Recording Clinical Practice Guidance to Nurses and Midwives

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Appendix Poster for display (A4 size)
'Recording Clinical Practice – Guidance to Nurses and Midwives'.

1. Introduction.

An Bord Altranais, under the terms of Section 6(1) of the Nurses Act, 1985, has been established

"… to promote high standards of professional education and training and professional conduct among nurses …".

The term "nurse" means a man or woman whose name is entered in the register and includes a midwife (Nurses Act, 1985, Section 2).

The quality of records maintained by nurses and midwives is a reflection of the quality of the care provided by them to patients/clients. Nurses and midwives are professionally and legally accountable for the standard of practice which they deliver and to which they contribute. Good practice in record management is an integral part of quality nursing and midwifery practice.

The aim of this document is to assist nurses and midwives:

(a) to appreciate the professional and legal issues regarding the compilation and management of nursing and midwifery documentation,

(b) to value professional responsibility associated with good practice in record management,

(c) to offer practical advice in attaining/maintaining acceptable standards of recording clinical practice.

These guidelines are not intended to replace any local/regional policies or guidelines that currently exist or that may be developed in the future. An Bord Altranais, through its publication *Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols,* (An Bord Altranais, December 2000) supports the development of such local policies or guidelines.

This guidance document develops on the values and standards articulated by An Bord Altranais in *The Code of Professional Conduct for each Nurse and Midwife* (April 2000), and the *Scope of Practice Framework* (April 2000).

The Requirements and Standards for Nurse Registration Education Programmes, Second Edition (An Bord Altranais, November 2000) identifies five Domains of Competence that must be achieved for entry to the General, Mental Handicap, Psychiatric and Sick Children's division of the Register of Nurses maintained by An Bord Altranais. Among the specifically identified indicators of competence is one that stipulates that an individual nurse should "establish and maintain accurate, clear and current client records within a legal and ethical framework" (Domain 3 – Interpersonal Relationships,

Performance Criteria 3.2, page 17). It is expected that any nurse or midwife engaged in professional practice, in any practice setting, is competent in this regard. This requirement is irrespective of whether the records are hand-written or computer-held.

The document, *Guidelines for Midwives, 3rd Edition,* September 2001, (page 11) published by An Bord Altranais, states that "record keeping is an integral part of midwifery practice and a reflection of the standard of an individual midwife's professional practice."

2. Purposes of Good Record Management

An individual nurse/midwife should establish and maintain accurate, clear and current client records within a legal, ethical and professional framework.

Nurses and Midwives are professionally and legally accountable for the standard of practice to which they contribute and this includes record keeping. Accountability is the cornerstone of professional nursing and midwifery practice. In the course of professional practice, nurses and midwives must be prepared to make explicit the rationale for decisions they make and to justify such decisions in the context of legislation, professional standards and guidelines, evidence based practice and professional and ethical conduct (*Scope of Nursing and Midwifery Practice Framework,* April 2000). Good record management therefore underpins professional practice.

Maintaining good clinical records is essential for the following reasons:

(a) to document nursing and midwifery care. At a minimum a patient/client record should include the following:

  i) an accurate assessment of the person's physical, psychological and social well-being, and, whenever necessary, the views and observations of family* members in relation to that assessment,

  ii) evidence in relation to the planning and provision of nursing/midwifery care,

  iii) an evaluation of the effectiveness, or otherwise, of the nursing/midwifery care provided.

(b) to facilitate communication between the patient/client, the family and all members of the healthcare team,

*In this document, the use of the word 'family' refers to any significant others, identified by the patient/client, and not necessarily blood relatives.

(c) to provide documentary evidence of the delivery of quality patient/client care. The Nursing/Midwifery record provides substantiation of practice for

i) continuity of care between health professionals

ii) clinical audit

iii) debriefing of patients/clients

iv) dealing with complaints

v) nursing/midwifery decision making

vi) fitness to practise enquiries

vii) nursing-legal enquiries

viii) teaching student nurses and student midwives

ix) reflecting on and evaluating practice

x) research of nursing and midwifery practice – subject to ethical considerations.

