Policy on Recording Clinical Practice	
Developed by: Drogheda Services for Older People.	**Date Developed: Revised February 2012** **Revised Feb 2015`,Aug 2018,Aug 2021, Sept 2023**
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Standard in relation to Documentation. (Health Information and Quality Authority

Each resident has his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence.

Criteria

Pre-admission

10.1 All necessary information relating to the resident's health, personal and social care needs is obtained prior to admission. In the case of emergency admissions, this information is obtained as soon as possible after admission and no later than 72 hours.

10.2 There are protocols in place to ensure appropriate continuity of care. These ensure that information concerning the resident's circumstances, medication, treatment and/or ongoing support by medical and other professionals is provided to the person in charge.

10.3 The resident is admitted to The Village Residence following a comprehensive assessment of his/her health, personal and social care needs, undertaken by appropriate professionals trained to do so. This includes any prospective resident making private arrangements for admission to the residential care setting. The resident participates in and contributes to the assessment, with the support of a family member or representative in accordance with his/her wishes.

On and subsequent to admission

10.4 A general risk assessment is carried out and recorded upon admission to The Village Residence and as indicated by the resident's changing needs or circumstances and no less frequently as at four-monthly intervals.

10.5 A comprehensive assessment of the resident's health, personal and social care needs, using a minimum data set tool, is completed within three days of his/ her admission

or sooner if the risk assessment indicates. This assessment is reviewed as indicated by the resident's changing needs or circumstances and no less frequently than at four-monthly intervals

10.6 Assessment findings are communicated to the resident or representative and to his/her family in accordance with his/her wishes.

Prior to discharge

10.7 Notwithstanding the resident's freedom to discharge him/her from the Village Residence , discharge decisions are based on assessment and are in accordance with the resident's care plan. The resident is discharged from The Village Residence in a planned manner and the discharge is discussed, planned for and agreed with the resident or his/her representative.

10.8 To ensure continuity of care, information concerning the resident's circumstances, medication, treatment and/or ongoing support by medical and other professionals is provided by the person in charge to the subsequent care provider, as appropriate.

The arrangements to meet each resident's assessed needs are set out in an individual care plan, developed and agreed with each resident, or in the case of a resident with cognitive impairment with his/her representative.

Criteria

11.1 The resident's care plan is commenced within 72 hours of admission, or earlier if indicated by the general risk assessment, from the comprehensive assessment drawn up with the resident. **(See Standard 10: Assessment**)

11.2 The care plan reflects the assessment findings and sets out in detail the action to be taken by staff, to ensure that all aspects of the health, personal and social care needs of the resident are met. Residents, including those with dementia/ cognitive impairment, are actively encouraged to participate in this process.

11.3 The care plan meets clinical guidelines produced by professional bodies concerned with the care of older people. It is updated regularly to reflect daily changing needs and best practice.

11.4 The resident or his/her representative has access to the care plan and is kept

informed of care changes.

11.5 The care plan is discussed, agreed and drawn up with the involvement of the resident and/or his/her representative. If the resident is unable or unwilling to participate, this is documented.

11.6 The care plan is formally evaluated by staff in consultation with the resident and/or his/her representative. It is updated as indicated by the resident's changing needs and circumstances and current objectives for health, personal and social care and no less frequently than at four-monthly intervals.

Actual Policy.

1.0. Purpose of Policy.

The purpose of this Policy is to ensure that all care in relation to residents is based on proper assessment using validated assessment tools, that there is a clear goal to nursing care and that there is an implementation plan documented and is clearly made known to all staff involved in the care of resident. An individual nurse should establish and maintain accurate, clear and current client records within a legal, ethical and professional framework.

Nurses 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 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 and 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 teams.

1.1. Recording of Clinical Practice. The Nursing and Midwifery Board Ireland are very specific in relation to the recording of clinical practice. The Nursing and Midwifery Board Ireland outline that each Nurse should establish and maintain accurate clear and current residents records within a legal, ethical and professional framework. In addition they emphasise that nurses are professionally and legally accountable for their own standard of professional practice.

1.2. These Guidelines should be read in conjunction with the contents of the document, Recording Clinical Practice – Guidance to Nurses and Midwives, 2002).

1.3. These Guidelines should also be read in conjunction with the contents of the document Professional Guidance for Nurses working with Older People, (Nursing and Midwifery Board Ireland, 2009).

