Royal College of Nursing
Northern Ireland

Recording Nursing Care and Treatment Using Digital Recording Systems and Electronic Records

Good record keeping is essential in delivering safe and effective nursing care and treatment, regardless of whether the recording system used is paper-based or electronic. The principles for recording are well established and fundamentally the same for both types of record keeping. These principles underpin the requirement within **the NMC code** (2018) (section 10), which states that registered nurses must: "keep clear and accurate records relevant to your practice".

Fundamental record keeping principles

- Handwriting must be legible.
- All entries to records should be signed. In the case of written records, your name and job title should be printed alongside the first entry.
- All records should include the date and time of entry – in real-time, in chronological order and as close to the actual time as possible.
- Records should be accurate and recorded in such a way that the meaning is clear.
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.
- Use your professional judgement to decide what is relevant and what should be recorded.
- Should there be a need to alter/amend a record, the name and job title of the person making the alteration must be clearly identified, and both the original record and the amendment must be clearly signed and dated. All amendments made, and the original record, must be clear and auditable.
- Do not falsify any record.

As Northern Ireland's health and social care system continues its journey to fully embracing a system of digital record keeping, there will be additional considerations for registered nurses when updating electronic records within digital systems.

Right training

- Ensure you have had the relevant training to allow you to use the digital system.
- One benefit of digital systems is that their design supports you in delivering safe and effective care.
- When trained to use the system you must follow the processes for operating the system. Do not develop your own workarounds, eg scanning a patient barcode from a record as opposed to their identifying armband. This type of practice compromises safe practice and is contrary to the requirements of **the code** (2018) (section 19).

Right log on details

- Ensure you have logged onto the system using your own details.
- Be aware that using another person's details will attribute that entry to them. This also means that you must never share your log on details with anyone else. Any entry they make when using your details will be attributed to you. Both circumstances could potentially be considered as falsifying records.
- If you are making an entry on behalf of a colleague – that is, they have provided you with details of care or treatment that they have delivered but you are the person making the entry, ensure the record makes this clear. If you ask a colleague to do this for you, ensure that you check that record and confirm its accuracy.
- Ensure that you log out of the record you have been updating. Do not leave a record 'open' – another person could add to that record under your 'open' login. Keep devices locked when not in use and/or unattended.
- If you are using a handheld device to access and update patient records, ensure that this is kept secure, and is unavailable to others and cannot be accessed by anyone else.

Right practice

- Ensure you are recording care for the right person within the correct digital record.
- If making a retrospective note after the care or treatment has been delivered, make this clear in your narrative. The entry will be time stamped to when you make the record as opposed to the time of the care/treatment.
- The principles of privacy and confidentiality apply (**the code** (2018), (section 5); **The Caldicott Principles - GOV.UK (www.gov.uk)**).
- This includes all relevant data protection and related governance training.
- Be aware that all electronic entries are traceable within the digital system. Deleting an entry from a record does not delete it from the system itself.
- Digital systems make a record of all entries and adjustments, so every interface with the system is traceable.
- Be aware that digital records allow for multiple staff to be documenting at the same time, meaning information will update in real time.
- Ensure that you adhere to all relevant legislation (data protection and GDPR requirements in particular) and organisational policies and procedures.
- Do not use other digital/electronic systems (such as text messaging, group chats, etc) to discuss or agree care and/or treatment. Use of such systems in this way could contravene privacy and security legislation. Do not transfer information to home computers, data sticks, flash drives or unencrypted laptops, etc.
- Adherence to good record keeping practice should be monitored by regular audits.
- Nursing students should be supported to use electronic record keeping systems by their higher education institution and while on practice placement, where such systems are used.

RCN Learn provides additional information, resources and training for using e-health technology.

Resources and further reading

GOV.UK (2020) *The Caldicott Principles*. Available at: **gov.uk/government/publications/the-caldicott-principles** (Accessed 07 June 2024).

Morris C, Scott R E and Mars M (2021) WhatsApp in Clinical Practice—The Challenges of Record Keeping and Storage. A Scoping Review, *International Journal of Environmental Research and Public Health*, 18(24), p. 13426.

NHS Digital (2023) *Section 6: Record-keeping best practice*. Available at: **digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/a-guide-to-confidentiality-in-health-and-social-care/hscic-guide-to-confidentiality-references/section-6** (Accessed 07 June 2024).

NHS Professionals (2021) *CG2 NHS Professionals Record Keeping Guidelines*. Available at: **https://www.nhsprofessionals.nhs.uk/-/media/hosted-documents/cg2---record-keeping-guidelines.pdf** (Accessed 19 February 2004).

NMC (2009) *Record keeping: Guidance for nurses and midwives*. Nursing and Midwifery Council (NMC). Available at: **muppet.pbworks.com/f/NMC+guidelines+for+recordkeeping.pdf** (Accessed 07 June 2024).

NMC (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council.* Available at: **nmc.org.uk/standards/code** (Accessed 07 June 2024).

Peacock A, Slade C and Brown Wilson C (2022) Nursing and midwifery students' perspectives of using digital systems on placement: A qualitative study, *Journal of Advanced Nursing*, 78(4), pp. 1128–1139.

Royal College of Midwives (2021) *Electronic Record Keeping Guidance and Audit Tool.* Available at: **rcm.org.uk/media/4818/rcm_guidance-report_elec_record_keeping.pdf** (Accessed 07 June 2024).

Royal College of Nursing Learn (no date) *RCN Learn*. Available at: **rcnlearn.rcn.org.uk** (Accessed 07 June 2024).

Tees, Esk and Wear Valleys NHS (2023) *Minimum standards for clinical record keeping*. Available at: **tewv.nhs.uk/content/uploads/2021/10/Minimum-standards-for-clinical-record-keeping.pdf** (Accessed 07 June 2024).

011 662 | June 2024