

# Good record keeping in protecting welfare of patients



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The purpose of this essay is going to look at four of the principles from the Nursing Midwifery Council (NMC) document, principles of good record keeping. The NMC is the United Kingdom's regulator for the nursing and midwifery professionals. It is a professional's responsibility to follow the NMC code, principles of good record keeping, to help safeguard the health and wellbeing of the public (NMC, 2009). These four principles chosen states, " Individuals should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements that have been made for future and ongoing care, including any details of information given about care or treatment" (NMC, 2009). " Ensure records should be accurate and recorded in such a way that the meaning is clear and additionally" (NMC, 2009). " Where appropriate the person in your care or their carer should be involved in the record keeping process" (NMC, 2009) and finally " Individuals have a duty to communicate fully and effectively with colleagues, ensuring that they have all information they need about the people in their care" (NMC, 2009). In addition to these four principles this essay is going to discuss each principle and the impact they have on a patient's care plan and how they are maintained in a patient's care plan.

Record keeping is a fundamental part of nursing and midwifery practice (Giffiths et al, 2007: 1324-1327). The role of good record keeping is to ensure that all healthcare professionals know what care and treatment the patient is receiving. The first principle of good record keeping being discussed states " individuals should record details of any assessments and reviews undertaken and provide clear evidence of arrangements that have

been made for the future of ongoing care. This should also include details of information given about care and treatment” (NMC, 2009).

One of the main evidenced based records in a care setting is a care plan. A care plan is a written record that informs individuals about the care and treatment of the patient (Barrett et al, 2009: 5-6). Care plans can be developed by using, the nursing process. This involves a step by step approach involving assessment, planning, implementing and evaluating. This method provides a frame work for professionals, enabling a care plan document to be produced to meet the needs of the patient and protect their welfare (Wright, 2005: 71-73).

When a patient is admitted into a care environment undergoing an assessment is essential. This should cover all basic needs such as hygiene, social, physical and safety needs of the patient, which also includes internal homeostasis needs like temperature, pulse, respiration and blood pressure (Geyer, 2007: 29-30). While patients care is ongoing, a document that is widely used within an acute side of the health care setting is EWS; this early warning sign document is a tool that protects the welfare of patients while receiving care from professionals. This tool can enable early detection of the deterioration of a patient, based on measuring vital signs. This tool can highlight risk when monitoring patients and detect when the need for further intervention is required off skilled practitioners (Mohammed et al, 2009: 18-24). Assessments can involve a variety of tools the purpose of these tools is to help professionals do their job properly and help toward assessing priority of care (Barrett et al, 2009: 87-94). Assessing and planning are ongoing while the patient is receiving treatment. Documenting in a patients record <https://assignbuster.com/good-record-keeping-in-protecting-welfare-of-patients/>

while care is ongoing shows clear evidence of what as to be established, demonstrating the interaction that multi disciplinary teams provides, from the time a patient is admitted in to a care setting to when they are discharged (Barrett et al, 2009: 20-23).

Within a care plan relevant information is stored about the patient, this should enable all professionals to develop a knowledge of the patient and enable them to have an empathetic understanding of the social, psychological and physical wellbeing of that individual (Barrett et al, 2009: 47-56). A patients individual file will also contain details about the history of the patient, this can highlight any risk apparent, ensuring all professionals delivering care to individuals are aware of the patient's condition, any known allergies, care required to be delivered and any treatment the patient is receiving.

The assessment and planning stage of the nursing process provides an accurate method of which the care plan document can guide professionals. The implementing stage enables professionals to deliver the care agreed and planned throughout written communication. The evaluating stage enables professionals to see if care has been planned effectively. These four methods of the nursing process is a requirement when developing a care plan this then enables multi-disciplinary teams to be able to provide effective care when protecting the welfare of patients (Wright, 2005: 71-73). It is important that the whole care planning process is documented from assessment to evaluation as soon as it has happened, incomplete documents can cause the patients to suffer through no fault of their own, professionals have a legal responsibility to record documents and the NMC insists that is has to be done <https://assignbuster.com/good-record-keeping-in-protecting-welfare-of-patients/>

