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The Importance of Documentation

Yorkshire & Lincolnshire BACCN Study Day

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The importance of documentation

- Why is record keeping so important?
- What makes good record keeping?
- Specific guidance for nurses
- Case study

Why is record keeping so important?

- Accountability
- Showing how decisions relate to patient care
- Supporting delivery of services
- Supporting effective clinical judgements and decisions
- Supporting patient care and communications
- Making continuity of care easier
- Documentary evidence of services delivered
- Promoting better communication and information sharing between members of the multi-professional healthcare team
- Identifying risks
- Supporting clinical audit
- Helping to address complaints or legal process

What makes good record keeping?

- Legible handwriting – readable when photocopied/scanned
- Entries signed with your name and job title
- Entries dated and timed
- Entries should be accurate and factual
- Avoidance of unnecessary jargon
- Clear evidence of arrangements for ongoing care
- Identify any risks or problems and how you intend to deal with them
- Involvement of the patient
- Easily understood language
- Avoid coded expressions

- A note on **alterations & misleading additions**

Guidance for Nurses

- Nurses and midwives should keep clear and accurate records which are relevant to their practice.

- Record keeping is covered by **The Code: Professional standards and behaviour for nurses and midwives** produced by the Nursing and Midwifery Council.

Key Points to take from The Code

- Statement 10
  - Keep clear and accurate records relevant to your practice
  - Includes but is not limited to patient records and all records relevant to your scope of practice

Key Points to take from The Code

- Statement 10 continued. To comply you must:

1. Complete all records **at the time or as soon as possible after** an event, recording if the notes are written some time after the event;

2. Identify any **risks or problems** that have arisen and the **steps taken** to deal with them, so that colleagues who use the records have all the information they need;

3. Complete all records **accurately and without any falsification**, taking immediate and appropriate action if you become aware that someone has not kept to these requirements;

Key Points to take from The Code

Statement 10 continued. To comply you must:

4. **Attribute any entries you make in any paper or electronic records to yourself**, making sure they are **clearly written, dated and timed**, and do not include unnecessary abbreviations, jargon or speculation;

5. Take all steps to make sure that all **records are kept securely**; and

6. **Collect, treat and store** all data and research findings appropriately.

Emails and IT

- Email exchanges are an important part of a patient's medical records and should be saved with the records

Case study – Bob*

- Suffered a seizure – taken to hospital by air ambulance
- Cannula in both hands
- No note in records of cannula being inserted into left hand
- Hand swelled and wound developed
- Hand became severely inflamed and wound burst open
- Plastic surgeon diagnosed necrotic eschar
- Bob required a skin graft
- Now suffers from tingling in hand and has a large scar

Case study – Bob*

- Can you identify any problems with the record keeping?

Case study – Bob*

- It is not possible to say whether there was an attempt to cannulate the vein in the left hand during the emergency transfer

- In an attempt to cannulate the vein, the sharp end of the needle accidentally cut through the skin close to the web and potentially cut the neurovascular bundle on the side of the finger which damaged the nerve, artery and veins and caused a large blister to form which later broke

Case study – Bob*

- Failure by paramedics to cannulate Bob's left hand using the appropriate technique and angle
- Failure to assess and monitor the cannulation and record this in the medical records.
- Failure to maintain medical records to a reasonable standard to record the Bob's cannulation and subsequent injury appropriately.

Case Study – Hayley*

- Had a cholecystectomy due to a gall stone
- An incomplete cholecystectomy was performed
- The discharge note read that a **total cholecystectomy** had been performed
- H and her GP were not aware that any of the gallbladder remained for six years and a remnant gall bladder was missed.
- Six years on she had to undergo further surgery

Case Study – Hayley*

- Can you identify any problems with the documentation?

Case Study – Hayley*

- Failure to accurately record the original operation that took place on the discharge note

- Caused Hayley to experience 6 years of abdominal pain

Case Study – Matt*

- Operation to remove lump
- Drain inserted whilst in hospital
- Treating nurse changed drain bag and cut pipe short but did not record this
- Pains in stomach
- X-ray showed pipe had gone into abdomen
- Surgery required to remove the pipe

Case Study – Matt*

- Can you identify any problems with the documentation?

Case Study – Matt*

- Had this been recorded, Matt would have avoided further problems

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Thank you!

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