GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Policy for the Completion and Maintenance of Maternity Records and Record Keeping

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INTRODUCTION

Record keeping is an integral part of clinical practice for nursing, midwifery and medical staff. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.
Good record keeping helps to protect the welfare of patients/ clients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multidisciplinary health care team
- Accurate account of treatment, care planning and delivery

Members of the public have the right to expect that health care professionals will practice a high standard of record keeping. The quality of a registrant's record keeping is a reflection of the standard of their professional practice. Good record keeping is a mark of a skilled and safe practitioner, while careless or incomplete record keeping often highlights wider problems with that individual's practice.

Good record keeping is, therefore, the product of good teamwork and an important tool in promoting high quality health care. (NMC 2005, HPC 2007, GMC, 2001).

AIM OF POLICY

This policy was developed inline with the Abertawe Bro Morgannwg NHS University Health Board 'Health Records Strategy' and aims to reduce the risk to patient care by:

- Improving record keeping standards by ensuring that patient information is recorded accurately and is stored securely in the health record.

- Ensuring that all relevant information is available to healthcare professionals either in paper or electronic format, wherever care is delivered.
- Ensure patient confidentiality is maintained at all times and that records are stored safely and securely.
- Key performance indicators are in place to ensure compliance with the policy.

OWNERSHIP OF RECORDS

The Secretary of State owns the records made by midwives employed by the NHS. The records of midwives employed in the private sector are owned by their employers. In the case of self-employed midwives, the midwife owns the records. In general the woman has a right of access to and copies of, records made about her care and that they should be written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. (NMC 2004)

RECORDS OF INDEPENDENT MIDWIVES/MIDWIVES EMPLOYED BY A DIFFERENT TRUST/HEALTH BOARD

When a midwife transfers a woman into a maternity unit from home or from one maternity unit to another, her records, with a detailed account of recent events, need to accompany the woman so that staff in the receiving unit can provide timely and appropriate care. This is in line with the principle of sharing records with other members of the healthcare team (NMC 2004). This principle equally applies to self-employed midwives and those employed by an organisation and not to do so could place the midwife in breach of her professional duty and for self-employed midwives, possible contractual duty to the woman.

On transferring care, the updated records should remain with the woman. Written duplicates of the original records should not be made as this could result in a delay. A summary is insufficient, as, by its very nature, it will omit information, which may be crucial to the on going care of the woman and her baby. It is acknowledged that in some cases photocopies of the records may be required however, this must not delay others in assessing the situation and providing necessary care to the woman and baby. The records of self-employed midwives should be returned to them after the care episode has been completed.

PATIENT RECORDS

All staff must ensure that records are kept correctly and securely and patient confidentiality is maintained at all times. All guidelines should be in line with current policies both local and national.

Everyone working for the NHS who records, handles, stores or comes across patient information has a personal common law duty of confidence to patients and to his/her employer. The duty of confidence continues even after the death of the patient or after an employee has left the NHS.

Information regarding patients has been historically stored in paper health records but with development in technology, some information is already being stored electronically.

RECORD KEEPING - COMPUTER HELD RECORDS

Health professionals are now regularly using information technology to record the planning, assessment and delivery of care. Computer-held records tend to be easier to read, less bulky, reduce the need for duplication and can increase communication across inter professional health care team. There is no requirement to keep manual duplicates of computer-held records and they do not replace the need to maintain dialogue throughout the inter-professional health care team. Safeguards for computer held records must be in compliance with the Computer Misuse Act 1990.
The principle of the confidentiality of information held about patients/ clients is as equally important in computer-held records as in all other records, including those sent by fax

PATIENT INFORMATION MANAGEMENT SYSTEM (PIMS IN THE EAST AND I.P.M. IN THE WEST)

The ward clerk and other administrative and clerical staff have an obligation to utilise the Patient Information Management Systems (PIMS+IPM) efficiently and effectively.

This is also the case for medical, nursing and midwifery staff that may have access to this system.

All individuals who in put PIMS+ and IPM must have their own password, and should not under any circumstances utilise that of a colleague.

LEGAL IMPLICATIONS

All health records are covered by this Policy whether they are hand-written or computerised and where they are held. Anything which makes reference to the care of the patient/client can be required by a Court or an Inquiry. This includes diaries containing patient information, other record books and correspondence relating to care of patients/clients. All clinical information should be recorded in the patient records. "If it is not recorded it has not been done". Patients can have access to both paper and computer held records governed by the access to health records (1990) and Freedom of information Act(2000).

