Introduction

Prideaux (2011) highlighted that good standards of record keeping are not only linked with improvements in the quality of care but enable the accountability of professionals to be safeguarded. The statutory regulators to varying degrees detail the importance of practitioners maintaining clear, accurate and legible patient/client records (General Medical Council (GMC) 2006, Health and Care Professions Council (HCPC) 2008). In particular the Nursing and Midwifery Council (NMC) state that “Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow” (NMC, 2009). Indeed, this ethos can be applied to all those who deliver care in whatever field they practice.

The Data Protection Act 1998 defines a record as “consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual” Records of health and social care are legal documents and can be called as evidence in any of the following:

• Coroner's inquests
• Criminal proceedings
• Fitness to practise investigation/disciplinary panels

Within a court of law it is generally viewed that if something is not recorded, then it has not been done. Therefore, good record keeping is essential for all practitioners in order to improve accountability, provide evidence of patient care/services, show how decisions relating to care were made and to improve communication between patients/carers and members of the multi-disciplinary teams.

Scope

These guidelines are intended to apply to all those who deliver care in health and social care settings. It is not intended to replace local NHS policies or guidelines and registered health professionals such as health visitors, physiotherapists, doctors, social workers etc should read them in conjunction with standards and guidance produced by their relevant regulatory organisation.

Defining features for high standard record keeping

Records that are completed to a high standard demonstrate that care has been planned and delivered in an organised and consistent way and illustrate that the practitioner is operating in a skilled and safe way. These records adhere to the principles of good record keeping that state they should be:

• Factual
• Consistent
• Accurate
• In a logical sequence
• Using accepted terminology
• Contemporaneous

These principles apply to all types of records, whatever the format, including:
• Hand written clinical records
• Electronic records
• Hand held records
• Emails
• Text messages
• Letters
• Reports
• Photographs
• Videos
• Tape recordings
• Print outs/scanned documents

Failure to maintain a high standard of record keeping is one of the main reasons that registered practitioners appear before their regulator.

Requirements for record keeping & documentation

• All clients who receive health/nursing/social care will be issued with an individual record and all care, consultations and interventions must be recorded in a chronological order.

• All those who deliver care must have the knowledge, skills and confidence to record the details of the care in the client’s record.

Recording information

There is currently no universal template for record design which means that the design will be different in different organisations. However, it is not permissible in law for the quality of the entry to differ

Key points

• The content and style of the record must be of sufficient quality to protect the client/patient and the practitioner e.g. from harm caused by missed or duplicated care.

• The practitioner must be able to explain and justify the content of the record even after the active episode of care has finished.

• All entries must have information about what you have done, why you have done it, and ways in which you are protecting the client’s safety.

The Legal position

Acts of Parliament and Common Law make up the two main sources of the law i.e.:

<table>
<thead>
<tr>
<th>Acts of Parliament</th>
<th>Common/Case Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislated by members of parliament (MP) and peers within the House of Commons and the House of Lords.</td>
<td>This law is not embodied in legislation. It is based on judicial/court decisions for actions in specific situations. This is sometimes referred to as a ‘duty of care’.</td>
</tr>
</tbody>
</table>
In relation to record keeping and documentation, all practitioners (qualified and non-qualified) must be familiar with the rationale and content of the following Acts of Parliament e.g.:

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Remit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Data Protection Act (1998)</td>
<td>Under the DPA people are entitled to see all information relating to their physical or mental health which has been recorded by or on behalf of a health professional in connection with their care. (The Act defines who is classed as a health professional)</td>
</tr>
<tr>
<td>Freedom of Information Act (2000)</td>
<td>People can ask to see personal information held on them</td>
</tr>
</tbody>
</table>

The law requires health records to be kept secure for specific time spans in order that the information can be obtained at a later date. Please refer to Records Management: NHS Code of Practice (DH 2006) for up to date timescales.

The preservation of records also refers to a work diary used by the practitioners. The duration that this is kept is determined by the employing authority/organisation under their information governance structures and details of which can be found within the record keeping and documentation policies, and the information governance strategy for the organisation.

A high standard of record keeping is illustrated by the inclusion of several components within the record i.e.

- a full account of the assessment
- a full account of the care you have planned and the care that you have provided
- factual information about the client’s condition and measures you have taken to respond to his/her needs
- evidence that you have taken all reasonable steps to care for the client
- evidence that any actions or omissions on your part have not compromised the client’s safety
- a full account of the plan of care arranged with the client or carer
- the date, time (24 hour clock), signature and the full name of the author must be printed alongside the first entry
- Entries are normally recorded in chronological order (NMC, 2009)

Frequently asked questions

**Q1. Who should sign &/or write the record?**

**A.** The person delivering the care must sign the entry that they have made in the client’s record. In some situations the employing organisation may stipulate that an entry which is made by a student nurse or a junior member of the team must be counter-signed by the qualified/senior member of the team. This is not a legal requirement because both practitioners must be able to answer for the content of the record if they were involved in writing it and giving the care. In these situations the qualified/senior member is only able to sign the record if he or she has seen the care being delivered e.g. during direct supervision/observation of the person delivering the care.