The importance of good record keeping, and the consequences of poor record keeping, have been highlighted repeatedly by such reports as the *Confidential Enquiry into Maternal Deaths* (Department of Health et al, 1997), the *Annual Report of the Ombudsman* (1997), the *Confidential Enquiry into Stillbirths and Deaths in Infancy* (Maternal and Child Health Research Consortium, 2001) and the *Report of the Inspector of Mental Hospitals* (Department of Health and Children, 2001).

3. Confidentiality

Confidentiality concerning the patient/client record is an expression of the trust inherent in the nursing/midwifery practice relationship with a patient/client. Ethical and legal considerations inform professional decision-making related to record management and the sharing of information. Managers of the nursing and midwifery service have a responsibility to ensure that systems are in place to support practitioners in relation to this vitally important aspect of their clinical work.

The Code of Professional Conduct

The Code of Professional Conduct for each Nurse and Midwife, April 2000, published by An Bord Altranais, states the following:

> *"Information regarding a patient's history, treatment and state of health is privileged and confidential. It is accepted nursing practice that nursing*

care is communicated and recorded as part of the patient's care and treatment. Professional judgement and responsibility should be exercised in the sharing of such information with professional colleagues. The confidentiality of patient's records must be safeguarded. In certain circumstances, the nurse may be required by a court of law to divulge information held. A nurse called to give evidence in court should seek in advance legal and/or professional advice as to the response to be made if required by the court to divulge confidential information.

The nurse must uphold the trust of those who allow him/her privileged access to their property, home or workplace.

It is appropriate to highlight the potential dangers to confidentiality of computers and electronic processing in the field of health services administration.

Nurses and midwives have a duty to familiarise themselves with local policy or guidelines that exist with regard to how confidentiality of records is maintained within a healthcare organisation. If nurses and midwives have concerns with regard to the appropriateness or security of local arrangements, they should bring those concerns to the attention of the appropriate local personnel.

Nurse and midwives who transport records outside the healthcare institution should take all reasonable steps to ensure the safety and security of such records. Records should be returned to their appropriate storage facility as soon as reasonably possible after use. Midwives who are self-employed should refer to the guidance given in Section 10.4 of the *Guidelines for Midwives, 3rd Edition* – September 2001 (An Bord Altranais, 2001) in this regard.

Freedom of Information Act, 1997

Under the terms of the *Freedom of Information Act, 1997,* patients/clients are entitled to access a copy of any healthcare record that applies to them and which is maintained by a Health Board/Health Authority or a voluntary hospital.

Freedom of Information Officers are employed by health service agencies and further information may be obtained by consulting them. Nurses and midwives should be aware of what arrangements exist, at local level, to comply with the requirements of the *Freedom of Information Act, 1997.*

Data Protection Act, 1988

The Data Protection Act, 1988 deals with computer records and protects an individual's right to privacy with regard to such records. The Act states that

data held must be accurate and, where necessary, kept up to date. Under the terms of the Act, an individual has the right to establish the existence of such data and has the right to access such data. A person has the right to have amended or corrected any records that are incomplete, incorrect or misleading. There are certain circumstances where access may be refused and these are detailed in the *Data Protection (Access Modification) (Health) Regulations, 1989.*

Electronic Commerce Act, 2000

Under the Electronic Commerce Act, 2000, 'electronic communication' has legal validity. Local policies and guidelines should be devised for the use of electronic communication for the purposes of the patient record.

Confidentiality and Child Protection and Welfare.

Nurses and midwives may, in the course of their professional practice, become aware of or suspect abuse of a child. Nurses and midwives, in those circumstances, should act in accordance with the guidelines developed in 1999 by the Department of Health and Children and published as *'Children First – National Guidelines for the Protection and Welfare of Children.'* The provisions in these guidelines will usually be reflected in local Health Board policy. Nurses and midwives should note that the *Code of Professional Conduct for each Nurse and Midwife* (An Bord Altranais, April 2000) is not intended to limit or prevent the exchange of information between different professional staff that have a responsibility for ensuring the protection of children. Giving information to key persons within the Health Board/Garda Siochana for the protection of a child is not a breach of confidentiality.

4. Documenting Consent to Treatment

Under the *Non-Fatal Offences against the Person Act, 1997* the age of consent to treatment has been reduced to 16 years.

Records should be used to document discussions and interactions with patients/clients about planning care. Consent to nursing and midwifery care should never be presumed.

