Record keeping: developing good practice

The last decade has seen a shift of attitude within the nursing profession towards the importance of record keeping. This change has been brought about predominantly by the promotion of patients’ rights and the empowerment of patients and relatives to be involved in their care, through the Patient’s Charter (DOH 1991). This has now been superseded by Patient Focus and Public Involvement (Scottish Executive 2001). This partnership approach has resulted in an increase in patients and relatives challenging the medical and nursing professions about their care and treatment.

Healthcare trusts have developed comprehensive and robust complaints procedures which reflect this change in culture and this, in conjunction with an increase in litigation (Donaldson 2000, Moody 2001), has resulted in the nursing profession becoming more pro-active in developing and monitoring practice in record keeping.

Flawed communication is repeatedly identified as a contributory factor in investigations into complaints or legal proceedings (Wilson 2001). Thorough documentation might, therefore, reduce the incidence of complaints. However, 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 patients by promoting continuity and consistency of care (UKCC 1998). It can also lead to enhanced evaluation of clinical practice.

This article explores the educational needs of a group of nurses with regard to their ability to comply with the UKCC’s guidelines concerning record keeping (UKCC 1998). This was achieved by reviewing the relevant literature, examining the UKCC’s (1998) guidelines and carrying out a needs analysis among nurses working in Ayrshire and Arran Primary Care NHS Trust.

Summary

This article explores the concept of record keeping in nursing practice and how it appears to be a forgotten skill that is rarely updated through education. Although the UKCC/NMC have been consistent in making guidance available to nurses, it would appear that application of this guidance is variable.

A literature review was carried out to identify the main positive and negative issues, in relation to current national practice in record keeping: the salient topics for this exercise were quality and legal implications. Professional responsibility and accountability are among the most important reasons for high-quality documentation and were to be core to any training programme developed.

Quality

Young (1995) defines record keeping as ‘any permanent form of information recorded about a patient or client’. The contents of nursing records must demonstrate a skilled and safe practitioner working within UKCC guidelines. Hence the quality of entries into patient records should reflect this. Fulbrook (1998) identifies two main themes that underpin the need for quality record keeping: the clinical needs of patients and legal implications.

Iyer and Camp (1995) describe documentation as the most significant professional function of the registered nurse, since effective recording of patient care will demonstrate the patient’s responses to nursing interventions. They state: ‘nurses make complex, sophisticated decisions concerning patient care, yet nursing documentation does not always reflect those decision-making responsibilities. Documentation must clearly communicate a nurse’s judgement and evaluation’.

A high standard of nursing documentation is vital since it may be used to inform other professionals subsequently involved in the care of the patient (Fulbrook 1998).

Common flaws in documentation identified within the literature include: lack of brevity, assumptions being made, use of abbreviations, and the use of unnecessary emotive language. Aumiller and Moskowitz (2000) offer a few simple rules when recording patient care, which include recording facts rather than opinions and avoiding confusing generalisations such as ‘patient doing well’.

Legal perspective

It is important for nurses to acknowledge that any record documenting patient care may be used as evidence by a court or as part of an investigation or complaints procedure. It is often not until an allegation of professional negligence or a complaint is made that a nurse appreciates the importance of keeping comprehensive
patient records. In most situations the patient’s records are the initial source of enquiry when investigating an allegation. The nature of health care is such that it is often the nurse who provides the majority of patient care and if, as suggested by Fulbrook (1998), the nursing documentation gives an accurate and comprehensive account, this will have the potential to inform the process of the enquiry. Tingle (1998) contends that: ‘Poor records mean a poor defence and no records means no defence.’ As cases might take years before coming to court, a nurse’s documentation is essential for the recollection of events surrounding the case. Therefore, comprehensive records are essential. If nurses can be discredited by their record keeping, they will be discredited as professionals.

Barriers to good record keeping

Why do nurses consider the skill of record keeping as second to other clinical skills? Currell et al (2000) suggest that nurses have difficulty striking the balance between meeting the needs of clinical practice and of management and administration. If nurses perceive the clinical practice they deliver to patients as their clinical priority, it stands to reason that developing practice in that area will be given priority over administrative tasks. However, the recording of patient care is not, and should not, be regarded as an administrative task, but as an integral part of the holistic-care package.

Nursing practice has developed considerably in the last decade. Nursing roles are constantly being reviewed and developed with the aim of improving the effectiveness and efficacy of patient care. To enable this, many new education opportunities have been established, such as venepuncture, intravenous therapy and male catheterisation. However, developments in documentation appear to have failed to keep pace.