All records are retained in line with Department of Health guidance, the Human Rights Act 1991 and the Caldicott Report, 1997. It is essential that all practitioners and their team members maintain a high quality system of record keeping, not only for safe and effective care of patients/clients, but to safeguard professional integrity.

THE DATA PROTECTION ACT AND 'CALDICOTT' AND CONFIDENTIALITY

Any enquiries regarding access to patient records should be processed to ensure the Caldicott Principles (DOH 1999b) and The Data Protection Act 1998 are met.
All practitioners are individually responsible for informing clients of any records created for them, the reasons they are kept and of any public health related data collected for the purposes of community profiling and health needs assessment, even if anonymous.
The Health Board has a Caldicott 'Guardian' in place to ensure the principles of the policy are implemented at local level. ABM UHB Caldicott "Guardian" is Dr. Bruce Ferguson.

All practitioners are obliged to protect all confidential information concerning clients obtained in the course of professional practice. They can only disclose information with the person's consent, where required by the order of a court, or where they can justify disclosure in the wider public interest and/or to protect a child/children or a vulnerable adult.

Particular care should be taken to protect confidentiality when leaving messages on answer phones and/or in message books.

EFFECTIVE RECORD KEEPING

(NMC 2009 PRINCIPLES OF GOOD RECORD KEEPING)

There are a number of factors that contribute to effective record keeping. This policy highlights that Patient /client records should ensure:

- Handwriting should be legible.
- All entries to records should be signed. In case of written records, the person's name and job title should be printed alongside the first entry.
- In line with local policy, you should put the date and time on all records. This should be in real time and chronological order and be as close to the actual time as possible.
- Your 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.
- You should use your professional judgment to decide what is relevant and what should be recorded.
- You should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
- Records should identify any risks or problems that have arisen and show the action taken to deal with them.
- You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information given about the people in your care.
- You must not alter or destroy any records without being authorized to do so.
- In the unlikely event that you need to alter your own or another healthcare professional's records, you must give your name and job title, and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable.
- Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.
- The language that you use should be easily understood by the people in your care.

- Records should be readable when photocopied or scanned.
- You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.
- You should not falsify records.

The N.M.C. midwives rule 9 states that practicising midwives shall keep (their notes) as contemporaneously as reasonable. Retrospective record keeping is not considered good practice. During emergency situations the role of record keeping can be allocated to a scribe. In the absence of a scribe, brief contemporaneous notes need to be taken and supplemented with further detail following the event. If supplementary record keeping is required it is essential that the date and time of writing is clearly recorded along with the date and approximate timing of events.

DOCUMENTATION

The assessment, planning and ongoing evaluation of the patients care must be documented. The registrant has a responsibility to ensure that any aspect of care delegated has been documented appropriately.
The registrant must use their professional judgment to decide what is relevant and appropriate to record – NMC Record keeping guidance(2009)
Registrants have both a professional and a legal duty of care. Their record keeping should therefore be able to demonstrate;

- a full account of the assessment and care that has been planned and provided;
- relevant information about the condition of the patient/client at any given time;
- the measures taken by the registrant to respond to their needs
- The frequency of entries will be determined both by the registrants professional judgement and local standards and agreements.
- Skill without knowledge, understanding and the appropriate attitude does not equate with competent practice. Thus, competence is 'the skills and ability to practice safely and effectively without the need for direct supervision' (UKCC, 1999; Watson 2002).

DELEGATION:

Registered nurses and midwives are professionally accountable for ensuring that any duties delegated to non registered members of the team are undertaken to a reasonable standard. Non-registered healthcare staff are a group of care providers that are neither registered or licensed by a regulatory body and have no legally defined scope of practice. The group includes titles such as Healthcare Support Workers, Associate Practitioners, Assistant Practitioners, Nursing Assistants etc.

If record keeping is delegated to a pre-registered nursing or midwifery student or a healthcare or midwifery assistant, these staff must be adequately supervised and the registered nurse or midwife should be sure the person is competent to perform the task. The registered nurse or midwife must countersign the entry with a full signature and remains professionally accountable for the consequences of any such entry.

MATERNITY RECORDS

BOOKING VISIT

Women booked for maternity care within ABM University Health Board carry their own personal maternity records as this system promotes continuity of care, and the woman's obstetric history is readily available to any maternity services she may need to access during the course of her pregnancy.

