

# DOCUMENTATION: KEEPING ACCURATE PATIENT RECORDS

The required high standards of consistency in healthcare can only be achieved through good communication and written documentation plays a significant part in this. Records will be subjected to audit as well as internal review and should match the standards set by individual healthcare organisations.

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Nursing documentation is the cornerstone of best practice. It serves many diverse, complex and important functions from ensuring consistency of clinical care and good communication between practitioners, to providing evidence in a court of law that patients have received appropriate, high-quality, evidence-based care... or, indeed, that they have not. The phrase 'if it is not documented, it was not done' should be the guiding principle used when documenting care in order to ensure that a clear picture of a patient's care history can be gained.

The NMC (2009) states that 'good record-keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow'.

A research study from 2006 found that nurse documentation suffered from disruption, incompleteness and inappropriate charting, which was attributed to the limited

competence, motivation and confidence of nurses, ineffective nursing procedures, and inadequate nursing audit, supervision and staff development (Cheevakasemsook et al, 2006). This highlights that nurses other healthcare workers have a long way to go before complete confidence can be placed in what is written by them.

## Documentation

The term 'documentation' is used to refer to any written or electronically generated information about a patient that describes the care or service they have received (College of Registered Nurses of British Columbia [CRNBC], 2007). An alternative, commonly-used term is 'record-keeping', where the word record may be defined in different ways, for example 'an account, as of information or facts, set down especially in writing as a means of preserving knowledge'; 'information or data on a particular subject collected and preserved'; 'the known history of performance, activities, or achievement'; or 'an account officially written and preserved as evidence or testimony' (see: <http://dictionary.reference.com/browse/record>).

Alternatively, the Data Protection Act 1998 defines a health record

as any electronic or paper information recorded about a person for the purposes of managing his or her health.

## The purpose of documentation

The NMC (2007) stresses the importance of the best record being one that has been agreed between the multidisciplinary team and the patient and is evaluated and adapted in response to changing needs.

Documentation serves many purposes such as aiding communication, providing evidence in case of litigation, research, statistical evidence, education, clinical audit and quality assurance, as well as contributing to care planning.

Qualified nurses are bound by the NMC's (2009) standards regarding accountability but all healthcare workers have a contractual accountability to their employer and are accountable to the law for their actions.

Good documentation provides evidence of continuity of care and communication. It also supports service delivery, effective clinical judgements and decision-making. Better communication and

effective sharing of information between the multi-professional healthcare team can ultimately improve patient care.

Good quality documentation will help to identify risks and enable early detection of complications. It also supports audit, research, allocation of resources and performance planning to ensure that the service can meet the changing needs of its users. Good quality documentation can also help when addressing complaints and/or informs the legal process and it may be used for or against the practitioner in legal cases.

The documentation recorded by all members of the multidisciplinary team (such as doctors, nurses, healthcare assistants, pharmacists, technicians, paramedics) may be subject to scrutiny by both internal reviewers and external bodies in case of complaint or alleged negligence.

### Scope of documentation

Practitioners must be clear about what is considered a healthcare record. The most commonly used are handwritten or computerised clinical notes, but many other forms of record are also used, for example letters, correspondence between healthcare professionals, emails, laboratory reports, X-rays, print-outs from monitoring equipment, photographs, videos, recordings of telephone conversations and text messages (NMC, 2009).

### Principles of record-keeping

The key principles that underpin

high quality records and record-keeping include addressing not only the content and style, but also the legal issues. The recording of all patient care must adhere to the following basic principles:

- ▶▶ Handwriting must be legible and permanent
- ▶▶ Dark ink should be used (so it will be clear when scanned or photocopied)
- ▶▶ All entries should be signed with a legible name and job title clearly stated
- ▶▶ Entries should include the date and time
- ▶▶ Records should be in chronological order, timely, concise and comprehensive
- ▶▶ Do not leave 'white space' – draw a line through it to indicate that the entry is complete
- ▶▶ Text should be clear, concise, unambiguous and accurate.

