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**Record Keeping Policy**

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**Version Control/Changes Made**

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| **Date** | **Version** | **Summary of changes** | **Author** |
| January 2025 | 4.0 | Full policy review and update. Policy template updated. Scope updated to include communication via Microsoft Teams. Updated references. Inclusive terminology to cover all FNHC service user records. | Rachel Foster |
| December 2021 | 3.1 | Appendix added ‘Record keeping principles for Child and Family Services’ and mentioned in 2.4 | Mo de Gruchy |
| March 2021 | 3.0 | Reviewed and updated to include additional references  | Mo de Gruchy |
| January 2020 | 2.0 | Updated to include electronic patients records. Updated to include The Data Protection (Jersey) Law which incorporates GDPR. | Allison Mills |

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# INTRODUCTION

Record keeping is a vital component of professional practice, supporting all aspects of the care process. Service user information is essential to Family Nursing & Home Care (FNHC) and plays a critical role in delivering high-quality, evidence-based healthcare. Accurate and effective record keeping underpins high-quality care, facilitates clear communication with other professionals involved in a service user’s care, and demonstrates individual professional accountability and responsibility. It is important that these records are accurate, up to date, and readily accessible to those who require them.

## Rationale

This policy aims to establish best practice and provide guidance for all service user records, regardless of their format, within FNHC. It ensures that these records meet the required standards of:

* Authenticity, integrity, and security
* Reliability and confidence in healthcare records and information
* Assurance to external inspectors that FNHC’s healthcare records, in all formats, are robust and reliable

All clinical, care and administrative staff involved in creating or contributing to service user records must ensure they are accurate and timely. These records will:

* Demonstrate accountability
* Facilitate decision-making
* Improve care by clearly communicating the rationale for assessment, treatment, and care planning
* Provide a consistent approach to partnership working
* Support the investigation of complaints or legal proceedings

## Scope

This policy applies to all records relating to FNHC service users, including but not limited to:

* Handwritten and electronic care records
* Fax messages
* Diaries
* Emails
* Text messages
* Microsoft Teams communications (e.g., messages, chats, and shared files)
* Incident reports and statements
* Photographs and videos

## Role and Responsibilities

**Chief Executive Officer**

The CEO has overall accountability for the management of records and record keeping within FNHC.

**Caldicott Guardian**

The Caldicott Guardian is responsible for ensuring that FNHC adheres to the Caldicott Principles when processing patient identifiable information.

**Director of Governance & Care**

The Director of Governance & Care is responsible for the overall development and maintenance of both corporate and health record keeping practices within FNHC, for drawing up guidance for good record keeping practice and promoting compliance with this policy

**Registered Managers**

Registered Managers must ensure that their staff are trained in the relevant aspects of record keeping and that there is compliance with FNHC policies and procedures. This should be in the form of induction training and relevant updates via the mandatory training schedule.

**Individual Responsibility**

All FNHC staff have a legal duty of care and are responsible for any records they may create or use. This responsibility is established and defined by law. Every employee’s contract of employment clearly identifies individual responsibilities for compliance with information governance requirements.

# POLICY

## Purpose of records

Provides evidence that policies, processes, and practices have been appropriately followed, reflecting professionalism and competency.

Documents the rationale behind professional practice, clearly outlining how decisions were made and demonstrating accountability for actions taken or not taken.

Offers a clear and comprehensive account of the individual’s story, including their wishes, views, and preferences. This information can be used by the individual and/or others to empower them and foster a better understanding of their situation and any care or support needs.

## General principles of record keeping

All relevant information must adhere to the following principles:

**Recorded**: If it is not recorded, it has not happened.

**Legible, Signed, Dated & Timed**: Records must be clear, signed, dated, and, where possible, typed. Digital records must be traceable to the person who provided the care that is being documented. (RCN, 2023)