The booking appointment is undertaken either in the community or at the hospital. The booking information is entered on the patient information management systems and the demographics are entered onto the C.M.I.S(east) and evolution(west) maternity information computer system. At Neath Port Talbot Birth Centre and Singleton maternity department, the hospital notes are also given to the woman following her booking appointment. At The Princess of Wales Hospital the hospital records are retained in the antenatal clinic.

SUBSEQUENT APPOINTMENTS

The woman is advised to ensure that she takes her personal maternity record/notes to all appointments with her midwife, doctor and the ultrasound department or any healthcare professional she sees whilst pregnant. She is also advised to take her notes with her on holiday or if travelling.

ANTENATAL CARE

Midwives and Obstetricians should have access to guidelines, standards, individual case notes (past and present) and information packs to formulate a plan of care. These should include:-

- Guidelines for initial antenatal booking interview
- Personal Maternity Record
- Old case notes (if previous delivery in Singleton Hospital old case note requests are via the Antenatal Clinic Reception Manager)
- HEA Pregnancy book
- NHS Antenatal Screening Wales Information pack
- ABM University Health Board obstetric case sheet

INTRAPARTUM CARE – NORMAL LABOUR

There is clear and concise guidance for the completion of Maternity records within the All Wales Clinical Pathways for normal labour. Where deviation causes exit from the pathway, documentation and labour summary returns to the 'Progress of labour' sheet within the woman's personal health records.
Maintenance of the Partogram within the clinical pathway is imperative.

INTRAPARTUM CARE – ABNORMAL LABOUR – HIGH RISK

Documentation is recorded within the progress of labour record sheets, partogram and the labour summary sheets. They must be clear, concise and contemporaneous using the policies, guidelines and procedures in place within the maternity unit.

Any hand-over of midwifery care – meal breaks, change of shift – must be documented within the woman's labour records / Clinical pathway.

IMMEDIATE POSTNATAL DOCUMENTATION

Documentation will follow the pathway the woman's labour progressed.

- All Wales Clinical Pathway – normal labour
- Progress of labour and summary sheets – abnormal/high risk labour.

When women are transferred to the post natal care a record of the handover of care must be recorded in the records.

LOST OR DAMAGED NOTES

If the records are lost or damaged, another set of records must be prepared. The records must be clearly labelled as replacement records. If the original records are found then both sets of records must be kept together. If records are lost an incident form must be generated. All women should be managed as potential high risk in the absence of their case records

COMPLETED NOTES

When the woman has delivered, the completed notes are retained by the Health Board and filed appropriately in accordance with Health Board policy. Post natal records relating to the care women and baby's receive in the community must be returned to the Health Board when the midwife transfers the care to the health visitor at around 28days.

All records relating to the care of the woman or baby must be kept for 25 years. This would include work diaries if they contain clinical Information. Other documents, for example, duty rotas, are a matter for local resolution and where national guidelines are available, these should be followed.

AUDIT

Audit can play a vital part in ensuring the quality of care being delivered to patients/clients. This applies equally to the process of record keeping. By auditing records, healthcare staff are able to assess the standard of record keeping and identify areas for improvement and staff development. Rule 10 of the NMC Midwives rules and standards (2004) permit supervisors of midwives to request that midwives records be audited. This is primarily to confirm they are being kept as required by Rule 9 and to assist the midwife in making records.

Patients and clients should be equal partners, whenever possible, in the compilation of their records. Annual multidisciplinary audit of record keeping will be undertaken in the Maternity unit in line with this directive.

Sample of Record Keeping Audit Proformas used in 2008-2009 audit. These proformas change annually in line with Clinical Governance requirements.

RECORD KEEPING AUDIT 2008-2009
HIGH RISK CASE

ABM
Ymddiriedolaeth Prifysgol GIG
Abertawe Bro Morgannwg
University NHS Trust

HIGH RISK WOMEN ANTENATAL	YES	NO	N/A	COMMENTS
1. Were records completed with women's name, address, DOB and hospital number on every page?				
2. Was the next of kin recorded on the booking sheet?				
3. Was the BMI, smoking and alcohol completed on the booking sheet?				
4. Was the lead professional clearly recorded in the case notes?				
5. Taking into account the risk assessment – was the lead professional the appropriate clinician?				
6. Was there a decision documented re place of birth?				
7. If appropriate, was there evidence of referral to another health professional, such as physician or specialist?				
8. Who was the first point of contact?	Midwife	GP	Other	Please specify

