Children's Health Ireland

Crumlin | Temple Street | Tallaght | Connolly

CHI NURSING PRACTICE GUIDELINES ON NURSING DOCUMENTATION

Area of use:	All of organisation ☒	CHI at Connolly ☐	CHI at Crumlin ☐
	CHI at Herberton ☐	CHI at Tallaght ☐	CHI at Temple Street ☐
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Contents

1.0 Guideline statement

Introduction

Nurses are required to "establish and maintain accurate, clear and current client records within a legal and ethical framework" (Nursing and Midwifery Board of Ireland, 2015 p4). Nursing documentation is essential to validate and justify patient care delivery (Follin, 2004). Good record keeping is fundamental to professional nursing practice and documentation quality reflects the quality of nursing care (An Bord Altranais, 2002, Nursing & Midwifery Board of Ireland, (NMBI) 2014). Patient care and documentation of that care are considered to be part of the nursing care continuum.

2.0 Scope

2.1 Employees: This guideline applies to all full-time, part-time and fixed term nursing employees employed by Children's Health Ireland (CHI).

2.2 Agents: Agents may be employees of suppliers, volunteers, students on placement or any other individuals associated with CHI. This policy applies to all such agents.

3.0 Procedures

Nurses are required to document care and contact with patients in a variety of places. The paper healthcare record (HCR), electronic healthcare record (EHCR), or in their own records for Clinical Nurse Specialist (CNSp). If documenting in an electronic record, please follow any additional guidance supplied for that record.

Inadequate documentation may lead to inadequate patient care through:

- Duplication in care – not documenting care could mean the patient receives medications twice!
- Omissions of care - care is not delivered if not documented one nurse thinks another has carried out care.
- Time wasting – two nurses could both attempt to carry out care if not documented.
- Poor quality care delivery - if nursing care is not documented the quality of this care cannot be assessed.
- Communication issues between staff.
- Failure to record important observations and conclusions may lead to a delay in a clinical intervention.

- Delays in detecting changes in a patient's condition - Paediatric Early Warning System (PEWS) may give a score that can alert to a potentially deteriorating child. Delay in documentation may delay this alert more than necessary which could compromise the child's condition.

'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 and responsible 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. Good record management therefore underpins professional practice'. (NMBI, 2015)

Nursing students must have their documentation overseen and co-signed by the registered nurse charged with the responsibility to supervise the student (NMBI, 2016). Undergraduate and Higher Diploma Nursing Students' documentation in patient records should be reviewed and clearly co-signed by the registered nurse who is supervising the student.

Nursing documentation may include manual, audio visual and electronic information which is guided by the law, national and organisational policy and procedure of which nurses have a duty to be familiar with (NMBI, 2016). Confidentiality with all patient documentation is imperative and electronic records need specific consideration (General Data Protection Regulations (GDPR), 2016; Government of Ireland, 1988; Government of Ireland, 2000; NMBI, 2014; Health Service Executive (HSE), 2011). Nurses must be aware of local and national child protection policy (Department of Children & Youth Affairs, 2017) and guidelines which require the sharing of sensitive records and information (NMBI, 2015). The Freedom of Information Act (Government of Ireland, 1997, 2003 (amended) & 2014) and the Data Protection Act (Government of Ireland, 1988, 2003 & 2016) entitle patients to access their Healthcare Records and the nurse must be aware of the procedure in relation to same. **Falsification of documentation is a disciplinary event.**

Nursing documentation must comply with the *Recording Clinical Practice Professional Guidance* (NMBI, 2015), *Health Service Executive Code of Practice for Healthcare Records Management: Abbreviations (HSE, 2010), Health Service Executive Standards and Recommended Practice for Healthcare Records Management (HSE, 2011)* and all associated CHI Polices and Guidelines.

Purpose of documenting patient care:

Nurses are obliged legally and professionally to maintain accurate clinical patient records for the following reasons:

- To provide an accurate nursing care history for the patient.
- To document an accurate assessment of the person's physical, psychological and social well-being, with views and observations of other family members recorded where necessary.
- To help verify and justify quality of care.
- To help ensure continuity of care, giving a clear unambiguous accurate record of care delivered.
- To assist with the planning, co-ordination and evaluation of care.
- To provide an exact chronological record of care, events and decisions made as they occurred.
- To 'justify care delivery in the context of legislation, professional standards, policies, procedures, protocols and guidelines, evidence, research and professional and ethical conduct' (HSE, 2011).
- To provide an authentic, factual, clear concise record of the patients complete care episode.
- To facilitate communication between the patient/family and members of the healthcare team.

(Jeffries, Johnson and Griffiths, 2010; HSE, 2011; NMBI, 2014).

Uses of nursing documentation: Documentary evidence of care delivery is required for the following reasons:

- To provide vital evidence in the event of a patient query or complaint.
- To allow for clinical audit in order to enhance the quality of patient care and documentation.
- All patient records including nursing documentation are legal documents.
- To support multidisciplinary continuity of care.
- To support nursing decision making.
- To provide evidence in the event of a Nurse Enquiry- Fitness to practice/Legal enquiry.
- For teaching purposes for nursing students in training.
- To promote reflection on and evaluation of nursing practice.
- For research purposes-subject to ethical approval.

