THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Nursing Documentation Guideline

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Related documents	**References** Austin.S (2011) Stay out of court with proper documentation. Nursing, April 2011, Vol 41, No 4, pp24-29 Bristol Royal Infirmary Inquiry (2001) Learning form Bristol: The report of the public enquiry in to children's heart surgery at the Bristol Royal Infirmary 1984-1995. Command Paper CM 5207 www.bristol-inquiry.org.uk Confidential Enquiry into Stillbirths and Death in Infancy (CESDI) (2000). CESDI 7th Annual Report. www.cesdi.org.uk Cowan J. (2000). Clinical Governance and Clinical Documentation: still a long way to go? British Journal of Clinical Governance, 5(3): 179. Cudmore J. (2000) Write it down, for everyone's sake. Nursing Times. March 9; 96(10): 26. Data protection Commission (1998) Data Protection Act LASSL (98) 16 www.dataprotection.gov.uk Dept. of Health (2001) The Essence of Care – Record Keeping www.doh.gov.uk/essenceofcare/index.htm FoI (2004). Freedom of Information Act: procedures for handling applications. Under the "General Rights of Access," Portsmouth Hospitals NHS Trust.

GDPR (2018) Guide to the General Data Protection Regulation. May 2018, Information Commissioners Office. Found at; https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation

Glover D. (1999) Keep your record clean. Nursing Times. December 1; 95(48): 26.

ICO (2019) Guide to the General Data Protection Regulation (GDPR) Information Commissioner's Office. Found at. https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/

Laming Lord (2003) The Victoria Climbe Inquiry: www.victoria.climbe-inquiry.org.uk/finereport/finport.htm

Lippincott (2018) Nursing Documentation: How to avoid the most common medical documentation errors. Nursing Education Blog. Found at; http://nursingeducation.lww.com/blog.entry.html

Mathioudakis.A et al (2016) How to keep good clinical records. Breathe 2016, Vol 12, 371-75

Modernisation Agency (2003). Essence of Care Benchmark for Record Keeping, Department of Health, Modernisation Agency. www.modern.nhs.uk

NHSE (1991) Access to Health Records Act (1990): A guide for the NHS.

NHS Litigation Authority (2005) CNST Clinical Risk Management Standard 4: Health Records.

NIP (2012) A guide to case notes and record-keeping. Nursing in Practice, 27th November 2012, 11.19am.

NMC (2009). Records & Record Keeping Guideline, Nursing and Midwifery Council. www.nmc-uk.org

NMC (2015) The Code. Professional standards of practice and behaviour for nurses, midwives, and nursing associates. Nursing & Midwifery Council, London.

Pinock S. (2004) Poor Communication lies at heart of NHS complaints, says ombudsman. BMJ 3 January; 328(10) doi:10.1136.

RCHM (2014) Clinical Guidelines (Nursing) Nursing Documentation. The Royal Children's Hospital Melbourne. Found at: https://www.rch.org.au/clinicalguide/about_rch_cpgs/welcome_to_the_clinical_practice_guidelines/

RCN (2012) Delegating record keeping and countersigning records. Royal College of Nursing. London.

RCN (2017) Record keeping the facts. Royal College of Nursing, found at; www.rcn.org.uk

Tingle J H (1999) Nurses are accountable for their records. British Journal of

	Nursing 8(11): 701 Wood C, (2003) The importance of good record-keeping for nurses: Nursing Times. 99(02):26
Implications of race, equality & other diversity duties for this document	This guideline must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation, or religion.

Contents

1.0 Aim of Guideline

Record keeping is an integral part of professional nursing practice and influences the nursing care process of all nursing staff, including Nursery Nurses. The quality of record keeping reflects the standard of individual professional practice. Good record keeping is the mark of a safe and skilled practitioner. The principles of good record keeping in nursing care are well established and should reflect the core values of patient individuality and partnership working.

Accurate documentation is essential to maintain continuity and inform health professionals of ongoing care and treatment. It is not only a legal requirement but also provides legal evidence.

2.0 Scope of Guideline

This policy can be applied to all health care professionals who are employed within the network.

