. This booklet is currently under regional review.
3. *The Day Case Nursing Assessment for In-patient Setting*
   This booklet is selected for patients admitted for day case procedures only within an inpatient setting.

The person-centred assessment, care planning and evaluation (PACE) framework of recording care is being phased into WHSCT. This framework places emphasis on the collaborative relationship between nurse and patient/client using an individualised approach. Care is prescribed, implemented and evaluated to evidence safe and effective person-centred care.

All nursing specialities are currently being reviewed under the auspices of NIPEC and the Regional recording care group. This work is at various stages, however, when the documents are finalised and approved these will become the only record for admission and assessment that should be used.

For Midwifery staff only

Midwives use Regional Maternity hand held notes for recording care. These maternity records incorporate both risk assessment and care planning.

Patient/client transfer from one ward to another

When a patient/client is transferred from one ward to another the ongoing care needs must be reassessed and recorded on transfer.

10.0 Electronic Records

Within community nursing (District Nursing and Rapid Response) the multi professional patient/client assessment tool in use is called the Northern Ireland Single Assessment Tool (eNISAT). This assessment tool has 5 primary components which are:

- Initial/Short Term Assessment
- Core Elements
- Specialist Assessment
- Consent
- Carers Assessment

This is an electronic record therefore all data protection and confidentiality around computer held records must be adhered to.

District Nursing records are currently undergoing a regional review facilitated by NIPEC.

For further information please access all relevant documents on the WHSCT Intranet site.

11.0 Patient/Client Held Records

There are occasions when patient/clients retain elements of their own records in their home environment such as District nursing. These records provide all the relevant assessment, care planning and evaluation information required to effectively care for a patient/client at home, especially when different professional groups are visiting in and out of hours. It is important that these records are kept in a safe place and returned to the nurse on discharge.

When the patient/client no longer requires District Nursing involvement nurses must ensure that all patient/client held notes are removed from the patient/clients home and filed appropriately with all other nursing documentation relating to the patient/client. This is to ensure that one file is stored for each patient/client with no risk of any documentation being stored/retained separately.

12.0 Access to Records

The Data Protection Act (1998) permits patient/clients the right to access their health records and obtain an explanation of their content. Nurses and midwives should ensure that any entries in health records can be clearly understood by both professionals and the public.

13.0 Key Performance Indicators and Audit

Record keeping is a key performance indicator led by the NIPEC Regional Recording Care Steering Group. Performance is reported to the steering group every quarter. Information is collated on the NIPEC online assessment tool (NOAT) as part of the WHSCT dashboard system. Please see link

http://sharepoint.westhealth.n-i.nhs.uk/sites/nd/Nursing%20Performance/Audit%20Tools/WHSCT%20Record%20Keeping%20Audit%20Tool.NOAT.xlsx

Records will be monitored regularly to ensure they meet internal and external audit requirements.

14.0 Diaries and Patient/Client Information

Diaries can be considered part of patient/client clinical record.

Care must be taken to ensure security and confidentiality of patient/client information recorded in diaries. Diaries must be locked securely when not in use.

In respect of disposing diaries, The Department Of Health, Good Management Good Records, (2014), Section J19, recommends, '*Diaries – professional for example, health visitors, district nurses, two years after the end of the year to which the diary relates. Patient specific information should be transferred to the patient record. Any notes made in the diary as an 'aide memoire' must also be transferred to the patient record as soon as possible'*

This recommendation is solely for the purpose of record keeping, however for diaries utilised for any other purpose, staff must adhere to local guidance pertaining to diary management.

15.0 Duplicate Records

Duplication must be avoided including statements about information recorded on other records.

16.0 References

Chief Nursing Officers for the UK and Nursing and Midwifery Council. (2017). *Enabling Professionalism in Nursing and Midwifery.* Bit.ly/CNOsProfessionalism

Department of Health *Co-production Guide Connecting and Realising Value Through People.* 2018
https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

Good management, good records | Department of Health 2014.
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Francis, R. 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary*. London: The Stationary Office.

Health and Social Care Board (HSC). 2016. *The Northern Ireland Single Assessment Tool, Interim Procedural Guidance*, Version 4 September.

Northern Ireland Practice and Education Council for Nursing and Midwifery. 2017 *Standards for person centred nursing and midwifery record keeping practice*. Belfast

Nursing and Midwifery Council 2018. The Code. *Professional standards of practice and behaviour for nurses, midwives and nursing associates.* London

The Regulation and Quality Improvement Authority. 2015. *Review of the Care of Older People in Acute Hospitals Overview Report*. Belfast.

The Data Protection Act. 1998. http://www.legislation.gov.uk/ukpga/1998/29/contents