Record Keeping for Nurses and Midwives Policy

Policy Number: 289

Standards For Healthcare Services No/s: 1 & 20

**Version No:**

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<th>Date Of Review</th>
<th>Reviewer Name</th>
<th>Completed Action</th>
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<td>1.0</td>
<td>01/05/12</td>
<td>Helen Humphreys</td>
<td>CPRG</td>
<td>29/05/12</td>
<td>May 2015</td>
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<td></td>
<td>Extension whilst review takes place</td>
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<td>BPPAC</td>
<td>30.6.2015</td>
<td>30.11.15</td>
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<td>2.0</td>
<td>November 2015</td>
<td>Chris Hayes</td>
<td>Policy reviewed – amendments to 6.4.6.7 6.9.1</td>
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**Brief Summary of Document:**

This policy provides the clear professional and organisational standards for record keeping for all nurses and midwives within Hywel Dda University Health Board.

**To be read in conjunction with:**

- 191 - Health Records Management Strategy
- 192 - Health Records Management Policy
- 195 - Clinical Record Keeping Policy
- 249 - Access To Health Records Policy
- 244 - Being Open Guidance
- 225 - Data Protection Policy
- 224 - Information Classification Policy
- 183 - Information Security Policy
- 238 - 238 - Information Governance Framework - V4
- 172 – 172 - Confidentiality Policy
- 173 - Freedom Of Information Policy
- 193 - Retention and Destruction of Records Policy (Including Health Records)
- 156 - Risk Management Strategy & Policy
- 008 - Consent To Hospital Post Mortem Examination Policy
- EAGLE – Organizational Development Strategy & Governance Framework
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**Record keeping for nurses and midwives policy**
### Record keeping for nurses and midwives policy

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#### Scope

<table>
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<th>ORGANISATION WIDE</th>
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<td>Head of Nursing Acute Services; Head of Maternity Services; Directorate Nurse Unscheduled Care; Head of Child Health</td>
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<td>Deputy Director of Primary Care, Community, Mental Health &amp; Long Term Care; Head of Nursing Mental Health &amp; Learning Disabilities Services Heads of Community Nursing Services – Pembrokeshire Ceredigion and Carmarthenshire</td>
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<td>Associate Director of nursing Infection Prevention &amp; Control; Senior Nurses Ward sisters Consultant Haematologist</td>
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#### Date Equality Impact Assessment Undertaken

| Group completing Equality impact assessment | In progress |

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Record keeping, documentation
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</tbody>
</table>
HYWEL DDA UNIVERSITY HEALTH BOARD

CONTENTS

1. INTRODUCTION .......................................................................................................................... 7
2. POLICY STATEMENT .................................................................................................................. 7
3. SCOPE ......................................................................................................................................... 7
4. AIMS ............................................................................................................................................ 7
5. OBJECTIVES ............................................................................................................................... 7
6. RECORD KEEPING ..................................................................................................................... 8
   6.1. THE IMPORTANCE OF RECORDS ......................................................................................... 8
   6.2. KEY FEATURES OF HEALTH RECORDS ............................................................................ 8
   6.3. PRINCIPLES OF GOOD RECORD KEEPING ......................................................................... 8
   6.4. CONSEQUENCES OF POOR RECORD KEEPING: ................................................................. 10
   6.5. LEGISLATION AND PROFESSIONAL OBLIGATIONS ......................................................... 10
   6.6. MIDWIVES’ STATUTORY RESPONSIBILITIES ..................................................................... 11
   6.7. CONFIDENTIALITY ............................................................................................................... 12
   6.8. ABBREVIATIONS AND OTHER SHORT FORMS I.E ACRONYMS, INITIALISATIONS AND ANY OTHER FORM OF TEXT REDUCTION. ......................................................... 12
   6.9. NURSING CARE RECORD .................................................................................................... 13
       6.9.1. ASSESSMENT ............................................................................................................... 14
       6.9.2. PLANNING .................................................................................................................. 14
       6.9.3. INTERVENTION ........................................................................................................... 15
       6.9.4. EVALUATION & OUTCOME ....................................................................................... 15
   6.10. MATERNITY RECORD .......................................................................................................... 15
       6.10.1. THE MATERNITY EPISODE OF CARE ..................................................................... 15
       □ RECORDS MUST BE COMPLETED IN INK ....................................................................... 15
       6.10.2. ANTENATAL .............................................................................................................. 16
       6.10.3. LABOUR AND DELIVERY ......................................................................................... 16
       6.10.4. POSTNATAL ............................................................................................................... 16
7. PROFESSIONAL ISSUES ............................................................................................................. 17
   7.1. DELEGATION ......................................................................................................................... 17
       7.1.1. HEALTH CARE SUPPORT WORKERS ....................................................................... 17
   7.2. COUNTERSIGNATURE .......................................................................................................... 18
   7.3. ELECTRONIC RECORDS ...................................................................................................... 18
8. ACCESS AND OWNERSHIP ......................................................................................................... 18
   8.1. RETENTION .......................................................................................................................... 19
9. STORAGE OF RECORDS ........................................................................................................... 19
10. MANAGING & FILING ............................................................................................................. 19
11. PATIENT/CLIENT INVOLVEMENT ............................................................................................ 20
12. PATIENT HELD RECORDS
13. MONITORING AND AUDIT
14. NURSING DOCUMENTATION STEERING GROUP
15. DEVELOPMENT OF NEW NURSING DOCUMENTATION
16. RESPONSIBILITIES

16.1. CHIEF EXECUTIVE
16.2. NURSING DIRECTOR
16.3. REGISTERED NURSES
16.4. WARD MANAGER/TEAM LEADER
16.5. COUNTY MANAGEMENT TEAM/DIRECTORATES
16.6. NURSING DOCUMENTATION STEERING GROUP

17. TRAINING
18. IMPLEMENTATION
19. REFERENCES
20. REVIEW

21. GLOSSARY OF TERMS

22. APPENDIX 1 - LIST OF AGREED ABBREVIATIONS
23. APPENDIX 2 - DEPARTMENT OF OBSTetrics AGREED ABBREVIATIONS
24. APPENDIX 3 - PROPOSAL FORM FOR THE DEVELOPMENT OF NEW NURSING DOCUMENTATION
25. APPENDIX 4 - DEVELOPMENT OF NEW NURSING DOCUMENTATION FLOWCHART
1. INTRODUCTION
Hywel Dda University Health Board recognises the importance of good quality record keeping and the purpose of this policy is to provide clear professional and organisational standards for record keeping for all nurses and midwives within Hywel Dda University Health Board. For the purpose of this policy, nurses and midwives will be referred to as ‘nurses’.

2. POLICY STATEMENT
A high standard of record keeping is fundamental to the delivery of safe and professional care. The provision of a record keeping policy provides the framework to guide professional practice. The important activity of making and keeping records is an essential and integral part of our activity and should not be seen as a distraction. ‘Poor records mean a poor defence and no records means no defence.’ (Tingle, 1998).

This policy has been prepared in accordance with the Nursing & Midwifery Council’s Code (2015) and sections of the Code have been incorporated into this policy.