Thames Valley		
Trust	**Hospital**	**Designation**
Oxford University Hospitals NHS Foundation Trust	- John Radcliffe Hospital, Oxford	NICU
Buckinghamshire Healthcare NHS Trust	- Stoke Mandeville Hospital, Aylesbury	LNU
Frimley Health NHS Foundation Trust	- Wexham Park Hospital, Slough	LNU
Milton Keynes University Hospital NHS Foundation Trust	- Milton Keynes General Hospital	LNU
Royal Berkshire NHS Foundation Trust	- Reading	LNU

Wessex		
Trust	**Hospital**	**Designation**
University Hospital Southampton NHS Foundation Trust	- Princess Anne Hospital	NICU
Portsmouth Hospitals University NHS Trust	- Queen Alexandra Hospital	NICU
Dorset County Hospital NHS Foundation Trust	- Dorset County Hospital, Dorchester	SCU
Hampshire Hospitals NHS Foundation Trust	- Basingstoke and North Hampshire Hospital	SCU (Temporary designation)
Hampshire Hospitals NHS Foundation Trust	- Royal Hampshire County Hospital, Winchester	SCU (Temporary designation)
Isle of Wight NHS Trust	- St Mary's Hospital	SCU
University Hospitals Dorset NHS Foundation Trust	- Poole Hospital	LNU
Salisbury NHS Foundation Trust	- Salisbury District Hospital	LNU
University Hospitals Sussex NHS Foundation Trust	- St Richard's Hospital, Chichester	SCU

3.0 Guideline Summary

- All health records are legal, confidential documents.
- Actions relating to an infant's care and treatment must be documented in the infant's record.
- Accurate documentation is essential to maintain continuity and inform health professionals of ongoing care and treatment.

- It is not only a legal requirement to keep accurate records but also provides legal evidence of care given. Remember that in a court of law “if it is not recorded, it has not been done.”
- Content and style should demonstrate:
    - Name & hospital number on every page/ screen – preferably a printed addressograph label on paper sheets, where paper notes are in use.
    - Clear attribution of entries made in any paper or electronic records to the author, making sure they are clearly written, dated, and timed and do not include unnecessary abbreviations, jargon, or speculations.
    - In handwritten records a signature should be followed by the author’s name in clear print, and the author’s professional designation.
    - All entries should be written or printed in indelible black ink.
    - Corrections must show the date and the time of the correction and if handwritten should be crossed out by a single line. The correction should be clearly attributable to the author.
    - In handwritten entries, space to the end of the line should be blocked off.
    - Entries made by students must be countersigned by a nurse- or other supervising registered professional - see NMC Guidance.
    - Only formally approved abbreviations should be used- refer to local hospital policy for list of accepted abbreviations.
    - Records should be written as soon as possible following the event – and in chronological order.
    - Each record should be factual, consistent, and accurate (including adverse incident forms)
    - Notes should not be written in retrospect and if written in retrospect should be clearly evidenced as such.

4.0 Guideline framework

4.1 Background information

- Good record keeping helps to protect the welfare of infants on neonatal units by promoting:
    - High standards of care
    - Accountability
    - Continuity of care
    - Better communication and dissemination of information between members of the inter-professional team and parents/carers
    - An accurate account of treatment, care planning and delivery of such care
    - The ability to detect problems, such as changes in the infant’s condition, at any stage during the care process and deliver appropriate care promptly.

- Good record keeping helps to protect the welfare of staff by:
    - Demonstrating how decisions related to patient care were made.
    - Providing documentary evidence of services delivered
    - Facilitating the management of complaints or legal processes
    - Support clinical audit, research, allocation of resources and performance planning.

- All health records are legal, confidential documents. Nursing staff are responsible for keeping accurate records and for ensuring professional guidelines for records and record keeping are followed. (NMC 2015).

- All records should be constructed and completed in such a manner as to facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.

- Nurses are subject to increasing scrutiny regarding their record-keeping. Legislation such as the Human Rights Act 1998 and the Data Protection Act 1998 has increased the profile of, and access to, health records (Dennemeyer, 2000; Sainsbury Centre for Mental Health, 2002) Whether complaints are resolved by healthcare providers or settled in court, comprehensive records are essential.

- It is important, therefore, that nurses keep abreast of legal requirements and best practice in record-keeping. The Code of Professional Conduct (NMC, 2002a) advises that good notetaking is a vital tool of communication between nurses. It states that nurses 'must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. The care plan should be written with the involvement of the parent/carer wherever practicable and completed as soon as possible after an event has occurred. It should provide evidence of the care planned, the decisions made, and the care delivered, and the information shared.'

