Family Nursing & Home Care

Record Keeping Policy

October 2021

Document Profile

Document Registration	Added following ratification
Type	Policy
Title	Record Keeping Policy
Author	Mo de Gruchy
Category	Governance
Description	To set out the standards and procedures within the organisation which aim to ensure that all members of staff are able to meet legal and best practice in relation to clinical record keeping.
Approval Route	Organisational Governance Approval Group
Approved by	Bronwen Whittaker
Date approved	6 October 2021
Review date	3 years from approval
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Version control / changes made

Date	Version	Summary of changes made	Author
January 2020	2	Updated to include electronic patients records. Updated to include The Data Protection (Jersey) Law which incorporates GDPR.	Allison Mills
March 2021	3	Reviewed and updated to include additional references	Mo de Gruchy
September 2021	3.1	Appendix added 'Record keeping principles for Child and Family Services' and mentioned in 2.4	Mo de Gruchy

CONTENTS

1. INTRODUCTION

Clinical record keeping is an integral part of professional practice, designed to inform all aspects of the care process. The use of patient information is an essential aspect of Family Nursing & Home Care (FNHC) and is a key element in supporting the everyday aspects of the delivery of high quality, evidence based health care.

Accurate and effective clinical record keeping is fundamental to high quality patient care. It enables effective communication with other professionals involved in the patient's care and expresses individual professional accountability and responsibility. It is important that these records are accurate, up to date and easily accessible to those who need to use them.

1.1 Rationale

This policy aims to set out best practice and guidance for all clinical records regardless of their format that currently exist within FNHC and ensure they meet the required standards of:

- Authenticity, integrity and security
- Reliability and confidence in clinical healthcare records/information
- Provide confidence to external inspectors that FNHC's healthcare records in all formats are robust and reliable

All clinical and administrative staff creating or contributing to the patient record will provide an accurate and timely health record which can determine accountability; facilitate clinical decision making; improve patient care through clear communication of the assessment, treatment and care planning rationale; provide a consistent approach to partnership working; and help in the investigation of complaints or legal proceedings.

1.2 Scope

This policy relates to all clinical records, such as:

- Handwritten and electronic care records
- Fax messages
- Diaries
- Emails
- Text messages
- Incident reports and statements
- Photographs/videos

This policy applies to all staff employed by FNHC, including bank staff and students who document in clinical records.

1.3 Role and Responsibilities

Chief Executive Officer

The CEO has overall accountability for the management of records and record keeping within FNHC.

Caldicott Guardian

The Caldicott Guardian is responsible for ensuring that FNHC adheres to the Caldicott Principles when processing patient identifiable information.

Head of Quality, Governance & Care

The Head of Quality, Governance & Care is responsible for the overall development and maintenance of both corporate and health record keeping practices within FNHC, in particular for drawing up guidance for good record keeping practice and promoting compliance with this policy

Operational Leads

Operational Leads must ensure that their staff are trained in the relevant aspects of record keeping and that there is compliance of FNHC policies and procedures. This should be in the form of induction training and relevant updates via the mandatory training schedule.

Individual Responsibility

All FNHC staff have a legal duty of care and are responsible for any records they may create or use. This responsibility is established and defined by law. Every employee's contract of employment clearly identifies individual responsibilities for compliance with information governance requirements.

2. POLICY

2.1 Purpose of records

- Evidences that policy, process and practice have been followed appropriately, demonstrating professionalism and competency.
- Provides the rationale behind professional practice, making it clear how a decision was arrived at and being accountable for why a particular course of action was taken or not taken.
- Gives a clear picture of the person's story, their wishes, views and preferences which can be used by them and / or others to empower and better understand their situation and any care or support needs. (O'Rourke 2010)

2.2 General principles of record keeping

All relevant information must be:

- Recorded - if it is not recorded it has not happened!
- Legible, signed, dated and ideally typed
- Contemporaneous and kept up to date
- Written in plain language, be clear, legible and logical
- Accurate in terms of grammar, punctuation and spelling
- Unambiguous, proportionate, concise and avoiding unnecessary repetition
- Distinguish between statements of fact and opinion
- Include the voice of the patient / client
- Show professional analysis, thinking, rationale for all decisions
- Record evidence of management oversight, where relevant
- Be free from unexplained technical terms, acronyms, abbreviations and jargon
- Be kept securely

2.3 Principles of professional writing

- Make recording part of the patient care and plan what will be written.
- Consider the person's desired outcomes – their views wishes and feelings (patient voice).
- Communicate information that facilitates decision making that is evidence based and defensible.
- Evidence use of professional knowledge, skills, analysis and evaluation of the information.
- Make clear recommendations in relation to actions / inaction, decision making and support which may help the person achieve their outcomes.
- Proof read and review what has been written

2.4 Knowledge and skills

Health care professionals must ensure they develop and maintain professional communication and information sharing skills, as accurate records are relied on at key communication points, especially during handover, when referring and in shared care situations

All FNHC staff will be made aware of their responsibilities for record-keeping and record management at Induction and complete specific/mandatory training as relevant to their role. Staff working within Child and Family Services will have additional principles to follow, set out in Appendix 1.

