NURSING & MIDWIFERY COUNCIL

Guidelines for records and record keeping

Protecting the public through professional standards

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Contents

Guidelines for records and record keeping was first published by the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC] in October 1998. In April 2002, this revised edition was published by the new Nursing and Midwifery Council [NMC]. The guidelines themselves remain unchanged and the only textual changes are a small number of minor amendments necessitated by the transfer to the new regulatory body. The NMC will keep these guidelines under review and will notify all registered nurses and midwives in advance of any changes that will lead to the publication of a revised edition.

Foreword

The Nursing and Midwifery Council [NMC] believes that record keeping is a fundamental part of nursing and midwifery practice. As the regulatory body for these professions, we have a legal responsibility to provide advice to registered nurses and midwives on standards of professional practice.
In 1993, the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC] published the first edition of *Standards for records and record keeping* in order to give guidance in this area to registrants. The UKCC published a revised second edition of the publication, entitled *Guidelines for records and record keeping*, in 1998. This NMC advisory booklet is simply a reprint of the 1998 publication.

The guidance is based upon extensive consultation with organisations representing the interests of patients and clients, registered nurses and midwives, professional organisations and trades unions, employers, managers and legal experts in record keeping. The consultation included conferences, individual submissions and discussions, together with comments upon an earlier draft of the text.

Like all NMC guidance, this is not a rule book that will provide the answer to every question or issue that could ever arise in the area of record keeping. Nor do we believe that it is the role of the NMC in this respect to define a rigid framework for the content and format of your record keeping. Instead, we seek to provide guidelines that we hope will help you to think through some of the issues and to exercise your professional judgement as an individual accountable registered nurse or midwife.

We hope that you will find this booklet helpful to you in all aspects of your professional practice.

Introduction

Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.

Good record keeping helps to protect the welfare of patients and clients by promoting:

- high standards of clinical care
- continuity of care
- better communication and dissemination of information between members of the inter-professional health care team
- an accurate account of treatment and care planning and delivery
- the ability to detect problems, such as changes in the patient's or client's condition, at an early stage.

The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice.

There is no single model or template for a record. The best record is one that is the product of the consultation and discussion which has taken place at a local level between all members of the inter-professional health care team and the patient or client. It is one that is evaluated and adapted in response to the needs of patients and clients. It is one that enables any registrant to care for the patient or client, regardless of where they are within the care process or care environment. It is an invaluable way of promoting communication within the health care team and between practitioners and their patients or clients. Good record keeping is, therefore, both the product of good team work and an important tool in promoting high quality health care.

The NMC believes that there are a number of key principles that underpin good records and record keeping. Some of these relate to the content and style of the record. In addition, there are some legal issues that you, as a registered nurse or

midwife, should be aware of and take into account in your record keeping practice. The following sections set out these principles and legal aspects. They are designed to help you to reflect upon your current record keeping practice and how you can develop it in order to benefit your patients and clients.

The principles set out in this document apply across all care settings and to both manual and computer-held records. The NMC accepts that, until there is national agreement between all health care professions on standards and format, records may differ depending on the needs of the patient or client. The record must, however, follow a logical and methodical sequence with clear milestones and goals for the record keeping process.

Content and style

There are a number of factors that contribute to effective record keeping. Patient and client records should:

- be factual, consistent and accurate
- be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient or client
- be written clearly and in such a manner that the text cannot be erased
- be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly
- be accurately dated, timed and signed, with the signature printed alongside the first entry
- not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- be readable on any photocopies.

In addition, records should:

- be written, wherever possible, with the involvement of the patient, client or their carer
- be written in terms that the patient or client can understand
- be consecutive
- identify problems that have arisen and the action taken to rectify them

provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

Audit

Audit is one component of the risk management process, the aim of which is the promotion of quality. If improvements are identified and made in the processes and outcomes of health care, risks to the patient or client are minimised and costs to the employer are reduced.

Audit can play a vital part in ensuring the quality of care that is delivered and this applies equally to the process of record keeping. By auditing your records, you can assess the standard of the records and identify areas for improvement and staff development. Audit tools should therefore be devised at a local level to monitor the standard of the records produced and to form a basis both for discussion and measurement. Whatever audit tool or system is used, it should primarily be directed towards serving the interests of your patients and clients, rather than organisational convenience. You may also wish to consider including a system of peer review in the process. The need to maintain confidentiality of patient and client information applies to audit just as to the record keeping process itself.

