Record keeping in the nursing profession

With all the important demands in any nurses' working day, as a nurse the individual may feel that keeping nursing records is a distraction from the real work that the members of a multidisciplinary team have to do: looking after patients. Unfortunately this is not the case; record keeping is actually one of the most important aspects of the nursing profession.

Without clear and accurate nursing records for each individual patient it is impossible for any member of the multidisciplinary team to remember everything that has been done and everything that has happened on a shift therefore affecting the wellbeing and safety of a patient. This aspect of patient safety and record keeping is not just beneficial to the nursing staff but also to the patient. The topics of record keeping and patient safety will be discussed throughout this essay with the use of articles from journals and NMC guidelines.

The Nursing and Midwifery council believes the record keeping is an integral and fundamental part of the nursing career. (NMC, 2010) Record keeping is a multidisciplinary approach and a professional tool which helps to assist in the caring process. Diamond States that all records must be kept but principle as part of the duty of care owed to the patient not for the protection of members of the multidisciplinary team. (Diamond, B, 2005)

A nures record keeping skills reflect on how they are as practitioners. If a nurses records are untidy, vague and just generally not good this suggest that the nurse in question is not as intersted in the patient or their safety as they should be, on the otherhand a nurse who is patient centred and cares

for their patients by ensuring that their nursing records are written following the NMC guidlines.

The NMC guidelines state that all records must be recorded timeously and consecutively and must be clearly written and permanent. They must also be factual, consistent and clear containing no jargon, abbreviation or meaningless phrases. Every entry into the patients notes regardless of which member of the multidisciplinary team has written it must all be dated, timed and signed with printed name and designation. If the individual has made an error they should never use correction fluid it should be singly scored, dated, timed and singed.

It is important that the records are written with the patient or carer and identifies the difficulties that the patient is having and the actions that are being taken to help the patient to overcome these difficulties. The records must show evidence of the care which is planned for the patient, decisions that were made, the care that the patient has received and the information shared and who it was shared with.

Good record keeping promotes a high standard for care as it suggests that the nurse is a safe and skilled practitioner with good communication who involves the patient in the discussions with other healthcare professionals. Good record keeping also provides an accurate account of care planning and delivery of care for each patient and may also provided a means of detecting a change in the patient’s condition early. Record keeping is a multidisciplinary way of working and is responsive to the patients needs.

There are various forms of records which nursing staff will keep regarding patient information and the care that they have or are receiving . These include care plans, the must screening tool and the early warning score chart.

The creation of a care plan is an intermediate stage of the nursing process. A care plan is a set of actions that a care worker will put in place to support the diagnosis that the nurse has given the individual. These diagnoses are determined by the initial nursing assessment. This helps to guide the ongoing care that the patient has received and assists in the evaluation of the care .

A care plan is also an agreement between a patient and the multidisciplinary team that they are closely working with to monitor their day to day health. The care plan may include goals that the individual would like to achieve, medicines, emergency contact details, eating and exercise plans and what services they require. When writing the care plan members of the multidisciplinary team have to take into consideration things like the must screening tool.

The malnutrition universal screening tool (MUST) is a five step screening tool used to identify adults who may be at risk of malnutrition or obese. It is the first step to identify individuals who may be a risk of malnutrition and who then may require some sort of intervention. It is a widely used tool by all members of a multidisciplinary team on first contact with a patient to enable them to decide on appropriate nutritional advice allowing them to develop an adequate care plan.

The five steps include weighing and measuring an individual's height to get their body mass index, noting the individuals unplanned weight loss and score using the appropriate tables, establish the effect the individuals health conditions have on their weight and score, add all scores from steps one, two and three together to find the individuals overall score then use local policy or management guidelines to develop the individuals care plan.

Finally members of the multidisciplinary team have to complete early warning score charts which are also part of the record keeping process. The early warning score chart is a method used by medical staff to be able to quickly determine if a patient is at risk of death by observing five physiological readings, these include the patients' blood pressure, respiratory rate, heart rate, body temperature and oxygen levels in the blood. They also observe the patients level of consciousness, nausea and how much pain they are in. Once all of these have been observed the chart is filled in and the patient is given a score for each between zero and three, if the individual has received a three for any of them then the appropriate implications can be put in place, if the score the individual receives is above five then there is an increased likelihood of death.

Every patient's information is protected by the data protection. The Data Protection Act 1998 defines a health record as " consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual". This applies to all types of records whether it is a handwritten note or a photograph.