HIGH RISK WOMEN ANTENATAL				
9. If appropriate, was there a management plan documented?				
10. If woman initially CBC but required referral to Consultant Care, was there a clear record of reason for referral?				
11. Is there evidence in hand-held records that routine enquire questions regarding domestic abuse had been asked?				
12. Did all CTGs have mother's name, hospital number and reason for performing CTG?				
13. Was there a signature at the end of the trace and ongoing plan of care?				
HIGH RISK INTRAPARTUM				
14. If high risk, is there evidence of a management plan written by medical staff prior to labour?				
15. If appropriate, is there evidence of documented risk factors when admitted in labour?				
16. Is there evidence of any telephone conversation in the records prior to admission in labour?				
17. If woman Consultant Led, is there evidence that the medical				

staff have reviewed the case notes and agreed an appropriate plan of care?				
18. Is partogram completed appropriately?				
19. Is there evidence of abdominal palpations prior to any vaginal examination?				
20. Did the records demonstrate evidence of change of carer for meal-breaks and change of shift?				
21. Did the CTG have details of mother's hospital number and reason for performing the CTG?				
22. Was the CTG stored appropriately?				
23. Was there evidence of timely and appropriate medical reviews during labour?				
24. If a N.F.B.S. was undertaken, is there evidence of an appropriate plan by medical staff?				
25. Is the summary of labour page completed?				

HIGH RISK POST DELIVERY				
26. If suturing was required, is there a record that swabs and needles are correct at the end of procedure?				
27. Is there documented evidence that armbands on baby have been checked with mother?				
28. If appropriate, is there evidence of Cord pH results in records?				
29. Is there evidence that care has been 'handed over' to the midwife on post-natal ward?				
HIGH RISK ON-GOING PUERPERIUM				
30. Is there evidence of a discussion of the birth experience by the appropriate professional?				
31. Is the discharge summary completed by the appropriate professional?				
32. Is there evidence of an appropriate post-natal plan being communicated to the community midwife?				

HIGH RISK GENERAL				
33. Were records completed in black ink?				
34. Were any entries difficult to read/understand?				
35. Did the records flow in an easy to read chronological order?				
36. Were the records in an appropriate condition?				
37. Did the records contain any abbreviations you didn't understand or may have had an ambiguous meaning?				
38. Were all entries signed by the caregiver with block signature (name printed) and designation on every page?				
39. Were pathology results filed appropriately?				
40. Was medication recorded appropriately?				
41. Were medicines recorded appropriately? 42. Was medication given, dated, signed and countersigned?				

RECORD KEEPING AUDIT 2008 – 2009
LOW RISK CASE

LOW RISK ANTENATAL	YES	NO	N/A	COMMENTS
1.Were records completed with women's name, address, DOB and hospital number on every page?				
2. Was the next of kin recorded on the booking sheet?				
3. Was the BMI, smoking and alcohol completed on the booking sheet?				
4. Was the lead professional clearly recorded in the case notes?				
5. Taking into account the risk assessment – was the lead professional the appropriate clinician?				
6. Was there a decision documented re place of birth?				
7. If appropriate, was there evidence of referral to another health professional?				
8. Who was the first point of contact?	Midwife	GP	Other	
9. Is there evidence in hand-				

held records that routine enquiry questions regarding domestic abuse have been asked?				
10. If a CTG has been undertaken, did it have mother's name hospital number and reason for performing CTG?				
11. Was there a signature at the end of the trace and ongoing plan of care?				
LOW RISK INTRAPARTUM				
12. IS there evidence of a completed part 1 of the pathway prior to completing part 2?				
13. Is part 2 completed appropriately?				
14. Are partograms on part 3 completed appropriately?				
15. Are variants recorded appropriately?				
16. If woman exits the pathway, is the reason for exiting clearly documented on the pathway?				
17. Did the pathway demonstrate evidence of				

change of carer for meal breaks and change of shift?				
18. Is the part 3 pathway documentation completed appropriately?				
LOW RISK POST DELIVERY				
19. If suturing was required, is there a record that swabs and needles are correct at end of procedure?				
20. Is there documented evidence that armbands on baby have been checked with mother?				
21. Is there evidence in the records that care has been 'handed over' to the midwife on the postnatal ward?				
LOW RISK PUERPERIUM				
22. Is there evidence of a discussion of the birth experience by the appropriate professional?				
23. IS the discharge summary completed by the appropriate professional?				
24. IS there evidence of an appropriate postnatal plan being communicated to the community midwife?				

