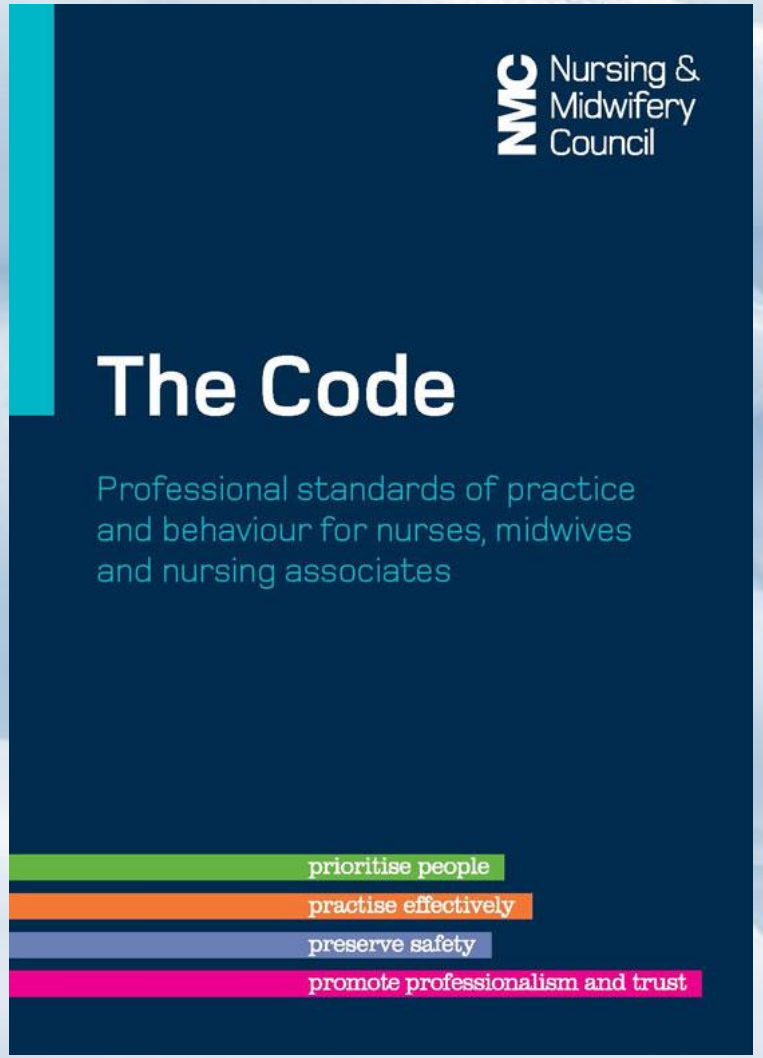
NHS Greater Glasgow and Clyde

Registered Nurse and Midwifery Induction

Record Keeping and Documentation Good Practice points

Our professional requirements



In your clinical environment with many demands on your time, keeping documentation records is a challenging but essential part of your role. All documentation records a part of the nursing process; assessment, planning, implementation and evaluation of care.

The NMC Code provides essential guidance on how to keep clear and accurate records relevant to your practice. Take your time to read through section 10 of the Code and make a note of the key points.

How good is your record keeping?

Whether you are very experienced or a newly qualified nurse or midwife, take a moment to reflect; what is the quality of your record keeping?

Good record keeping is an essential part of effective communication and integral to promoting safety and continuity of care for patients.

Be clear about your responsibilities for record keeping in whatever format your patient records are kept.

Patient records provide evidence of care provided. What we record as registrants can be used for a wide range of purposes. These includes care assurance, response to complaint, NMC enquiry, police investigation and public enquiry.

NMC Nursing & Midwifery Council

Principles of good record keeping ……

- Provide clear and concise evidence of planned care
- Entries should be:
  - Dated and timed as soon as possible after the care intervention
  - Signed and printed with name and designation
  - Legible, actual and factual
  - Written in black ink which cannot be erased or deleted
- Records should never be tampered with or falsified
- Alterations should be signed and dated
- Errors should be scored through with a single line, signed and dated

Avoid ……

- Unnecessary professional jargon
- Irrelevant speculation
- Subjective statements or value judgements
- Remarks which might be construed as offensive
- Abbreviations

Reflect person centred care in your record keeping

A good place to start is to use patient's preferred name and think of the '5 must does'

- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me, without me.
- Personalised contact

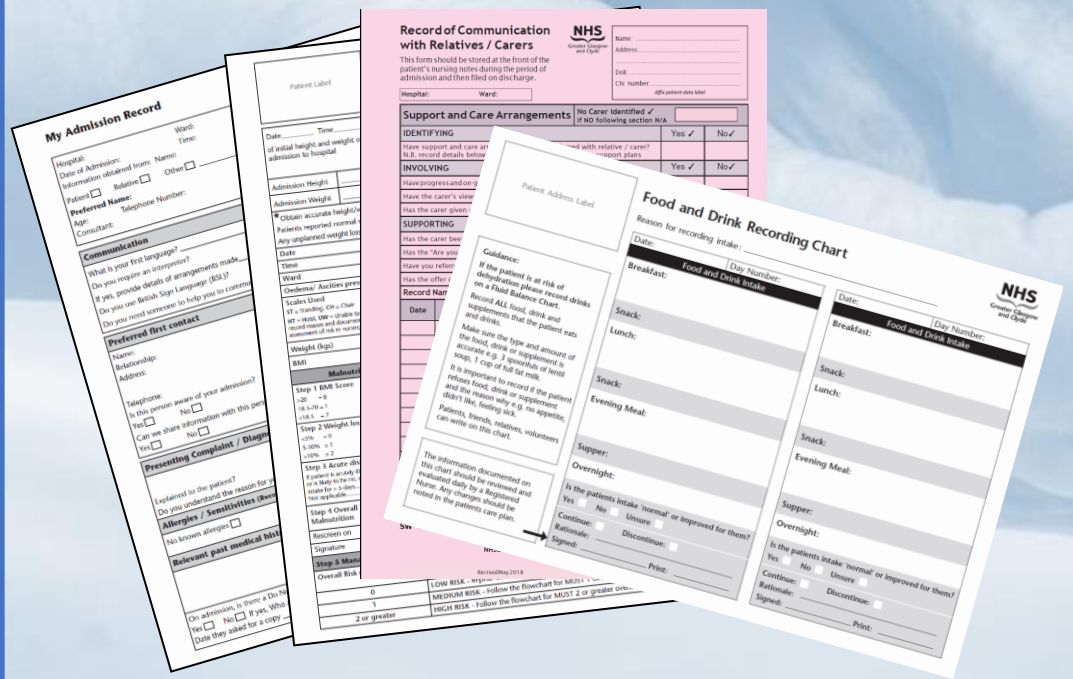
Countersigning

- Record keeping can be delegated to Health Care Support Workers (HCSW) and student nurses/midwives to allow the documentation of care
- As with any delegated activity, the registered nurse or midwife must ensure that HCSW or student nurse/midwife is competent to record care
- **All documentation entries (notes and charts) need to be clearly countersigned by the registered nurse/midwife**

Learning Activity

We are moving to digital health and care patient records across NHSGGC as we know this is the best option for staff and ultimately patient care. Meantime paper records are still used widely.

Make up a pack of each paper document used within your clinical area to familiarise yourself with completion.



Find out which digital systems are in use and ask your SCN/M how to access training for these.

TrakCare

Clinical Portal

BadgerNet

Hospital Electronic Prescribing and Medicines Administration

Datix