3. SCOPE
The Data Protection Act (1998) makes the following statement: “A health record for the purpose of the Act is one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the case of that individual. Thus with the exception of the anonymised information, most if not all NHS information concerning patients whether held electronically or on paper will fall within the scope of the act.”

A health record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care, including:

- Personal health records (electronic, microfilm, scanned images and paper based)
- Radiology and imaging reports, photographs and other images
- Audio and video tapes, cassettes, CDROM etc
- Computer databases, output and disks and all other electronic records
- Material intended for short term or transitory use including notes and ‘spare copies of documents
- Digital records
- Health Records Management Policy 2015

This policy refers to all nursing records. A record is anything that contains information, which has been created or gathered as a result of any aspect of the work of NHS employees.

Nursing staff employed by the Health Board are required to ensure confidentiality, integrity, accuracy and appropriate availability of health records whether held manually or electronically.

4. AIMS
To ensure that all registered nurses adhere to the standards laid down in this Health Board Policy.

5. OBJECTIVES
To ensure accurate record keeping in compliance with the NMC and legal duty of care requirements.
6. RECORD KEEPING

6.1. The Importance of Records

Effective record keeping is a means of:
- Communicating with others and describing what has been observed or done.
- Organising communication and the dissemination of information among the members of the team.
- Demonstrating the chronology of events, the factors observed and the response.
- Demonstrating properly considered decisions.

The purpose of records is to:
- Provide accurate, current, comprehensive and concise information.
- Provide a record of any problems that arise and the action taken in response to them.
- Provide evidence of requirements, actions taken and results.
- Include a record of any factors that appear to affect the outcome.
- Support standard setting, quality assessment and audit.
- Provide a baseline record against which improvement or deterioration may be judged.

6.2. Key features of Health Records

In addition to fulfilling the purposes, properly made and maintained records will:
- Be made in a timely manner.
- Identify factors which jeopardise standards or place the patient or client at risk.
- Provide evidence of the need, in specific cases, for practitioners with special knowledge and skills.
- Aid patient or client involvement in their own care.
- Provide evidence to answer possible complaints which may be made.
- Be written, wherever possible, in terms which the patient or client will be able to understand.

6.3. Principles of Good Record Keeping

Every Registered Nurse must keep clear and accurate records (NMC 2015) and this includes all records relevant to their scope of practice. Every Registered Nurse must:
- complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event;
- identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need;
- complete all records accurately and without any falsification, taking immediate and appropriate action if they become aware that someone has not kept to these requirements;
- attribute any entries they make in any paper or electronic records to themselves, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation;
- take all steps to make sure that all records are kept securely, and
- Collect, treat and store all data and research findings appropriately.

(NMC 2015)

In addition, the midwifery record must be able to demonstrate:
- An account of the assessment made regarding the woman and her family, and evidence of the planning for provision of subsequent care.
- Relevant information about the condition and progress of the woman and details of any measures or interventions undertaken in response to their needs.
Evidence that the professional has understood and honoured the duty of care to the woman and her family.

Evidence that no act or omission to act has compromised the woman’s safety in any way.

A record of any arrangements that have been made for the transfer and continuing care of the woman and her baby.

(NMC 2004)

In addition good record keeping standards states:

- All records must be made as soon as possible after the events to which they relate.
- They must be written legibly and indelibly, in black ink/biro, which is recommended for the purpose of clear photocopying, electronic scanning and microfilming.
- They should be accurate, clear and free from ambiguity.
- All entries will be written in full and must not contain any unusual abbreviation or symbols.
- Abbreviations will only be used when they can be understood by professional colleagues reading the clinical record and have the approval of the Heads of Professional/Care Services (See section 6.7 for additional information).
- Once an entry has been made it must not be removed from the document.
- Tippex or corrective fluid must NOT be used to erase any part of a health record.
- Any errors made should not be obliterated e.g. with correction fluid. Mistakes should be crossed through with a single line, the written statement ‘written in error’ should be made and the entry signed, dated and timed. Reasons for the error should always be noted e.g. wrong patients’ records.
- Every entry should clearly state the date and time. The twenty-four hour clock must always be used.
- All entries must be signed with full signature, not initials.
- Following the first signature in a set of records, the printed name and designation of the individual must be added. It is also best practice to include professional registration number. (Where a signature sheet forms part of the Documentation set, this sheet must always be completed when making an entry in the record for the first time - this entry will be deemed to be the ‘first signature’ in the set of records). Thereafter, each entry should be signed with the name of the person making the entry.
- It is quite appropriate for student nurses and support workers to sign records (following the principles outlined above). However; the nurse or professional who has delegated the task must countersign the entry (See section 7.1 for additional Information).
- Following an entry, the remainder of the line must be scored through to the end followed by a signature, date and time. Empty spaces must not be left between entries.
- Additions to existing entries must not be made. If additions are needed, they must be documented as a separate entry, signed, dated and timed.
- Demographic data i.e. name, address, next of kin etc must be documented immediately on admission or in the event of an emergency, as soon as possible.
- Written evidence supporting an initial assessment must be documented prior to the health care professional finishing their shift.
- Particular care must be exercised and frequent record entries made where patients have complex problems, show deviation from the norm, require more intensive care than normal, are confused and disorientated or in other ways give cause for concern.
- In situations where the condition of the patient is apparently unchanging, reassessment must occur within a maximum of seven days, the results of which must be recorded.
- Document facts, not opinions or subjective statements.
HYWEL DDA UNIVERSITY HEALTH BOARD

- Personal or offensive comments must not be made in the record as the patient has a right to view or receive copies of anything that is written about them or held on a computer system.
- When writing statements of a personal nature the clinician should always bear in mind that they would be held to account, to justify these judgments. This also applies to third party information.
- In situations where confidential information must be recorded but cannot, at that point, be viewed by patients or relatives, it should be documented on an evaluation sheet, dated, signed and lodged with the assessment sheet.
- Post It Pad messages must NOT be left in the health records, as once it is placed on the record it becomes a permanent part of the record.

6.4. **Consequences of poor Record Keeping:**
A number of common problems with record-keeping have been identified and these include:

- Absence of clarity e.g. the meaning of ‘had a good day’ and ‘slept well’ is not clear
- Failure to record action taken when a problem is identified
- Missing information, e.g. administration of a drug not documented
- Spelling mistakes, e.g. error in name resulting in wrong diagnosis
- Inaccurate records, e.g. changing a dressing or giving medication, when in fact the patient had not received the recorded treatment
- Failure to document conversations/telephone calls
- Failure to document care given
- Failures in communication between healthcare professionals

The consequences of poor record keeping include:

- Poor patient care
- Risk to patient safety
- Lack of continuity of care
- Mistakes
- Complaints
- Scrutiny of documentation

Health care professionals have a duty to keep up to date with, and adhere to, relevant legislation, case law and national and HB policies relating to information and record keeping.

Breaches of this policy could result in disciplinary procedures.