LOW RISK GENERAL				
25. Were records completed in black ink?				
26. Were any entries difficult to read/understand?				
27. Did the records flow in an easy to read chronological order?				
28. Were records in an appropriate condition?				
29. Did the records contain any abbreviations you didn't understand or may have had an ambiguous meaning?				
30. Were all entries signed by the caregiver with block signature (name printed) and designation on every page?				
31. Were pathology results filed appropriately?				
32. Was medication recorded appropriately?				
33. Were medicines recorded appropriately?				
34. Was medication given, dated, signed and countersigned?				

DIRECTORATE OF WOMEN & CHILDREN'S SERVICES

PROFORMA FOR AUDIT OF POSTNATAL RECORDS

		YES	NO
1.	Is the front sheet completed?		
2.	Has the information for community care been completed?		
3.	Was there evidence of a good handover of care on the midwifery process to the community midwife?		
4.	Has the postnatal discharge sheet been completed (back of records)?		
5.	Has each entry been dated and timed?		
6.	Has the midwife documented reason for the visit?		
7.	Is each entry signed by the midwife?		
8.	Is there evidence of advice given to the woman, which will be clear for the next midwife to follow up on?		
9.	Is there documented evidence that the woman has been asked how she is coping/adapting to parenthood (psychological assessment)?		
10.	If any problems are identified, is there documented evidence of any actions taken and possible outcomes?		
11.	Has the woman been offered an opportunity to discuss her birth experience following her labour?		
12.	Is there evidence that an observation of a breast feed has been undertaken by the midwife		
13.	Has advice been given on contraception?		
14.	Is there written evidence that the midwife has transferred/handed over care to the Health Visitor		
15	How many visits did the community midwife undertake?		

Record keeping: notes and FAQs

Frequently asked questions and notes to accompany the NMC record keeping guidelines. The numbers below correspond to the numbered principles of good record keeping.

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1. The main benefit of keeping electronic records, instead of paper records, is that electronic records are much easier to read. If a hand-written record is illegible, the reader may not be able to understand what is recorded.

2. It is the signature that assists the mechanism of accountability since it is this that ensures that the actions of an individual can be traced. For a paper record this amounts to a signature. In electronic records this includes access logs, authentication and audit trails.

3. **How often am I expected to make entries into the record?**
You should use your professional judgement and follow your employing organisation's local policy. You should make entries more often for people in your care who:

- have complex problems;
- show deviation from the norm;
- are vulnerable, or at risk of harm or abuse;
- require more intensive care than normal;
- are confused and disoriented;
- generally give cause for concern.

Use your professional judgement and, if necessary, discuss the case with other members of the health care team to decide whether any of these circumstances apply.

4. Records provide documentary evidence of care that has been provided. They can be used to investigate complaints, at a local level and in criminal proceedings. They can also be used by supervisors of midwives, or local supervising authority midwifery officers, investigating critical incidents involving maternity care. They can also be used in evidence by NMC Fitness to Practise committees, which consider complaints about nurses and midwives.

You should assume that your records about the people in your care, may be scrutinised at some point. Care plans, diaries, birth plans and anything that makes reference to the person in your care may be used as evidence.

5. **Am I allowed to use abbreviations?**
Abbreviations are just one of the 'short forms' that are often used by nurses and midwives. Types of 'short forms' include acronyms, initialisations and other forms of text reduction. The use and management of short forms is inconsistent and there is no point of reference for acceptable, official or universally accepted short forms in healthcare.

We do not believe it is possible to provide an approved list of abbreviations for all nurses and midwives

across the UK. However, at a local level, it is important that abbreviations are unambiguous and universally understandable and do not rely on the context to give the meaning.

6. **Is it true that 'if it is not written down, it did not happen'?**
Courts of law tend to adopt the approach that 'if it is not recorded, it has not been done'. They base this on the assumption that:

- on any given day a nurse or midwife may provide advice or treatment to a large number of people in their care.

In contrast:

- the person in their care will not receive advice very often.

If there is no up to date record, and the matter comes down to one person's recollection, the courts and the NMC are more likely to accept the patient's account if:

- the patient denies that the incident happened; and
- the health professional has no direct record, or recollection, of it happening.

You must use your professional judgement to decide what is relevant and should be recorded, in particular when the condition of the person in your care is apparently unchanging and no record has been made of the care delivered. A local policy should be in place to define what a reasonable time lapse for these cases should be. Where the care delivered follows a recorded care plan, your own records should clearly state this fact.