It is not necessary that written consent be obtained for most nursing/midwifery care, however, where a suggested procedure carries with it any significant risk, the explanation of this should be documented in the patient's/client's notes. The agreement of the patient/client to the procedure should be documented.

Nurses and midwives should only obtain consent for procedures that they

themselves will complete. Medical or other healthcare staff are responsible for obtaining consent for procedures or treatments that they will perform.

If a patient/client refuses a recommended procedure or treatment, then this should be documented in the patient/client records. Any information or advice given to a patient/client about the possible consequences of such a refusal should also be documented.

5. Legal Considerations

Records are legal documents. There is no limit to the range of records that may be required to aid the legal process. Nursing/midwifery records may be, and frequently are, used as evidence in legal cases.

5.1 Use of records in criminal prosecutions

On occasions, records will be used in the prosecution of criminal offences e.g. assault, sexual assault, domestic violence. Two issues, which should apply to all record keeping, are particularly important in these circumstances;

5.1.1 documentation of findings following assessment:

All information documented should be factual and not based on summation. For example, it should be recorded "Anne Jones had a smell of alcohol on her breath, her gait was unsteady and her speech was slurred". It should not be recorded, "Anne Jones was drunk".

5.1.2 information regarding what was reported by the patient/client:

Comments with regard to third parties should always be documented as such. It is best if the exact words used are quoted in the records. If it is not possible to quote exactly what was stated, then the content of what was stated should be accurately summarised. For example, it should be recorded, "Mary Smith stated that her injuries were caused by her husband John". It should not be recorded, "Mary Smith was beaten up by her husband".

5.2 Nursing-legal claims

Nurses and midwives have a legal, as well as a professional, duty of care. It is expected that the standard of care will be such that it matches the standard that would be provided by any other nurse/midwife practitioner of equal status and skill if acting with ordinary care. Expert nurse/midwife witnesses are utilised to determine what the standard of care should have been and whether, in a particular case, the standard was met.

In most nursing-legal cases, the view is taken that 'if it was not charted, then it was not done.' It is very difficult for nurses/midwives to show that they acted appropriately and provided an appropriate standard of care if they have not documented it adequately.

5.2.1 The Statute of Limitations

An additional aspect of medico-legal and nursing-legal claims is the Statute of Limitations. This refers to the time limit, imposed by law, in relation to the initiation of a medico-legal case. In Ireland, the Statute of Limitations is governed by the *Statute of Limitations Act, 1957* and the *Statute of Limitations (Amendment) Act, 1991.* This allows the initiation of medico-legal claims in the following circumstances:

(a) Up to three years after the date of the cause of action i.e. three years after the alleged negligent act or omission took place.

(b) Up to three years after the date of knowledge of the cause of action i.e. three years after the individual gained knowledge of the injury they have sustained and which they believe was caused by a negligent act or omission.

(c) In the case of children, the Statute of Limitation does not come into effect until the child reaches the Age of Majority, which in Ireland is at the age of eighteen years. A case may be initiated up to three years after this time, i.e. twenty-one years.

(d) In the case of brain damaged children, the Statute of Limitations does not apply and a case may be initiated at any time.

The Statute of Limitations allows medico-legal cases to be initiated many years after an alleged negligent act has taken place. Some cases are known to have come to court up to thirty years later. The average length of time is between five and seven years. Nurses/midwives should be aware of how easy or difficult it would be for them to describe and defend their actions based on what they had documented in a patient's/client's record many years previously.

5.2.2 Storage of records

Because of the implications of the Statute of Limitations, records need to be kept for varying lengths of time depending on the status of the individual patient/client. The Policy for Health Boards on Record Retention Periods, published by the National Freedom on Information Liaison Group (Health Boards) October 1999, gives

useful guidance in this regard. All healthcare facilities should have in place a system for the safe storage of past and current records. Nurses and midwives should adhere to the requirements of their employers in regard to the storage of records. If nurses or midwives have concerns about the system in place, they should bring this to the attention of their employer.

Midwives who work independently must take responsibility themselves for the appropriate storage of records and should consult Section 10.4 of the Guidelines for Midwives, 3rd Edition for further information in this regard.