**“Accurate descriptions strengthen documentation so use specific quantities, actual dates and distances and, where pertinent, exact quotes from patients.”**

Notes should be detailed and objective. Accurate descriptions strengthen documentation so use specific quantities, actual dates, time frames and distances and, where pertinent, use exact quotes from patients. Vague and meaningless expressions or clichés such as 'slept well'; 'had a good day'; 'up and about' and 'wound healing well' should be avoided as they do nothing to enhance communication between clinicians.

All entries must be factual and should not include

jargon, abbreviations or irrelevant speculation. Many organisations have an approved list of abbreviations and only these should be used. Using unauthorised abbreviations can cause serious errors or, at the very least, waste people's time when trying to find out what they mean.

The individual's professional judgement must be used to decide what is relevant and should be recorded and what is unnecessary. Details of assessments and reviews should be recorded with notes made of any risks identified or any problems that arose with the actions taken to remedy the situation clearly stated. There is a duty to communicate fully with colleagues to ensure that they have all the information they need about patients.

How much is 'enough'? A general rule of thumb will be that any clinically significant information that shows the progression of the patient's care and condition must be evident in the documentation.

Unexpected events must be documented together with what happened or was done as follow-up to the event and commentary on the outcome. For example, when a patient complains of pain an entry should be made about what pain relief was provided, whether the pain subsided and whether the patient was satisfied with the intervention.

Records must not be destroyed or altered without authorisation and where alterations have been necessary they should be dated, timed and accompanied by the name, job title and signature of

the person making the changes. Any alterations made must be clear and auditable and reflect the local organisation's policy. Under no circumstances should records be falsified.

Where possible, the patient and/or carer should be involved in the record-keeping process. It is important that the language used is understood by patients and colleagues and should not include coded expressions or sarcastic or humorous abbreviations to describe people being cared for. Value judgements, culturally insensitive comments and labelling that may imply discrimination must also be avoided.

Any entries should be written by the person with personal knowledge of the patient and the event or actions taken, not by a third party as this may lead to errors and/or inaccuracies (Grant and Ashman, 1997).

Co-signing entries made by colleagues may also lead to problems if the action or event was not actually witnessed, for example a student or healthcare assistant should not report on the classification of a grade 2 pressure ulcer as they may not be qualified to accurately grade pressure ulcers. Accountability lies with the qualified nurse and this responsibility must be taken seriously.

Significant communications between nurses and other members of the team, including telephone calls, must be recorded with details of the date, time and the information exchanged as well as the resulting changes

to care and the outcomes. Communications with family members and carers can also influence the care provided and should be recorded to inform the management of care, particularly if a patient or their relative is upset or angry about an incident. It might be necessary to complete an incident form depending on local policy.

The basic principles for record-keeping, accountability and safeguarding confidentiality apply to electronic records as well as paper-based systems. It is important to maintain the confidentiality of passwords and/or other access information by logging off when not using a system and taking necessary precautions to protect confidential information displayed on monitors.

**“The principles of record-keeping apply to electronic records as well as paper-based systems.”**

Ambiguous comments in the chart may be funny to read but they may lead to misinterpretation and harm to the patient. Some reported medical ‘bloopers’ include: ‘She stated that she had been constipated for most of her life, until she got a divorce’; and ‘Patient has two teenage children, but no other abnormalities’ (Carenurse, 2011).

To summarise the basic principles of record-keeping, documentation must be consistent with professional and organisational standards, complete, accurate, concise, factual, organised as well as timely, lengthy, prudent and confidential.

## Conclusion

The required high standards of consistency and continuity in healthcare can only be achieved through good communication and written documentation plays a significant part.

Transparency in what practitioners document about patients is an essential element as they or their authorised representatives have the right to access those records under the Data Protection Act 1998 and the Access to Health Records Act 1990, which regulates access to the records of the deceased. Records will be subjected to audit as well as internal review and external scrutiny and should match the standards set by individual healthcare organisations. **WE**

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