well. There are a variety of ways documents can be recorded. However, written and electronic methods are the main ones widely used within a care environment. With whatever method used records should remain accurate and easily understood. The principle of good record keeping from the NMC, 2009 also suggests that “ records should be accurate and recorded in such a way that the meaning is clear” (NMC, 2009). Implementing good record keeping in a care plan is relevant for the importance of promoting the welfare of patients. All health records should be legible, as clinical records are shared the whole time a patient is receiving care or treatment. Health professionals read through records on a daily basis and it is important that the information in documents can be understood (Powell, 2009: 300-301). Records can contain poor handwriting and can be very difficult to read, this can have an effect on how care is delivered to the patient. If individuals do not understand the writing within a patient’s records, mistakes can occur and put patients at greater risk. Health care records provide a lot of information about patients and it is vital it remains correct. The type of errors made when recording information can include, unreadable hand writing, jargon, spelling errors, typing errors and not recording essential information. Missing out information while documenting in records can put a patient at jeopardy and this highlights a cause for concern. For example a patient who has been given their medication; then the nurse who gave the medication forgot to document it. If professionals do not receive information of when and what time and date medicines were given to a patient, it may mislead other nurses taking over from another shift causing professional errors and risk of an overdose may occur to the patient (Dimond, 2005: 568-570).

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When recording in medical documents using medical abbreviations can be confusing, especially if the nurse is not familiar with the medical terminology. Medical terminology can be shortened down into a variety of abbreviations. The nursing and midwifery council make it clear that abbreviations should not be used as there are dangers in using them. Professionals may mistake abbreviations in documents and cause harm to the patient if the misunderstanding is implemented to the patient. For instance NFR; not for resuscitation or either way this could mean neurophysiological facilitation of respiration, which is a physical therapy. This abbreviation could cause fatal consequence if it suggests in a patient document that the patient is not required to have NFR and it is not made clear that within records. This is why abbreviations should not be used when recording information as all records should express a clear detailed response (Dimond, 2008: 196-198). Information in records should remain clear and accurate as they are a legal document, not only for the safety of the patient but it protects individuals from charges of negligence and other forms of malpractice. If a patient comes into any legal disputes, documents should remain professional as it is an individual responsibility as a professional to be legally responsible for what they write and all records should be legible to stand up in court if necessary (Powell, 2009: 300-301), this shows how crucial record keeping is. Brooker & Waugh 2007 states “ If nursing care is not written down then it did not happen”.

When documents are being produced, “ where appropriate the person in your care, or their carer, should be involved in the record keeping process” (NMC, 2009). This principle is an ongoing development throughout nursing

practice, as well as involving patients in any decisions about care and treatment. Communication between nurse and patient as to be developed to deliberate on the arrangement of care. Information within this discussion may come from close family members or carers, if the patient is not able to speak for themselves. Professionals require Information from relatives and other individuals close to the family it is vital in the within the process of record keeping, exchanging information is essential to provide safe care to proceed towards the patient. When information has been has been obtained from the persons involved, consent does have to be given by the patient/carer. Throughout the development of record keeping it is important to involve the patient or carers to clarify what care has been discussed, this is important because the client's needs have to be agreed with the overall concept of the care plan and the process of its delivery. This enables information to be shared throughout multi-disciplinary teams and allowing professionals throughout a variety of services to have access to their medical records whenever they may require it (NMC, 2008). Patient's records can be vital to staff members who do not know the patient to well, individuals giving consent for their file to be shared helps professionals to do their job for the best interest of the patient. This then allows the individuals to provide a duty of care and enables professionals to protect the welfare of their patients.

The last principle to be discussed additionally advises that “ Individuals have a duty to communicate fully and effectively with colleagues, ensuring that they have all information they need about the people in their care” (NMC, 2009). Nursing records are a significant communication tool; healthcare records are largely significant in communicating detailed information from

one service to another. Clinical records are a source of communication throughout the healthcare sector, providing information to protect the wellbeing of individuals. It is essential that communication is developed throughout multi-disciplinary teams to ensure all information is passed on regarding patients for which they have to deliver care. When professionals are exchanging information it provides a foundation for which the continuity of care to patients can continue. Information should be clearly reported to professionals so they are well informed of the client's condition, not only verbally but manually. (McGeehan, 2007: 51-54). It is not just about verbal communication throughout handovers, handing over information at the end of a shift can be quite brief, written documentation gives professionals the opportunity to look up on patient's information which holds important details regarding the patient. This is most valuable especially for staff covering shifts, on some occasion's relief staff have to be called in to cover staff shortage, they would not know the patient and it enables them to read up and gain an insight of the patient, including medical history, current treatment and what care to be delivered, therefore enabling them to deliver care confidently (Featherstone, 2008: 860-864).