If a system of patient/client-held records is in use, then a system for monitoring the return of the records should be put in place. Local policy should clearly identify whose responsibility it is to ensure the safe return of the record.

5.3 Mental Health Act, 2001

Nurses providing care to an individual being cared for under the terms of the *Mental Treatment Acts or Mental Health Act, 2001* must be familiar with the provisions and their responsibilities under the terms of these Acts.

Psychiatric nurses should also ensure that clinical practice for which they are responsible is reflective of the *'Guidelines on Good Practice and Quality Assurance in Mental Health Services'* as published by the Department of Health and Children in 1998.

6. Use of Records in Research

When patient/client records are utilised in research, they should be subject to the same ethical considerations as any other type of research. Nurses and midwives must integrate accurate and comprehensive knowledge of ethical principles in fulfiling their duty of care. Nursing and midwifery practice must be in accordance with the rights of the patient/client. Ethical approval should be sought from the appropriate authority. The principles of privacy, confidentiality and anonymity must be respected. Competence in research requires that confidentiality be ensured in respect of records. If nurses/midwives have concerns about the use of records for research purposes, they should make their concerns known to the appropriate authority.

7. Guidelines for Good Practice in Recording Clinical Practice

An individual nurse/midwife should establish and maintain accurate, clear and current patient/client records within a legal, ethical and professional framework.

7.1 The quality of a nurse's/midwife's record keeping should be such that continuity of care for a patient/client/family is always supported.

- At a minimum, a patient/client record should include the following;

  i) an accurate assessment of the person's physical, psychological and social wellbeing, and, whenever necessary, the views and observations of family* members in relation to that assessment,

  ii) evidence in relation to the planning and provision of nursing/midwifery care,

  iii) an evaluation of the effectiveness, or otherwise, of the nursing/midwifery care provided.

- Narrative notes should be written frequently enough to give a picture of the patient's/client's condition and care to anyone reading them. They should provide a record against which improvement, maintenance or deterioration in the patient's/client's condition may be judged.

- All healthcare staff should be encouraged to read each other's entries in the record as this facilitates good communication between healthcare staff.

7.2 All narrative notes are individualised, accurate, up to date, factual and unambiguous.

- Narrative notes should be devoid of any jargon, witticisms or derogatory remarks.

- Subjective comment may require substantiation.

- Narrative notes should be written in terms that the patient/client can understand, in so far as is possible.

- Local policies should reflect how often records should be updated for patients/clients in long-term care. It is not acceptable that weeks would pass without any documentation in the patient's/client's records. It must be clear from the records that the patient/client has been assessed and their individualised care planned, provided and evaluated even if the

condition of the patient/client and care requirements are unchanged over a period.

- Nurses, caring for patients/clients in nursing homes, must comply with the requirements of Section 19.1 of the *Nursing Homes (Care and Welfare) Regulations, 1993* with regard to record keeping. In particular it should be noted that nursing records must be completed on admission and thereafter on a daily basis.

7.3 All written records are legible.

- It is the writer's responsibility to ensure that the writing in a record is clear and legible.
- Handwriting that is difficult to read should be in print form.
- It is appropriate to ask a professional colleague to rewrite an instruction/record to ensure legibility, should there be an issue related to clarity. This is particularly important in the case of prescriptions for medical preparations, and other direct interventions, where legibility is an issue.
- Care should be taken to ensure that the record is permanent and facilitates photocopying if required. Pencil should never be used, as it can be altered or erased.

7.4 All entries are signed.

- Nurses/midwives should sign entries using their name as entered on the Register of Nurses and Midwives maintained by An Bord Altranais.
- A signature that is difficult to decipher should also be printed the first time that an entry is made in the record.
- The use of initials is not acceptable except on charts where there is a designated place to write a full signature and initials and thereafter, in that chart, initials are used e.g. a drug administration record.
- If all health professionals write in the same part of the record, then the status of the professional should also be indicated e.g. Staff Nurse (S/N) or RGN.
- It is good practice for healthcare facilities to keep a sample signature from all past and current staff members to facilitate recognition of signatures in the event of future enquiries.

7.5 All entries are dated.

- It is recommended that local policy should determine a format, e.g. time/day/month/year.

7.6 Entries in the records are in chronological order.

- Entries in the patient's/client's care record should normally appear in chronological order. Any variance from this needs to be explained.

