Record Keeping Policy

Your World

Record Keeping Policy

Record keeping for healthcare workers

Record keeping is an integral part of clinical care. It is a significant tool of professional practice and one that supports the delivery of care in an integrated way. The quality of record keeping is a reflection of the standard of professional practice, whether the records are based on paper or by an electronic method of recording. A good standard of record keeping is the mark of skilled and safe practitioners.

Failure to record information accurately in health records can have serious consequences for patients and their relatives. These failures may result in reduced quality of care and litigation, for poor record keeping is a major factor in litigation cases brought against healthcare organisations. This in turn hinders the defence of defensible cases.

Good record keeping helps to protect the welfare of patients and clients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multiprofessional health care team
- An accurate account of treatment and care planning and delivery
- The ability to detect problems, such as changes in the patient's or client's condition, at an early stage

Good record keeping enables professionals:

- To meet legal requirements
- To protect workers in legal situations
- To meet professional statutory requirements
- To support clinical audit

All registered and unregistered healthcare workers have a legal duty of care to keep accurate records of patient care and are responsible for any records used or created. This responsibility is established and defined by the law. Registered professionals may find more directive standards on their registration body website but in general workers are expected to adhere to the following:

- Be factual and consecutive, in chronological order
- Not include any abbreviations (except those recognised by the local trust), jargon, meaningless phrases, irrelevant speculation and offensive, subjective statements
- Identify problems that have arisen, and the action taken to rectify them
- Provide clear evidence of the care planned, the decisions made, the care delivered, and the information shared
- Be accurately dated, timed and signed, with the writer's name printed alongside the first entry on the page, together with professional status
- Further entries on that page will not require a printed name (this is to ensure the writer can be identified, which may not be possible from the signature). The use of a signature sheet is permissible
- The entry must be timed using the 24-hour clock to prevent any confusion regarding the timing of the entry, except in outpatient records
- The entry must include the time and date (using the 24-hour clock), of the intervention or event
- Be recorded clearly and in such a manner that the text cannot be erased, and no space is left between the entries. Under no circumstances must a blank space be left in notes so that entries can be made at a later date. Any gaps made in error should be scored through with a single line across the space
- Where records are manual, entries must be written in permanent black ink/biro in order that they are readable on any photocopies or faxes, except in relation to the recording of patient alerts (use of red ink)

Your World Recruitment Group | Floor 4, 69 Wilson Street, London, EC2A 2BB | Tel: 020 7220 0811 | www.yourworldrecruitmentgroup.com | info@yourworld.com | Company No. 8275588

- Be recorded in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly with an explanation for their late inclusion
- Be recorded in such a manner that deletions are made by crossing the entry through with a single line, and are signed, dated and timed. Corrective/erasing products such as Tippex must not be used
- Have entries made in the clinical records at every contact - either direct or indirect
- Not contain judgements of a personal nature

It is worth bearing in mind that at times, as a result of complaint or litigation, your record keeping may be scrutinised. As such, it is critical to have fully accounted for your care in writing.

Further information

https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/protecting-children-and-young-people/keeping-records

https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/

The Code (nmc.org.uk)

Record keeping: The facts | Publications | Royal College of Nursing (rcn.org.uk)

Your World Recruitment Group | Floor 4, 69 Wilson Street, London, EC2A 2BB | Tel: 020 7220 0811 | www.yourworldrecruitmentgroup.com | info@yourworld.com | Company No. 8275588