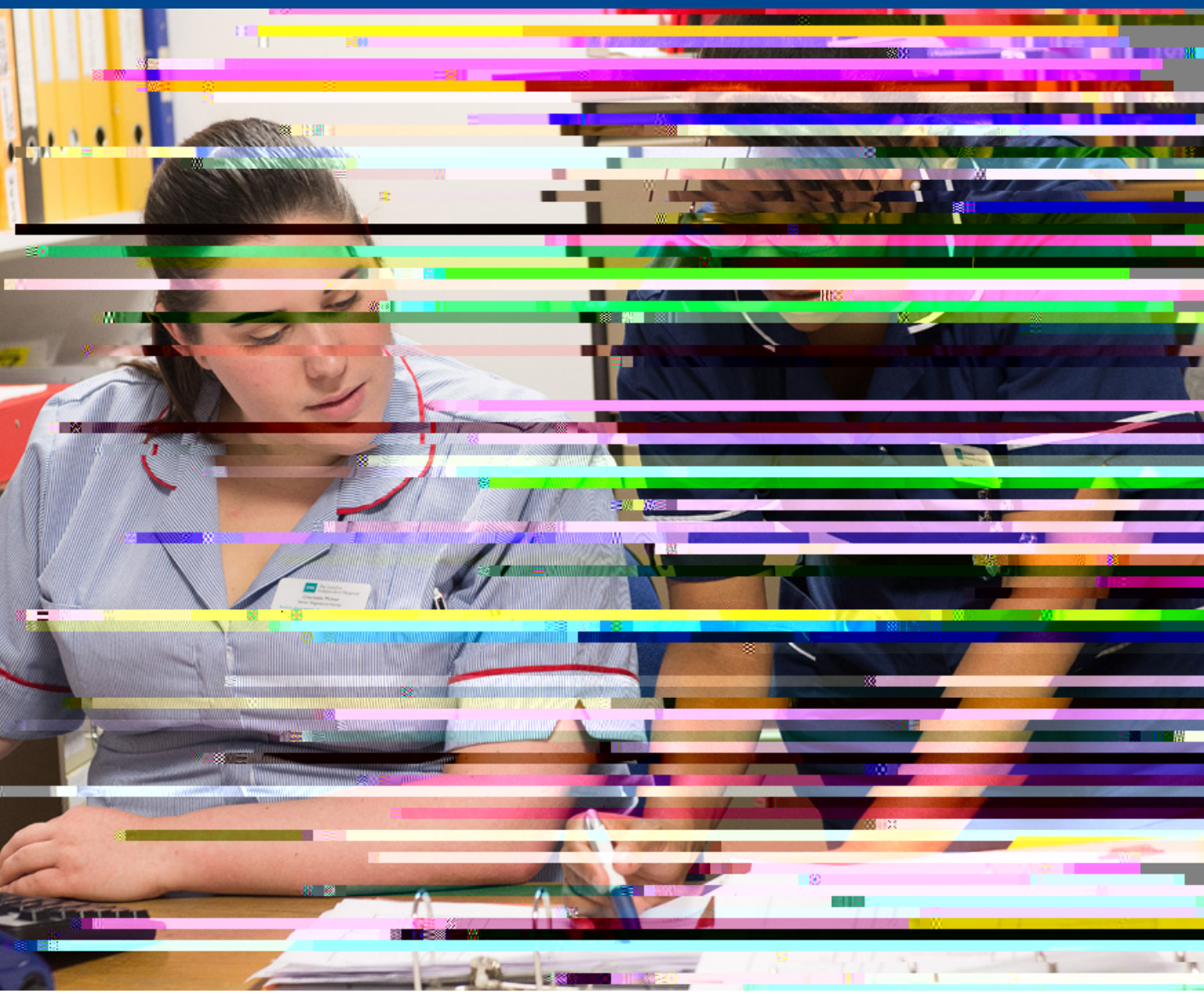
Record keeping

The facts



Good record keeping is a vital part of effective communication in nursing and integral to promoting safety and continuity of care for patients and clients.

All members of the nursing team need to be clear about their responsibilities for record keeping in whatever format records are kept.

Key principles

- Records should be completed at the time or as soon as possible after the event.
- All records must be signed, timed and dated if handwritten. If digital, they must be traceable to the person who provided the care that is being documented.
- Ensure that you are up to date in the use of electronic systems in your place of work, including security, confidentiality and appropriate usage.
- Records must be completed accurately and without any falsification and provide information about the care given as well as arrangements for future and ongoing care.