6.5. **Legislation and Professional Obligations**
All NHS Records are public records under the Public Records Act. The Health Board will take actions as necessary to comply with legal and professional obligations such as:

- The Data Protection Act 1998
- The Common Law Duty of Confidentiality and
- The Confidentiality Code of Practice
- Medical Reports Act 1988
- Caldicott: Principles into Practice
- Access to Health Records Act 1990
- And any new legislation affecting health records management as it arises
Freedom of Information Act (2000): The Lord Chancellor’s Code of Practice under section 46 of the FOI Act recognizes that everyone has the right to know how public services such as NHS Wales are organized and run, how much they cost and how you can make complaints if you need to. From January 1st 2005 Health Boards have to respond to requests about the information, which they hold and patients/clients have a right of access to that information. The rights to request and access this information are subject to some exemptions, which the Health Board has to take into consideration before deciding what information can be released.

Mental Health Act 1983 and Mental Health (Wales) Measure 2010: The Mental Health Act 1983 states there is a legal requirement to complete specific recordings on specific forms, with the Mental Health (Wales) Measure 2010 also requiring specific recordings on specific forms. These are a requirement for all Mental Health & Learning Disability staff.

In relation to electronic record keeping staff must be familiar and adhere to the Health Board Information Security Policy (183). Passwords must be kept confidential and never disclosed to others.

All patient related records/documents could be required as evidence in formal proceedings, for example internal incident / complaint investigations, disciplinary investigations and / or adult / child protection investigations and serious case reviews, coroner’s inquest. An outcome of these proceedings may result in proceedings in a court of law, professional conduct committee and other similar regulatory bodies. This must be considered when undertaking any documentation. Internal and external proceedings, including courts of law are likely to consider the approach to record keeping that ‘if it is not recorded, it has not been done’. Professional judgment should be used to decide the depth of detail that should be documented within the record, although every action should be recorded.

6.6. Midwives’ Statutory Responsibilities
Records: Rule 6, Midwives Rules and Standards 2012

1. A must midwife must as soon as reasonably practicable ensure that all records relating to the care or advice given to a woman or care given to a baby are, following their discharge from that care
   a) Transferred to the midwife’s employer for safe storage; or
   b) Stored safely by the midwife herself if she is self employed: but if the midwife is unable to do this, transferred to the local supervising authority in respect of her main geographical areas of practice for safe storage

2. Where a midwife ceases to be registered with the NMC she must as soon as reasonably practicable, ensure that all records relating to the care or advice given to a woman or care of a baby are transferred for safe storage as above.

A local supervising authority must publish local guidelines for the transfer of midwifery records from self employed midwives.

All records relating to the care of the woman or baby must be kept securely for 25 years. This includes work diaries if they contain clinical information.

Self employed midwives should ensure women are able to access their records and should inform them of the location of the records if these are transferred to the local supervising authority.
6.7.  Confidentiality
Information contained in patient/client’s records should be held in complete confidence and viewed only by those directly involved in the care of the patient/client.

It is strictly forbidden for employees to knowingly browse, search for or look at any information relating to themselves, their own family, friends or other persons, without a legitimate Health Board purpose. Action of this kind will be viewed as a breach of confidentiality and of the Data Protection Act.

When dealing with person-identifiable or confidential information of any nature, staff must be aware of their personal responsibility, contractual obligations and undertake to abide by the policies and procedures of the HDUHB. If staff have concerns about this issue they should discuss it with their Line Manager or Information Governance Team.

HB Confidentiality Policy (2015)

The patient/client can give written consent for release of information to specified individuals.

When patient information is required for clinical audit it must be presented in anonymous form to protect confidentiality. Anonymous form means that any means of identifying the patient is removed.

Patient records may be shared under information governance arrangements if the patient is believed to be a risk to themselves or others or if the Health Board is subpoenaed to provide evidence in a court of law.

Every nurse or midwife owes a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately. Every nurse or midwife must:

- Respect a person’s right to privacy in all aspects of their care
- Make sure that people are informed about how and why information is used and shared by those who will be providing care
- Respect that a person’s right to privacy and confidentiality continues after they have died
- Share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and
- Share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand.

NMC 2015

6.8.  Abbreviations and other short forms i.e acronyms, initialisations and any other form of text reduction.
The NMC (2015) Code - professional standards of practice and behaviour for nurses and midwives advises that patient/client records should not include unnecessary abbreviations.
Abbreviations can be misinterpreted with significant risks to patient safety and quality of care. Some abbreviations are known to lead to an increase in errors. Despite the concerns, the use of abbreviations in patient/client records is common practice (RCN, 2012). On balance, the Health Board recognises that Nurses use abbreviations in practice and a list of commonly used nursing abbreviations is included as part of this policy (Appendix 1). This list will be reviewed as new guidance on the use of abbreviations is published. Appendix 2 lists the Department of obstetrics agreed abbreviations.

In order to ensure safe, effective care and communication, patient/client records must be up to date, factual, accurate, and written so that the meaning is clear to everyone who uses the record. The Registered Nurse is accountable for the accuracy and completeness of his or her record of patient care. Abbreviations that are well understood in a local setting could be open to misinterpretation by other groups/teams and therefore the Registered Nurse must ensure that when abbreviations are used that the meaning is clear to everyone who uses the record and if there is any concern regarding the meaning of the abbreviations then the words must be written in full.

6.9. **Nursing Care Record**

The nursing record includes all documentation relating to the nursing care of the patient/client. This includes records relating to:

- **Assessment** including specialist assessments such as Pressure Sore Prediction Score, nutrition, risk of falls and All Wales Manual Handling Assessment.
- **Provision and plan of care** including care plans, bundles, nursing contribution to integrated care pathways.
- **Intervention** including bundles, food/fluid charts, administration of medication.
- **Evaluation** including evaluation forms/sheets, bundles, wound assessment charts.
- **Outcome** – any document that records outcomes from the care provided, both patient and nursing outcomes e.g. evaluation forms/sheets, the patient record.

The provision of care, which includes assessment, planning, intervention, evaluation and outcome is an integral part of the nurse’s role, which aims to provide continuity of care for the patient and its main purpose is to promote the implementation of individualized patient care through identifying a clear problem and goals, which inform a plan of care that is continuously evaluated (Webb and Pontin 1997).

The principles discussed in this policy would apply to whatever type of record being used e.g. bundle, integrated care pathway, in whichever location e.g. acute care setting, community care.

The plan of care needs to:

- Meet the NMC’s guidelines on record keeping.
- Meet the HB policies on record keeping.
- Be patient focused and individualized.
- Use a holistic approach.
- Identify patient’s perceptions of his or her problems or needs.
- Identify patient’s experiences of planned care.
- Have an appropriate review period which reflects the nature of the care required by the patient - in the acute setting, the review period may be hours, next shift or next day whilst in the long-term or community setting, the review period will likely be longer.
- Be clear and concise.
- Written in a format that the patient can easily understand.
Be re-evaluated on a regular basis, with changes being made as needed. Unscheduled updates should also be made as condition warrants.

When a problem/care need has resolved, then the problem should be discontinued.

If the patient has had a major change in a problem area that result in changes in goals and approaches, it may be easiest to resolve the problem and enter an entirely new problem, goal(s) and approaches, rather than making many changes to the existing problem.

Have goals which are specific, measurable and attainable.

Be evidence based and referenced.

Include, where applicable, the Care & Treatment Plan as dictated to in the Mental Health (Wales) Measure (2010). This is a legal document which staff are legally required to complete when assessing and planning care for a patient in their care. When the Measure is in place Health Boards will be accountable for ensuring that these detailed Care and Treatment Plans are complete and they have specific fields that require completion.

