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Documentation and record keeping

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Aims and objectives

- To provide information on documentation and record keeping
- To understand why records are kept
- To examine legal issues relating to record keeping
- To gain an understanding of the standards required for documentation

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Documentation

- The writing of the patient record is an integral role of the registered nurse, midwife & Healthcare Assistant
- The nursing record is the written evidence of nursing practice (Tapp 1990) if it is accurate, timely and comprehensive, it reflects quality care.

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Documentation

- The key principles for quality records are outlined in Nursing and Midwifery Council (NMC) guidelines (2009).

- Good record keeping - integral part of nursing and practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. (NMC 2009)

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Why keep quality records?

- Greater involvement of patients in making choices about care
- Patient centred care
- Patients having access to their own records
- Technology
- Clinical audit
- Clinical negligence

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Poor record keeping

- Inappropriate remarks
- Abbreviations
- Undermines patient care
- Makes you vulnerable to legal and professional problems
- Increases your workload
- Vague comments – “reasonable”, “adequate”

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Guidelines for practice

- Frequency of entries should be determined by professional judgement and local standards.
- Records need to follow a logical sequence with clear milestones and goals.
- Things that have not been done need to be documented as well as those that have.
- Registered nurses are **not** professionally accountable for entries made by student nurses and healthcare assistants

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Patient records should:

- Be factual, consistent and accurate
- Be written as soon as possible after an event has occurred
- Provide current information on the care and condition of the patient
- Dated, timed and signed with the *signature printed alongside the first entry*
- Be written in terms the patient can understand, and when possible with the involvement of the patient
- Not include abbreviations, jargon, meaningless phrases, irrelevant speculation or offensive subject terms
- Be readable on any photocopies- you should therefore write in black ink
- Alterations must be crossed out *with one line*, dated and signed. Ensuring the original entry can still be read

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Do not mistake Assumption for Fact

- If you didn't see it, hear it or do it, you don't know it. For example, rather than "the patient fell out of bed," write "I found the patient on the floor in a position consistent with a fall
- Record patients' comments and requests and those of relatives
- Use phrases such as "it was further reported that" write what the patient said they felt or perceived

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How much is enough?

- Use your professional judgement. Ask yourself: if I were caring for this patient for the first time, what would I need to know?

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Keep notes contemporaneous

- In an emergency situation there is not always time to make notes at every step but it is vital to record information as soon as possible and by law within 24 hours

Only write meaningful statements

- Comments such as “patient slept well” or “as per care plan” are meaningless. If you are suggesting changes in care, update the care plan accordingly and act on them
- Remember – if it isn’t in the notes, it didn’t happen

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Avoid abbreviations

- Abbreviations in one place may not mean the same in another. For example, CNS can be central nervous system or clinical nurse specialist. All staff – and the patient must be able to understand.

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Negligence & Law

- Careful and accurate records may assist if you are defending claims of negligence

- It is important that you record the reason for decisions, as well as the actual intervention undertaken

- To prove liability in negligence a claimant must establish 3 elements
  - Existence of a duty of care
  - Breach of that duty of care
  - Damage or injury

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Legal proceedings

- The first thing they ask to see is the records
- Patient records are often the deciding factor in whether or not a legal case proceeds
- If they find shoddy records, they assume shoddy practise and are more inclined to go ahead with a claim

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Negligence and Law

- Limitation act 1980

  3 years from which the injury occurred

  Negligence is a term used by the legal profession to assess in any given situation, whether a person's action or omissions have fallen below what is regarded by law as acceptable

  The employing authority is vicariously liable for any negligence which may be committed by a healthcare professional in the course of their employment

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ANY QUESTIONS?

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