1.4. A copy of both of these documents are to be found in Appendix One and Appendix Two of this Document.

1.5. A summary of the document Recording Clinical Practice has been distributed to all units and should be displayed in a prominent place.

2.0. 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 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.

2.1. The Code of Professional Conduct

The Code of Professional Conduct for each Nurse and Midwife, April 2000, published by

The Nursing and Midwifery Board Ireland, 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 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.

2.2. **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 care should never be presumed.

It is not necessary that written consent be obtained for most nursing 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 should only obtain consent for procedures that they themselves will complete. Medical or other healthcare staffs are responsible for obtaining consent for procedures or treatments that they will perform.

If a resident refuses a recommended procedure or treatment, then this should be

documented in the resident. Any information or advice given to a resident about the possible consequences of such a refusal should also be documented.

2.3. Legal Considerations

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

2.4. 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. Please refer to Policy on Storage of Records.

2.5. Guidelines for Good Practice in Recording Clinical Practice

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

2.5.1 The quality of a nurse'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, THIS IS A HIQA REQUIREMENT SO MUST BE DOCUMENTED THAT FAMILIES ARE INCLUDED IN THE CARE PLAN. PLEASE REFER TO INTRODUCTION LETTER TO FAMILIES.

ii) Evidence in relation to the planning and provision of nursing care,

iii) An evaluation of the effectiveness, or otherwise, of the nursing 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.

- **A copy of the Common Single Summary Assessment Record must be in place for All Residents admitted under Fair Deal. This must include a copy of the persons MMSE must also be present in the Resident's Chart**
- **For residents admitted with dementia there must be documented evidence from a Medical Consultant that the person has actually received a diagnosis of dementia**.

2.5.2. **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. In this Service all care plans and assessments must be reviewed at a minimum of four monthly 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 The Health Information and Quality Authority. See Standard above.

2.5.3. 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.

2.5.4. **All entries are signed.**

• Nurses should sign entries using their name as entered on the Register of Nurses and Midwives maintained by The Nursing and Midwifery Board Ireland.

• 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. This will be necessary over the next few weeks.

• 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.

2.5.5. **All entries are dated.**

All entries must be dated in the following example e.g. date, month, Year 01/08/2010.

2.5.6. **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.

2.5.7. 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 should not “squeeze” a late entry into existing notes, nor write in the margins.

• Nurses ought not to charge entries ahead of time, or otherwise, predate entries.

• Nurses ought not re-write entries in the record or discard the originals, even if it is for a simple reason e.g. a torn page or a spilled drink.

2.5.8. Care Assistant Staff.

Care assistant staff may record practices so long as they are under supervision of a Registered Nurse. **The standard of record keeping of those under supervision in the clinical area e.g. student nurses or nurses 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.

2.5.9 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.

2.5.10. **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. PLEASE REFER TO LIST OF APPROVED ABBREVIATIONS (HSE, 2010).

2.5.11. 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.

2.5.12. **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.

2.5.13. **A nurse 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 who took the call and the person giving the information or advice should be clearly identified.

2.5.14. **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 intervention and it requires documentation within the record particularly in changing circumstances.

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

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

Any resident who is being discharged with medical equipment must have that equipment fully explained to them, how it works, how it is cleaned and how and where it can be serviced.

2.5.16. **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 Policy of this Service is to store records for a minimum of eight years.

• The keeping of supplementary records should be the exception rather than the norm.

2.5.17. **The residents name 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.

2.5.18. 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."

2.5.19. **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. The Nursing and Midwifery Board Ireland

recommends that nurses 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.

REFERENCES

Nursing and Midwifery Board Ireland

- • *The Code of Professional Conduct for each Nurse and Midwife,* (April 2000).
- • *Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols,* (December 2000).
- • *Guidelines for Midwives, 3rd Edition,* (September 2001).
- • *Scope of Nursing and Midwifery Practice Framework,* (April 2000)
- Recording Clinical Practice. Guidance for Nurses and Midwives (November 2002).
- Standards for Nurses working with Older People.

Appendix One.

Recording Clinical Practice Guidance for Nurses and Midwives, 2002.

Appendix Two.

An Bord Altranais (2009) Professional Guidance for Nurses Working with Older People. An Bord Altranais.