6.9.1. Assessment
The first step in care planning is accurate and comprehensive assessment. This applies to patients in any care setting. A thorough nursing assessment should be undertaken on first contact with the patient or as soon as reasonably possible* and this should be followed by regular reassessments, the frequency determined by the patient's status. (*It is acknowledged that there are occasions when a full assessment cannot be undertaken on first contact with the patient and on these occasions the nurse needs to prioritise the assessments that are undertaken and clearly document what assessments have been completed and which assessments need to be undertaken at a later date and the rationale for the decisions made also needs to be documented).

The nursing assessment should:

- Provide a comprehensive and holistic nursing assessment of the patient’s needs.
- Be person centered and reflect the patient’s needs and views and not be based on the care setting the patient is being cared in.
- Provide greater objectivity and reliability of patient assessment.
- Should reflect the fundamental aspects of care identified in the Health & Care Standards (2015) document.
- Accurately capture nursing needs and type of intervention required.
- Meet the standards required for legal considerations such as Care and Treatment Planning as part of the Mental Health (Wales) Measure 2010.
- Include, where applicable the minimum core data set requirements identified in the Integrated Assessment, Planning and Review Arrangements for Older People (2013) to ensure that individuals can rely on having assessments undertaken in a consistent way and to provide uniformity and coherence across documents.

Although assessment is considered to be the starting point of nursing intervention, the assessment phase is ongoing throughout the patient period of care.

6.9.2. Planning
Once the initial assessment is completed, a problems list should be generated and a plan of care agreed with the patient. Problems should be documented in an unambiguous way, in language that the patient understands and should be patient focused.

Problems fall into three categories:
1. Patient problems that can be resolved or will show signs of improvement - the goals will reflect that this can be achieved within the review period.

2. Patient problems that are not going to get better, but generally intervention can prevent or minimize complications or decline.

3. Patient problems, that are not likely to improve, and deterioration is inevitable - the goals should be focused on what care can be provided to optimise quality of life, comfort and dignity for this person. These patients’ problems are going to cause deterioration as a natural progression of the disease process. Care/intervention may delay some of the complications or problems, for example, by administering certain medications or treatments, but decline is inevitable in the long term. The goal, therefore, becomes providing optimal quality of life within the limitations of the disease process.

4. Patient problems that are chronic in nature that have long-term care needs, which are subject to section 37/41, of the Mental Health Act where there is a legal requirement to provide care, until such time as the Home Office reviews the section.

The plan of care needs to be reviewed and amended, as the patient’s status changes.

The plan of care should be written in terms of:

- Being directly related to the patient assessment.
- Being patient centred and identifying the patient’s objective.
- Having a nursing objective.
- The desired outcome.
- Be specific.
- Be realistic.
- Be observable.
- Be measurable.
- Consider the patient’s preferences, routines, strengths & limitations.
- Should be evidence based.
- Meet the standards required for legal considerations such as Care and Treatment Planning as part of the Mental Health (Wales) Measure 2010.
- Where applicable, meet the minimum requirements for a care and support plan as outlined in the Integrated Assessment, Planning and Review Arrangements for Older People (2013) document.

6.9.3. Intervention
The nursing intervention/care should be measurable and realistic.

6.9.4. Evaluation & Outcome
The plan of care should be evaluated to:

- Review degree to which the anticipated outcome was achieved.
- Include changes in patient’s condition.
- Determine need to continue, revise, or discontinue care/intervention.
- Meet the standards required for legal considerations such as Care and Treatment Planning as part of the Mental Health (Wales) Measure 2010.

6.10. Maternity Record
6.10.1. The Maternity Episode of Care
- Records must be completed in ink.
- Each entry must be dated and signed, or the block signature page must be completed in the maternity records.
- Signatures must be legible and at the beginning of each page must be printed.
• Records must be contemporaneous whenever possible. If written in retrospect this must be indicated in the text.
• Change of staff, including meal breaks, must be recorded in the notes and on Cardiotocograph (CTG) tracings where in use.

6.10.2. Antenatal
• General information as indicated for the maternity episode of care.
• Indicate on hand-held maternal records discussions relating to health education – screening tests, diet, lifestyle, work, maternity benefits, benefits and management of breastfeeding.
• Document references made to antenatal preparation and participation groups.
• Care planning (including birth plan) drugs used for thurs stage of labour, methods of pain relief and reference to additional subject matters.
• Evidence of risk assessment, planning, implementation and evaluation of care.

6.10.3. Labour and Delivery
General information as indicated for the maternity episode of care:

Documentation to be completed:
• It should be noted that two forms of labour documentation are currently in use. The labour record is recorded in the case notes on the Labour/delivery record for Consultant Led Care
• If the woman is booked for Midwife Led Care, then the All Wales Clinical Pathway for Normal Labour is used. Any variation/deviation from the pathway must be coded and recorded in the documentation as per guidelines.
• The partogram and CTG must be completed contemporaneously, as must any other appropriate documentation, e.g. fluid balance chart. Or necessary intervention.
• Obstetric anaesthesia record.
• Summary of labour sheet.
• Partogram.
• Front page of the case notes.
• Neonatal record.
• Birth notification / electronic registration.
• Record of transfer to the ward area. Any other documentation should be completed prior to transfer to any ward area, e.g. high dependency charts, medication charts, etc.
• In instances where a baby is born and a set of notes is required, e.g. born with a congenital anomaly, baby records must be generated with their own individual unit number.
• Be aware of any extra documentation required for any ongoing audit, e.g. LSCS standards times and All Wales Clinical Pathway for Normal Labour audit tool.

6.10.4. Postnatal
• General information as indicated for the maternity episode of care written within the HB Postnatal Care Pathway.
• Evidence of care planning including baby feeding assessments
• Evidence of transfer between hospital and community staff.
• Evidence of discharge from community midwifery teams and hand over of care to Health Visitor Service.
7. PROFESSIONAL ISSUES
All Registered Nurses must adhere to the standards laid down in the Health Board Policy regarding record keeping and have a legal duty of care and records must be kept in accordance with this.

The roles of Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) are extremely diverse. Whilst all work as independent practitioners to some degree, some have a remit for caring for patients with a specific medical diagnosis whilst others focus on particular patient problems or symptoms. However, no matter how a CNS and NP works, it is essential that accurate and appropriate records are maintained and this policy is complied with.

7.1. Delegation
The Health Board recognises that there will be a need for registered professionals to delegate tasks to other workers, including registered professionals outside of their own profession, student nurses and Health Care Support Workers (HCSW). Where this is required, all staff are required to remain within an identified scope of practice for their role, they will undertake the appropriate level of training, and will have been assessed as competent in performing the duties delegated to them (EAGLE Strategy, 2011).

The NMC (2015) Code: professional standards of practice and behaviour for nurses and midwives states that every nurse or midwife must:
- Only delegate tasks and duties that are within the other person’s scope of competence, making sure that they fully understand your instructions
- Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
- Confirm that the outcome of any task you have delegated to someone else meets the required standard.