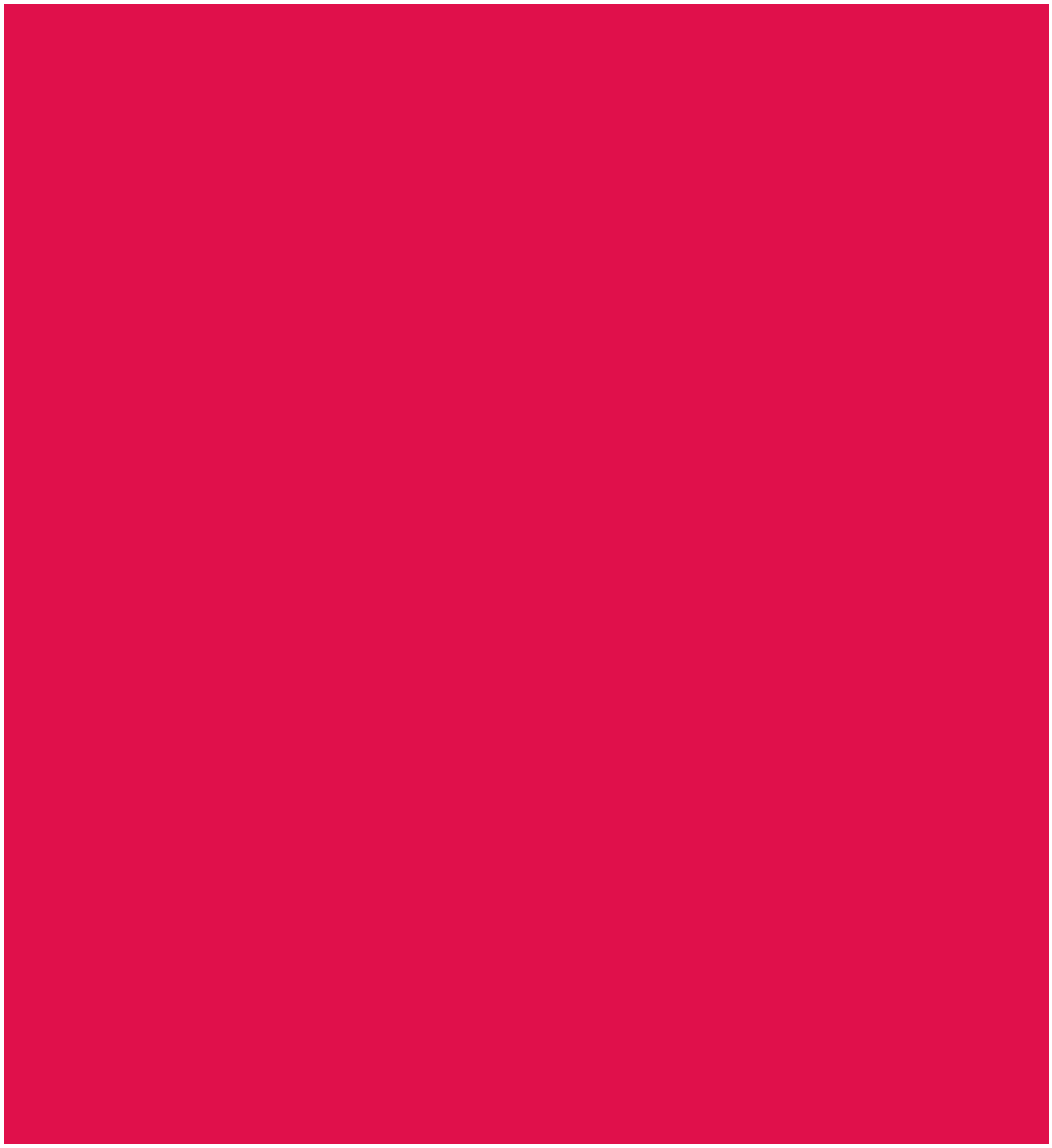
- Jargon and speculation should be avoided.

Countersigning

- Record keeping can be delegated to health care assistants (HCAs), assistant practitioners (APs), trainee nursing associates (TNAs), nursing associates (NAs), nursing apprentices and nursing students so that they can document their care.
- As with any delegated activity, the registered nurse needs to ensure that the HCA, AP, TNA, NA, nursing apprentice or student is competent to undertake the activity and that it is in the patient's best interests for record keeping to be delegated.

- Supervision and a countersignature are required until the HCA, AP, TNA, NA, nursing apprentice or student is deemed competent at keeping records.
- Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.

Always follow your local policy.



Workplace representation: advice, practical guidance and support on

011 016 | July 2023