The clinical governance agenda should ensure that the evaluation of record-keeping skills has the same level of importance as other clinical skills.

Identifying the training need

A proposal detailing the literature reviewed and an analysis of record keeping across the trust evidenced the rationale for recommending that training should be made available to nurses. For the majority of nursing staff, no training had been available in the post-registration period.

Following a presentation to professional nurse advisers from all nursing disciplines across the trust, it was agreed that a training programme would be developed and made available to these senior nurses to deliver to staff. The evaluation undertaken was twofold. The first aspect was from anecdotal evidence provided by the nurse managers who, through the activities involved in their role as professional nurse adviser, had encountered many incidents of poor record keeping or to be more specific, non-compliance with the UKCC (1998) Guidelines for Records and Record Keeping (Box 1). The other aspect was a small scale evaluation collated from a sample of 25 records. The documents examined included assessment profiles, care plans and evaluation documents.

Developing a training package

Ayrshire and Arran Primary Care NHS Trust are proactive in promoting and developing nursing practice and are committed to the implementation of the Lifelong Learning Strategy (Scottish Executive 1999). A training programme that would address the issues identified in the literature, those common to complaint investigations and meet the aims and objectives of the UKCC (1998) guidelines was developed.

Issues within the literature

The aim of the programme was to communicate information regarding the principles of good practice in record keeping to promote change in professional practice. The training outcomes were defined as:

- The purpose of keeping records.
- Benefits of proficient record keeping.
- Principles of good record keeping and professional accountability.
- Responsibility of record keeping.

Piloting of the training programme

The programme was piloted to evaluate if the training outcomes had been achieved. Two training sessions were arranged and 42 qualified nurses from two hospital settings attended. Each session lasted two hours.

Training methods employed

It was important to establish the existing knowledge and current practice of the delegates to build on this throughout the training. This was achieved by group discussion at the outset of each topic, allowing delegates the opportunity to share existing good practice.

Although the training was of a preset structure, the current knowledge and skills of the group directed the process and it was delivered informally, encouraging discussion and debate around the key topics. The trainers promoted the development of the delegates’ knowledge and skills by encouraging them to address the gaps in their knowledge and current practice. This was achieved by setting ground rules, thus ensuring confidentiality was maintained. The training sessions were predominantly inter-
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Tingle J (1998) Nurses must improve their
Scottish Executive (1999)
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Moody M (2001) Why nurses end up in
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active using case studies to assist the nurses in understanding and applying the principles of good record keeping (Box 2). The documentation in current use within the trust was used throughout the training session, allowing the application of knowledge to practice with the added benefit of encouraging debate and resolution of both practical and professional issues.

Evaluation

Evaluation was core to the final version of the training programme. It was vital that relevant issues raised from the evaluation of the pilot were considered and included, if appropriate, within the final training session.

The training methods were considered by trainees and participants as effective and comments were made about the benefits of case studies encouraging theory into practice. Some additional issues were raised that could not be resolved within the training, for example, nursing assistants writing into patients’ notes, but these gave those attending the knowledge and confidence to pursue these with senior nursing colleagues.

The trainers’ perception of the programme was that those who attended felt they had benefited from the knowledge gained on this important topic. Through the level of participation, the delegates demonstrated that they took responsibility for their own learning. As the training session progressed, areas of practical implementation of the UKCC guidelines were aired and this was of benefit to the trainers and participants.

Recommendations

This training has highlighted the importance of regularly reviewing and updating the nurse’s skill of record keeping.

Following the positive evaluation and perceived value of the training, it is recommended that recordkeeping training be available to all health professionals. This training programme is now available for staff to access via their professional nurse advisors in Ayrshire and Arran Primary Care NHS Trust.

Conclusion

It is often in response to a situation that results in a nurse’s documentation being reviewed that the importance of good record keeping is appreciated. Tingle (1998) raises the point that record keeping for nurses is not only a professional skill but must be continuously reviewed and improved and that can be achieved through audit and feedback.

Nurses should acknowledge their vulnerability in this area and take time to reflect on their recordkeeping practice and their compliance with UKCC guidelines. A challenge for nurses is to continue to deliver a high level of care of which record keeping is an integral part.

The UKCC/NMC state that ‘record keeping is an integral part of nursing care’ (UKCC 1998). This statement intimates that the recording of a nurse’s intervention with a patient is as important as the delivery of nursing care.