Southern Health and Social Care Trust
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Regional Person Centred Nursing and Midwifery Record Keeping Practice

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Directorate responsible for document:	Nursing, Midwifery, Allied Health Professionals and Functional Support Services.
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Policy Checklist

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Director responsible for Policy:	Heather Trouton
Directorate responsible for Policy:	Nursing Midwifery and Allied Health Professions Directorate
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1.0 Introduction

1.1 This policy outlines a framework to support the achievement of professional standards for person centred nursing and midwifery record keeping practice.

1.2 The term 'patient/client' or 'person' refers to all individuals receiving care and treatment within any health and social care setting, or organisation engaged in care provision, such as the independent and voluntary sectors. This includes children, adolescents and adults across all programmes of care. Patient/client records must demonstrate patient/client/carer involvement in the patient/client journey from admission to discharge from the service.

1.3 The principles and standards contained in this policy are based on those developed for the region by the Northern Ireland Practice and Education Council (NIPEC) for nursing and midwifery in consultation with representatives from all care settings in the five Health and Social Care (HSC) Trusts and other relevant stakeholders in 2013, reviewed in 2016 and 2019. The standards for person centred nursing and midwifery record keeping practice[1] are attached at Appendix 1.

2.0 Purpose and Aims

Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- Helping to improve accountability.
- Showing how decisions related to patient/ client[2] care were made.
- Supporting the delivery of services.
- Supporting effective clinical judgements and decisions.
- Supporting patient care and communications.
- Making continuity of care easier.
- Providing documentary evidence of services delivered.
- Promoting better communication and sharing of information between members of the multi-professional healthcare team.
- Helping to identify risks, and enabling early detection of complications
- Supporting clinical audit, research, allocation of resources and performance planning.
- Helping to address complaints, incidents/ other investigations, public enquiries or legal processes.

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[1] Northern Ireland Practice and Education Council. (2017) *Standards for Person Centred Nursing and Midwifery Record keeping Practice*. Belfast, NIPEC. Working from revised unpublished document 2020.

[2] 'patient/client' or 'person' refers to all individuals receiving care and treatment within any health and social care setting, or organisation engaged in care provision, such as the independent and voluntary sectors. This includes: women, children, adults, and those people with mental health needs or learning disabilities.

3.0 Objectives of this Policy

This policy has been designed to support the Trust to comply with corporate and professional regulatory governance requirements ensuring safe and effective care for patients and service users.

4.0 Policy Statements

4.1 The Standards for Nursing and Midwifery record keeping practice developed by NIPEC were mandated for use by all Trusts by the Chief Nursing Officer for Northern Ireland in 2013. Reflecting the principles in the NMC Code[3], all nurses, midwives, nursing or midwifery students and nursing assistants (NAs), senior nursing assistants (SNAs) and midwifery support workers (MSWs) aligned to the family of nursing and midwifery.

4.2 Nursing and Midwifery records are fundamental to the quality and safety of patient care. Any document, which records any aspect of the care of a patient or client, can be required as evidence before a Coroner's court, a court of law or before the Professional Conduct Committee of the NMC. Good record keeping ensures that there is historical evidence of the standard of person centred nursing and midwifery practice, should it be required to be relied upon for example when providing a complaint response, quality improvement processes, serious adverse incidents reviews, workload analysis or public inquiries

4.3 Records are there to give a clear and accurate account of the care and treatment of patients/clients and to assist in making sure they receive the best possible clinical care. They form a permanent record of individual considerations and the reasons for decisions. They contribute to good communication between and across healthcare professionals. Patient/client records are essential to ensure that an individual's assessed needs are met comprehensively and in good time. The record is a nurse's or midwives' main defence if assessments or decisions are scrutinised.

5.0 Scope of Policy

5.1 The scope of this policy spans all forms of records that nurses, midwives, nursing and midwifery students and nursing assistants (NAs), Senior Nursing Assistants (SNAs) and Midwifery Support Workers (MSWs) aligned to the family of nursing and midwifery will make.

5.2 Where nursing or midwifery students or other non-registered staff make entries to care records, they do so under the delegated authority of a registered nurse or midwife.

5.3 The type or format of record of care that nurses and midwives keep may vary, for example electronic or hard copy; however, the standards required for good record

[3] Nursing and Midwifery Council (2018). *Professional standards of practice and behaviour for nurses, midwives and nursing associates.* London, NMC.

keeping practice apply to all types of records, regardless of format including, but not exclusively:

- All types of handwritten clinical records, including multi-professional records
- All types of electronic clinical records, including multi-professional record
- Emails/texts
- Letters to other health professionals, patients and carers
- Laboratory reports
- Printouts from monitoring equipment
- Incident reports and statements

6.0 Responsibilities

This policy has been designed to support the Trust to comply with corporate and professional regulatory governance requirements ensuring safe and effective care for patients and service users. Implementation of this policy is the responsibility of individual directors.