NMC 2015

7.1.1. Health Care Support Workers
“Health care support workers provide a direct service to patients in a variety of care settings. They should undertake a range of delegated duties under the supervision of a registered or assistant practitioner. Health care support workers should carry out a range of tasks, depending on the type of environment they work in and the people they look after” (EAGLE Strategy, 2011). Delegated tasks include some aspects of record keeping and refer to the recording on specific charts. HCSW’s should only be undertaking this following training and assessment of competency. For example:
- The recording of patient observations.
- Food intake and fluid intake and output.
- Blood glucose monitoring.

A Registered Nurse retains accountability for the delegated tasks. HCSW’s are responsible for their actions in accepting the task, and must take on the responsibility only if they feel competent to do so.

A healthcare support worker must:
- “Communicate effectively and consult with colleagues as appropriate.
- Document and maintain clear and accurate record of your care, and report any changes or concerns in the condition of individuals, immediately to a senior nurse member of staff”.

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All charts must be developed in compliance with this policy and must, where deemed appropriate include a reference to the frequency of countersignature.

Where a HCSW records information on patient assessment, care planning, intervention, evaluation and outcome then this must be clearly defined in the core job description and included in the scope of practice for the role (in accordance with the EAGLE Strategy).

7.2. Countersignature
Although there is no legal requirement for a registered nurse to countersign entries made by students nurses/Health Care Support Workers into the patient record, the Health Board policy is that the nurse who has delegated the task MUST countersign all entries made by pre-registration nurses and HCSW (frequency will be determined by Health Board policies and practices e.g. food chart require twice daily countersigning).

Registered Nurses are accountable for ensuring that the Student Nurse/HCSW is competent to make entries into the patient record as part of the overall provision of care, and whether it is in the patient’s best interests for recording of care to be delegated.

The registered nurse should not be countersigning notes unless they have witnessed or can validate the activity as having taken place (RCN 2012).

7.3. Electronic Records
Any access to, or recording made in an electronic record by a member of staff is automatically electronically recorded under the member of staff’s name, this ensures and provides an audit trail of entries.

In the case of electronic record keeping a specific procedure must be in place to ensure the countersignature of non-registrants. Registered staff must ensure they regularly check entries of health care support workers/students e.g. once a HCSW or Student nurse has made an entry into the electronic record and signed off, the registered nurse must follow the agreed process to electronically countersign the record. This process would create an automatic audit trail.

8. ACCESS AND OWNERSHIP
Any entries made in a patient or client record can be scrutinized at a future point. Patients and clients not only have a legal right to see their records but they are increasingly participating in writing and holding them.

The Access to Health Records Act 1990 gives patients/clients the right to access manual health records about themselves that were made after 1 November 1991.

The Data Protection Act 1984 gives patients and clients access to their computer-held records. It also regulates the storage and protection of patient and client information held on computer.

Under the Data Protection Act (1998), all patients are entitled to:
- Be informed whether personal data is processed (which includes being held or stored).
- Have a description of the data held, the purposes for which it is processed and to whom the data may be disclosed.
- Have a copy of the information constituting the data.
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- Have information as to the source of the data.
- If a service user requests access to any data held on them the request must be made in writing and no reason need be given. The applicant must then be given a copy of the information and if appropriate an explanation.

In exceptional circumstances information may be withheld from a patient. The decision to refuse access to records must be made by all professionals involved in the patient’s care. The reasons for this decision must be clearly documented in the patient’s notes.

In some areas it may be possible for patients to be responsible for holding their own records.

Any access to or recording made in, an electronic record by a member of staff is automatically recorded under the member of staff’s name with their individual electronic ‘identifier’, time and date – ensuring an audit trail of entries. For additional information please refer to the Health Board good practice guide for electronic security.

8.1. Retention
Legislation requires that patient records should be kept for a minimum of eight years after conclusion of treatment and, in the case of a child, at least to the date of the child’s 25th birthday. For additional information on specific patient groups, please refer to Health Board Policy 193 Retention and Destruction of Records Including Health Records.

Every Registered Nurse must be aware that some electronic devices may not produce a hard copy image/record that can be permanently archived or the image/record will deteriorate over time. It is the responsibility of the nurse to ensure that, if there is concern that the image/record cannot be permanently archived, there is a record made in the patient record identifying the date, time and findings.

9. STORAGE OF RECORDS
Records must be stored in an area that ensures neither other patients, members of the public, or unauthorised members of staff can gain access to them. Where records are stored in areas that do not have 24-hour staff presence then they must be stored in an area that can be securely locked when the premises are unstaffed.

If records need to be transported from one clinical area to another it is the responsibility of the staff member to ensure that at no point could the records be accessed by an unauthorised individual. It is the staff member’s responsibility to ensure any records are stored safely and securely whilst in transit.

In terms of electronic record keeping staff must ensure they log off the PC/laptop when they are not using it. This will prevent records being accessed or information being entered by another person under their name.

10. MANAGING & FILING
All health care professionals have responsibilities to ensure that patient’s records are consistently organised, comprehensive and up to date, contain appropriate information correctly filed and retained for an agreed length of time as per Health Board policies.

It is the responsibility of the designated staff in each clinical area to file the relevant information in the patients’ records.
11. PATIENT/CLIENT INVOLVEMENT
Wherever possible, patients/clients should be equal partners in the compilation of their own records. The Data Protection Act 1984, the Access Modification (Health) Order 1987, and the Access to Health Records Act 1990 define their rights of access.

12. PATIENT HELD RECORDS
Patients increasingly hold their health care records and this should be encouraged as far as it is appropriate and as long as they are happy to do so. It enables them to be more closely involved in their own care and enables the nurse to share with them information about their assessment and care.

Patients should be informed of the purpose and importance of the record and their responsibility for keeping it safe. These same principles apply equally to parent-held records.

Keeping a supplementary record should be the exception rather than the norm, and should not extend to keeping full duplicate records. Wherever possible, concerns should be shared with the patient and the relevant entry should be jointly compiled. You must be able to justify keeping such a supplementary record and its existence needs to be made clear to other members of the health care team, who must be able to access the information readily but without compromising patient confidentiality.

13. MONITORING AND AUDIT
Monitoring of the policy will be ongoing to ensure effectiveness and impact of such policy.

Audit can play a vital part in ensuring the quality of care that is delivered and this applies equally to the process of record keeping. By auditing records, the standard of records can be assessed and areas for improvement and staff development can be identified. The need to maintain confidentiality of patient/information applies to audit just as to the record keeping process itself.