2.5 Security & Confidentiality

All patients/parents will receive a leaflet called 'How we use your information' and explains why FNHC collects information about them and how it is used.

All staff have a duty to act in accordance with the data protection legislation in maintaining patient confidentiality.

Patient records must be kept safe at all times. How and where records are stored and who has access to them all impact on maintaining confidentiality of patient records.

All staff should be fully aware of the legal requirements and guidance regarding confidentiality, and ensure their practice is in line with national and local policies FNHC Confidentiality Policy

2.6 Access

A patient's right of access to their health records (both paper and electronic) is governed by the provisions of the Data Protection (Jersey) Law 2018.

- Patients should be informed that information on their care records may be seen by other people or agencies involved in their care
- Patients have the right to ask for their information to be withheld from health professionals.
- Patients have a legal right to see their records in the majority of circumstances. FNHC Subject Access Request Policy

2.7 Disclosure

Information that can identify a patient must not be used or disclosed for purposes other than healthcare without the individual's explicit consent. However, this information can be disclosed if the law requires it, or where there is a wider public interest ie if it will help to prevent, detect, investigate or punish serious crime or if it will prevent abuse or serious harm to others

3. PROCEDURE

3.1 Record Keeping Process

- Records should be completed at the time or as soon as possible after the event within 24 hours unless there are exceptional circumstances. If the notes are written sometime after the event, this must be recorded (NMC 2018).

- Records must be completed accurately and without any falsification and provide information about the care given as well as arrangements for future

and ongoing care. Be factual and avoid use of jargon, speculation and abbreviations (also see 3.2).

- Clinical alerts such as allergies or adverse drug reactions must be clearly recorded in the appropriate area of both the paper and electronic record
- Consider the persons desired outcomes – their views wishes and feelings (patient voice). Make clear recommendations in relation to actions / inaction, decision making and support which may help the person achieve their outcomes.
- Consent to treatment and care must be recorded clearly and carefully in accordance with the FNHC Consent Policy.
- Handwritten records must be signed, timed and dated in permanent black ink. Records should be written clearly and legibly and be readable when photocopied or scanned.
- Each page of a patient's handwritten record should detail the patient name and date of birth or EMIS Number
- Blank spaces or empty lines should not be left between entries, a line should be drawn though any empty space at the end of an entry.
- Any alterations to handwritten records are scored through with a single line and are dated, timed and initialled in such a way that the original entry can still be read clearly. Correction fluid and highlighter pen must not be used.
- Alterations to digital records are traceable within the system. Digital/electronic records must be traceable to the person who provided the care that is being documented.

3.2 Use of Abbreviations

- FNHC endorses the advice of the Nursing and Midwifery Council (NMC 2018) and Royal College of Nursing (RCN 2014) and discourages the use of abbreviations by any member of staff. This will ensure that the information contained in health records and other documents produced by FNHC is clear and understandable to all persons having access to them. If an abbreviation is to be used, it should be written out in full the first time it is used within that particular entry with the abbreviation in brackets.

3.3 Delegation of Record Keeping Process

- Record keeping can be delegated to non-registrants providing direct patient care, so that they can document the care that they have delivered (RCN 2019).
- As with any delegated activity, the nurse needs to ensure that the non-registrant is competent to undertake the activity and that it is in the patient's best interests for record keeping to be delegated.

- Supervision and a countersignature are required until the non-registrant is deemed competent at keeping records.

- Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.

3.4 Security & Confidentiality

- Paper records should be stored in a secure base. Supplementary records held should be stored in an agreed place in patient's home, with advice given on suitable locations to maintain security and privacy of information and protected records from damage.

- When it is not possible to return records to their secure base at the end of a working day, it will be permissible for such records to be held overnight by staff in their homes, provided these are kept securely to maintain confidentiality. Under no circumstances should records be left in staff vehicles overnight or when such vehicles are left unattended. Records should not be left unattended on vehicle seats or visible within the vehicle

- Electronic devices must be secured by using password/code authentication. When being transported between patient visits, staff must keep electronic devices secure in a nursing bag or uniform pocket.

