University Hospitals Birmingham NHS Foundation Trust

Nursing Standards for Record Keeping

CONTROLLED DOCUMENT

CATEGORY:	Procedural Document
CLASSIFICATION:	Clinical
PURPOSE	To provide clear standards and expectations for completion of Trust nursing documentation.
Controlled Document Number:	1018
Version Number:	1.2
Controlled Document Sponsor:	Executive Chief Nurse
Controlled Document Lead:	Lead Nurse Standards
Approved By:	Executive Chief Nurse
On:	February 2017
Review Date:	January 2020
Distribution: • **Essential Reading for:**	All registered nurses, nursing assistants And nursing students.

Contents

1. Introduction

The process for documenting nursing assessment, care planning and evaluation of care, for admitted patients, is illustrated in Appendix A.

2. Assessment

2.1 All patients must, at the point of admission, on transfer, and at least once in each 12 hour period (or more frequently as required by the patients clinical condition) have baseline observations taken and recorded, including:

- Temperature
- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturations
- Urinalysis (on admission)
- Blood glucose (where clinically appropriate)
- Pain score

2.2 It is the responsibility of the admitting registered nurse to:

2.2.1 Ensure completion of the following Prescribing and Information Communication System (PICS) risk assessments within 6 hours of admission (inpatients):

- Waterlow score
- Patient Handling
- Malnutrition Universal Screening Tool (MUST)
- Falls screening

2.2.2 Ensure completion of the following mandatory paper assessments on admission:

- Patient Details and Initial Assessment

2.3 All admitted patients must have appropriate risk assessments completed and recorded on admission dependant on their individual needs (eg. Dysphagia; Mental capacity; Oral hygiene; Alcohol withdrawal; Barthel; Enhanced care etc).

2.4 All risk assessments must be reviewed and recorded as a minimum every 7 days, on transfer and if the patient's condition changes.

3. Care Planning

3.1 Planned interventions for admitted patients must be documented on the "Care Plan" within the "Patient Details and Initial Assessment".

Planned care is also identified within the “Patient Daily Care Record”. These documents should ideally be stored in the end of bed folders.

3.2 The following prompts are available for reference:

- Pressure ulcer prevention
- Falls prevention
- Post fall
- Meticillin-resistant staphylococcus aureus (MRSA)
- Clostridium difficile
- Continence product chart
- Equipment selection flow chart for pressure ulcer prevention and management

4. Evaluation of Care

4.1 The “Patient Daily Care Record” and associated “Patient Care Evaluation” must be updated by the registered nurse with responsibility for the patient at least twice in each 24 hours period (ie usually once per shift or more frequent if the patients’ condition requires this) and must include reference to all the fundamental nursing care provided or omitted (with reason/rationale if omitted) for the patient during that shift. The record is required to include an update on progress against care needs identified by initial and subsequent nursing assessments.

4.2 Each “Patient Daily Care Record” will last a week. Continuation sheets are available for the “Patient Care Evaluation” section. When completing the “Patient Daily Care Record” the registered nurse must tick the appropriate box for each of the numbered Activities of Daily Living (ADL).

- If the box is Green no additional documentation is required.
- If the box is Orange the registered nurse must use clinical judgement to decide whether further documentation is required in the “Patient Care Evaluation”
- If the box is Red the registered nurse must document the care provided in the “Patient Care Evaluation”.
- If the registered nurse ticks green for all ADL’s they must still document that they have completed the assessments and time date, sign, print their name and add designation i.e. There must be a clear name and signature of a registered nurse for each entry and all ticks.

4.3 Nursing Assistants and Nursing Students may record care they have provided within the “Patient Care Evaluation” but completion of the “Patient Daily Care Record” is the responsibility of the Registered Nurse.

4.4 Key events/ communication with patient must be documented in the medical notes.

4.5 Care Records must be completed for lines, equipment and devices e.g. urinary catheters and central venous access devices.

4.6 Where the nursing and/or multi-disciplinary team assessment of a patient identifies a need for close monitoring, appropriate records must be commenced (e.g. Fluid Balance Chart). These must be reviewed on shift/daily basis and changes in frequency made and recorded depending on the patients' clinical condition. When monitoring is no longer required, this must be documented and the discontinued/completed charts filed into the patient's medical records.

4.7 All assessments and referrals made to plan the discharge of a patient must be documented in the medical notes. All patients must also have a PICS Nursing Discharge Summary fully completed.

