

## DOCUMENTATION GUIDELINES FOR NURSING STAFF


<b>Version Number</b>	1
<b>Date of Issue</b>	March 2015
<b>Reference Number</b>	DGNS-02-2015-FONCG-V1
<b>Review Interval</b>	3 yearly
<b>Approved By</b> Name: Title:	Signature: <i>Fionnuala O'Neill</i> Date: February 2015
<b>Authorised By</b> Name: Title:	Signature: <i>Rachel Kenna</i> Date: February 2015 <small>Rachel Kenna Director of Nursing</small>
<b>Author/s</b>	Name: Fionnuala O' Neill (NPDC) Carmel Gallagher (CPC)
<b>Location of Copies</b>	On Hospital Intranet and locally in department

### Document Review History


<b>Review Date</b>	<b>Reviewed By</b>	<b>Signature</b>
2018		

### Document Change History

<b>Change to Document</b>	<b>Reason for Change</b>

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 2 of 8	

	<b>Contents</b>	<b>Page No</b>
<b>1.0</b>	Introduction	<b>3</b>
<b>2.0</b>	Definition of Guidelines	<b>5</b>
<b>3.0</b>	Applicable to	<b>5</b>
<b>4.0</b>	General requirements for all entries in the healthcare record	<b>5</b>
<b>4.1</b>	Correct patient identification	<b>5</b>
<b>4.2</b>	Legibility and Language	<b>5</b>
<b>4.3</b>	Documenting date and time	<b>6</b>
<b>4.4</b>	Deletions or alterations to patient documentation	<b>6</b>
<b>4.5</b>	Abbreviations	<b>6</b>
<b>5.0</b>	Implementation Plan	<b>7</b>
<b>6.0</b>	Evaluation	<b>7</b>
<b>7.0</b>	References	<b>7</b>


Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 3 of 8	

## 1.0 Introduction

Nurses are required to “establish and maintain accurate, clear and current client records within a legal and ethical framework” (An Bord Altranais (ABA) 2005 p14). Nursing documentation is essential to validate and justify patient care and delivery (Follin 2004). Good record keeping is fundamental to professional nursing practice and documentation quality reflects the quality of nursing care (ABA 2002, NMBI 2014). Patient care and care documentation are considered to be two sides of a coin, “You can’t have one without the other”. Inadequate documentation may lead to inadequate patient care through: duplication or omissions of care, communication issues between staff, failure to record important observations and conclusions and delays in detecting changes in a patient’s condition (Ombudsman 2012a).

Accountability is an integral component of professional nursing practice, with the nurse being accountable professionally and legally for their practice (ABA 2002). With regard to nursing students, their documentation must be overseen by the registered nurse charged with the responsibility to supervise the student (ABA 2002). Undergraduate nursing student’s documentation in patient records should be reviewed and clearly signed. **Nursing documentation may include manual, audio visual and electronic information** which is guided by the law, national and hospital policy and procedure of which nurses have a duty to be familiar with (ABA 2002). Confidentiality with all patient documentation is imperative and electronic records need specific consideration (Data Protection Act 1988, Electronic Commerce Act 2000, NMBI 2014, HSE 2011). Nurses must be aware of local and national child protection policy and guidelines which require the sharing of sensitive records and information (ABA 2002). The Freedom of Information Act (1997, 2003 (amended) & 2014) and Data Protection Act (1988 & 2003) entitle patients to access their medical records and the nurse must be aware of procedure in relation to same. **Falsification of documentation is not permitted.**

Nursing documentation must comply with the ‘Recording Clinical Practice Guidance to nurses and Midwives’ (ABA 2010), ‘*Health Services Executive Standards Code of Practice for Health Care Records Management: Abbreviations* (HSE 2010), *Health Services Executive Standards and Recommended Practices for Healthcare Records Management* (HSE 2011) and OLCHC policies and Guidelines including: ‘*Guideline for use of Nursing Care Plans and Evaluation Sheets*’ (NPDU 2012).

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 4 of 8	

**Purpose of documenting patient care:** Nurses are obliged legally and professional to maintain accurate clinical patient records for the following reasons:


- To provide an accurate medical 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 2011Pg 73).
- 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.

(ABA 2002, HSE 2011, NMBI 2014).

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

- Vital evidence in the event of a patient query or complaint.
- Clinical audit in order to enhance the quality of patient care and documentation.
- All patient records including nursing documentation are legal documents.
- Multidisciplinary continuity of care.
- Nursing decision making.
- Nurse Enquiry- Fitness to practice/Legal enquiry.
- Teaching purposes for nursing students in training.
- Reflecting on and evaluating nursing practice.
- Research purposes-subject to ethical review.

(ABA 2002, Ombudsman 2012a, Ombudsman 2012b, HSE 2011)

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 5 of 8	

## 2.0 Definition of Guidelines

**Guidelines** represent the written instructions about how to ensure high quality services are delivered. Guidelines must be accurate, up to date, evidence-based, easy to understand, non-ambiguous and emphasise safety. When followed they should lead to the required standards of performance.

