RECORD KEEPING
Why is there a need for nursing documentation

“Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow”

(Nursing & Midwifery Council April 2002)
The last decade has seen a shift of attitude towards the importance of record keeping. This change has been brought about predominantly by the promotion of patients and relatives to be involved in their care.
Partnership in care

There is an increasing partnership in care between the patient and health care professional

This has resulted in patients and relatives challenging the medical and nursing professions about their care and treatment
Keeping records of patient care and treatment is an integral part of nursing practice.
What is required

- All records must be signed by the person making the entry together with the date and time of the entry.
- Any later alterations or additions must be carefully indicated, ensuring that the original entry can still be clearly read.
Records should demonstrate

- A full account of your assessment and the care you have planned and provided
- Relevant information about the condition of the patient or client at any given time and the measures you have taken to respond to their needs
Evidence that you have understood and honoured your duty of care, that you have taken all reasonable steps to care for the patient or client and that any actions or omissions on your part have not compromised their safety in any way

- A record of any arrangements you have made for the continuing care of a patient or client
Nurses are professionally accountable for ensuring that any duties they delegate to members of the MDT who are not registered with the NMC, are done to a reasonable standard.

If a student, CSW or adaptation nurse completed nursing records, then a registered nurse must countersign the entry, which shows that they agree with the content.
When making a record

- You should be aware of the reliance which your colleagues will have on it
Nursing staff have a duty to retain the confidential nature of patient records at all times.

Disclosure of any information held in patient records is a serious offence.
Patient and client records are sometimes called in evidence before a court of law, by the Health Service Commissioner or in order to investigate a complaint at local level.
What records may be called

- Care plans
- Diaries
- Birth plans
- Anything that makes reference to the care of the patient or client.
Litigation

- Is becoming an occupational hazard

- So having accurate, comprehensive records is not just an important part of the job – it is critical
For most nurses who find themselves involved in legal proceedings, nursing records are the most crucial defence, with cases being won or lost on the quality of documentation. You should always imagine when writing your notes, that one day they might be read out in court.
Access to records

- Patients now have a legal right to see their own records.
- In some cases, patients are not only holding their own records but are also participating in writing them.
Acts

1. The access to health records act 1990 gives patients the right of access to their manual records.
2. The data protection act 1984 gives patients the right to access their computer-held records.
What do these rights mean?

That all records should be written in terms that the patient can understand.
Confidentiality

- What does Confidentiality mean?
- What is Confidential Information?
- The Legal Context?
- Security of Information?
- Access to records?
Relevant Laws

- Human Rights Act 1998
- Data Protection Act 1998
- Access to Health Records Act 1990
- Freedom of Information Act 2001
Human Rights Act    Article 8

Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law........
Data Protection Act – What’s covered

- Personal data
- Processing
- Relevant Filing System
Fair Processing

- Sensitive personal data may only be processed if:
- The data subject has given their consent to the use of their information for this purpose.
Unless

- necessary to comply with legal requirements
- Necessary to protect the vital interests of the data subject (i.e. life and death)
- The information is in the public domain
- Necessary for legal proceedings
- In the greater interest of the public
- Ordered by the Secretary of State
- Necessary for medical purposes
Medical Purposes

“Purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.”
Appropriate Security Measures

Shall be taken to prevent unauthorised access to confidential data, to prevent accidental loss, damage or destruction to the data.
The Caldicott Principles

- Justify the purpose
- Do not use unless absolutely necessary
- Use minimum amount of information
- Access on a strictly ‘need to know’ basis
- Everyone should be aware of their RESPONSIBILITIES
- Understand and comply with the law
Where to be aware

- Speaking on the phone
- Sending faxes
- Talking to colleagues
- Using electronic information
- Generally
Speaking on the phone

- Exercise caution and discretion when using the phone
- Ensure sensitive conversations are not overheard
- Ensure you are talking to an Authorised person before passing on personal information
- If someone is requiring information about staff, ask them to fax or send a letter with proper letter-heading
Talking to others