You should enter any departures from the care plan in your records. This is called "exception reporting". Midwives must ensure that they are fully aware of, and comply with, the requirements set out in Rule 9 of the NMC's Midwives rules and standards, about maintenance and retention of records.

9. Nurses and midwives are increasingly expected to work in close collaboration with a wide range of health and social care agencies. It is expected that nurses and midwives will ensure that services delivered are appropriate to the needs of the people in their care and of high quality. This implies that nurses and midwives should communicate all relevant information to ensure that services delivered are both consistent and fully compatible with patient needs.

Sharing information about the people in your care is a highly sensitive and complex issue and is essential for safety and continuity of care. The right information should be available to the right people at the right time to provide individual care whilst preserving confidentiality.

To enable better joint working and secure a better focus on safeguarding children to support professionals in working together and sharing information The Children Act 2004 requires organisations to ensure that staff are appropriately trained and put processes in place to ensure that information is appropriately shared.

10. **What if I make a mistake in the record?**
Paper records: every entry in the record must be legible, even if it is has been entered by mistake. If you

make an error in a paper record, put a single line through the entry and sign it. Do not use correction fluid or anything that might make the entry hard to read.

Electronic records: there are specific requirements for electronic records to ensure their integrity, including an audit trail to track data entered and any changes made. Electronic records do change occasionally, and there are good reasons why entries may need to be changed, or removed from view on the record. (This is known as a deletion, however the unwanted record is not deleted from the system, but is not displayed on the screen.)

Tracking these changes is known as an "audit trail". This separate record is stored alongside the current electronic record. It acts as a log of all additions, changes or "deletions" to the original record. It enables a record to be taken back to any date and viewed as it was on that date. Audit trails are essential to see exactly what was happening at a given time. Without an audit trail, there is no reliable way of confirming that an entry is a true record of events at that time.

12. People receiving care are becoming increasingly involved in recording and holding their own health records. This should be encouraged as far as possible, provided that the person in your care is happy to be involved. It allows them a greater say in their own care, and gives you the opportunity to share information with them that is relevant to their ongoing care. You should explain the purpose and importance of the record, and that they are responsible for keeping it safe.

These principles also apply to records held by parents of young children. At the end of a period of care, the organisation responsible for delivering that care and compiling the record must retrieve records held by patients or parents. The records should then be kept as long as necessary.

Who owns the record?
The organisation that employs the record keeper is the legal owner of the record. Nurses and midwives working in an independent practice are self-employed, so they are the owners of the record. However, people in the care of self-employed nurses and midwives have the right to be given copies of their notes. They also have the same rights to confidentiality.

14. **Is there a legal requirement to use black ink for record keeping?**
Historically, nurses and midwives have been advised to use black ink so that their records are more legible should it be necessary to photocopy or scan them. However, with the advances in photocopier technology and the advent of electronic records the need for black ink is less of an issue.

Confidentiality
17. People have the right to confidentiality under data protection and human rights legislation, as well as common law. We expect all nurses and midwives to be aware of the laws that affect records and record keeping, and to familiarise themselves with their own organisation's local policies. Brief summaries of some of the relevant laws are listed below.

Common law duty of confidence
Common law supports the long established principle that health care professionals have a duty of confidence to the people in their care. There are exceptions to this duty. Some organisations, including the

Care Quality Commission, the Audit Commission and Primary Care Trusts are legally entitled to request the disclosure of information, Confidential patient information can only be disclosed:

a) with a patient's consent;
b) where it is required or allowed by law; or
c) where the disclosure is in the public interest - and this is considered to be greater than the individual's right to confidentiality.

Data Protection Act 1998
The Data Protection Act sets out eight principles which define the conditions under which processing (including recording, storage, manipulation and transmission) of personal data can be determined to be legally acceptable or otherwise. The Act also identifies the sensitive nature of health information and particular needs of health professionals to communicate that information between them. The Act gives patients rights of access to their medical records and applies to electronic and paper-based record systems. The eight principles state that the data should be:
1 – fairly and lawfully processed;
2 – processed for limited purposes;
3 – adequate, relevant and not excessive;
4 – accurate;
5 – not kept for longer than is necessary;
6 – processed in line with subjects' rights;
7 – secure; and
8 – not transferred to countries without adequate protection.

The Act states that patients should know who will see their personal data and for what purposes. It does not prevent the use of clinical data for health purposes, but the patient's consent may be needed for other uses. The common law requirement for consent, on the other hand, applies to all uses of confidential patient information. Ignoring any of these eight principles could be considered a criminal offence under the Act.