However, discussing these four principles regarding the process of record keeping highlights the vast amount of impact these principles can have throughout a care plan document. This involves communicating throughout recorded documentation alerting multi-disciplinary teams of patient's details based on facts. This allows professionals to know what the patient requires and continue the care agreed to protect the patient from any harm.

Communication as an impact throughout a care plan, all recorded



information helps towards the progression of continuity of care that gets delivered throughout the whole healthcare sector enabling successful care delivery. Care plans are a document of evidence of arrangements made of which has to be delivered and the care that has been agreed. It provides stability to patients and professionals in connection to medical intervention between those involved ensuring a secure environment for which care can be delivered (Barrett et al, 2009: 13-14). The impact these principles have on a care plan can be recognised but the acknowledgment of the impact is highlighted when a care plan is being maintained.

Maintaining a care plan is a fundamental process which is established by reviewing and audits. Using these methods to maintain a care plan is essential as it is an ongoing process to protect the welfare of patients, reviewing and auditing can instigate the cause for professionals to look into a care plan further.

Audits of records allows professionals to determine how well policies are implemented within a care environment and how standards of care delivery are set. This helps establish best practice in nursing records and helps to reduce any risk towards the patient safety, which can arise from poor record keeping (Griffiths et al, 2007: 1324-1327). Information that has been recorded draws attention upon the needs of the patient. If a patient was complaining of chest pain over a period of time this would alert nurses and doctors to investigate the problem further and further medical intervention maybe required (Geyer, 2007: 23-24). Simply doing an audit raises awareness of the need to improve practice. Regular audits on documentation

have to take place to identify any necessary errors and ensure standards are maintained within healthcare facilities.

Reviewing is essential as ongoing factual records of a patient's health status can highlight changes in a patient's condition enabling professional's records to amend changes for the best interest of the patient when reviewing documentation (Brooker & Waugh, 2007: 368-369). Reviews are put in place to help evaluate a patient's plan of care, making sure that the care they receive is relevant to their needs at the time. The aim of reviewing documents and how they are maintained in a care plan is purposely to ensure that the welfare of the patient is being protected. Reviewing documents in a care plan focuses very much on the individual receiving care. However, the persons involved in providing care to the patient play a big part in the reviewing process to ensure all care is specific to the needs of the patient (Miller & Gibb, 2007: 271-271). Reviews and audits play a big part in how records are maintained keeping documents and practice current and up to date ensuring the best interest of the patient.

## Conclusion

The main purpose of record keeping is the care of the patient and it is considered as a fundamental part of nursing practice. It is crucial to the well-being of the patient and the delivery of care; it also ensures that professional standards are being upheld within a healthcare environment. Documents have an impact on everybody involved and the importance that records are written well and comply within the record keeping principles, sets standards to professional's in turn help contribute to the quality of care being given.

The consequences of poor record keeping are quite clear hence the requirement for medical staff to ensure that the proper procedures are undertaken. Professionals need to keep records to safe guard their patients while protecting their welfare, this highlights the need for this to remain as precise as possible throughout maintaining records while care is ongoing. Recording in documents can assist towards the continuity of care which provides a safe stable environment for the patient. Professional who work in an health care environment are aware that there work load can become be very busy, it is important that they do not let this effect their need to keep records. Time should be set aside for record keeping, if records are rushed errors can develop and poor quality of records can never be contributed to the quality of care. Good record keeping is a characteristic of a skilled practitioner and it is largely about the various forms of communication from one service to another. Communicating throughout delivery of care highlights why records should be recorded appropriately to the NMC 2009 principle of good record keeping guidelines. Following these principles enhances the fact of how vital record keeping is used to protect the welfare of the patient.