**Contemporaneous and Up-to-Date**: Information should be documented promptly and maintained regularly.

**Clear and Logical**: Use plain language that is clear, legible, and logically structured.

**Accurate**: Ensure proper grammar, punctuation, and spelling throughout.

**Unambiguous and Concise**: Avoid unnecessary repetition, and keep records proportionate to the situation.

**Fact vs. Opinion**: Distinguish clearly between factual statements and professional opinions.

**Include the Patient's Voice**: Reflect the views, preferences, and wishes of the patient/client.

**Professional Analysis**: Demonstrate professional thinking, analysis, and the rationale behind decisions.

**Management Oversight**: Where relevant, include evidence of management review or oversight.

**Avoid Jargon**: Exclude unexplained technical terms, acronyms, abbreviations, or jargon.

**Secure Storage**: Ensure all records are kept securely to maintain confidentiality and compliance.

## Principles of professional writing

When creating professional records, the following principles should be followed:

**Integrate Writing into Patient Care**: Make recording an integral part of the patient’s care plan, and plan in advance what will be documented.

**Focus on Desired Outcomes**: Reflect the person’s desired outcomes, including their views, wishes, and feelings (the patient’s voice).

**Facilitate Evidence-Based Decision Making**: Communicate information that supports evidence-based and defensible decision-making.

**Demonstrate Professional Competency**: Show the application of professional knowledge, skills, analysis, and evaluation in the documentation.

**Provide Clear Recommendations**: Include specific recommendations related to actions, inactions, decisions, and support to help the person achieve their outcomes.

**Proofread and Review**: Carefully proofread and review all written records to ensure clarity, accuracy, and professionalism.

## Knowledge and skills

Healthcare professionals must continuously develop and maintain their professional communication and information-sharing skills. Accurate records are relied upon during key communication points, such as handovers, referrals, and shared care situations.

**Responsibilities and Training**: All FNHC staff will be made aware of their record-keeping and record management responsibilities during induction. They will also complete specific and mandatory training tailored to their role.

**Additional Principles for Child and Family Services**: Staff working within Child and Family Services will follow additional principles outlined in [Appendix 1](#_Appendix_1_Record).

## Security and confidentiality

**Information Leaflet**: All service users will receive a leaflet titled “How We Use Your Information”, which explains why FNHC collects information about them and how it is used.

**Staff Responsibilities**: All staff have a duty to act in accordance with data protection legislation to maintain confidentiality.

**Safe Storage of Records**: Care records must be kept safe at all times. The methods and locations of storage, as well as access controls, are critical to ensuring the confidentiality of records.

**Awareness and Compliance**: Staff must be fully aware of the legal requirements and guidance regarding confidentiality. They must ensure that their practice aligns with both national and local policies, including the FNHC [Information Governance Policy](https://www.fnhc.org.je/procedure-library/).

## Access

**Access Rights**: A person’s right to access their health and care records (both paper and electronic) is governed by the provisions of the Data Protection (Jersey) Law 2018.

**Transparency**: People should be informed that their care records may be accessed by other professionals or agencies involved in their care.

**Withholding Information**: People have the right to request that specific information be withheld from certain health professionals.

**Right to View Records**: In most circumstances, people have a legal right to access and review their health records.

**Relevant Policy**: For further details, refer to the FNHC [Information Sharing Policy](https://www.fnhc.org.je/procedure-library/).

## Disclosure

Information that identifies someone must not be used or disclosed for purposes other than healthcare without the individual’s explicit consent. Exceptions to this rule apply in cases where disclosure is required by law or where there is a wider public interest. For example, information may be disclosed to prevent, detect, investigate, or prosecute serious crimes, or to prevent abuse or serious harm to others.

# PROCEDURE

## Record Keeping Process

**Timely Documentation**: Records should be completed at the time of the event or as soon as possible thereafter, ideally within 24 hours, unless there are exceptional circumstances. If notes are written after the event, this must be documented, clearly stating the time of the event, and the time of documentation (NMC, 2018).

**Accuracy and Integrity**: Records must be completed accurately and without any falsification. They should provide information about the care given as well as arrangements for future and ongoing care. Be factual, avoid jargon, speculation, and abbreviations (see also [3.2](#_Use_of_Abbreviations)).

**Clinical Alerts**: Key information such as allergies or adverse drug reactions must be clearly recorded in the appropriate sections of both paper and electronic records.

**Person-Centred Documentation**: Consider the person’s desired outcomes, including their views, wishes, and feelings. Include clear recommendations regarding actions, inactions, decision-making, and support that may help the person achieve their outcomes.