The data protection act protects the rights of the individual in relation to data which is obtained, stored and processed or supplied regarding them. (NMC, 2010) The act requires that appropriate measures will be taken against unauthorised access to, or alterations, or destruction of personal data. Breaches are identified by the information commissioner.

It is also important that all records are kept confidential. All NHS staff have a duty to keep all records and information contained in those records about an individual confidential and stored away securely. (NMC. 2009) The only way personal health information may be shared with other is if the individual needs to know relevant information about the patients health such as a social worker, care or home help. The information may only be shared if it is needed to give the patient appropriate care and treatments or if the patient has given consent.

Usually Staff of the NHS will not share any information with relatives or carers without out the patients' permission but there are a few exceptions that can be made. These include if the patient is under 16. If this is the case the information in the records can only be shared if doctor doesn't think that the individual can make a medical decision then someone with parental responsibility may be allowed to look at the childs health records and make a decision on their behalf.

If the patient is over 16 information kept in the patients records can only be shared if the individual cannot make decision for themselves or cannot tell others their decisions, the law allows someone else to have access to their records and discuss their care if the individual has given them a welfare

power of attorney or a court has given them a welfare guardianship or a welfare intervention order. If this is the case then the individual will only be able to see information that is necessary for them to make particular decisions for the individual about their health and will not receive information that staff feel would be harmful to the health of the individual or others.

Confidentiality benefits patients' safety by providing a secure environment in which they are most likely to seek medical care and to give a detailed account of their illness. It also expresses respect for patients' right: They have a right to choose who will have access to information about them, and a rule of confidentiality for medical practitioners reassures patients that they can determine who will be having access to their personal information.

The main purpose of integrated record keeping is to have an accurate account of the care and treatments that the patient has previously had or is currently having. This allows the individualsp progress to be monitored and a clinical history to be developed. Having this clinical history will allow members of a multidisciplinary team to protect the patient as it gives information regarding the individuals' previous illnesses, allergies and previous medications. This allows the multidisciplinary team to organise a plan of action for the individual and prevents the individual for receiving unnecessary treatment or coming to unnecessary harm. Having this clinical history to hand will allow the patient to make the most of the time they have with any member of the multidisciplinary team, allowing them to get the adequate medical attention that they require. It also enables a common sharing of the elements of clinical process including the planned pattern of

care, the way it is delivered and the ongoing evaluation of the patient thus making the patient feel supported. At the same time, it will allow members of the multidisciplinary team to share their views on the patient and allow for data to be recorded and presented according to the views of members of this team. It also should include ways in which to monitor the quality of care.

Record keeping is a good tool for members of the multidisciplinary team to communicate effectively. (Hutchisons, C: Sharples, C. 2006) Being able to communicate through this media allows them to share important information about a patient's medical history or needs without having to talk about them. This will prevent the patient from coming to inadvertent harm.

Communication is an important aspect of good record keeping and patient safety as it is essential that the individual understands everything that is happening or is going to happen to them regarding their care and health. It also enables members of the nursing team whether it is physiotherapists, nurses or doctors to have knowledge of their patients' health. This is done through record keeping.

Another important consideration is the legal significance of nursing records. If an individual makes an official complaint about the care they received then the nursing records that are kept are the only proof that the members of the multidisciplinary team have fulfilled their duty of care to the patient. The records will show a full account of the patients' assessment, planning, the implications of their care and the evaluation of their care. It also enables lawyers to see all the measures taken to respond to the patients assessed needs. The records will show that the multidisciplinary team has understood

their duty of care and all the reasonable steps that the members of the multidisciplinary team have been taken to maintain the patients safety. They also include the arrangements for continuing care and the entries frequency are written to commensurate with the patients conditions.

In conclusion record keeping is beneficial to maintaining patient safety as it allows members of the multidisciplinary team have clinical history that prevents the patients from coming to any unnecessary harm. It also encourages good communication within a multidisciplinary team which will effectively plan the future care or current care of an individual. It includes all the important information that may help determine what the individual may have required medical attention for, for example passed medical conditions or allergies that the individuals may have. This allows members of the nursing staff notice any underlying health issues and resulting in the staff being able to treat it effectively, resulting in maintaining patient safety. Having good record keeping skills prevents from errors and mistakes from being made or going unnoticed therefore mainaing the safety of the patient at all times. This suggests that record keeping skills are essential in the nursing profession not just for the nursing staffs safety but that of the patients too.