

# The importance of good record keeping



**ASSIGN  
BUSTER**

The purpose of this essay is going to look at four of the principles from the 2009 NMC document, Principles of Good Record Keeping. This is going to discuss how these four principles have an impact on a patient's care plan and how they are maintained in a patient's care plan.

The four principles that this essay will reflect on from the NMC 2009 Principle of good record keeping are:

1. Individuals should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing care, including any details of information given about care or treatment.
2. Records should be accurate and recorded in such a way that the meaning is clear.
3. Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.
4. 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.

### **Main body**

Record keeping is a fundamental part of nursing and midwifery practice, excellent record keeping can help protect the welfare of patients. (Giffiths et al, 2007). The role of good record keeping is to ensure that all members of the multi disciplinary team know what care and treatment the patient is receiving.

Individuals should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for the future of ongoing care. This should also include details of information given about care and treatment

A care plan can be developed by using, the care planning cycle. The care plan cycle involves, assessment of needs, setting goals and planning care, implementing care and evaluating care. This provides a frame work for professionals assessing, implementing and reviewing the care that patients require. Nazarko, (2007). (Elaborate) Explain care planning process

This principle from the NMC 2009 provides a base line which must be followed. When a patient is admitted into a care environment assessment is essential. Assessment is the first stage of the nursing process. This gives the opportunity for communication to develop between professionals and individuals receiving care, it enables discussions to take place that confirms the needs and requirements of an individual for ongoing care. Depending on the patient's need a variety of assessments can be put in place, these can include risk assessments, moving and handling assessments, continence assessments and dietary assessments. Assessments like these can help professionals establish a suitable plan of care for those individuals who require it. Assessments that are made are recorded for future ongoing care and can help towards the priority of care given, enabling the practitioner to maintain a duty of care towards persons involved. Some assessments are required to be carried out by professionals with different skill level, which enables supports mechanisms can be put in place to protect the welfare of people receiving care. Dimond, 2005). All these assessments can establish

clear evidence to provide a foundation base of what care and treatment professionals will be providing to the patients

The second stage of the nursing process involves goal setting and planning care. Patients who are receiving care within a health care environment should have a designated plan of care and this information is documented in a care plan. Care planning is a term that is used to demonstrate activities that multi disciplinary teams provides from the time a patient is admitted in to a care setting to when they are discharged. Settings can vary from hospital, care home to a community. (Barrett et al, 2009). Within this file relevant information is stored about the patient, this should enable all professionals to have an insight of who the patient is as a person and enable them to have an empathetic understanding of the social, psychological and physical wellbeing of that individual. (Dimond, 2005). 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. When a care plan is being structured the importance of how this should be documented should be taking into account. Two of the principles of good record keeping from the nursing and midwifery council 2009, suggests all handwriting should be legible and records should be accurate and recorded in such a way that the meaning is clear. (NMC, 2009). This principle from the NMC 2009 should be implemented in a care plan as it is relevant for the importance of good record keeping and promoting the welfare of patients.

All records in any documentation should be accurate and recorded in a way that the meaning is clear. Within all health records handwriting should be legible 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). When professionals are reading documents an ability to understand what is in the document is essential when protecting the welfare of patients. 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. Without having an understanding of what treatment or care should be given, mistakes can occur and put patients at greater risk. Care plans provide a lot of information about patients and it takes one minor error in how that document has been recorded. The error could include, hand writing should remain clear and readable and avoid any jargon or slang, missing information, spelling errors or not recording essential information. Missing out information out of patients records can put patients at risk. For instance any medication a patient is taking. Risk of an over does may occur, If professionals do not receive information of when and what time and date medicines where given to a patient, this may mislead other nurses taking over from another shift and cause errors. (Dimond, 2005).

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. Clinical records are a source of communication throughout the health sector, providing information to protect the wellbeing of individuals. It is essential that communication is developed throughout multi-disiplinary

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 base line to continue the continuity of care to patients. Information should be clearly reported to ensure that professional are well informed of the clients condition. (McGeehan, 2007). 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 patients information. This is vital especially for staff covering shifts for example is a relief staff have to be called in to cover shifts, as they would not know the patients it enables them to read up and gain an insight of the patient, including medical history, current treatment and what care to be delivered.

The Impact on a care plan

Protects the welfare and safety of patients

Safeguards harm to patients

Promotes continuity of care

Promotes good communication of care delivery between multi disciplinary teams

Care required to be delivered for the patient and the treatment the patient is receiving.

In a health care setting, 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. (Powell, 2009). As all healthcare documents are a legal document, documents should be legible to stand up in court if necessary. Brooker & Waugh 2007 states “ If nursing care is not written down then it did not happen”.

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Maintained in a care plan

### Reviews & Audits

Assessments and reviews on a patients care plan hold's evidence of patient's ongoing care. These are essential as records can highlight changes in a patient's condition by providing an ongoing factual record of the patient's health status. These can expose any risk developing with regard to the patient and enable individuals to amend changes when reviewing documentation and changes can be made for the best interest of the patient. (Brooker & Waugh (2007) 368).