<table>
<thead>
<tr>
<th>Area</th>
<th>Audit requirements:</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult inpatient areas</td>
<td>Audits of 5 patient records using the approved Health Board audit tool. The service-specific audit will monitor compliance with:</td>
<td>Bimonthly as a core requirement of all services BUT frequency can be increased if results suggest this required; or decreased via an ‘Earned Autonomy’ process, by the Head of Nursing/Midwifery for the service</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>• documentation standards including NMC Code &amp; HB policy</td>
<td></td>
</tr>
<tr>
<td>District Nursing teams</td>
<td>• documentation processes including access and ownership, legislation confidentiality &amp; storage</td>
<td></td>
</tr>
<tr>
<td>Mental Health &amp; Learning Disabilities</td>
<td>• the completion of the nursing record to include assessment documents, risk assessments, care plans &amp; evaluation</td>
<td></td>
</tr>
<tr>
<td>Health Visiting and School Nursing</td>
<td>Compliance/performance data will be entered onto the Care Indicator Module of the health and care Standards Monitoring System.</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Annual audit of notes facilitates the requirements of the Welsh Risk Pool Standards, Standard 15: Maternity (2003) to monitor the:</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>• guideline for compliance, review and evaluation of maternity care,</td>
<td>NB Further work to develop/adapt an audit tool for more</td>
</tr>
</tbody>
</table>
Record keeping for nurses and midwives policy

- to provide evidence of a nominated clinical team member responsible for intrapartum care,
- to provide evidence of a system for ensuring that the handover of care between shifts of doctors and midwifery staff maintains continuity of care,
- to provide evidence of compliance with written policies for management of patients with key conditions
- To provide evidence of compliance with the procedure regarding the management of babies who are still-born or severely abnormal.

All audit tools (which will be service specific) will be located on the Nursing and Midwifery Information Zone on the HUHB Intranet site

In addition where the nursing team review patient case notes, compliance with the policy should be considered e.g. claims & concerns.

14. NURSING DOCUMENTATION STEERING GROUP
The Nursing Documentation Steering Group is a Sub group of the Senior Nursing and Midwifery Team and has delegated responsibility for the decision making around nursing record keeping. The Nursing Documentation Sub Group reports to the Health Records Committee and is accountable to the Senior Nursing and Midwifery Team.

The Steering Group is accountable for
- Ensuring the standards of record keeping comply with the NMC Code of Conduct and NMC Recording Keeping: Guidance for Nurses and Midwives
- Ensuring that systems are in place for the implementation, monitoring and improvement of compliance with the Record Keeping for Nurses and Midwives policy
- Monitoring progress against any Health Board actions/action plans developed in relation to record keeping
- Ensuring that there is a quality assurance process in place for the management of any new documentation
- Identifying any training requirements around record keeping, accountability and any new documentation implemented

The role of the steering group is to
- Provide strategic leadership and direction in the revision and development of all nursing documentation
- Develop and monitor the nursing documentation work plan
- Ensure that all nursing documentation is evidenced based and complies with the All Wales Minimum standards and dataset for Adult Documentation and any new legislation/standards/guidance affecting nursing documentation.
- Approve all new and revised documentation relating to nursing

15. DEVELOPMENT OF NEW NURSING DOCUMENTATION
Any new documentation related to nursing **MUST** be approved by the Nursing Documentation Steering Group which has delegated responsibility for the decision making around record
keeping. This includes any document that a nurse would be expected to complete and/or contribute to e.g. referral forms, prescription charts, pathways.

Key questions to be considered before considering any new documentation should include:

- Why is it required?
- Which clinical areas does it apply to?
- Who is going to be involved in the development of the new documentation?
- Does it replace any existing documentation?

Any changes/amendments to existing Nursing documentation also need to be approved by the Nursing Documentation Steering Group.

A submission form **MUST** be completed prior to the work commencing (Appendix 3) – Work should not commence until approval has been sought from the Nursing Documentation Steering Group.

Key principles for developing new nursing documentation include the need to:

- Reduce variation
- Minimise duplication
- Have a standard approach across the HB
- Develop documents ‘instead of’ rather than ‘as well as’ existing documents

In addition all new documentation will be pre-printed and not photocopied

Please refer to the flowchart for additional information (Appendix 4).

**16. RESPONSIBILITIES**

16.1. **Chief Executive**

The Chief Executive has overall accountability for ensuring that Health Records management operates appropriately and in compliance with the requisite legislation within the Health Board.

16.2. **Nursing Director**

The Nursing Director has the responsibility to ensure that systems are in place for ensuring

- Compliance with the NMC Code (2015) including the standards for record keeping
- Compliance with this policy and all HB policies relating to record keeping

16.3. **Registered Nurses**

All Registered Nurses employed by the Health Board are responsible for complying with the relevant professional standards as well as those set out by the HB:

- Compliance with the NMC Code (2015)
- Compliance with this policy and all HB policies relating to record keeping
- Maintaining their individual professional development around record keeping ensuring that evidence of learning is included in their portfolio.

16.4. **Ward Manager/Team Leader**

The Ward Manager/Team Leader is responsible for:

- Monitoring compliance within their area of responsibility.
- Addressing any areas of concern with individuals and teams.
- Including record keeping as part of individual personal development reviews
- Escalating concerns as appropriate.
16.5. **County Management Team/Directorates**
The County Management Team/Directorates are responsible for ensuring that:
- An audit process is in place to demonstrate compliance.
- Areas of concerns with individuals and teams are addressed.
- Staff access training and educational opportunities and evidence their work based learning in their portfolios.

16.6. **Nursing Documentation Steering Group**
The Nursing Documentation Steering Group is responsible for:
- Approving proposals for development of new documentation relating to nursing (See Appendix 3).
- The approval and ratification of new documentation relating to nursing.
- Ensuring that Health Board documentation reflects and adopts any All Wales work that has or will be developed e.g. food and fluid charts, oral hygiene bundles.

In the absence of any Nursing Documentation Steering Group meetings any decisions requiring approval will be taken via chairman’s action or via Senior Nursing and Midwifery team meetings.

17. **TRAINING**
Record keeping is an integral part of nurse education and there will be a requirement for staff to access both internal and external training opportunities on record keeping as identified in personal development reviews and plans e.g., accountability workshops, RCN study days.

Record keeping training is mandatory training for nursing staff and all Registered Nurses are expected to access relevant training every three years or as identified in their personal development reviews and plans. The nursing care and record keeping sessions offered as part of the Learning and Development prospectus and delivered by the University of Swansea raise awareness of key issues relating to documentation and record keeping and its relevance within the nursing and healthcare context. Relevant case law on this topic will be considered as will Ombudsman reports and case studies for discussion.

For midwives, training will also be guided by the NMC – Midwives Rules and standards (2004) Guidelines for records and record keeping (2009) and Welsh Risk Pool Standards, Standard 15: Maternity (2003) Midwives will be supported by their supervisor of midwives and annual supervisory interviews will incorporate a review of record keeping (Healthcare Inspectorate Wales, 2008).

Within Mental Health and Learning Disability services there is specific training to address standards of electronic record keeping which is provided to all MH&LD staff on induction.

18. **IMPLEMENTATION**
The policy will be implemented through usual policy distribution channels to appropriate areas and an implementation plan developed.