7.7 Documentation in the record is carried out as soon as possible after providing nursing/midwifery care.

- It should always be clear from the notes what time an event occurred and what time the record was written.
- This may prove to be difficult in an emergency situation. Late entries are acceptable provided that they are clearly documented as such.
- The nurse/midwife should not "squeeze" a late entry into existing notes, nor write in the margins.
- Nurses/midwives ought not to charge entries ahead of time, or otherwise, predate entries.
- Nurses/midwives ought not re-write entries in the record or discard the originals, even if it is for an simple reason e.g. a torn page or a spilled drink.

7.8 All entries are timed, especially where the condition of the patient/client is changing or liable to change frequently.

- Timing of entries should always be made using the 24-hour clock.

  The time of requesting attendance by medical staff or calling for assistance in an emergency should always be recorded.

7.9 Abbreviations should only be used if drawn from a list approved by the healthcare facility.

- It is recommended that each healthcare facility draw up an approved list of abbreviations. The list should be periodically reviewed and, if necessary, updated.

7.10 Accepted grading systems should only be used.

- Urinalysis results (+++) are an example of an official grading system.
- +++, < > should be avoided except where part of an accepted grading system. Upward or downward arrows to denote changes in heart rate or other vital signs should not be used.

7.11 Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated.

- No attempt should be made to alter or erase the entry made in error. Erasure fluid should never be used.
- If an enquiry or litigation is initiated, then the record must not be altered in any way either by the addition of further entries or by altering an entry made in error.

7.12 A nurse/midwife making a referral or consulting with another member of the healthcare team should clearly identify, by name, the person in the record.

- 'Seen by doctor' or 'doctor informed' is not acceptable. If another member of the healthcare team sees the patient/client, then that individual is responsible for his or her own record keeping.
- If information or advice is given over the telephone, then that should be recorded as such by the nurse/midwife who took the call and the person giving the information or advice should be clearly identified.

7.13 All decisions to take no immediate action but review the situation later ('wait and see') should be clearly documented.

- Continuous assessment/monitoring and evaluation of a patient's/client's state/condition is a legitimate nursing /midwifery intervention and it requires documentation within the record particularly in changing circumstances.

7.14 Any information, instruction or advice given, including discharge advice, by a nurse/midwife, to a patient/client should be documented.

- Patient education is a legitimate nursing/midwifery intervention and should be recorded as such.

7.15 All written data in respect of a patient/client/family should be kept in a designated area with a view to forming a complete single record.

- The practice of maintaining a number of record files on an individual patient/ client is not recommended. A local policy related to the maintenance of a record is recommended. Transcription of material ought not to occur.
- The keeping of supplementary records should be the exception rather than the norm.

7.16 The patient's/client's name and record number (i.e. hospital number) should appear on every page of the record.

- The identity of the person for whom the record is being maintained should always be obvious to a reader.

7.17 Nurses/midwives should not, as a general rule, record or document care on behalf of someone else.

- If this becomes necessary, e.g. if a nurse telephones from home after going off duty and reports that she/he has forgotten to document care, then this should be clear from the record. Example:

  "30/07/2001, 21.40 hours. S/N Mary Jones phoned at 21.30 hours. She stated that at 15.40 hours approximately she had … and that she had forgotten to document this in Mr Michael Smith's chart. Signed: S/N Anne O'Reilly."

7.18 The standard of record keeping of those under supervision in the clinical area e.g. student nurses/midwives or nurses/midwives undertaking supervised clinical practice prior to registration, should be monitored by the nurse/midwife charged with responsibility for the supervision or her/his delegate.

- Students are required to learn the practice of writing /documenting the delivery and management of nursing care. This skill requires instruction/supervision, as the student cannot be held totally accountable for the record while under supervision.
- If an entry by someone under supervision needs to be amended, then the procedure for any entry made in error should be followed.

7.19 Regular audit is an integral part of maintaining quality records.

- The practice of regularly auditing records has been shown to improve the standard of record keeping and hence patient/client care. An Bord Altranais recommends that nurse and midwife managers develop a system of regular audit of record keeping in order to monitor and maintain standards.
- Regular audits of records ought to form an element in Quality Assurance processes.

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