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Community Practitioners Responsibilities for Record Keeping: Best Practice in an Electronic Age

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Practice Context

Patients have access & control over their record

Information for choice & helping patients navigate systems

The primacy of the electronic record over the paper version

Changing practice – email, video conferencing

Continuing electronic record evolution

Information Governance - sharing & shared records

Outcome measures

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NMC Record Keeping: Guidance for Nurses & Midwives 2010

Applies to both paper and electronic records

Explains what is expected from all NMC Registrants

Record Keeping Standard currently under development

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Good Record Keeping

- an integral part of nursing and midwifery practice, and essential to the provision of safe and effective care

- not an optional extra to be fitted in if circumstances allow – is part of the episode of care

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Our Journey

Previously:

Paper records - child and generic

National PCHR (Red Book) with locally designed inserts

Developments overseen by a Records Group

Practice supported by locally agreed Standards based on NMC Guidelines and national policy

Record Audits and Training Programme *Defendable Documentation*

Changes made in light of national changes and when NMC Guidelines reissued

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Next Steps

Electronic Record Keeping System (SystmOne) introduced September 2009

Bespoke training

Back of house – RA, System Configuration & Development

Phased “Go Live” over four month period

Lessons learned & implemented during deployment

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Current and Future Developments

Established Electronic Records and Processes Group (ERPG)

- Participation and engagement critical
- Safeguarding Named Nurse core member

Online Information Governance training

Optimisation of SystmOne

Organisational Systems Group

Data Quality Improvement Programme

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Electronic Records & Processes Group

Review Templates to reflect Implementation of NICE Guidance, Essence of Care, and Organisational Policy

Caseload Organisation application of Service Levels
Caseload Administration

Development of Standards associated with electronic records & specific interventions for example School Nurse Pop In's, Health Visitor Clinics

Hazard Review & Quality Assurance process

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Data Quality

Endorses an accurate record of care events

Meets predefined specifications including reflecting effective delivery of the Healthy Child Programme

Allows consistent interpretation – by anyone

Enables tools for true measurement of business activity & evaluation of the clinical interventions and outcomes

Helps deliver accurate and timely payment for services provided

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Record Quality Issues

Use of language – succinct and unambiguous

Record reflects the decision making process – includes conclusions or explanations for actions, or omissions, to be planned or actions taken

Outlines the rationale for action based on your judgment of the situation and potential outcomes

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Questions and Comments

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