NORTHUMBRIA NURSES

STRONGER TOGETHER IN UNISON

Guidelines for record keeping
“Record keeping is an integral part of nursing, midwifery and specialist community public health nursing practice. It is a tool for professional practice and one that should help the care process. It is not separate from this process and is not an optional extra to be fitted in if circumstances allow” (NMC, 2009a).

This document has been produced to assist our members both Registered and Health Care Assistants with their document keeping.

According to the Nursing and Midwifery Council (NMC, 2009b) an average of 8.8% of Fitness to Practice cases referred annually to them concern poor record keeping.

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 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 or legal processes.
## Record Keeping

A number of common problems with record-keeping have been identified (Dimond, 2005, HSC, 2003-2004). These are:

- Absence of clarity e.g. the meaning of 'Had a good day' and 'slept well' is not clear
- Failure to record action taken when a problem is identified, e.g. 'is suffering increasing pain' then no record of action taken
- Missing information, e.g. administration of a drug not documented
- Spelling mistakes, e.g. error in name resulting in wrong diagnosis
- Inaccurate records, e.g. changing a dressing or giving medication, when in fact the patient had not received the recorded treatment (leading to a nurse being removed from the Register)
- Failure to document conversations
- Failure to document care given
- Failure to document special need
- Failure to record telephone calls, e.g. on risk of suicide
- Failures in communication between healthcare professionals
- Too much jargon
- Patient identification, e.g. entry of information on an identity band, clinical documentation and failure to transfer patient details on continuation sheets
Principles of good record keeping

- Handwriting should be legible.
- All entries to records should be signed. In the case of written records, the person’s name and job title should be printed alongside the first entry.
- In line with local policy, you should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible.
- Your records should be accurate and recorded in such a way that the meaning is clear.
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.
- You should use your professional judgement to decide what is relevant and what should be recorded.
- You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
- Records should identify any risks or problems that have arisen and show the action taken to deal with them.
- You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.
- You must not alter or destroy any records without being authorised to do so.
- In the unlikely event that you need to alter your own or another healthcare professional’s records, you must give your name and job title, and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable.
- Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.
- The language that you use should be easily understood by the people in your care.
- Records should be readable when photocopied or scanned.
- You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.
- You should not falsify records.
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