**Q2. What do I need to write in a record for it to be considered high standard?**

**A.** All practitioners have a legal and professional duty of care to complete health/nursing/social care records to a high standard.

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Remit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Data Protection Act (1998)</td>
<td>Under the DPA people are entitled to see all information relating to their physical or mental health which has been recorded by or on behalf of a health professional in connection with their care. (The Act defines who is classed as a health professional)</td>
</tr>
<tr>
<td>Freedom of Information Act (2000)</td>
<td>People can ask to see personal information held on them</td>
</tr>
</tbody>
</table>

**Q3. How do I record that the client or carer has given informed consent for the procedure/care?**

**A.** Informed consent implies that the client has received information about the procedure/care and that he/she has agreed to accept it based on the information that he/she has been given. All records must contain written information about the process of gaining informed consent i.e.

- Your assessment of the client’s/carer’s ability to understand the information and make the decision to accept or refuse the care/treatment (e.g. Fraser Competence, mental capacity).
- The purpose of the procedure.
- The anticipated outcome.
- Any side effects.
- Alternative procedures that the client may have.
- The client’s response to the information.

It is also important that you are aware of the specific requirements for informed consent e.g. who is able to give consent and the circumstances required for consent e.g. age, competence, capacity, parental responsibility (DOH, 2001, 2006, Department of Constitutional Affairs, 2007).

**Q4. How do I correct errors and mistakes in records?**

**A.** All information that is documented within the record must be legible even if it has been written in error. The process for dealing with an error or mistake must include all of the following points:

- A single line through the entry
- Write the initials of the person correcting the entry and the date when the correction was made
- Do not use correction fluid or anything that makes the entry illegible.

(NMC, 2009, NIPEC, 2010)
Q5. The Health/Social care organisation that I work for stipulates that I have to maintain a set of patient held records and base held records for every patient on my caseload.

Do I have to write in both sets of records every time I see the client?

A. You must ensure that both records are kept up to date and that duplication of information is kept to a minimum e.g. by using a duplicate sheet to record the details of the consultation/care given and putting a copy in each record. Alternatively, you could cross reference the entries e.g. document the date of the consultation in the base record and refer the reader to the patient held record where a full account of the consultation is documented. It is also good practice to explain to the client that a second set of records are being kept and the reasons for doing this.

Q6. I work alongside practitioners from other professions and we all use the same record to document care. Is this acceptable in terms of the law i.e. confidentiality?

A. This practice is not breeching confidentiality because all practitioners documenting in the records will be involved in the client’s care. It is important that you explain to the client and/or carer that the records are shared with practitioners involved in the client’s care and the reasons for doing so e.g. it encourages continuity of care, improves communication between the carers and reduces the potential for duplication and missed care. An example of a shared record is the Common Assessment Framework (CAF). When using shared records practitioners are accountable and responsible for documenting the care in the record in the same way as if they were the only professional documenting in the record.

Q7. What is an open record?

A. A record is considered to be open if the content has been shared with the person to whom it refers i.e. the practitioner has discussed the content with the client as it is being written. This is considered to be good practice. There may be situations in which the health practitioner feels that it is not in the client’s best interest to share the information or that sharing the information would place them or others associated with them at risk of harm. These situations are rare e.g. concern about undisclosed domestic violence where the person inflicting the violence may have access to the record. In these situations the health practitioner will need to document in a second record that can not be accessed by the client/carers. It is imperative that in these situations both records are kept up to date and mechanisms are in place to ensure this happens.

Q8. Who owns the record?

A. The organisation providing the care ultimately owns the record but it delegates responsibility for storing the record, to the service that delivers the care directly to the client. The health practitioners who are delivering the service/care are responsible and accountable for keeping the record secure and for ensuring that the information within the record is only accessible to those authorised to access it (NMC, 2009. The employing authority is bound to comply with these arrangements by the regulatory bodies that monitor and audit their performance in relation to service and care delivery. Clients/patients have a legal right to apply to access the information that is held within their health/nursing records. This is now covered by the Data Protection Act, (1998). The application process will consider the client’s ability to deal with the information contained within the record (e.g. Fraser competence, mental capacity).

Q9. I spend my time seeing my clients of which I have a lot and I am not able to keep up to date with my records because I feel that it is more important to see the clients. Should I be concerned?

A. Yes. All health professionals are accountable for their practice and must be able to justify their actions and omissions; being too busy to write in the records is not considered to be a justification in law or by the regulators for not doing it. Measures must be taken by the health professional to ensure that he/she is able to complete the records as well as deliver the care to the client. For example, the professional must inform the line manager in writing about the issues of concern and the measures that she/he is taking to rectify the problem e.g. reducing the number of clients/patients seen in a day in order to make time to complete the records. Remember that, in the eyes of the law, if something is not written, it has not been done.

Q10. How do I balance the need to share information with other professionals and the need to preserve the confidentiality of the client?

