



Record Keeping

&

The Law

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Unite/Community Practitioners' and Health Visitors Association is a professional section of Unite Health Sector which has about 100,000 members working in the health sector. Unite / CPHVA is the third largest professional nursing union and is the only union, which has public health at its heart. The Unite/ CPHVA is the UK professional body that represents registered nurses, nursery nurses and health visitors who work in a primary or community health setting.

The sector is itself part of the Unite trade union with two million members nationwide. Unite was formed by an amalgamation of Amicus and the Transport and General Workers' Union in May 2007.

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Introduction

“Record keeping is an integral part of nursing, midwifery and specialist community public health nursing practice. It is a tool for professional practice and one that should help the care process. It is not separate from this process and is not an optional extra to be fitted in if circumstances allow” (Nursing and Midwifery Council 2005).

Defining features of high standard records

Records that are completed to a high standard demonstrate that care has been planned and delivered in an organised and consistent way and illustrate that the practitioner is operating in a skilled and safe way. These records have several defining features e.g.

a. Accurate	b. Clearly written	c. Complete	d. Concise	e. Consistent	f. Consecutive
g. Logical	h. Contemporaneous	i. No abbreviations / jargon	j. Factual	k. Provide clear evidence of care planned, delivered and information shared	l. Written in partnership with the patient / client, whenever possible

NMC (2005)

Failure to maintain a high standard of record keeping is one of the main reasons that registered practitioners are ‘struck off’ the Nursing and Midwifery Council (NMC) Register.

Requirements for record keeping & documentation

- a. All clients who receive health/nursing care will be issued with an individual record and all care, consultations and interventions must be recorded in a chronological order.
- b. All those who deliver care must have the knowledge, skills and confidence to record the details of the care in the client’s record. Currently in the multi -skilled health visitor and school nursing teams this may include student nurses, student health visitors and school nurses, nursery nurses, registered nurses and support workers.

Examples of records used in specialist community public health nursing practice (e.g. health visiting and school nursing)

- The work diary
- The child health record
- The family health record
- The personal child health record (PCHR)
- The care plan
- The clinic card
- The ‘looked after’ children health record
- Immunisation recording sheet

The Law

A record is considered to be a legal document because it contains information about the care that has been planned and delivered to a client or patient and because it may be requested by a court of law (Dimond 2002).

In terms of the law, a record does not prove that something has happened, but greater credibility is given to it, if it can be proven that it was completed at the time of the event or within 24 hours of the event i.e. is a contemporaneous record of events (NMC 2005). This is achieved by documenting the date of the event and the date that the entry was made in the record, especially if these dates are different.

Acts of Parliament and Common Law make up the two main sources of the law i.e.

Acts of Parliament	Common / Case Law
Legislated by members of parliament (MP) and peers within the House of Commons and the House of Lords.	This law is not embodied in legislation. It is based on judicial/court decisions for actions in specific situations. This is sometimes referred to as a 'duty of care'.

In relation to record keeping and documentation, all practitioners (qualified and non qualified) must be familiar with the rationale and content of the following Acts of Parliament e.g.

Legislation	Remit
The Access to Health Records Act (1990)	Now only covers access to health records for deceased people.
The Data Protection Act (1984)	Replaced by the 1998 Act
The Data Protection Act (1998)	Gives clients access to their paper and computer records. Regulates the storage and protection of client information held on computer. Access to health records of living people. Client's right to have inaccurate information about them corrected.
Freedom of Information Act (2000)	Access to information that does not contain patient identifiable information

NMC (2005)

The law requires health records to be kept secure for specific time spans in order that the information can be obtained at a later date if required e.g.

Record	Duration
Obstetric	25 years.
Records relating to children and young people	Until the patient's 25 th birthday or eight years after the last entry.
Record relating to the mentally ill	Twenty years from the date which the doctor considers the condition to have ceased or diminished and the patient does not need any more treatment or care.
All other personal health records	Eight years after the treatment has finished.

Clarke (1999)

The preservation of records also refers to the work diary used by the practitioner. The duration that this is kept is determined by the employing authority/organisation under their information governance structures and details of which can be found within the record keeping and documentation policies, and the information governance strategy for the organisation.