Legal matters and complaints

Patient and client records are sometimes called in evidence before a court of law, by the Health Service Commissioner or in order to investigate a complaint at a local level. They may also be used in evidence by the NMC's Professional Conduct Committee, which considers complaints about professional misconduct by registered nurses and midwives. Care plans, diaries, birth plans and anything that makes reference to the care of the patient or client may be required as evidence.

As a registered nurse or midwife, you have both a professional and a legal duty of care. Your record keeping should therefore be able to demonstrate:

- a full account of your assessment and the care you have planned and provided
- relevant information about the condition of the patient or client at any given time and the measures you have taken to respond to their needs
- evidence that you have understood and honoured your duty of care, that you have taken all reasonable steps to care for the patient or client and that any actions or omissions on your part have not compromised their safety in any way
- a record of any arrangements you have made for the continuing care of a patient or client.

The frequency of entries will be determined both by your professional judgement and local standards and agreements. You will need to exercise particular care and make more frequent entries when patients or clients present complex problems, show deviation from the norm, require more intensive care than normal, are confused and disoriented or generally give cause for concern. You must use your professional judgement (if necessary in discussion with other members of the health care team) to determine when these circumstances exist.

The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. You must use your professional judgement to decide what is relevant and what should be recorded. This applies particularly to situations where the condition of the patient or client is apparently unchanging and no record has been made of the care delivered. Local standards should be set to define what is a reasonable time lapse if this is the case. Midwives must ensure that they are aware of and comply with the requirements set out in the NMC's *Midwives rules and code of practice* that relate to the maintenance and retention of records.

If you are working with clients who are subject to mental health legislation, you must ensure that you have a thorough working knowledge of these statutory powers as they apply to your particular area of practice. When making entries in records for these clients, you must comply as appropriate with the guidance given by the Mental Health Act Commission for England and Wales, the Mental Welfare Commission for Scotland or the Mental Health Commission for Northern Ireland.

In making a record, you should also be aware of the reliance which your professional colleagues will have upon it. Good communication is therefore essential. Furthermore, you are professionally accountable for ensuring that any duties that you delegate to those members of the inter-professional health care

team who are not registered practitioners are undertaken to a reasonable standard. For instance, if you delegate record keeping to pre-registration students of nursing or midwifery or to health care assistants, you must ensure that they are adequately supervised and that they are competent to perform the task. You must clearly countersign any such entry and remember that you are professionally accountable for the consequences of such an entry. You must ensure that any entry you make in a record can easily be identified. If your signature is unclear, you should print your name alongside it. You are strongly advised not to use your initials only as a signature.

Access and ownership

You need to assume that any entries you make in a patient or client record will be scrutinised at some point. Patients and clients not only have a legal right to see their records but they are increasingly participating in writing and holding them.

Access to records – legal aspects

The *Access to Health Records Act 1990* gives patients and clients the right of access to manual health records about themselves that were made after 1 November 1991. The *Data Protection Act 1984* gives patients and clients access to their computer-held records. It also regulates the storage and protection of patient and client information held on computer.

In some cases, registered nurses and midwives can withhold information from a patient or client that they believe could cause serious harm to the physical or mental health of the patient or client, or which would breach the confidentiality of another patient or client. If you make the decision to withhold information in this way, you must be able to justify it and you must record it. The system for dealing with applications for access is explained in the *Guide to the Access to Health Records Act 1990*, which is published by the government health departments. As a registered nurse or midwife, you must be aware of the rights of patients or clients in these circumstances.

Inter-professional access to records

The NMC supports the principle of shared records in which all members of the health care team involved in the care and treatment of an individual make entries in a single record and in accordance with an agreed local protocol. The ability to obtain information whilst respecting patient and client confidentiality is essential. Each practitioner's contribution to such records should be seen as of equal importance. This reflects the wider value of collaborative working within the inter-professional health care team.

The same right of access to records by the patient or client exists where a system of shared records is in use. It is essential, therefore, that local agreement is reached to identify and publicise who is responsible for considering requests from patients and clients for access in particular circumstances.

Retention

The period for which patient or client records may be required to be kept can depend upon a number of pieces of legislation or health services policy statements issued by government health departments. Your employer should have protocols that you should follow and which will probably require you to keep any record you have made for at least eight years and, in the case of a child, at least to the date of the child's 21st birthday. If you are self-employed, you should also ensure that no record you have made relating to the care of a patient or client is destroyed within a period of eight, or 21, years respectively as above.