- When transporting electronic devices in a vehicle they should be stored securely and out of sight eg in a locked boot of a vehicle. Staff must not leave electronic device in a vehicle overnight

- It is essential that staff are aware of the location of the records in their charge, that those records are accessible whenever required and are retained according to the Organisation's Record Retention Schedule, as per FNHC Records Management Policy.

4. CONSULTATION PROCESS

Name	Title	Date
Claire Whelan	Head of Information Governance and Systems	20/04/2021
Judy Foglia	Director of Governance Regulation and Care	20/04/2021
Elspeth Snowie	Clinical Effectiveness Facilitator	01/04/2021
Teri O'Connor	Home Care Manager	20/04/2021
Tia Hall	Operational Lead Adult Nursing	20/04/2021
Michelle Cumming	Operational Lead Child and Family Services	20/04/2021
Clare Stewart	Operational / Clinical Lead Out of Hospital Services	20/04/2021

Justine Le Bon Bell	Education Lead	20/04/2021

5. IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	
Forms/templates to be uploaded to Central Filing	Head of Information Governance and Systems	

6. MONITORING COMPLIANCE

Clinical audit may be used to monitor the standard of recordkeeping. Team Leaders should also monitor the standard of record keeping as part of the oversight of clinical care. The quality of recordkeeping may also be monitored during investigations that involve reviewing patient records.

7. EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Values of Family Nursing & Home Care underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity

- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See Appendix 1 for the Equality Impact Assessment.

8. GLOSSARY OF TERMS

None

9. REFERENCES

Government of Jersey (2019) *The Code of Practice: Professional standards of practice and behaviour for Health and Social Care Support Workers in Jersey.* Available: https://carecommission.je/wp-content/uploads/2020/01/Code-of-Practice-Sept-2019-Final.pdf Last accessed 24th March 2021

Jersey Care Commission (2019) *Standards for Home Care.* Available: https://carecommission.je/home-care-standards/ Last accessed 24th March 2021

NHSX (2020) *Records Management Code of Practice 2020.* Available at Records Management Code of Practice 2020 (nhsx.nhs.uk). Last accessed 27th April 2021

Nursing and Midwifery Council (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* Available at nmc-code.pdf. Last accessed 26th April 2021

O'Rourke, L. (2010) *Recording in Social Work: not just an administrative task.* Bristol, The Policy Press

Royal College of Nursing (2014) *EHealth Technology in Practice: Abbreviations and other short forms in patient/client records.* Available: https://joinup.ec.europa.eu/sites/default/files/document/2014-12/Royal%20College%20of%20Nursing%20Guidance%20Document%20-%20Abbreviations%20and%20other%20short%20forms%20in%20patient-client%20records.pdf Last accessed 30th March 2021

Royal College of Nursing (2019) *Record Keeping: The Facts.* Available: https://www.rcn.org.uk/professional-development/publications/pub-006051 Last accessed 29th March 2021

10. APPENDIX

Appendix 1 Record keeping principles for Child and Family Services

Record keeping principles for Child and Family Services

- The Mother's record is the Primary document until birth. After birth the child's record becomes the Primary document. For example, the new birth visit template is only attached to child's record and not duplicated
- The importance of linking families on EMIS reduces duplication and ensures quality safeguarding
- References to sibling's/parent's records can be made in the current open record to reduce time in record keeping and by avoiding duplication
- Hold information proportionately ie not opening father/partner records unless they are the main carer; record safeguarding in appropriate record with cross reference from linked records e.g DV, MARAC, JMAPPA
- Should a father's record (outside of Baby Steps Programme) be required to be created on EMIS without consent, there must be a legal basis for doing so and a rationale documented in the records
- Use 'Working Together' approach to collate a picture of the family. Focus should be on actions/analysis and plans
- In line to the principle of 'Working Together', not to summarise minutes/notes of meetings but an analysis, plan and action focus of record keeping
- Be mindful of Subject Access Requests - A record should always be written with a view to that person being able to request and read the record

Appendix 2 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: Record Keeping Policy			
Date of Assessment	September 2021	Responsible Department	Governance
Name of person completing assessment	Mo de Gruchy	Job Title	Quality Performance and Development Nurse

Does the policy/function affect one group less or more favourably than another on the basis of :	**Yes/No**	**Comments**
• Age	No	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	No	
• Ethnic Origin (including gypsies and travelers)	No	
• Gender reassignment	No	
• Pregnancy or Maternity	No	
• Race	No	
• Sex	No	
• Religion and Belief	No	
• Sexual Orientation	No	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions** (what needs to be done to minimise / remove the impact)	**Responsible Officer**

Monitoring of Actions
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level