Recording information

There is currently no universal template for record design which means that the design will be different in different organisations. However, it is not permissible in law or in terms of the NMC for the quality of the entry to differ (NMC 2005).

Key points

- a. The content and style of the record must be of sufficient quality to protect the client/patient and the practitioner e.g. from harm caused by missed or duplicated care.
- b. The practitioner must be able to explain and justify the content of the record even after the active episode of care has finished. This may be up to 25 years after the last contact with the client.
- c. All entries must have information about what you have done, why you have done it, and ways in which you are protecting the client's safety.

Frequently asked questions

1. Who should sign & / or write the record?
2. What do I need to write in a record for it to be considered high standard?
3. How do I record that the client has given informed consent for the procedure / care?
4. How do I correct errors and mistakes in records?
5. The Primary care trust/health care organisation that I work for stipulates that I have to maintain a set of patient held records and base held records for every patient on my caseload. Do I have to write in both sets of records every time I see the client?
6. I work alongside practitioners from other professions and we all use the same record to document care, is this acceptable in terms of the law i.e. confidentiality?
7. What is an open record?
8. Who owns the record?
9. I spend my time seeing my clients of which I have a lot and I am not able to keep up to date with my records because I feel that it is more important to see the clients. Should I be concerned?
10. How do I balance the need to share information with other professionals and the need to preserve the confidentiality of the client?
11. What colour ink should I use to write in the client record?
12. What date was the latest guidance about record keeping published by the NMC?
13. I am so busy at work that I often take records home with me to write them up. Is this acceptable?
14. What do I do if a patient/client asks to see their records?
15. What do I do if management insists that I counter-sign entries in records for junior/non-qualified staff even if I am not directly observing or supervising the care they give to the client?
16. How do I present information in the records?

17. I am currently dealing with an issue that has arisen about a client that I cared for 20 years ago when I was a member of a different union. Who will provide indemnity cover for me my current union or the one I was with at the time?

Q. Who should sign & / or write the record?

A. The person delivering the care must sign the entry that they have made in the client's record. In some situations the employing organisation may stipulate that an entry which is made by a student nurse or a junior member of the team must be counter-signed by the health visitor / school nurse (as qualified / senior member of the team). This is not a legal requirement because both practitioners must be able to answer for the content of the record if they were involved in writing it and giving the care. In these situations the health visitor / school nurse is only able to sign the record if he or she has seen the care being delivered e.g. during direct supervision / observation of the person delivering the care.

Q. What do I need to write in a record for it to be considered high standard?

A. All practitioners have a legal and professional duty of care to complete health / nursing records to a high standard. A high standard of record keeping is illustrated by the inclusion of several components within the record i.e.

- A full account of the assessment
- A full account of the care you have planned and the care that you have provided
- Factual information about the client's condition and measures you have taken to respond to his / her needs
- Evidence that you have taken all reasonable steps to care for the client
- Evidence that any actions or omissions on your part have not compromised the client's safety
- A full account of the plan of care arranged with the client or carer
- The date, time, signature and the writer's name must be printed alongside the first entry

(NMC 2005)

Q. How do I record that the client or carer has given informed consent for the procedure / care?

A. Informed consent implies that the client has received information about the procedure / care and that he / she has agreed to accept it based on the information that he / she has been given. All records must contain written information about the process of gaining informed consent i.e.

- Your assessment of the client's / carer's ability to understand the information and make the decision to accept or refuse the treatment / care (e.g. Fraser Competence)
- The purpose of the procedure
- The anticipated outcome
- Any side effects
- Alternative procedures that the client may have
- The client's response to the information

It is also important that you are aware of the specific requirements for informed consent e.g. who is able to give consent and the circumstances required for consent e.g. age, competence, parental responsibility (DH 2006).

Q. How do I correct errors and mistakes in records?

A. All information that is documented within the record must be legible even if it has been written in error. The process for dealing with an error or mistake must include all of the following points:

- a. A single line through the entry
- b. Write the initials of the person correcting the entry and the date when the correction was made (NMC 2005).
- c. Do not use correction fluid or anything that makes the entry illegible.