19. **REFERENCES**
Access to Health Records Act 1990
Database No:289
Page 24 of 31

HYWEL DDA UNIVERSITY HEALTH BOARD


Caldicott – Principles into Practice


Health and Care Standards (2015)


HIW (June 2008) Local Supervising Authority Guidelines and Standards

Mental Health Act (1983)


Royal College of Nursing (2012) Abbreviations and other short forms in patient/client records Learning and Development Institute, Royal College of Nursing, London


20. REVIEW
This Policy will be reviewed every 3 years, (or sooner if new legislation, codes of practice or national standards are introduced)

21. GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
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### Physical Observations/General

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>Temperature</td>
</tr>
<tr>
<td>P</td>
<td>Pulse</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>R</td>
<td>Respiration</td>
</tr>
<tr>
<td>O2</td>
<td>Oxygen</td>
</tr>
<tr>
<td>BM</td>
<td>Blood Glucose Monitoring</td>
</tr>
<tr>
<td>Ht</td>
<td>Height</td>
</tr>
<tr>
<td>Wt</td>
<td>Weight</td>
</tr>
<tr>
<td>NAD</td>
<td>No abnormality detected</td>
</tr>
<tr>
<td>SOB</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Pre Op</td>
<td>Before Operation</td>
</tr>
<tr>
<td>Post Op</td>
<td>After Operation</td>
</tr>
<tr>
<td>NBM</td>
<td>Nil by Mouth</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>ITU</td>
<td>Intensive Therapy Unit</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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### Staff

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Sr</td>
<td>Sister</td>
</tr>
<tr>
<td>S/N</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>St/N</td>
<td>Student Nurse</td>
</tr>
<tr>
<td>HCSW</td>
<td>Health Care Support Worker</td>
</tr>
<tr>
<td>SW</td>
<td>Social Worker</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>SALT</td>
<td>Speech and language therapist</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>DoB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>NoK</td>
<td>Next of Kin</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-disciplinary Team</td>
</tr>
<tr>
<td>IA</td>
<td>Integrated Assessment, Planning and Review Arrangements for Older People (2013)</td>
</tr>
<tr>
<td>DST</td>
<td>Decision Support Tool</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
</tr>
<tr>
<td>PSPS</td>
<td>Pressure Sore Prediction Score</td>
</tr>
</tbody>
</table>

### Pharmacy Abbreviations
<table>
<thead>
<tr>
<th>Stat</th>
<th>Immediately</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO</td>
<td>Per oral</td>
</tr>
<tr>
<td>PR</td>
<td>Per rectal</td>
</tr>
<tr>
<td>PV</td>
<td>Per vagina</td>
</tr>
<tr>
<td>BD</td>
<td>Twice a day</td>
</tr>
<tr>
<td>TDS</td>
<td>Three times a day</td>
</tr>
<tr>
<td>QDS</td>
<td>Four times a day</td>
</tr>
<tr>
<td>Mane</td>
<td>Morning</td>
</tr>
<tr>
<td>Nocte</td>
<td>Night</td>
</tr>
<tr>
<td>PRN</td>
<td>When required</td>
</tr>
<tr>
<td>I/M</td>
<td>Intra-muscular</td>
</tr>
<tr>
<td>I/V (I)</td>
<td>Intra-venous (Infusion)</td>
</tr>
<tr>
<td>SC</td>
<td>Sub cutaneous</td>
</tr>
<tr>
<td>NEB</td>
<td>Nebuliser</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled Drug</td>
</tr>
<tr>
<td>TTH (O)</td>
<td>To Take Home (Out) drugs</td>
</tr>
</tbody>
</table>

### Equipment

<table>
<thead>
<tr>
<th>NGT</th>
<th>Naso gastric Tube</th>
</tr>
</thead>
<tbody>
<tr>
<td>AES</td>
<td>Antiembolic Stocking</td>
</tr>
<tr>
<td>PEG</td>
<td>Percutaneous Endoscopic Gastrostomy</td>
</tr>
<tr>
<td>ET Tube</td>
<td>Endotracheal tube</td>
</tr>
</tbody>
</table>

### Common Tests/Procedures/Investigations

<table>
<thead>
<tr>
<th>FBC</th>
<th>Full Blood Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>HB</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>K</td>
<td>Potassium</td>
</tr>
<tr>
<td>Na</td>
<td>Sodium</td>
</tr>
<tr>
<td>U/E</td>
<td>Urea and electrolytes</td>
</tr>
<tr>
<td>INR</td>
<td>international normalised ratio</td>
</tr>
<tr>
<td>WCC</td>
<td>White Cell Count</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardio Pulmonary Resuscitation</td>
</tr>
<tr>
<td>PEG</td>
<td>Percutaneous Endoscopic Gastroscopy</td>
</tr>
<tr>
<td>TPN</td>
<td>Total Parenteral Nutrition</td>
</tr>
<tr>
<td>TPR</td>
<td>Temperature Pulse Respiration</td>
</tr>
<tr>
<td>DNAR</td>
<td>Do Not Attempt Resuscitation</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>U/S</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Ba</td>
<td>Barium</td>
</tr>
<tr>
<td>CT Scan</td>
<td>Computerised Tomography</td>
</tr>
<tr>
<td>CSF</td>
<td>Cerebro-spinal Fluid</td>
</tr>
<tr>
<td>LP</td>
<td>Lumbar Puncture</td>
</tr>
<tr>
<td>MSU</td>
<td>Mid Stream Urine</td>
</tr>
</tbody>
</table>
## APPENDIX 2 - DEPARTMENT OF OBSTETRICS AGREED ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ve</td>
<td>Positive</td>
</tr>
<tr>
<td>-ve</td>
<td>Negative</td>
</tr>
<tr>
<td>A.F.P.</td>
<td>Alpha Feto Protein</td>
</tr>
<tr>
<td>A/N</td>
<td>Antenatal</td>
</tr>
<tr>
<td>A.P.H.</td>
<td>Ante partum Haemorrhage</td>
</tr>
<tr>
<td>A.R.M.</td>
<td>Artificial rupture of membranes</td>
</tr>
<tr>
<td>AFP/HCG</td>
<td>&quot;Double Test&quot;</td>
</tr>
<tr>
<td>Amnio</td>
<td>Amniocentesis</td>
</tr>
<tr>
<td>B.B.A</td>
<td>Born before arrival</td>
</tr>
<tr>
<td>B.P.D/</td>
<td>Bi parietal Diameter</td>
</tr>
<tr>
<td>B.Wt</td>
<td>Birth weight</td>
</tr>
<tr>
<td>B/P</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>C.C.T.</td>
<td>Controlled cord traction</td>
</tr>
<tr>
<td>Ceph</td>
<td>Cephalic</td>
</tr>
<tr>
<td>CPD</td>
<td>Cephalo pelvic disproportion</td>
</tr>
<tr>
<td>C.T.G</td>
<td>Electrocardiograph</td>
</tr>
<tr>
<td>C.V.S.</td>
<td>Chorionic Villus Sampling</td>
</tr>
<tr>
<td>Cx</td>
<td>Cervix</td>
</tr>
<tr>
<td>D &amp; C</td>
<td>Dilation and Curettage</td>
</tr>
<tr>
<td>D.N.A.</td>
<td>Did not attend</td>
</tr>
<tr>
<td>D.V.T.</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>EBL</td>
<td>Estimated blood loss</td>
</tr>
<tr>
<td>E.B.M.</td>
<td>Expressed Breast Milk</td>
</tr>
<tr>
<td>E.D.D.</td>
<td>Estimated Date of Delivery</td>
</tr>
<tr>
<td>EPU</td>
<td>Early Pregnancy Unit</td>
</tr>
<tr>
<td>E.U.A.</td>
<td>Examination Under Anaesthetic</td>
</tr>
<tr>
<td>E.W.A</td>
<td>Examination Without Anaesthetic</td>
</tr>
<tr>
<td>El LSCS</td>
<td>Elective Lower Segment Caesarean Section</td>
</tr>
<tr>
<td>EM.LSCS</td>
<td>Emergency Lower Segment Caesarean Section</td>
</tr>
<tr>
<td>ERPC</td>
<td>Evacuation of retained products of conception</td>
</tr>
<tr>
<td>F.B.C.</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>F.B.S.</td>
<td>Fetal blood sample</td>
</tr>
<tr>
<td>F.H.</td>
<td>Fetal heart</td>
</tr>
<tr>
<td>FHH</td>
<td>Fetal heart heard</td>
</tr>
<tr>
<td>FHHR</td>
<td>Fetal Heart Heard Regular</td>
</tr>
<tr>
<td>F.L.</td>
<td>Femus length</td>
</tr>
<tr>
<td>F.M.</td>
<td>Fetal movements</td>
</tr>
<tr>
<td>F.M.F.</td>
<td>Fetal movements felt</td>
</tr>
<tr>
<td>F.S.E.</td>
<td>Fetal scalp electrode</td>
</tr>
<tr>
<td>Gest</td>
<td>Gestation</td>
</tr>
<tr>
<td>H.C.</td>
<td>Head circumference</td>
</tr>
<tr>
<td>Hb</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>HVS</td>
<td>High Vaginal Swab</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
</tbody>
</table>