Computer Misuse Act 1990
The Computer Misuse Act covers a range of offences relating to unauthorised access or changes to computer records. It may apply where an unauthorised third party accesses information during its transfer. The Act is hard to enforce, so prosecutions are rare.

If the system is used by anyone other than authorised staff for approved purposes, it is likely to be considered a criminal offence.

Access to Health Records Act 1990
In the case of someone who has died, the Access to Health Records Act allows certain people right of access to that person's health record if they have an interest in the estate of the deceased. This rule only applies to records created after 1 November 1991.

Individuals could be refused access to the health records if the deceased person gave advance notice that such people were to be denied access to their record after their death.

Electronic Communications Act 2000

This Act sets in place an approval scheme for businesses providing services, such as electronic signatures and confidentiality services. It covers the processes under which electronic signatures are generated, communicated or verified.

Under this Act, the NHS are allowed to create and issue electronic prescriptions provided specified conditions are met.

Human Rights Act 1998
The Human Rights Act is based on the European Convention of Human Rights. The act identifies 15 human rights in Schedule 1 and requires public authorities to ensure that their activities do not violate these rights.

The Act provides a right to respect for privacy (article 8) that can only be legally set aside if it is considered necessary. The Government states that this right should be fully respected where the Data Protection Act 1998 and the Common Law duty of confidence apply.

Freedom of Information Act 2000
The Freedom of Information Act gives the public rights of access to all types of records held by public authorities. This includes GP practices. It sets out a series of obligations that public authorities have to meet. It also lists a number of exemptions from the rules about general rights of access.

Health and Social Care Act 2001
Under the Health and Social Care Act, the Secretary of State for Health (in England and Wales) may allow or request the release of patient information where disclosures would otherwise be restricted under common law. These powers have been exercised to some extent in The Health Service (Control of Patient Information) Regulations 2002, mainly in cases about processing patient information for the diagnosis and treatment of cancer, recognition, control and prevention of communicable diseases, or other risks to public health.

The powers provided under section 60 of the Health and Social Care Act can be used to provide exemption from the need to obtain the patient's consent under the common law duty of confidence. There is no exemption from the rules governing the Data Protection Act 1998.

What are the minimum retention periods for health records?
The NMC has no mandate for setting retention periods for health records. You should check the policy of your employing organisation to identify local requirements. The NHS Records Management: NHS Code of Practice Part 2 provides an authorative source of information on the retention period for health record types. For example:
Diaries – health visitor and district nurse - It states the minimum retention period as "2 years after the end of year to which diary relates. Patient relevant information should be transferred to the patient record."

19. Records may be used for research, teaching purposes and clinical supervision but the principles of access and confidentiality remain the same and the right of the person in your care to refuse access to their records should be respected. The local research ethics committee should approve the use of records in research.

Access

22. Although the people in your care can expect their health records to be seen by different members of the multi-professional health care team, this should only be where necessary. Information should not be made available or disclosed to unauthorised individuals. Organisations must ensure that access to clinical information is controlled, so that only authorised individuals have access. Only authorised Health and Social Care professionals involved in a person's care can access that person's record. Access will be on a 'need to know' basis according to the nature of the person's job. Authorised staff can see the information if they have a 'legitimate relationship' which means they are involved in that person's care. They only see the information they need to do their job.

Disclosure

27. The person receiving care must give their "informed consent" before their confidential information can be used or shared with other parties. A patient's consent can be implied or expressed, but they must be fully informed about their rights and aware that they have a choice. This rule will apply unless there is a clear legal basis for overriding confidentiality, or it is in the public interest to breach confidentiality. There should be a balance between individual and public interests. The Human Rights Act 1998 says that public interests should only prevail over an individual's interests if it is necessary to do so to achieve a legitimate aim in an appropriate manner.

28. What information must I disclose to the police ?

Under English law, citizens do not have to answer questions asked by the police. However, there are some situations where disclosure is required by law. For example, under the Terrorism Act 2000, a person can be prosecuted if they withhold information relating to acts of terrorism. The Road Traffic Act 1998 requires nurses and midwives to give the police, when asked, the name and address of drivers who may be guilty of an offence.

The police have no automatic right to demand access to a person's records. Police access to medical records for their enquiries is regulated by law. Usually, if the police want to see a person's medical records, they must have a warrant under the Police and Criminal Evidence Act 1984. For example, if the police want to enter a hospital, to examine medical records or samples of human tissue, they must apply to a circuit judge for a warrant. The police do not have to tell the patient that they are accessing confidential information about them, only the person who is holding the information must be told.

