Record keeping on patient safety and nursing practice

The following essay is going to explore how record keeping impacts on patient safety and on nursing practice. The assignment will explore four of the sixteen principles the Nursing and Midwifery Council (hereafter referred to as the NMC) has issued for good record keeping practice and how they are maintained. Documentation and record keeping are important to all aspects of nursing care and is essential in order to provide safe and effective care (Brooker & Waugh 2009: 368, NMC, 2009; 2) .

In order to discuss record keeping further it is necessary to define what a record is. The definition given in the data protection act is " A health record is any electronic or paper information recorded about a person for the purpose of managing their health care"(Data Protection Act, 1998) Examples of records are care plans, food charts, emails or texts with relevant information regarding the patients care (Glasper et al 2009; 75-76). McGeehan (2008; 52) states that because of the pressures of nursing and the lack of time allocated to documentation maintaining good standards of record keeping can be difficult.

The function of patient records are to have an accurate documented account of the care and treatment that a patient has received (Griffith 2007; 363). This will allow the nurse and other staff involved with the patient's wellbeing to monitor progress and develop a clinical history. (Griffith 2007; 363). Griffith (2007; 363) also states that record keeping is an integral part of care that is every bit as important as direct care provided to patients. McGeeham (2007; 51) corroborates by conveying that " good practice in record-keeping can help protect the welfare of patients by ensuring high standards and

continuity of care in addition to improved communication between members of the healthcare team”

In addition to having an essential clinical function, patient records also provide an important legal aid (Griffith 2007; 363), as they provide evidence of a nurse’s involvement in the delivery of care for that patient, if they are sufficiently detailed (Griffith 2007; 363). Good record keeping is a vital means of recollection for a nurse who is facing litigation(Wood 2003; 26) eg, if a nurse is facing litigation the patient’s records will have been studied, from this an impression is formed of the professionalism of the nurse (Wood 2003; 26). A litigation outcome will be influenced by evidence from the patient record and more than the recollection of the nurse (Griffith 2004; 123). Griffith (2004; 123) maintains that litigation cases are won and lost depending on the strength of a patients’ records. Good record keeping reflects the care given (McGeehan 2007; 52) and any court will assume that “ if it has not been recorded, it has not been done” (NMC 2005).

Handwriting should be legible (NMC 2009; 2). All records whether they take the form of instructions, referrals or prescriptions need to be written in such a way that they are legible to anyone who needs to view them (Griffith 2004; 123). Griffith(2004; 123) validates this by stating “ It is essential that record entries can be read”. When writing in a care plan the nurse has a duty of care to ensure their writing is legible and if a record is illegible anyone who reads it may either miss-understand the text or not understand it at all (NMC 2009; 1). If any harm comes to a patient due to others not being able to read a nurses writing the writer will have some liability in negligence towards that patient (Griffith 2004; 123).

The first aspect of legibility that will be discussed is the clarity of the entry into the record. In order to maintain a record that is clear an ink must be used that contrasts with the colour of paper , such as black ink on white paper as suggested by Griffith (2004: 123)

According to Griffith (2004: 123) a good standard of Handwriting is also a part of the duty of care the nurse has towards a patient, therfore if hand-writing is illegible it can lead to misinterpretations of the record and can cause harm to the patient (Banning 2005; 69) Legibility also applies to the signature of the person who makes an entry in any records. (Griffith 2007; 364).

“ All entries to records should be signed. In the case of written records, the persons name and job title should be printed alongside the first entry” (NMC 2009; 2). It is vital that the author of any statement in a health record is clearly and easily identifiable (Dimond 2005; 461) . Dimond (2005; 461) states that the person who administers the care or treatment should document the actions that they took and sign it. The access to health records act states that “ only health professionals or qualified practitioners allied to medicine and healthcare are eligible to sign documents. Glasper et al(2009: 77) state this means that all student nurse entries into healthcare records must be countersigned by a qualified practitioner. They go on to suggest that the name of the signatory must be printed or written in block capitals under the signature at least once during the course of the record (Glasper et al 2009; 301). A signature could also take the form of an access log or authentication trail when dealing with electronic records (NMC 2009). If malpractice occurs the signature would help in identifying who is

accountable (Griffith 2007; 364). Dimond (2005; 461) insinuates that in order to maintain this principle there should be some form of system in place, which is easily understood and can be used by all applicable staff. Some examples of this could be using name stamps, nursing personal identification numbers, having a central register of all staff signatures or having summary information in all health records. (Dimond 2005; 461)

“ You should record details of any assessments 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; 2) It is vital that all assessments that a nurse performs are recorded, documenting a full and factual account of any assessment that has taken place, the planned care made on the basis of the assessment and later the outcome of the care given (Glasper et al 2009; 77). This means that progress made and care that will be implemented must be clearly stated (Griffith 2004; 124). While writing in the health care record the nurse should give clear, objective information that includes any actions they took with regard to observations or changes(Glasper et al 2009; 77).