- Be discrete
- When you are discussing patients try not to be overheard by others
- If you do not need to identify patients, then don’t
- Tell people only what is relevant, they don’t necessarily need to know EVERYTHING
Using Electronic Information

When working with patient information DON’T

- Leave your computer unattended
- Display your passwords on boards
- Write your password down, instead use a keyword
- Let others use your sign on name
- Forget to log off when you finish
Measures to counter threats

Simple measures are often effective

- Locking doors
- Don’t leave documents lying about
- Keep passwords secure
- Confidential phone conversations in private area
- Think security and confidentiality!
complaints

- Flawed communication is repeatedly identified as a contributory factor into investigations and complaints
Let's look at a case study
Nurse with fifteen years experience, completed degree, highly regarded nurse by colleagues, patients and relatives

Incident: Patient within ward fell

Circumstances: Patient fell due to a faulty catch on cot side. Patient fractured femur

What Happened next: Following the incident, the nurse reacted appropriately and the patient was cared for in an appropriate manner – assessment, medical examination etc.,
Complaint: Patient’s relative lodges a complaint with the trust. At the interview, the nurse gives a full and true account of the situation. As part of the complaint process, the patient’s records are examined to complement the interview. However, as the priority had been to make sure that the patient received medical attention, the nurse had neglected to complete the records with the appropriate detail – this was identified in the nurses statement.
**Outcome:** the nurse is discredited as a professional. A consideration of her account given during her statement was deemed inaccurate as it was not supported in the documentary evidence.

**Additional circumstances:** on the day of the incident, the patient fell at 2.50pm. When the nurses shift finished at 3.15pm, she had a personal commitment to collect her children from school – she did not take sufficient time to complete her documentation.
What would you have done?

On her return home, the nurse could have documented the incident fully on a separate piece of paper and inserted this into the patient’s notes the next day. ‘contemporaneous’
What actions would you take if a patient told you they wanted to complain?
Good Practice

- Computer records
- Factual, consistent and accurate
- Avoid jargon or colloquialisms
- Legible and signature identifiable
- Record relevant information
- Be aware that records may be scrutinised at a later date
- Be written as soon as possible after an event as occurred, providing current information on the care and condition of the patient
- Maintain patient confidentiality
- Avoid speculation or offensive comments
- Be readable in black ink
- Always include any advice given from colleagues or other medical staff
- Be consecutive
- Identify problems that have arisen and action taken to rectify them
- Never erase any text
- Records should be audited regularly to improve technique
Accurate record keeping is not merely concerned with nurses protecting themselves from litigation; it is primarily aimed at enhancing patient care.

Precise record keeping can protect the welfare of the patients by promoting continuity and consistency of care (UKCC 1998)

It can also lead to enhanced evaluation of clinical practice
So what are the barriers

- Why do nurses consider the skill of record keeping as second to other clinical skills?
- Recording patient care should not be seen as an administrative task but as an integral part of the holistic care package.
RECORD KEEPING

- Clinical Governance gives record keeping the same importance as other clinical skills
- Documentation has been identified by the DH as one of the key targets for benchmarking
- NMC states that you can assess the standards of records and identify areas for improvement and staff development
Faxing of Personal Data

Under the Data Protection Act 1998 and the guidance of the Caldicott Report of 1997, the faxing of an individual’s personal details, e.g. name, address, date of birth, medical details etc., is subject to the same conditions of confidentiality as all other forms of personal data.
Sending Faxes

- Use a safe haven fax wherever possible
- Double check the number before sending
- Tell the recipient to wait by the fax
- Ask them to phone and tell you they have received it
Safe Haven Faxes

- A safe haven fax machine is a machine situated in a secure room away from public access.
- Personal information must be faxed from, and if possible to a safe haven fax machine.
Future Developments
electronic patient records

- Advantages
- Disadvantages
- confidentiality
Is your record keeping up to scratch
Further information

- Trust policies & Procedures
- www.informationcommissioner.gov.uk
- NMC (2002) Guidelines for records and record keeping
Any questions