**Consent**: Consent to treatment and care must be recorded clearly and in accordance with the FNHC [Consent to Treatment and Care Policy](https://www.fnhc.org.je/procedure-library/).

Handwritten Records:

* Handwritten entries must be signed, timed, and dated in permanent black ink.
* Records should be clear, legible, and readable when photocopied or scanned.
* Each page of a handwritten record should include the person’s name and date of birth or EMIS number.
* Blank spaces or empty lines between entries should be avoided. Draw a line through any empty space at the end of an entry.
* Any alterations to handwritten records must be scored through with a single line, dated, timed, and initialed, ensuring the original entry remains legible. Correction fluid and highlighter pens must not be used.

Digital Records:

* Alterations to digital records must be traceable within the system.
* Digital/electronic records must clearly identify the individual providing the documented care.

## Use of Abbreviations

Family Nursing & Home Care endorses the guidance of the Nursing and Midwifery Council (NMC, 2018) and the Royal College of Nursing (RCN, 2014), discouraging the use of abbreviations by any member of staff. This ensures that the information in health records and other documents produced by FNHC is clear and understandable to all individuals accessing them. If an abbreviation is used, it must be written out in full the first time it appears in a particular entry, followed by the abbreviation in brackets.

## Delegation of Record Keeping Process

Record keeping can be delegated to non-registrants providing direct care, allowing them to document the care they have delivered (RCN, 2023).

As with any delegated activity, the registered professional must ensure that the non-registrant is competent to perform the task, and that delegating record keeping is in the service user’s best interests.

Supervision and a countersignature is required until the non-registrant is deemed competent in record keeping. Registered professionals should only countersign if they have witnessed the activity or can validate that it occurred.

## Security & Confidentiality

**Paper Records**

Paper records must be stored in a secure location.

Supplementary records kept in a service user’s home should be stored in an agreed location, with advice provided to ensure the security, privacy, and protection of the information from damage.

**Storing Records Overnight**

If it is not possible to return records to their secure base at the end of the working day, staff may store them overnight in their homes, provided they are kept securely to maintain confidentiality.

Under no circumstances should records be left in staff vehicles overnight or when vehicles are unattended. Records must not be left on vehicle seats or visible within the vehicle.

**Electronic Devices**

All electronic devices must be secured using password or code authentication.

During home visits, electronic devices should be stored securely in a bag or uniform pocket.

When transporting electronic devices in a vehicle, they must be stored securely and out of sight, such as in a locked boot. Devices must not be left in vehicles overnight.

**Record Accountability**

Staff must always be aware of the location of the records in their care.

Records should be accessible when required and retained in line with the Organisation’s Record Retention Schedule, as outlined in the FNHC [Information Governance Policy](https://www.fnhc.org.je/procedure-library/).

# MONITORING COMPLIANCE

Clinical audit may be used to monitor the standard of record keeping. Team Leaders should also monitor the standard of record keeping as part of the oversight of care. The quality of record keeping may also be monitored during investigations that involve reviewing service user records.

# CONSULTATION PROCESS

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Date** |
| Claire White | Director of Governance and Care | 27/12/2024 |
| Elspeth Snowie | Head of Quality and Safety |
| Tia Hall | Operational Lead and Registered Manager Adult Services |
| Michelle Cumming | Operational Lead and Registered Manager Child and Family Services |
| Teri O’Connor | Registered Manager – Home Care |
| Claire Whelan | Head of Information Governance and Systems |
| Justine Le Bon Bell | Head of Education and Development |

# EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and ‘religion, belief, faith and spirituality’ as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

**Always:**

* Putting patients first
* Keeping people safe
* Have courage and commitment to do the right thing
* Be accountable, take responsibility and own your actions
* Listen actively
* Check for understanding when you communicate
* Be respectful and treat people with dignity
* Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See below for the Equality Impact Assessment for this policy.

