

Discussing principles and importance of good record keeping nursing essay



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This essay aims to focus on record keeping. It will briefly discuss the Nursing and Midwifery Council (2009) guidance for nurse's and midwives and the importance of good record keeping in the health care setting. This literature will also discuss four of these principles. The first principle is of detailed assessment and reviews which helps set up a care plan. It then moves on to the next principle which discusses hand writing and how it should be written legible. The next principle that has been discussed is the one that records should be accurate and recorded in a way that meaning is clear. Finally the last principle that has been discussed is that records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation. It then progressively moves on to discuss how these four principles impact on a care plan and how they are maintained.

The Nursing and Midwifery Council (NMC 2009: 1) have guidelines for good record keeping, this helps nurses maintain good record keeping skills. Good record keeping skills is an important part of a nurse's role in the health care setting. It helps nurse's provide the correct and safe care towards a patient. Computer documentation is used in many of the health care settings, however hand writing in documentation is still widely used. The guidelines are used for both written and electronic record keeping.

The process of record keeping is every bit as important as hands on clinical skills to helping maintain patient's safety within the health care setting. It is not only important for monitoring a patient's treatment and medical condition, it is also important for any legal issues that may arise when providing care to a patient regarding any care or treatment they have received when in a health care setting (Griffith 2007: 363).

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There is a principle in the NMC 2009 for good record keeping that states “ you should record details of any assessment 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” (NMC 2009). This principle can help when putting a care plan in place for the care needs of a patient. When a patient first comes into any health care setting the first form of documentation is a written assessment of the patient and what their care needs are. This is a very important part of record keeping as it is the beginning of the care planning process.

Assessment forms will include vital information on the patient’s medical condition and what their care needs are. It is also important to have all information regarding next of kin in case a patient’s condition was to deteriorate (Miller and Gibb 2007: 250). A part of an assessment that is vital to a patient’s safety can be information regarding any medication. This can highlight what a patient may be taking at the present time or any medication that they have an allergy to. If information regarding allergies is clearly documented then all care staff involved are aware when delivering care to the patient (Diamond 2005: 460). The next stage in the care planning process is to put a plan into action to what treatment is best for the patient’s needs. All aspects of the patient’s care needs get reviewed so that all the patient’s care needs can be met.

Implementation moves on from the planning stage in a care plan. This stage involves the nurse in charge of the patient getting referrals from other care professionals to meet the care needs of the patient.

Evaluation is the final part of a care plan which looks at all the information recorded in a care plan. If the care needs of the patient have not been met then the health care professionals are able to make changes to the care plan for the best interest of the patient. This may include professionals at a different skill level, specifically to deliver that care and treatment. It is the health care professional's responsibility to record and review all information regarding patients care. This enables care progress and makes sure the patient's care needs are being met safely (Brooker and Waugh 2007 358).

One of the principles for good record keeping is regarding handwriting "hand writing should be legible" (NMC 2009). A way in which badly written documents can cause problems is if prescribed medication that has been recorded is not written clearly, not only the type of medication but also information on administering medication. If a patient's records are written clearly there is less risk to the patient's safety (Reddy 2006: 330). In any care setting good writing skills are very important as other multidisciplinary teams can be involved in a patient's care. It is important that they can easily read any treatment and care a patient is receiving and that all needs of the patient are being met. A care plan is a legal document so it is vital that all information can be easily read.

Any care professional who writes any information in a care plan is personally responsible for the information that they have written (Powell 2009: 300).

When a nurse writes in a care plan regarding treatment to a patient they may make a mistake and need to correct what they have written, this is the only reason why information can be changed. Correction fluid should never

be used in a care plan to cover any written mistake. A line should be put through the error that has been made and the appropriate notes should be written in. The person making the change to the care plan should sign and date when they made the correction so other health care professionals can see why the correction was made to the care plan (Diamond 2005: 261). This makes all written information in a patient's or clients care plan more easily to read and any individual who writes in the care notes should try and use a black ink pen on white paper. A patient's care plan is the main tool used in a care setting to communicate with different care professionals and services who may be involved in the care of a patient. In a variety of different care settings different coloured paper is used for certain medical interventions. It is important that any paper and ink that is used in a care plan can be easily photocopied, as at times copies of some of the patient's care plans may be needed (Griffith 2004: 123).

There is also a principle in the NMC that states “ your records should be accurate and recorded in a way that the meaning is clear”. All notes that are written about a patient's care should be clear so that any other care professionals who need to read the care plan know and understand what has been written. If a nurse was to write settled day what meaning does that actually have to other care staff. Care plans are helpful at finding out any care issues a patient may have. If there has been a problem regarding a patient's care and it has been resolved then this has to be clearly documented. When a nurse comes on shift and takes over the care of a patient and the patient's care notes may read awake most of the night due to being in pain and then did not write how she helped the patient overcome

this problem then this is poor record keeping skills. Highlighting every intervention while delivering care is vital and information should not be missed out. It may be the case that the patient received pain relief medication at the end of that previous nurse's shift. If this was not documented in the patient's care notes or kardex then the nurse who has taken over care of the patient may administer pain relief again, putting the patient's safety risk. Documenting and recording clear and meaningful information regarding a patient's care and any changes in a patient's condition is a skill, and it is essential care professional in a care setting get it right. All written and computerised notes should be spelt accurately and have a clear meaning. Spelling may not always put a patient's safety at risk but it's not always that way regarding miss spelt medication. Many medications do sound the same when you say them but they are spelt differently and this can put a patient's safety at risk (Diamond 2005: 568).