## 3.0 Applicable to

All staff

## 4.0 General requirements for all entries in the healthcare record – HSE 2011


### 4.1 Correct patient identification

- Identify that the documentation belongs to the correct patient – cross check patient identity band.
- Include the patient's name and hospital identification number/ identity label on each page on which patient care is documented and on each computer screen on which patient care is documented include the patients name and hospital identification number.

### 4.2 Legibility and Language

- Use black permanent pen in all written documentation. In OLCHC multicolour pens are permitted to document in the patient observation sheets/fluid balance sheets as agreed by the Healthcare Records Steering group.
- 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)**
- 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: OLCHC drug kardex.
- Nurses documenting in patient's healthcare records must have their signature recorded in a hospital signature bank.
- Leave no blank spaces or blank pages between entries.

*HSE Code of practice for Healthcare Records Management (2012)*

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 6 of 8	

#### 4.3 Documenting date and time

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

#### 4.4 Deletions or alterations to patient documentation


- Incorrect records should be amended but never destroyed
- Place a single line through errors, date, sign (included 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 Services Executive Standards 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 be abbreviated to 'l' or 'R' the exception is where 'l' or 'R' is contained within an abbreviation e.g. 'RIF' - right iliac fossa.
- Only when the following abbreviations are included in an official grading system can they be used: '++', '<' and '>'

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 7 of 8	

## 5.0 Implementation Plan


Include communication of the clinical guidelines, implementation strategy that manages any barriers, training

## 6.0 Evaluation and Audit

Monitoring of compliance is an important aspect of procedural documents. However, it is not possible to monitor all procedures.

## 7.0 References

- An Bord Altranais (2002) *Recording Clinical Practice Guidance to Nurses and Midwives*. ABA, Dublin. ✓
- An Bord Altranais (2005) *Requirements and standards for Nurse Registration Education Programmes*. ABA, Dublin. ✓
- Data Protection Commissioner (2008) *Data Protection Acts 1988 & 2003 - Informal Consolidation*. (Web accessed May 2009)  
<http://www.dataprotection.ie/viewdoc.asp?DocID=796&ad=1>
- Freedom of Information (FOI) Central Policy Unit (2005) *FOI - General issues*. (Web accessed May 2009)  
<http://www.dataprotection.ie/ViewDoc.asp?fn=%2Fdocuments%2Fguidance%2Fdefault%2Ehtm&CatID=6&m=m>
- FOI Central Policy Unit (no date) *Short Guide to the Freedom of Information Act 1997 & Freedom of Information (Amendment) Act 2003* (Web accessed May 2009).  
<http://www.foi.gov.ie/short-guide-to-the-foi-acts> This seems to be inaccessible – try again
- Follin S.A. (2004) *Nurse's Legal Handbook 5<sup>th</sup> ed*. Lippincott Williams & Wilkins: London.
- Government of Ireland. *Freedom of Information Act 1997*. The stationery office: Dublin ✓
- Government of Ireland. *Freedom of Information (amendment) Act 2003*. The stationery office: Dublin ✓
- Government of Ireland. *Data Protection Act 1988*. The stationery office: Dublin ✓
- Government of Ireland. *Electronic Commerce Act 2000*. The stationery office: Dublin ✓
- HSE: National Healthcare Records Management Advisory Group (2011) *Health Services Executive Standards and Recommended Practices for Healthcare Records Management*. HSE: Tipperary Check if blue piece correct.
- Health Services Executive: *Health Services Executive Standards Code of Practice for Health Care Records Management: Abbreviations*. 2010.
- Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*. NMBI: Ireland
- National Hospitals Office (2007b) *National Hospitals Office: Abbreviations*. NHO: Tipperary.

Our Lady's Children's Hospital, Crumlin		
Document Name: Documentation Guidelines for Nursing Staff		
Reference Number: DGNS-03-2015-FONCG-V1	Version Number: 1	
Date of Issue: March 2015	Page 8 of 8	

- Ombudsman (2006) *Complaints against the Public Health Service: A Report by the Ombudsman to the Health Service Executive*.  
<http://www.ombudsman.gov.ie/en/Publications/InvestigationReports/ComplaintsagainstthePublicHealthService> (Accessed Feb 2009) Net
- Ombudsman (2008) *Annual Report of the Ombudsman 2007*.  
<http://www.ombudsman.gov.ie/en/Publications/AnnualReports> (Accessed Feb 2009) Net
- Ombudsman (2012a) A Report by the Ombudsman to the Health Service Executive. June 2012. New correct reference
- Ombudsman (2012b) Office of the Ombudsman Annual Report 2012. Office of the Ombudsman: Dublin. New correct reference

©2015, Our Lady's Children's Hospital Crumlin, Dublin 12. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the copyright holder. Every effort has been made to ensure that the information provided is accurate and in accord with standards accepted at the time of printing.