Ownership of records

Organisations that employ professional staff who make records are the legal owners of those records. This does not mean, however, that anyone in the organisation has an automatic right of access to the records or the information contained within them. You have a duty to protect the confidentiality of the patient or client record. This is particularly important when there are potential areas of conflict, such as occupational health records, where the record itself belong to the organisation but the information contained in the record is confidential and should only be released, even to someone within the organisation, with the consent of the patient or client.

Patient-held records

Patients and clients increasingly own their health care records and this should be encouraged as far as it is appropriate and as long as they are happy to do so. It

enables them to be more closely involved in their own care and enables you to share with them the information that you consider relevant to your assessment and care of them. Patients and clients should be informed of the purpose and importance of the record and their responsibility for keeping it safe. These same principles apply equally to parent-held records.

Sometimes, you may feel that your particular concerns or anxieties require you to keep a supplementary record to which access by the patient, client or family members is limited or withheld. Keeping a supplementary record should be the exception rather than the norm, however, and should not extend to keeping full duplicate records. Wherever possible, concerns should be shared with the patient or client and the relevant entry should be jointly compiled. You must be able to justify keeping such a supplementary record and its existence needs to be made clear to other members of the health care team, who must be able to access the information readily but without compromising patient and client confidentiality.

Research, teaching and access

Patient and client records may be used for research, teaching purposes and clinical supervision. The principles of access and confidentiality remain the same and the right of the patient or client to refuse access to their records should be respected. The use of patient or client records in research should be approved by your local research ethics committee.

Information technology and computer-held records

Many registered nurses and midwives are now regularly using information technology to record the planning, assessment and delivery of care. There are obvious advantages to this. Computer-held records tend to be easier to read, less bulky, reduce the need for duplication and can increase communication across the inter-professional health care team. However, the same basic principles that apply to manual records must be applied to computer-held records. You do not need to keep manual duplicates of computer-held records and they do not replace the need to maintain dialogue throughout the inter-professional health care team.

Security, access and confidentiality

The principle of the confidentiality of information held about your patients and clients is just as important in computer-held records as in all other records, including those sent by fax. You are professionally accountable for making sure that whatever system is used is fully secure. Clear local protocols should be drawn up to specify which staff have access to computer-held records. Although patients and clients can expect their health records to be accessed by different members of the inter-professional health care team, this should only be done where necessary.

Patients and clients do not have the right to limit the amount of information relevant to their care or condition that is incorporated in their records. However, they can limit access to certain information about themselves and you must respect their right to do so. Local guidelines and protocols should address this right and these procedures should also include ways of establishing the date and time of any entry, the person who made the entry, and should ensure that any changes or additions to entries are made in such a way that the original information is still visible and accessible.

Patient and client involvement

As with manual records, patients and clients should be equal partners, whenever possible, in the compilation of their own records. The *Data Protection Act 1984*, the *Access Modification (Health) Order 1987*, the *Access to Health Records Act 1990* and the *Access to Health Records (Northern Ireland) Order 1993* define their rights of access.

Accountability and computer-held records

You are accountable for any entry you make to a computer-held record and you must ensure that any entry you make is clearly identifiable.

Further information and advice

We hope that you have found this booklet helpful. Further information and advice are available by contacting the NMC's professional advice service by telephone on 020 7333 6541/ 6550/ 6553, by e-mail at advice@nmc-uk.org, by fax on 020 7333 6538 or via the NMC's website at www.nmc-uk.org.

For a list of current NMC publications, please refer to our website at www.nmc-uk.org or write to the Publications Department at the NMC's address or by e-mail at publications@nmc-uk.org.

Please note that copies of the government legislation cited in these guidelines are available from your local branch of The Stationery Office and not from the NMC.

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Summary

Record keeping is an integral part of nursing and midwifery practice

Good record keeping is a mark of the skilled and safe practitioner

Records should not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements

Records should be written in terms that the patient or client can easily understand

By auditing your records, you can assess the standard of the record and identify areas for improvement and staff development

You must ensure that any entry you make in a record can easily be identified

Patients and clients have the right of access to records held about them

Each practitioner's contribution to records should be seen as of equal importance

You have a duty to protect the confidentiality of the patient and client record

Patients and clients should own their health care records as far as it is appropriate and as long as they are happy to do so

The principle of the confidentiality of information held about your patients and clients is just as important in computer-held records as in all other records

The use of records in research should be approved by your local research ethics committee

You must use your professional judgement to decide what is relevant and what should be recorded

Records should be written clearly and in such a manner that the text can not be erased

Records should be factual, consistent and accurate

You need to assume that any entries you make in a patient or client record will be scrutinised at some point

Good record keeping helps to protect the welfare of patients and clients.

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