CARE PLANNING DOCUMENTATION
Does good record keeping distinguish a skilled and safe practitioner, when compared to incomplete record keeping? How?
KEY PRINCIPLES

❖ Records must be current, factual, accurate and evidence based, with SMART (specific, measurable, achievable, realistic and timed) objectives.

❖ Records must be written as soon as possible after an event has occurred or following an significant change in the residents level of need.

❖ Records should not include irrelevant speculation, jargon, inappropriate subjective statements and meaningless phrases.

❖ Professional judgement and criterial thinking must be used when recording
KEY PRINCIPLES

- Entries must be chronological.
- Entries should be written in a manner that cannot be erased.
- Entries must include the date, time and a signature or electronic authentication.
- Access to records is limited. Confidentiality and privacy apply.
- Records should be regularly audited.
What would you expect to see in your care planning documentation?
CARE PLANNING IS ...

- a clinical skill.
- a sets of written instructions for specific activities to be undertaken to assist the resident achieve their desired outcome.
- a guide for health care assistants on how residents daily care and support needs are to be met.
- nurse is legally and professionally accountable for any actions or omissions.
PURPOSE OF RECORD KEEPING IS ...

- to form the basis of residents care, support, treatment, review, and evaluation of progress.
- to assist with the continuity of care provided by staff.
- to meet legal, professional and statutory requirements.
What does the HDC complaint data show?

- In 30% of cases in the HDC complaint data inadequate documentation was noted as an issue, and this was most often in relation to residents’ progress notes and care plans. In complaints that have undergone a formal investigation, HDC has frequently found that inadequate documentation and care plans have contributed to care deficiencies.

Health and Disability Commissioner: 2010-2014’ Report
COMMON FAILINGS IDENTIFIED IN RESIDENT RECORDS ARE ...

- Each page of documentation not having the residents name, NHI and date of birth recorded.
- Illegibility of contents (including use of correction fluid) and staff signature.
- Date, time and signatures of staff not recorded on entries to records.
- Failure to record comprehensive initial and re-assessments of resident needs.
- Failure to complete assessments or assessments not completed in full.
- Failure to used assessment information to inform care planning.
- Failure to record comprehensive notes.
- No record or poor evidence of the changing needs of the resident.
- Failure to record conversations with other professionals.
- Inappropriate or none authorised use of abbreviations.
Are you personally accountable for any actions or omissions in your practice? Do you have to justify your decisions/professional judgements?
LEGAL, PROFESSIONAL AND STATUTORY OBLIGATIONS

- Health and Disability Services Standards 2008
- Health Records 2002
- HDC Code of Health and Disability Services Consumers' Rights Regulation 1996
- Privacy Act 1993
- DHB Service Agreement
- Employment Agreement
- Code of Conduct – Nursing Council of New Zealand
Health and Disability Services Standard 2.9

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

<table>
<thead>
<tr>
<th>Criteria 2.9.1</th>
<th>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</th>
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<tbody>
<tr>
<td>2.9.2</td>
<td>The detail of the information required to manage consumer records is identified relevant to the service type and setting.</td>
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<td>2.9.3</td>
<td>Where the service is responsible for the NHI registration of consumers, the recording requirements specified by the NZHIS are met.</td>
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<td>2.9.4</td>
<td>Where the service is not required to meet the data requirements of the NZHIS adequate consumer detail is collected to safely manage consumer information.</td>
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<td>2.9.5</td>
<td>The service keeps a record of past and present consumers.</td>
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<td>2.9.6</td>
<td>Management of health information mets the requirements of appropriate legislation and relevant professional and sector standards where these exist.</td>
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RESIDENT RIGHTS

- making the care and support of residents the first concern, treating them as individuals and respecting their dignity.

- working with others to protect and promote the health and wellbeing of residents.

- assisting with the continuity of care and support; with written evidence that a care / service have been delivered.

- providing a high standard of care and support at all times.

- being open and honest, and acting with integrity.
Progress Notes - Standards and Guidelines Published in and for the Health and Disability Sector.

- Document each assessment, event, visit, treatment, intervention, procedure and consultation as soon as practicable after an event (Standards New Zealand 2001).

- Include the time of recording and current information on the person’s care and condition (Standards New Zealand 2001).

- Document as frequently as the person’s clinical condition indicates is necessary (Standards New Zealand 2001).

- Document each client contact in the health record, or one entry per shift, whichever is more appropriate (Standards New Zealand 2001).

- Provide consumer information that is uniquely identifiable (Standards New Zealand 2008).

- Record information in an accurate and timely manner, appropriate to the service type and setting (Standards New Zealand 2008; NCNZ 2009).

- Use up-to-date and relevant consumer records (Standards New Zealand 2008).

- Maintain confidentiality of information (Standards New Zealand 2008; NCNZ 2009).

- Maintain records within a legal and ethical framework (NCNZ 2009).
REFERENCES

- Health and Disability Commissioner: 2010-2014’ Report
- HealthCERT Bulletin Issue 1, July 2010
- Health and Disability Services Standards 2008
- Health Records 2002