Nursing & Midwifery Council

NMC

Record keeping:
Guidance for nurses and midwives

The Nursing & Midwifery Council exists to safeguard the health and wellbeing of the public.

- We register all nurses and midwives and ensure that they are properly qualified and competent to work in the UK.
- We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have fair processes to investigate allegations made against nurses and midwives who may not have followed the code.

Record keeping:
Guidance for nurses and midwives

The way in which nurses and midwives keep records is usually set by their employer. The NMC recognises that, because of this, nurses and midwives may use different methods for keeping records. However, the principles of good record keeping are well established, and should reflect the core values of individuality and partnership working.

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.

National programmes for the use of information communication technology and electronic record keeping are being introduced throughout the UK. Although electronic records are evolving, it is clear from nurses and midwives that paper based records are still commonly used. This guidance applies to both paper and electronic records. It explains what we expect from all nurses and midwives.

Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information between members of the multi-professional healthcare team
- helping to identify risks, and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning, and
- helping to address complaints or legal processes.

The Data Protection Act (1998) defines a health 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."

The principles of good record keeping apply to all types of records, regardless of how they are held. These can include:

- handwritten clinical notes
- emails
- letters to and from other health professionals
- laboratory reports
- x-rays
- printouts from monitoring equipment
- incident reports and statements
- photographs
- videos
- tape-recordings of telephone conversations
- text messages.

Principles of good record keeping

1. Handwriting should be legible.
2. All entries to records should be signed. In the case of written records, the person's name and job title should be printed alongside the first entry.
3. In line with local policy, you should put the date and time on all records. This should be in real time and chronological order and be as close to the actual time as possible.
4. Your records should be accurate and recorded in such a way that the meaning is clear.
5. Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.
6. You should use your professional judgement to decide what is relevant and what should be recorded.
7. You should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
8. Records should identify any risks or problems that have arisen and show the action taken to deal with them.
9. You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.
10. You must not alter or destroy any records without being authorised to do so.

11 In the unlikely event that you need to alter your own or another healthcare professional's records, you must give your name and job title, and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable.

12 Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.

13 The language that you use should be easily understood by the people in your care.

14 Records should be readable when photocopied or scanned.

15 You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.

16 You should not falsify records.

Confidentiality

17 You need to be fully aware of the legal requirements and guidance regarding confidentiality and ensure your practice is in line with national and local policies.

18 You should be aware of the rules governing confidentiality in respect of the supply and use of data for secondary purposes.

19 You should follow local policy and guidelines when using records for research purposes.

20 You should not discuss the people in your care in places where you might be overheard. Nor should you leave records, either on paper or on computer screens, where they might be seen by unauthorised staff or members of the public.

21 You should not take or keep photographs of any person, or their family, that are not clinically relevant.

Access

22 People in your care should be told that information on their health records may be seen by other people or agencies involved in their care.

23 People in your care have a right to ask to see their own health records. You should be aware of your local policy and be able to explain it to the person.

24 People in your care have the right to ask for their information to be withheld from you or other health professionals. You must respect that right unless withholding such information would cause serious harm to that person or others.

25 If you have any problems relating to access or record keeping, such as missing records or problems accessing records, and you cannot sort out the problem yourself, you should report the matter to someone in authority. You should keep a record that you have done so.

26 You should not access the records of any person, or their family, to find out personal information that is not relevant to their care.

Disclosure

27 Information that can identify a person in your care must not be used or disclosed for purposes other than healthcare without the individual's explicit consent. However, you can release this information if the law requires it, or where there is a wider public interest.

28 Under common law, you are allowed to disclose information if it will help to prevent, detect, investigate or punish serious crime or if it will prevent abuse or serious harm to others.

Information systems

29 You should be aware of, and know how to use, the information systems and tools that are available to you in your practice.

30 Smartcards or passwords to access information systems must not be shared. Similarly, do not leave systems open to access when you have finished using them.

31 You should take reasonable measures to check that your organisation's systems for recording and storing information, whether by computer, email, fax or any other electronic means, are secure. You should ensure you use the system appropriately, particularly in relation to confidentiality.

Personal and professional knowledge and skills

32 You have a duty to keep up to date with, and adhere to, relevant legislation, case law and national and local policies relating to information and record keeping.

33 You should be aware of, and develop, your ability to communicate effectively within teams. The way you record information and communicate is crucial. Other people will rely on your records at key communication points, especially during handover, referral and in shared care.

34 By auditing records and acting on the results, you can assess the standard of the record keeping and communications. This will allow you to identify any areas where improvements might be made.

Further reading

This guidance is supported by further notes and frequently asked questions which are available at www.nmc-uk.org

European Convention on Human Rights Act 1950

National Health Service Venereal Disease Regulations (SI 1974 No 29)

Access to Health Records (1990)

The Computer Misuse Act 1990

Human Fertilisation and Embryology Act 1990

The Civil Evidence Act (1995)

Caldicott Report (DH) 1997

Access to Medical Reports Act (1998)

Data Protection Act (1998)

The Road Traffic Act 1998

The Data Protection Order (2000)

The Electronic Communications Act (2000)

The Freedom of Information Act 2000

The Terrorism Act 2000

The Freedom of Information (Scotland) Act 2002

The Communications Act 2003

Confidentiality: NHS Code of Practice (2006)

Security Management NHS Code of Practice (2007)

NHS Information Governance Guidance on legal and professional obligations (2007)

Records management best practice in relation to the creation, use, storage, management and disposal of NHS records Scotland (2008)

NMC advice sheet on confidentiality (2009)

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This guidance on record keeping was published in July 2009, for implementation from 1 August 2009. It replaces *Guidelines for records and record keeping* (NMC 2002) and the *NMC advice sheet on record keeping* (NMC 2007).

Further information to support this guidance is available on our website.

This guidance will be reviewed in 2012.

PB-RCDKP-A6-0609