Ensuring best practice in clinical record-keeping

Clinical record-keeping is essential to facilitate communication between health professionals and provide evidence of care for incident investigations and legal cases.

Clinical record-keeping is central to the planning and provision of nursing care, and nurses have a responsibility to document care according to the principles of the Nursing and Midwifery Council (2008) guidance and their employer’s local policy. The move towards electronic care documentation systems can add a logistical challenge to record-keeping, but the principles remain the same.

Legal issues
Nurses are increasingly being made aware of the role of clinical records in healthcare litigation, and being urged to ensure their notes are “meticulous”; from a legal perspective: “if it wasn’t documented then it didn’t happen” (Gasper, 2011).

The recent focus on health litigation has led to nurses being instructed and prepared by lawyers to write clinical records as if they were defending their care in courts (Gasper, 2011). While this helps nurses to step back from their clinical records and view them objectively, the danger of over focusing on the role of clinical records in health litigation can lead to a belief that nurses only complete them to "cover themselves". This can be a cause of negative and defensive attitudes towards recording-keeping, rather than viewing clinical records as part of an ongoing process of providing the right care.

Communication tool
Although there is no clear evidence that comprehensive and clear clinical records improve care, it is clear that poor clinical records contribute to errors and sub-standard care (Parliamentary and Health Service Ombudsman, 2010; National Resources and Learning Service, 2007). Many incidents involving episodes of poor care are a result of incomplete clinical records, where information has not been clearly communicated between health professionals. Clinical records provide a medium for communication to ensure that all practitioners have the information they need about a patient so they can assess and make appropriate clinical decisions.

Nurses need to be able to both rationalise why they are implementing a particular care intervention and what the expected goal of this intervention will be. The evaluation of care and progress notes will then be a clear measurement of where the patient is now compared with the ultimate goal. If progress is not as predicted the patient should be reassessed and goals or planned interventions may need to be amended.

There are many frameworks to guide patient assessment and ensure the correct care is planned and implemented. Nurses tend to use a nursing model, such as Roper, Tierney and Logan, which is based on daily activities of living (Roper et al, 2000), as well as a host of assessment tools to help assess risk relating to falls, pressure ulcers, phlebitis in cannula sites and skin integrity assessments.

Investigations
Clinical records are often used to establish what has happened when a serious incident or complaint is raised. The purpose of the investigation is to establish a timeline or audit trail showing everything that happened to the patient to establish what went wrong and led to the incident. This can enable healthcare providers to implement changes to prevent the incident from recurring.

The process by which an incident is investigated is often known as a root-cause analysis (RCA). Patient clinical records form a large part of serious incident investigations, especially when the incident is directly related to patient care. They are used to establish, for example, what happened and when, what actions were taken, why these actions were taken and who was informed about this incident. Investigations are difficult to complete when this information has not been recorded. Incomplete records not only imply that inadequate care was given, but also they make it difficult for the root cause of the incident to be established and solutions to be put in place to address this.

Negligence
Nurses may have to attend court to give an account of care they have given. Charges of negligence that caused patient harm are mostly heard in the civil courts as opposed to charges relating to intentionally harming a patient that are heard in a criminal court. In order for the nurse or trust to be found “guilty” the courts have to satisfy three main areas:

- The nurse had a duty of care to the patient;
- The nurse was negligent through actions or omissions;

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The negligence caused the patient harm.

Nurses’ duty of care is defined by their contract of employment and the code of conduct (NMC, 2008). Whether nurses have fulfilled their duty of care to individual patients will be determined by what has been documented in the patient’s clinical records.

Determining whether a nurse has been negligent is not easy. Negligence refers to both the actions we take and those we decide not to take (acts and omissions). The courts determine whether the care implemented is negligent by doing a reasonable practitioner test. This involves asking another practitioner (of the same seniority and working in the same clinical field) what they thought was reasonable action for the situation described (Stone, 2011). If the practitioner thinks the actions or omissions were reasonable the nurse under investigation is not negligent; if the practitioner thinks the actions or omissions were not reasonable the nurse would be found negligent.

Until 1997, the reasonable practitioner test was the only test used to determine negligence. In a test case (the Bolitho case) the reasonable practitioner test was not effective in determining negligence, as the practitioners had opposing views about what they considered reasonable practice (Stone, 2011). The judge asked the defendant to explain her actions then ruled that they were justified and that she was not negligent. The ruling from this case was that it is not enough simply to implement reasonable care; we must also be able to give clinical reasons for our care and evaluations according to the nursing process framework, but also the clinical reasoning that informs our care.

Accountability

Accountability is an important issue relating to clinical record-keeping; it refers to whom nurses are obliged to “give an account” of their practice (NMC, 2008).

Registered nurses are accountable to:

- The NMC to demonstrate fitness to practise and adherence to the code of conduct;
- Their employer or trust to demonstrate fulfilment of their contractual agreement and that they are performing at the right standard for their role;
- The courts if there are claims of negligence or criminal acts (law);
- The patient and family.

When working with unregistered practitioners, such as student nurses or healthcare assistants, nurses are accountable for ensuring the unregistered practitioner is competent to carry out any care delegated, and to document the care. The unregistered practitioner is then accountable for both the care provided and its documentation. It is not necessary for registered nurses to countersign unregistered practitioners’ recorded entries in patient notes (RCN, 2013), but they must regularly document their own ongoing assessment and evaluation of their patients’ progress. NT

The learning unit is by Kerri Wright, who is a nurse and freelance writer

References


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What is the purpose of a root-cause analysis?

A. To find the causes of an incident and implement solutions
B. To identify who is to blame for the incident
C. To support audit
D. To find out the cause of incidents

What guidance must nurses follow when documenting in clinical records?

A. Royal College of Nursing guidance
B. Local policies for employing organisation
C. Nursing and Midwifery Council standards for record-keeping
D. Data Protection Act 1998

What is a nurse accountable for in relation to patient care?

A. All the care provided to the patient
B. Delegating care to the appropriately trained unregistered staff
C. The overall nursing care and management of the patient
D. Ensuring delegated care has been completed
E. Only the care the nurse directly gives to the patient

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