Sign up to safety

Record keeping and documentation

Good record keeping is the mark of the skilled and safe practitioner and is an integral part of everyday practice. The records you produce are there to give a clear and accurate account of the care and treatment of patients, helping to ensure they receive the best possible clinical care.

Records should be:

- Legible and jargon free.
- Demonstrate thorough assessment and clearly state a plan of care
- Include nursing care plans individualised to meet the needs of the patient
- Dated and timed (using 24hour clock) with the individuals name printed and signed including professional registration numbers where applicable.
- Written with the patient/carer wherever possible

New nursing documentation goes live on 17 November – please ensure you are familiar with the changes that affect you.

Core nursing care plans can be found on the nursing and midwifery intranet page – http://stas16/intranet/services-a-z/nursing-and-midwifery-professional-practice/nursing-care-plans/