4.8 Evidence of interventional rounding review of patients and their bed spaces is incorporated into the "Patient Daily Care Record". These boxes must be ticked at least twice in every 24 hour period.

5. Documentation Standards

5.1 All entries must be clear, legible and where written on paper (as opposed to electronic), written in indelible black ink.

5.2 All entries must use clear and unambiguous language, and only Trust approved abbreviations should be used.

5.3 All entries must be signed (initialling is not acceptable other than for alterations).

5.4 All entries must have a designation, surname and initial printed next to them.

5.5 All entries must be fully dated (day; month; year) and timed using the 24 hour clock.

5.6 All documentation must have the patient's name and unit number on both sides of each sheet.

5.7 All corrections and changes must be crossed out with a single line, dated, timed and initialled.

5.8 All entries in the record must be factual and accurate (avoiding subjective remarks).

5.9 All information must be written and filed using a clear and logical format.

5.10 All entries must be up to date with no unexplained gaps.

5.11 All entries will be written as soon as possible after the event. All staff must complete relevant documentation before the end of their shift.

5.12 All referrals, significant events, changes in condition, treatment, or care must be documented.

5.13 All entries written by nursing students must be countersigned by a registered nurse.

5.14 All entries written by nursing assistants require supervision and a countersignature until the nursing assistant is deemed competent at the activity and keeping records. The principles of accountability and delegation apply.

5.15 All staff members should take immediate action to challenge if they see relatives, carers or visitors reading patient documentation that has been stored in the end of bed folder.

5.16 A patient can 'opt out' of having their nursing documentation being held in their end of bed folder. In this case, their documentation should be stored in the medical notes. This must be clearly communicated during each nursing handover.

6. Bibliography

Nursing and Midwifery Council (2015) **The Code. Professional standards of practice and behaviour for nurses and midwives.**
https://www.nmc.org.uk/standards/code/
[Accessed 10.01.17]

7. Associated Policy and Procedural Documentation

Monitoring of Health Records Standards
http://uhbpolicies/assets/HealthRecordsMonitoringProcedure.pdf
[Accessed 13.03.17]

Appendix A: Nursing Documentation Process for Admitted Patients

Mandatory assessments

- Patient Details and Patient Initial Assessment (on paper)
- MUST/ Waterlow/ Falls/ Patient Handling Assessment Form (PHAF) (on PICS)

Complete additional assessments if required:

- Dysphagia
- Mental capacity
- Oral hygiene
- Alcohol withdrawal
- Opiate withdrawal
- Barthel
- Enhanced care risk assessment
- All about Me

Mandatory minimum care planning

Identify key interventions as applicable on the "Care Plan" within the "Patient Initial Assessment" document.

Planned care is also identified within the "Patient Daily Care Record". (on paper and stored in end of bed folder)

Prompts available:

- Pressure ulcer prevention
- Falls prevention
- Post fall
- MRSA
- Clostridium difficile
- Continence product chart
- Equipment flow chart

Mandatory minimum planning and evaluation of care

- The **Patient Daily Care Record** must be completed as a minimum, twice in every 24 hour period (after every shift worked) detailing all fundamental nursing care.
- Details of care must be recorded in the **Patient Care Evaluation**.
  Note: Continuation sheets are available for the Patient Care Evaluation.
- Document key events/ communication with patient etc in the **medical notes**.

Additional planning and evaluation of care if required:

- If the patient has a wound, the **Wound Care Plan** must be completed.
- If the patient has and device/ line equipment in place the appropriate **Care Record** must be completed. (E.g. Peripheral Venous Catheter, Central venous Access Device, urinary catheter, tracheostomy, plaster cast.
- Evidence of care may need to be documented on **Charts** (e.g. Fluid Balance; hydration; food diary; Antecedent, Behaviour, Consequence; Enhanced care handover).

(Note: other specialty charts e.g. Parkinson's on /off)

- Theatre documentation and procedural pathways must be completed where necessary.

Each ward is required to perform "comfort rounds". This means all patients will be intentionally checked as a minimum, mid-morning, before every meal, mid-afternoon and before bed. Elements of this check are incorporated into the Patient Daily Care Record for at least twice daily recording.

The following must be considered:

Positioning	**Personal needs**	**Pain**	**Placement**
Making sure the patient is comfortable and assessing the risk of pressure ulcers	Scheduling patient trips to the bathroom to mitigate against falls	Asking patients to describe their pain level	Making sure that the items a patient needs are within easy reach