Under the Police and Criminal Evidence Act 1984, nurses and midwives can pass on information to the police if they believe that someone may die, or be seriously harmed, if the police are not informed. You should always discuss the matter fully with colleagues before you do this. You may also want to consult the NMC or your professional body or trade union. You should make sure that you are aware of your organisation's local policies for dealing with such matters. If possible, you should also discuss the matter with the individual concerned and ask for their consent to disclose confidential information about them. If you pass on information to the police without the person's consent, you must tell them that you have done so. You must keep a record of the discussion and your decision.

Information systems
29. What does the NMC think about electronic patient records?

We are keen to ensure there is a clear process for the safe transition from paper-based records to electronic records. We support all efforts to design and develop new Information Communication Technology (ICT) systems.

The templates for paper records may vary but, generally, nurses and midwives find them easier to use. Computer systems for electronic records vary between suppliers. Also, many nurses and midwives are not confident about using ICT.

Your main focus when deciding on the content of electronic records must be the people in your care. Information systems should enable you to practise safely while meeting our and your organisation's standards.

All four countries of the UK now have national programmes for Information Communication Technology (ICT) aimed to support healthcare staff to deliver better, safer care. You can find out more by visiting these websites:
England – www.connectingforhealth.nhs.uk
Wales – www.wales.nhs.uk/ihc
Scotland – www.ehealth.scot.nhs.uk
Northern Ireland – www.dhsspsni.gov.uk

What about email?
The practice of transferring clinical data by email is not yet widespread in healthcare. With the exception of emailing pathology results, few organisations receive information from outside in this way. However, the NHS plans to introduce electronic communications across the organisation. In the future, GPs can expect to see emails relating to referrals and discharges, radiology reports, electronic prescriptions and GP-to-GP transfer of records.

What about text messaging?
All staff should be fully trained to use new forms of communications local protocols should be put in place, together with an up-to-date confidentiality policy that includes the use of mobile phones. All messages should be documented and include the following information:

- text
- telephone number
- time
- response
- any appointment made or referral to other agencies
- date
- signature of nurse/midwife

This information should then be treated in the same way as other records, in keeping with NMC guidelines and local policy.

31. Confidentiality should not be put at risk because of the way information has been recorded. This means that paper and electronic record keeping systems should include measures to control access and make sure that the system is secure and private. There should also be measures in place to ensure that communication between different systems is protected. You must be aware of, and comply with, all security measures designed to protect people's health records. Your organisation should have local policies and procedures in place to ensure that this happens, together with disciplinary procedures where necessary.

Personal and professional knowledge and skills

33. **What is the NMC's view on students and Health Care Support Workers (HCSW) in relation to record keeping?**

If you delegate duties to members of the multi-professional health care team who are not registered practitioners, you are responsible for ensuring that these tasks are carried out to a reasonable standard. (Delegation means asking a colleague to provide treatment or care on your behalf.)

Although you will not be accountable for the decisions and actions taken by the delegated person, you will be responsible for the overall management of the person in your care. You will also be accountable for your decision to delegate. If you delegate the task of record keeping to pre-registration students of nursing or midwifery, or to HCSWs, you must ensure that they have the knowledge and skills to carry out this task, and that they are properly supervised. If the student or HCSW is not yet considered competent in keeping records - an opinion that may have been voiced in their performance assessments for example - then you must countersign their entries, either in writing or electronically. You have a duty to ensure that records completed by students or HCSWs under your supervision are clearly written, accurate and appropriate.

34. **What does the NMC think about the audit of records?**

An audit is part of the risk management process, the aim of which is to promote and improve quality. If we improve the processes and outcomes of health care, the risks to people in our care are minimised. Improvements also help to reduce our costs.

While an audit plays a vital part in ensuring quality of care, it also helps with record keeping. An audit will help you assess the standard of record keeping and identify areas for improvement and staff development. Organisations should agree how they are going to monitor and measure the standards of record keeping and encourage discussion. Whatever audit tool or method is used, it should focus on the interests of people, rather than the organisation's interests.

It may be useful, when auditing, to include a system of peer review. The need to maintain confidentiality applies equally to the auditing process as it does to the record keeping process.

Under rule 10 of the NMC Midwives rules and standards (2004) your supervisor can ask for your records to be audited. Primarily, this is to confirm that they are kept as required by Rule 9, but it will also help you when you are making records.

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