- It is significant that allegations concerning shortcomings in nurses' record-keeping were the second most common category of hearing brought before the UKCC in 2000-2001 and only surpassed by allegations of abuse (NMC, 2002b; UKCC, 2001).

4.2 Legal matters, risk management and confidentiality

- Remember that in a court of law "if it is not recorded, it has not been done."
- Documentation which includes patient identifiable data must be stored safely to ensure confidentiality.
- Any documentation containing patient identifiable data attached to emails must be sent, from a secure Trust or nhs.net email, whichever is applicable to local teams.
- Personal information about patients held by health professionals is subject to a legal duty of confidence.
- The content of the health record should include information which permits the reader, a full understanding of events that have occurred and the ability to retrospectively analyze care delivered.
- Staff must be aware of responsibilities to maintain confidentiality according to Trust policy.
- There is a local Trust policy relating to parent access to their infant's record.
- There are systems in place for storage and retrieval of patient records.
- Patient records should be stored away from the observation of the public and should not be left unattended at any time. (See 4.7 for Electronic Data)
- All staff should ensure that their documentation:
    - Provides accurate information on the condition, care, and treatment of the patient.
    - Records the chronology of events and the reasons for any decisions made.
    - Demonstrate that their care and treatment follow evidence-based guidance or supporting documents describing best practice, or that there is an explanation of any variance.
    - Demonstrate that where necessary local guidelines relating to risk management have been followed and critical incidents reported.
    - Includes identification of equipment used with asset numbers.

4.3 Delegating and countersigning records

- Record keeping CAN be delegated to nursing students so that they can document their care.
- As with any delegated activity, the nurse needs to ensure that the student is competent to undertake the task and that it is in the patients' best interest for record keeping being delegated.

- Supervision and a countersignature are required until the student is deemed competent at record keeping.
- Nurses should only countersign if they have witnessed the activity or can validate that it took place.
- In some hospital Trust it may be local policy that all student record keeping is countersigned- so refer to local policy.

4.4 Parent / professional partnership

- Parents/carers must be given information to enable them to participate in their infants' care.

- Within the record there should be evidence of the following:
    - Individualised parent education
    - Parent/professional discussions have taken place and where outcomes exist, they are recorded.
    - Areas of concern are highlighted e.g. parenting skills.
    - Any written information given to the parents is recorded.
    - There is an opportunity for the parents to contribute to the record, in partnership with staff according to local policy.
    - Activities that the parents undertake with their baby are recorded.

4.5 Communication and information sharing across professional and organisational boundaries

- Healthcare professionals responsible for the care of any patient must communicate effectively with each other.
- Members of the multi-professional team involved in the care and treatment of the infant must be clearly identifiable from the record.
- Actions relating to an infant's care, and treatment must be documented in the infant's record.
- Timely referrals to other professional disciplines should be made to meet the infants' needs. These are dated, documented, and actioned.
- Patients ideally have single, multi-professional records.

4.6 Competent use of computers for collecting and storing data

- The onset of paperless documentation means staff must be proficient in the use of computer technology. This includes.
    - Staff must be trained in the use of relevant programmes.
    - Computer programmes are password protected and compliant with GDPR guidance.
    - Staff maintain confidentiality by observing computer protocol e.g., log off, guarding the screen.
    - Staff accurately input data.
    - Staff regularly update information.
    - Medical results from computerized care records must be transferred into a patients' notes where necessary.

4.7 Audit

- Audit should play a vital part in ensuring the quality of care that is delivered, as it identifies areas for improvement and staff development. Therefore, every health care provider must ensure.

    - Records are audited using a record keeping tool.
    - Audits are undertaken annually.
    - There should be is evidence that action has been taken because of the audit that occurred.

Version Control:

Version	Date	Details	Author(s)	Comments
3	March 2019	Reviewed by lead nurses and practice development leads	KR/ Team	
	Feb 2020			Changes from feedback added. Ratified Sept 2020.
4	November 2023	Review	KR LL CS	Reviewed by lead Care Coordinator & Neonatal Governance Facilitator. Changes made following comments on circulation. Ratified March 2024.
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