The implications for colleagues

Nurses should also bear in mind, when compiling records, that their colleagues rely on the information they record when taking over a patient’s care. This can resolve any uncertainty over how much to write in patients’ notes. The frequency and content of entries is determined both by a nurse’s professional judgement and local standards, but an acid test is: ‘If a nurse were coming to care for a patient for the first time, what would they need to know?’ Colleagues should be able to look at a nurse’s notes and continue caring for the patient in a seamless continuum. If a named nurse was unable to return to work, then from the patient’s point of view this should make no difference to the care they receive.

Nurses are also professionally accountable for ensuring that any duties they delegate to unregistered staff are undertaken to a reasonable standard. For example, if a nurse delegates record-keeping to students or nursing assistants, she or he must ensure that they are adequately supervised and capable of carrying out the task. The nurse is accountable for the consequences of those records and such entries must be clearly countersigned.

How to improve record-keeping

By adopting the following habits, nurses should avoid problems related to record-keeping.

- Get into the habit of using factual, consistent, accurate, objective and unambiguous patient information;
- Use your senses to record what you did, such as ‘I heard’, ‘felt’, ‘saw’, and so on;
- Use quotation marks where necessary, such as when you are recording what has been said to you;
- Ensure there is a reasoned rationale (evidence) for any decision recorded, for example, denying access to a visit from children;
- Ensure notes are accurately dated, timed, and signed, with the name printed alongside the entry (initials should be avoided);
- Follow the SMART model (Specific, Measurable, Achievable, Realistic and Time-based) or similar when planning care;
- Write up notes as soon as possible after an event and, by law, within 24 hours, making clear any subsequent alterations or additions;
- Document any objections you may have to the care that has been given;
- Do not include jargon, meaningless phrases (for example ‘slept well’), irrelevant speculation, and offensive subjective statements;
- Write the notes, where possible, with the involvement and understanding of the patient or carer (NMC, 2002c).

Expressions such as ‘had a good day’ should not feature in isolation. Notes should explain why the patient had a good day – for example, if a relative visited or the patient was lively and interacting with staff and other patients (Dimond, 1999). There are also misconceptions around the use of subjective words such as ‘appears’. This cannot be used as a factual observation such as ‘appeared unsteady on his feet’ – a patient either is or is not unsteady on his feet. However, such an expression could be used where the facts would be impossible to establish, for example a confused and inarticulate patient who ‘appeared to be experiencing auditory hallucinations’.

The nurse could not be certain what the patient was experiencing, but would need to elaborate and describe the behaviour that led to this conclusion.

Errors should be corrected by putting a single line through the incorrect statement and signing and dating it. If records are used in evidence, it must be clear what was originally written and why it was changed, therefore correction fluids should not be used.

Sometimes professionals may face conflicting ethical pressures – for example it may be considered ‘kinder’ not to keep informing a patient with dementia that they are in hospital under a section of the Mental Health Act when they repeatedly ask where they are. Provided that nurses know what they are doing and why, and are prepared to justify it, this should not cause undue legal problems (Andrews, 2002; NMC, 2002c; Department of Health, 1999). Ultimately, professional nurses must be able to justify why they have taken a particular course of action.

The NMC’s position on abbreviations is that they should not be used (NMC, 2002c). However, a number of everyday medical abbreviations are used appropriately and safely, such as BP (blood pressure). To write these in full each time would add considerably to the time taken to complete records. However, there are dangers in the use of abbreviations. For example ‘PT’ could mean patient, physiotherapist or part time; ‘BD’ could mean twice or brought in dead. Misunderstandings can be avoided by generating an agreed list which is reviewed regularly. This list should be attached to patients’ records (Andrews, 2002; NMC, 2002c; Dimond, 1999).

Conclusion

Vigilance is required to ensure high standards in record-keeping, whether records are in written or electronic form. The audit of patient documentation is a facet of risk management, and can help to promote quality (NMC, 2002c) as it means standards can be assessed and areas for improvement identified (Dimond, 1999).

Maintaining good quality records has both immediate and long-term benefits for staff. It can directly benefit them, for example in respect of safety, by promoting the early identification and appropriate treatment of potentially violent patient behaviour. In the long term it protects individuals and teams from accusations of poor record-keeping, and the resulting drop in morale. It also ensures that the professional and legal standing of nurses are not undermined by absent or incomplete records, if they are called to account at a hearing.

Good record-keeping promotes better communication as well as continuity, consistency, and efficiency, and reinforces professionalism within nursing. For the sake of patients and colleagues – as well as their own protection and peace of mind – every nurse should get into the habit of recording their actions and observations accurately and professionally.

REFERENCES


Nursing and Midwifery Council (2002b) Complaints about Professional Conduct. London: NMC.

Nursing and Midwifery Council (2002c) Guidelines for Records and Record Keeping. London: NMC.


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