(NMBI, 2014; HSE, 2011)

Applicable to

All nursing staff and nursing students

4.0 General requirements for all entries in the Healthcare Record- HSE-2011

4.1 Correct positive patient identification

- Identify that the documentation belongs to the correct patient – cross check patient's full name, date of birth and Healthcare Record Number with that on their identity band.
- Include the patient's name and Healthcare Record number/ addressograph label on each page on which patient care is documented. Each computer screen on which patient care is documented must include the patient's full name, date of birth and Healthcare Record Number.

4.2 Legibility and Language

- Use black permanent pen in all written documentation. Multicolour pens are permitted to document in the patient observation sheets/fluid balance sheets.
- Writing must be legible and clear.
- All documentation must be in English.
- Documentation must be clear, objective and factual.
- Sign and date all entries indicating and printing: **grade, title** and **bleep number** *(If appropriate)* of the person documenting the care.
- Nurses should sign their name as held on the Register of Nurses and Midwives by NMBI.
- The use of initials is not permitted except on specific patient documentation which includes a bank for signatures and initials, example: the Medication Administration Record.
- Nurses documenting in patient's healthcare records must have their signature recorded in a hospital signature bank.
- Blank spaces or blank pages must never be left between entries.

HSE Code of practice for Healthcare Records Management (2012)

4.3 Documenting date and time

- The time an event occurred and the time of recording must be clearly indicated for each entry.
- The time is recorded using the 24-hour clock and date as follows: day/month/year
- When a request is made for assistance and/or review by medical staff or to attend in an emergency the time the request was made must be recorded

Retrospective entries: Nursing care should be documented as soon as possible after each intervention. If an entry is retrospective this should be clearly indicated and the reason for same included.

4.4 Deletions or alterations to patient documentation:

- Incorrect records should be amended but never destroyed.
- Place a single line through the erroneous entry, record the date and your signature (include printed name in capitals) and counter signature if appropriate.
- Include reason for amendment and make amendment as close as possible to original recording.
- Correction fluid (Tippex™) is not permitted.

4.5 Abbreviations

- Only abbreviations approved by the HSE are permitted in patient documentation and must be written in UPPER CASE.
- Anyone documenting in the health care record must be familiar with and refer to the '*Health Service Executive Code of Practice for Health Care Records Management: Abbreviations (2010)'.*

Abbreviations are not permitted in the following incidences (HSE, 2010):

- On transfer, discharge or external patient documentation or on incident forms.
- Medication names should not be abbreviated, use approved generic name.
- Reference to individual healthcare professionals should include: full name, title and bleep number. It is not acceptable to state "reviewed by physio" or "seen by SALT"
- When referring to "the patient", no abbreviations are permitted (e.g. "pt"). Instead use the patient's name.
- 'Right' and 'Left' must never be abbreviated to 'R' or 'L' the exception is where 'R' or 'L' is contained within an abbreviation eg. 'RIF' - right iliac fossa.

5.0 Monitoring, audit and evaluation

This Guideline will be reviewed and updated at least every three years by the document author/owner, or earlier if required due to updated guidance, evidence or legislation. Compliance with key principles or procedures described within this Guideline will be audited on an annual basis. Monitoring of compliance is an important aspect of procedural documents. However, it is not possible to monitor all procedures. Nursing sensitive indicators – Quality Care Metrics are used to monitor the quality of nursing care delivered. Each clinical area audits 5 healthcare records at least monthly. All aspects of nursing care are audited against a required standard giving nursing management assurance of the quality of nursing care delivery in each and

every clinical area. (HSE, 2018) https://healthservice.hse.ie/filelibrary/onmsd/national-guideline-for-nursing-and-midwifery-quality-care-metrics-data-measurement-in-childrens-services.pdf

6.0 Key stakeholders

The following key stakeholders were involved in developing and/or reviewing this document:

Name	Title	Department
Caroline O' Connor	NPDC	CHI at Temple Street
Siobhan O' Connor	NPDC	CHI at Tallaght
Fionnuala O' Neill	NPDC	CHI at Crumlin

7.0 Communication and training

All approved policies, procedures, protocols and guidelines (PPPGs) will be available on the Qpulse system or hospital intranet. Heads of Department and Line Managers must ensure that their staff are aware of all PPPGs relevant to their role and have access to same. Where required, training should be provided on the contents of this Guideline.

8.0 References

- Department of Children and Youth Affairs (2017) Children First: National Guidelines for the Protection and Welfare of Children. Dublin: Department of Children and Youth Affairs.
- Follin, S.A. (2004) *Nurse's Legal Handbook 5th ed*. Lippincott Williams & Wilkins: London.
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- Government of Ireland. *Electronic Commerce Act 2000.* The Stationery Office: Dublin
- Government of Ireland**.** *Freedom of Information (amendment) Act 2003.* The Stationery Office: Dublin
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- Health Service Executive: National Healthcare Records Management Advisory Group (2011) *Health Services Executive Standards and Recommended Practices for Healthcare Records Management.* HSE.

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- National Hospitals Office (2007b) *National Hospitals Office: Abbreviations*. NHO: Tipperary.
- Nursing and Midwifery Board of Ireland (2014) C*ode of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*. NMBI: Ireland
- Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Guidance to Nurses and Midwives.* NMBI Dublin.
- Nursing and Midwifery Board of Ireland (2016) *Nurse Registration Programmes, Standards and Requirements,* NMBI, Dublin.
- Office of the Nursing and Midwifery Services Director Health Service Executive (2018) *National Guideline for Nursing and Midwifery Quality Care Metrics Data Measurement in Children's* Services. HSE