### Fetal positions:
- A: Anterior
- L: Left
- M: Mentum
- O: Occiput
- P: Posterior
- R: Right
- S: Sacro
- T: Transverse

For example:
- LOA; ROP; LSA

### Other abbreviations:
- EBL: Estimated blood loss
- E.B.M.: Expressed Breast Milk
- E.D.D.: Estimated Date of Delivery
- EPU: Early Pregnancy Unit
- E.U.A.: Examination Under Anaesthetic
- E.W.A.: Examination Without Anaesthetic
- El LSCS: Elective Lower Segment Caesarean Section
- EM.LSCS: Emergency Lower Segment Caesarean Section
- ERPC: Evacuation of retained products of conception
- F.B.C.: Full Blood Count
- F.B.S.: Fetal blood sample
- F.H.: Fetal heart
- FHH: Fetal heart heard
- FHHR: Fetal Heart Heard Regular
- F.L.: Femus length
- F.M.: Fetal movements
- F.M.F.: Fetal movements felt
- F.S.E.: Fetal scalp electrode
- Gest: Gestation
- H.C.: Head circumference
- Hb: Haemoglobin
- HVS: High Vaginal Swab
- IM: Intramuscular
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOL</td>
<td>Induction of Labour</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>I.U.D.</td>
<td>Inter Uterine Death</td>
</tr>
<tr>
<td>I.U.G.R.</td>
<td>Intra Uterine Growth Restriction</td>
</tr>
<tr>
<td>I.U.C.D.</td>
<td>Intra Uterine Contraceptive Device</td>
</tr>
<tr>
<td>L.M.P</td>
<td>Last menstrual period</td>
</tr>
<tr>
<td>L.S.C.S.</td>
<td>Lower segment caesarean section</td>
</tr>
<tr>
<td>Misc</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>MROP</td>
<td>Manual Removal of Placenta</td>
</tr>
<tr>
<td>M.S.U.</td>
<td>Mid stream specimen of urine</td>
</tr>
<tr>
<td>N.A.D.</td>
<td>No abnormality detected</td>
</tr>
<tr>
<td>NSD</td>
<td>Normal spontaneous delivery</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-patients Department</td>
</tr>
<tr>
<td>PCA</td>
<td>Patient Controlled Analgesia</td>
</tr>
<tr>
<td>P.K.U.</td>
<td>Phenolketonurea</td>
</tr>
<tr>
<td>P/N</td>
<td>Postnatal</td>
</tr>
<tr>
<td>P.P.</td>
<td>Presenting Part</td>
</tr>
<tr>
<td>P.P.H.</td>
<td>Post Partum Haemorrhage</td>
</tr>
<tr>
<td>P.V.</td>
<td>Per vaginam</td>
</tr>
<tr>
<td>Reg.</td>
<td>Registrar</td>
</tr>
<tr>
<td>Rh</td>
<td>Rhesus</td>
</tr>
<tr>
<td>S.B.</td>
<td>Still birth</td>
</tr>
<tr>
<td>S.B.R.</td>
<td>Serum Bilirubin</td>
</tr>
<tr>
<td>S.H.O.</td>
<td>Senior House Officer</td>
</tr>
<tr>
<td>S.R.O.M.</td>
<td>Spontaneous Rupture of Membranes</td>
</tr>
<tr>
<td>S.V.D.</td>
<td>Spontaneous Vertex Delivery</td>
</tr>
<tr>
<td>T.E.N.S.</td>
<td>Transcutaneous Electronic Nerve Stimulation</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>T.T.H.</td>
<td>To take home</td>
</tr>
<tr>
<td>U.S.S.</td>
<td>Ultra sound scan</td>
</tr>
<tr>
<td>U.T.I.</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>V.E.</td>
<td>Vaginal examination</td>
</tr>
<tr>
<td>Vx</td>
<td>Vertex</td>
</tr>
</tbody>
</table>
## APPENDIX 3 - PROPOSAL FORM FOR THE DEVELOPMENT OF NEW NURSING DOCUMENTATION

<table>
<thead>
<tr>
<th>Name of Document:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Lead Author:</td>
<td>Signature:</td>
</tr>
<tr>
<td>Name of Senior Nurse:</td>
<td>Signature:</td>
</tr>
</tbody>
</table>

### Why is it required?

### Which clinical areas does it apply to?

### Who’s going to be involved in the development of the new documentation?

### Does it replace any existing documentation? Yes { } NO { } if Yes, state what?

### Proposed timescale:

### Agreement to Support Development of Proposed New Documentation

| Date initially presented at meeting | Signed (Chair/Vice Chair) |

### Presentation of New Documentation

| Date: |  |
| Recommendations (including implementation plan): |  |

Signed (Chair/Vice Chair)
All new documentation and any changes/amendments to existing Nursing related Documentation must be approved by the Nursing Documentation Steering Group (NDSG) which has delegated responsibility for the decision making around record keeping for nurses.

Discuss development of new/changes to existing Nursing documentation with Senior Nurse/Clinical Director Nurse/Head of Service

To ensure a Health Board approach consider/establish whether related/similar documentation that is being proposed is being used in another hospital/directorate/service.

If Development of New Documentation supported by Senior Nurse/Clinical Lead - Approval Form to be completed and agreed by Operational team

If submission supported by Operational Team submit approval form to NDSG

Approval Form submitted to NDSG

Development of New or changes to existing documentation approved

Undertake the work on the new/changes within the agreed timescale

Present new documentation to NDSG for final ratification – presentation to include recommendations and implementation plan

Development of New or changes to existing documentation declined

The Nursing Documentation Steering Group (NDSG) has delegated responsibility for the decision making around record keeping for nurses.

All Proposal forms to be forwarded to the Professional and Practice Development Nurse for inclusion on the NDSG agenda