Q. The PCT/health care organisation that I work for stipulates that I have to maintain a set of patient held records and base held records for every patient on my caseload. Do I have to write in both sets of records every time I see the client?

A. You must ensure that both records are kept up to date and that duplication of information is kept to a minimum e.g. by using a duplicate sheet to record the details of the consultation / care given and putting a copy in each record. Alternatively, you could cross reference the entries e.g. document the date of the consultation in the base record and refer the reader to the patient held record where a full account of the consultation is documented. It is also good practice to explain to the client that a second set of records are being kept and the reasons for doing this.

Q. I work alongside practitioners from other professions and we all use the same record to document care. Is this acceptable in terms of the law i.e. confidentiality?

A. This practice is not breaching confidentiality because all practitioners documenting in the records will be involved in the client's care. It is important that you explain to the client and / or carer that the records are shared with practitioners involved in the client's care and the reasons for doing so e.g. it encourages continuity of care, improves communication between the carers and reduces the potential for duplication and missed care. An example of a shared record is the Common Assessment Framework (CAF).

When using shared records practitioners are accountable and responsible for documenting the care in the record in the same way as if they were the only professional documenting in the record.

Q. What is an open record?

A. A record is considered to be open if the content has been shared with the person to whom it refers i.e. the practitioner has discussed the content with the client as it is being written. This is considered to be good practice and is promoted by the NMC (NMC 2005). There may be situations in which the health practitioner feels that it is not in the client's best interest to share the information or that sharing the information would place them or others associated with them at risk of harm. These situations are rare e.g. concern about undisclosed domestic violence where the person inflicting the violence may have access to the record. In these situations the health practitioner will need to document in a second record that can not be accessed by the client / carers. It is imperative that in these situations both records are kept up to date and mechanisms are in place to ensure this happens.

Q. Who owns the record?

A. The organisation providing the care ultimately owns the record but it delegates responsibility for storing the record, to the service that delivers the care directly to the client e.g.

Record	Ownership	Storage responsibility
Health visiting records	The primary care trust (PCT); employing health care organisation	The health visiting service
School nursing records (state schools)	The primary care trust (PCT); employing health care organisation	The school nursing service
GP records	The strategic health authority, local health boards (Wales)	General Practitioner service (GP)
Personal Child Health Record (PCHR)	The primary care trust (PCT); employing health care organisation	The parent / person with parental responsibility

The health practitioners who are delivering the service / care within these services are responsible and accountable for keeping the record secure and for ensuring that the information within the record is only accessible to those authorised to access it (NMC 2005). The employing authority is bound to comply with these arrangements by the regulatory bodies that monitor and audit their performance in relation to service and care delivery.

Clients / patients have a legal right to apply to access the information that is held within their health / nursing records. This is now covered by the Data

Protection Act (1998). The application process will consider the client's ability to deal with the information contained within the record (e.g. Fraser competence).

Q. I spend my time seeing my clients of which I have a lot and I am not able to keep up to date with my records because I feel that it is more important to see the clients. Should I be concerned?

A. Yes. Health visitors and school nurses (all nurses) are accountable for their practice and must be able to justify their actions and omissions; being too busy to write in the records is not considered to be a justification in law or by the NMC for not doing it. Measures must be taken by the health visitor to ensure that he / she is able to complete the records as well as deliver the care to the client. For example, the health visitor or school nurse must inform the line manager in writing about the issues of concern and the measures that she / he is taking to rectify the problem e.g. reducing the number of clients / patients seen in a day in order to make time to complete the records. Remember that, in the eyes of the law, if something is not written, it has not been done.

Q. How do I balance the need to share information with other professionals and the need to preserve the confidentiality of the client?

A. This is a common concern felt by many practitioners. The law states that you should consider the answer to this in terms of what is in the best interest of the client and what action will keep them and others safe (DH 1997, NMC 2005). Several key issues must be addressed when you are sharing information i.e.