To keep records accurate all information written in a patient's care plan must have a date with the day, month and year the staff member who has documented the information in the care plan. The time of documentation should also be added using the 24 hour clock. If all information in a patients care plan is accurate and up to date it helps maintain good communication between all care professionals involved in the patients care (Griffith 2004: 124).

Moving on to another principle in the NMC for maintaining good record keeping is the one that states " records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation". One way this can cause a problem is if a nurse were to write in <https://assignbuster.com/discussing-principles-and-importance-of-good-record-keeping-nursing-essay/>

a patient's care notes using abbreviations or jargon. Nurse's who come on to a shift to take over the care of patient's have to be able understand what has been written to help them deliver care effectively. Records are an important part of a patient's care in which various health care professionals are involved in. Using abbreviations or jargon can put a patient's safety at risk as it may have a totally different meaning to another person (Brooker and Waugh 2007: 154).

The NMC try to advice health care staff not to use abbreviations and follow the principles for record keeping. In some health care settings abbreviations will be used and nursing students need to be aware of what they mean to avoid any confusion. One of the abbreviations that are used safely in a health care setting is BP which means blood pressure. Abbreviations get used in health care settings to try and save time on record keeping as it does take up a lot of the health care staffs time (Diamond 2005: 665). When care professionals follow these four principles of good record keeping it has an impact on a patient's care plan in many ways. A care plan has all the relevant information regarding a patient. Having the correct and up to date information regarding a patient helps maintain a patient's safety. Good record keeping has an impact on a patient's health and helps recognise any sudden changes in a patient condition. If all information is written clearly with the correct spelling then other care professionals involved in the care of the patient can clearly understand what has been written. A well documented care plan helps maintain good communication between all care staff involved in the care of the patient. Some care staff who are involved in the patient's care never see each other and a care plan is the only tool they

have and would use for communicating and knowing what treatment and care the patient has been given and what care still needs to be delivered to the patient (Greyer 2005: 24). A care plan is a legal document and all written information has to be accurate, clearly written and should not have any jargon or abbreviations contained in it. If a care plan is clearly documented with all the relevant information it impacts on the healthcare staff by safe guarding them in regards to any legal issues involving patient's including the care staffs involvement (Diamond 2008: 119).

A care plan is maintained by reviewing this document at regular intervals. Reviewing care plans helps maintain accurate and safe care towards a patient. The main purpose for reviewing care plans is to maintain continuity of care. A review will help care staff determine if all care needs of the patient are being met and to notice if any of the care needs of the patient have changed from the initial assessment (Miller and Gibb 2007: 272). An audit is another way to help maintain good record keeping of a care plan. An audit will check that all information is written clearly, with meaning, up to date and its accuracy. Audits can help highlight any inaccurate documentation and changes that can be made to rectify the inaccuracies within a document (Anderson 2000: 355).

Throughout this essay record keeping has been discussed and the importance of record keeping in the health care setting. It looked at the Nursing and Midwifery Council (2009) guidance for nurses and midwives and four principles of record keeping. It later discussed how these principles impact and are maintained in a care plan. Record keeping is an important skill that nurse's should have to maintain good communication between <https://assignbuster.com/discussing-principles-and-importance-of-good-record-keeping-nursing-essay/>

other care staff members regarding care needs of a patient. All care professionals involved in the care needs of a patient may never meet and only communicate through what they write in a patient's care plan. It is important that all information is written clearly and can be easily understood to help maintain continuity of care towards the patient. There could be a problem for some nurse's when it comes to writing information in a patient's care notes. One way of doing this is if a nurse comes from another country and English is not their first language then they might have some difficulty writing care notes and they need to be assessed to see if they are capable to write up notes correctly. Writing up care notes regarding a patient does take up time, many nurses feel the time used documenting information could be time used to treat a patient, but care plans are very important in the health care setting. Nurse's should try and not leave writing up care notes to near the end of their shift, they should try and set aside time to document all relevant information regarding care given and nursing interventions of patient. If nurse's leave writing up care notes to near the end of their shift and rush through what they are recording then this may cause them to miss out important information and could put a patient's safety at risk. A care plan is a legal document and nurses should be aware of this when writing any care or treatment in a patient's care notes. If all care notes are written clearly with no jargon then all other care professionals can easily read what the care needs are of the patient. Student nurses should be aware that good record keeping is a skill and it is every bit as important as clinical skills they will learn. If a nurse finds it difficult to read any information in a care plan, they should inform the person in charge. Care notes are vitally important to protect healthcare staff in the event of any legal allegations that a patient

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has made regarding care or treatment they have received from the nurse. A care plan is a very important document for a variety of different reasons so good record keeping is important in all health care settings.

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