This policy applies to all nurses, midwives, nursing and midwifery students, NAs, SNAs and MSWs aligned to the family of nursing and midwifery working in the Southern Health and Social Care Trust.

6.1 Chief Executive and Executive Directors

The Chief Executive is the overall accountable officer for records management within the Trust, supported by the Director of Planning, Performance and Informatics. The Executive of Director of Nursing has professional accountability for nurses, midwives NAs, SNAs and MSWs aligned to the family of nursing and midwifery and is responsible for ensuring this policy has been appropriately communicated, and has appropriate governance arrangements to assure compliance within current reporting frameworks.

6.2 Managers and Leads of Nursing and Midwifery staff

Managers and Leads of Nursing and Midwifery staff, should ensure that all nurses, midwives, nursing and midwifery students, NAs, SNAs and MSWs aligned to the family of nursing and midwifery, who make entries in patient/client records are aware of this policy and comply with it. Managers of staff who handle records in any capacity should ensure that staff understand their responsibilities, whether for clinical entries covered by this policy or for the maintenance and use of the manual records covered by Good Management Good Records standards (DoH[4]).

Managers of Nursing and Midwifery services should have systems in place to ensure that:

[4] https://www.health-ni.gov.uk/topics/goodmanagement-good-records

1. Staff have access to the appropriate training and/or induction as appropriate as soon as possible before commencement of involvement with patient/client records, with regular updates of training as required.
2. Reflective supervision discussions include consideration of the standard of record keeping practice for registrants.
3. Documenting of relevant information within the clinical record meets NIPEC standards.
4. Record keeping is a key performance indicator for the SHSCT. The effectiveness of this policy will be monitored by all Nursing and Midwifery Professional Leads in conjunction with relevant managers by:-
    - Each service area is required to complete a monthly audit of 10 patient/ client records carried out by a nursing registrant using an agreed relevant audit tool.
    - With results being uploaded on to the SHSCT Nursing Quality Indicator Dashboard.
    - Where there are concerns regarding poor compliance, remedial action should be implemented and the Ward Manager/Charge Nurse is to adhere to the Quality Improvement Process.

6.3 Service Leads/Team Leads/Lead Nurses and Midwives/ Specialist and Advanced Practitioners

This group of staff will provide assurance to the Directorate leads/ Service Lead Nurses/Midwives that actions 1 – 4 listed in para 6.2 are undertaken within their area of responsibility.

6.4 Nurses, midwives, nursing and midwifery students, NAs, SNAs and MSWs aligned to the family of nursing and midwifery must:

- Adhere to the standards for record keeping practice set out in this policy, supplemented where necessary by departmental standards and protocols and standards set by the Nursing and Midwifery Council (NMC)
- As part of reflective supervision processes, take time to reflect on their own practice, determine learning needs and seek training if required to enable improvements where appropriate.
- Work under the Delegation Framework for non-registered staff

7.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

This policy should also be read in conjunction with the NMC Code, particularly section 10; A Record Keeping Practice Framework for Health Care Support Workers (NIPEC, 2016[5]); HSC Trust Records Management policies, and other organisational policies related to record keeping practice, including local protocols.

8.0 Equality Considerations

[5] NIPEC to review this framework

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission of Northern Ireland Guidance states that the purpose of screening is to identify those policies that are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them. Using the Equality Commission's screening criteria no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

8.1 Human Rights Considerations

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed compatible with the European Convention of Human Rights contained in that Act. This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

9.0 Sources of Advice & Further Information

The Lead Policy Authors, NIPEC and responsible Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

10.0 Evidence Base References

This policy should also be read in conjunction with:-

- Recording Care | NIPEC (hscni.net)
- NMC (2015) The code Professional standards of practice and behaviour for nurses and midwives
- A record Keeping Practice Framework for Health Care Support Workers (NIPEC 2016) Record Keeping Practice Framework for Nursing Assistants | NIPEC (hscni.net)
- Good Management Good Records standards (DoH) An introduction to Good Management Good Records | Department of Health (health-ni.gov.uk)
- Health and Social Care Records Management Policies

Other organisational policies related to record keeping practice, including local protocols

Appendix 1

The Northern Ireland Practice and Education Council for Nursing and Midwifery: Standards for person centred nursing and midwifery record keeping practice (Revised: unpublished, 2020)

Revised-Standards-fo
r-Nursing-and-Midwi

A Record Keeping Practice Framework for Health Care Support Workers

May (NIPEC, 2016)

Final Framework for
HCSW Staff.pdf

Deciding to Delegate: A decision making framework to support nurses and midwives. (NIPEC, 2019).

NIPEC Deciding to
Delegate Decision Sup

Appendix 2

NOAT (Emergency
Department) Audit T

NOAT Audit Tool -
Acute and Non Acut

NOAT_CYP_Templat
e.pdf

Record Keeping
(Learning Disability).

Additional audit tools for record keeping will be added as required