- Information is shared on a 'need to know basis' (DH 1997, ICO 2007).
- The principle of confidentiality is overridden if the law requires the information e.g. Acts of Parliament (National Health Service Act 1977, Births, Deaths and Marriages Registration Act 1995, Public Health Act 1984, The Children Act 2005).
- It is good practice to inform the patient / client whenever possible, that you are planning to share the information. However, in situations when the law requires the information this is not a prerequisite for sharing it and the lack of consent should not be a reason for not sharing information if this is deemed to be necessary.
- It is essential to confirm that the information has reached the person it was intended for.

Sharing information with members of the multi / inter - professional team is advocated in the spirit of true working together / collaborative working. It is not acceptable in law or in terms of the NMC to fail to share information without a valid rationale and justification for doing so. All decisions and judgements about this must be documented within the record.

Q. What colour ink should I use to write in the client record?

A. The law states that health / nursing records must be completed using indelible ink not pencil and a colour that can be photocopied. There is currently no stipulation in terms of the law or the NMC for the colour ink to use. However the employing organisation will usually stipulate the colour to use in the record keeping and documentation policies as part of the information governance structures. It is usually black ink.

Q. I am so busy at work that I often take records home with me to write them up. Is this acceptable?

A. As a general rule it is not considered to be good or safe practice to take records out of the work place because this reduces the potential to keep the information within them safe and secure. It is certainly not acceptable for a practitioner to take the records home in order to write them up. If you are finding that this is necessary then you must discuss your workload issues with your line manager immediately and devise an action plan to resolve the issues. Information about the specific circumstances in which it is considered acceptable to take records out of the work base will be documented within the information governance strategy and the record keeping and documentation policy for the employing authority / organisation.

Q. What date was the latest guidance about record keeping published by the NMC?

A. The most up to date publication for record keeping from the NMC was produced in 2005 and can be accessed via the NMC website, www.nmc-uk.org

Q. What do I do if a patient /client asks to see their records?

A. The best course of action to take when writing in a client's record is to discuss what you are writing at the time, in line with the principles of openness and transparency. In situations where this is not possible or has not been done then clients must be advised that they can apply in writing to the health care organisation to see their records. There is usually an administrative cost involved which must be met by the client. The process for applying to see the record is outlined within the health care organisation's information governance strategy. It is good practice to give the client written information about this process.

Q. What do I do if management insists that I counter-sign entries in records for junior/non-qualified staff, even if I am not directly observing or supervising the care they give to the client?

A. This is a difficult situation and one that more and more practitioners are experiencing with the move towards skill mix and team working practices. The process of counter-signing by a senior / qualified practitioner is usually

promoted as a way in which to prove that the care was given by a junior level practitioner in line with the care plan and to the required standard. The practice of counter-signing for another practitioner who delivered the care in your absence is incorrect and, more importantly, is unsafe practice.

When responding to this instruction it is important to ensure that the principles of record keeping and accountability remain i.e.

- The person delivering the care must record the information
- You are answerable for you actions / omissions (accountability)

It is good practice to respond to the manager in writing outlining the reasons why you will not be abiding by the instruction. It is also good practice to outline what measures you have put in place to promote client safety when care is to be delegated to other members of the team e.g. provision of clearly written care plans, provision of clearly written instructions to the practitioner, a process for ensuring a practitioner's competence to deliver care, for giving and receiving feedback, for reviewing the progress of the treatment and the care plan and a process for up dating the care / treatment plan.

Q. How do I present information in the records?

A. All information that is written in the record must be based on the facts of the situation e.g. what actually happened, what you actually saw. It is important to distinguish between fact *and* opinion when including information in the record e.g. you thought the person may have been upset (is your opinion of the situation), but you saw the person crying (the factual information). There may be times when you need to include your opinion / appraisal of the situation based on the facts of the situation e.g. Ms Smith did not attend the child health clinic as arranged to review the baby's weight gain (fact). This may be because she forgot about the appointment, or it could be because she does not want to engage with the health visitor service (opinion / appraisal of the situation).

Q. I am currently dealing with an issue that has arisen about a client that I cared for 20 years ago when I was a member of a different union. Who will provide indemnity cover for me my current union or the one I was with at the time?

A. The indemnity cover is provided by the organisation providing cover at the time of the incident. In this situation you would need to contact the union that you were a member of at the time of the event.

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