A. This is a common concern felt by many practitioners. The law states that you should consider the answer to this in terms of what is in the best interest of the client and what action will keep them and others safe (DOH, 1997, GMC 2006, HCPC 2008, NMC 2008, NMC, 2009). Several key issues must be addressed when you are sharing information i.e. information is shared on a ‘need to know basis’ (DOH, 1997).

- It is good practice to inform the patient/client whenever possible, that you are planning to share the information. However, in situations when the law requires the information this is not a prerequisite for sharing it and the lack of consent should not be a reason for not sharing information if this is deemed to be necessary.
- It is essential to confirm that the information has reached the person it was intended for. Sharing information with members of the multi/inter-professional team is advocated in the spirit of true working together/collaborative working. It is not acceptable in law or in terms of the NMC to fail to share information without a valid rationale and justification for doing so. All decisions and judgements about this must be documented within the record.
Q12. What colour ink should I use to write in the client record?

A. The law states that health/nursing records must be completed using indelible ink not pencil and a colour that can be photo-copied. There is currently no stipulation in terms of the law or the regulators for the colour ink to use. However the employing organisation will usually stipulate the colour to use in the record keeping and documentation policies as part of the information governance structures. It is usually black ink.

Q13. I am so busy at work that I often take records home with me to write them up. Is this acceptable?

A. As a general rule it is not considered to be good or safe practice to take records out of the work place because this reduces the potential to keep the information within them safe and secure. It is certainly not acceptable for a practitioner to take the records home in order to write them up. If you are finding that this is necessary then you must discuss your workload issues with your line manager immediately and devise an action plan to resolve the issues. Information about the specific circumstances in which it is considered acceptable to take records out of the work base will be documented within the information governance strategy and the record keeping and documentation policy for the employing organisation.

Q14. What do I do if a patient/client asks to see their records?

A. The best course of action to take when writing in a client's record is to discuss what you are writing at the time, in line with the principles of openness and transparency. In situations where this is not possible or has not been done then clients must be advised that they can apply in writing to the health care organisation to see their records. There is usually an administrative cost involved which must be met by the client. The process for applying to see the record is outlined within the health care organisation's information governance strategy. It is good practice to give the client written information about this process.

Q15. What do I do if management insists that I counter-sign entries in records for junior/non-qualified staff, even if I am not directly observing or supervising the care they give to the client?

A. This is a difficult situation and one that more and more practitioners are experiencing with the move towards skill mix and team working practices.

The process of counter-signing by a senior/qualified practitioner is usually promoted as a way in which to prove that the care was given by a junior level practitioner in line with the care plan and to the required standard. The practice of counter-signing for another practitioner who delivered the care in your absence is incorrect and, more importantly, is unsafe practice. When responding to this instruction it is important to ensure that the principles of record keeping and accountability remain i.e.

- You are answerable for you actions/omissions (accountability).
- It is good practice to respond to the manager in writing outlining the reasons why you will not be abiding by the instruction. It is also good practice to outline what measures you have put in place to promote client safety when care is to be delegated to other members of the team e.g. provision of clearly written care plans, provision of clearly written instructions to the practitioner, a process for ensuring a practitioner's competence to deliver care, for giving and receiving feedback, for reviewing the progress of the treatment and the care plan and a process for updating the care/treatment plan.

Q16. How do I present information in the records?

A. All information that is written in the record must be based on the facts of the situation e.g. what actually happened/what you actually saw. It is important to distinguish between fact and opinion when including information in the record e.g. you thought the person may have been upset (is your opinion of the situation), but you saw the person crying (the factual information). There may be times when you need to include your opinion/appraisal of the situation based on the facts of the situation e.g. Ms Smith did not attend the child health clinic as arranged to review the baby’s weight gain (fact). This may be because she forgot about the appointment, or it could be because she does not want to engage with the health visitor service (opinion/appraisal of the situation).

Q17. I am currently dealing with an issue that has arisen about a client that I cared for 20 years ago when I was a member of a different union. Who will provide indemnity cover for me; my current union or the one I was with at the time?

A. The indemnity cover is provided by the organisation providing cover at the time of the incident. In this situation you would need to contact the union that you were a member of at the time of the event.
References

DEPARTMENT OF CONSTITUTIONAL AFFAIRS (2007)
Mental Capacity Act 2005 Code of Practice

DEPARTMENT OF HEALTH (2006)
Records Management: NHS Code of Practice.
www.dh.gov.uk

DEPARTMENT OF HEALTH (2009)
Reference guide to consent for examination or treatment

LEGISLATION.GOV.UK (1990)
Access to Health Records Act

LEGISLATION.GOV.UK (1998)
Data Protection Act

LEGISLATION.GOV.UK (2000)
Freedom of Information Act

GENERAL MEDICAL COUNCIL (2006)
Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice.asp

HEALTH AND CARE PROFESSIONS COUNCIL (2008)
Standards of conduct, performance and ethics
http://www.hpcuk.org/aboutregistration/standards/standardsofconductperformanceandethics/

NIPEC (2010)
Evidencing care: Improving record keeping practice.
Northern Ireland Practice and education council: Belfast
www.nipec.n-i.nhs.uk

www.nmc-uk.org