## EQUALITY IMPACT SCREENING TOOL

|  |
| --- |
| **Stage 1 - Screening**  |
| Title of Procedural Document: Record Keeping Policy (2025) |
| Date of Assessment | January 2025 | Responsible Department | Governance |
| Completed by | Rachel Foster | Job Title | Quality and Performance Development Nurse |
| **Does the policy/function affect one group less or more favourably than another on the basis of**: |
|  | **Yes/No** | **Comments** |
| Age | No |  |
| Disability*(Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia)* | No |  |
| Ethnic Origin *(including hard to reach groups)* | No |  |
| Gender reassignment | No |  |
| Pregnancy or Maternity | No |  |
| Race | No |  |
| Sex | No |  |
| Religion and Belief | No |  |
| Sexual Orientation | No |  |
| **If the answer to all of the above questions is NO, the Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 2.** |
| **Stage 2 – Full Impact Assessment** |
| **What is the impact** | **Level of Impact** | **Mitigating Actions****(what needs to be done to minimise / remove the impact)** | **Responsible Officer** |
|  |  |  |  |
| **Monitoring of Actions** |
| The monitoring of actions to mitigate any impact will be undertaken at the appropriate level |

# IMPLEMENTATION PLAN

|  |  |  |
| --- | --- | --- |
| **Action** | **Responsible Person** | **Planned timeline** |
| Policy to be uploaded to the Procedural Document Library | Education and Development Administrator | Within 2 weeks following ratification |
| Email to all staff  | Education and Development Administrator | Within 2 weeks following ratification |
| Upload policy (+/- assessment tool) to Virtual College and allocate to relevant staff | Education and Development Department | Within 2 weeks following ratification |
| Relevant staff to sign (via Virtual College) that they have read and understood policy. | All staff notified via Virtual College. | Within 2 months of notification |

# GLOSSARY OF TERMS

None

# REFERENCES

Government of Jersey (2018) Data Protection (Jersey) Law 2018. Available online via link: <https://www.jerseylaw.je/laws/current/l_3_2018> Last accessed 27/12/2024

Government of Jersey (2019) The Code of Practice: Professional standards of practice and behaviour for Health and Social Care Support Workers in Jersey. Available online via link: <https://carecommission.je/wp-content/uploads/2020/01/Code-of-Practice-Sept-2019-Final.pdf> Last accessed 24/12/2024

Jersey Care Commission (2022) Standards for Home Care. Available online via: <https://carecommission.je/home-care-standards/> Last accessed 24/12/2024

NHS England (2023) Records Management Code of Practice. Available online via link: <https://transform.england.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice/> Last accessed 24/12/2024

Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Available online at <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> Last accessed 24/12/2024

Royal College of Nursing (2014) EHealth Technology in Practice: Abbreviations and other short forms in patient/client records. Available online via: <https://interoperable-europe.ec.europa.eu/sites/default/files/document/2014-12/Royal%20College%20of%20Nursing%20Guidance%20Document%20-%20Abbreviations%20and%20other%20short%20forms%20in%20patient-client%20records.pdf> Last accessed 01/01/2025

Royal College of Nursing (2023) Record Keeping: The Facts. Available online via: <https://www.rcn.org.uk/Professional-Development/publications/rcn-record-keeping-uk-pub-011-016#detailTab> Last accessed 27/12/2024

# APPENDICES

## Appendix 1 Record keeping principles for Child and Family Services

|  |
| --- |
| Record keeping principles for Child and Family Services |
| The Mother’s record is the Primary document until birth. After birth the child’s record becomes the Primary document. For example, the new birth visit template is only attached to child’s record and not duplicated  |
| The importance of linking families on EMIS reduces duplication and ensures quality safeguarding  |
| References to sibling’s/parent’s records can be made in the current open record to reduce time in record keeping and by avoiding duplication |
| Hold information proportionately ie not opening father/partner records unless they are the main carer; record safeguarding in appropriate record with cross reference from linked records e.g DV, MARAC, JMAPPA  |
| Should a father’s record (outside of Baby Steps Programme) be required to be created on EMIS without consent, there must be a legal basis for doing so and a rationale documented in the records |
| Use Jersey Children First and Team Around the Child to collate a picture of the family. Focus should be on actions/analysis and plans |
| In line to the principle of ‘Working Together’, not to summarise minutes/notes of meetings but an analysis, plan and action / outcomes of record keeping |
| Be mindful of Subject Access Requests - A record should always be written with a view to that parent or child being able to request and read the record |