THE DATA PROTECTION Act 1998 defines a health record as any electronic or paper information recorded about a person for the purpose of managing his or her health care. Guidelines for records and record keeping published by the Nursing and Midwifery Council (NMC 2002) state that: ‘good record keeping is a mark of the skilled and safe practitioner’. Record keeping promotes better communication between members of the primary healthcare team, accounts for care planning and delivery of treatment, and enables changes in the patient’s condition to be detected (NMC 2002).

Standards for record keeping

While recognising that record keeping is an integral part of nursing and promotes good practice, the NMC provides little guidance on how records should be written (Griffith 2004). However, it would be unrealistic to assume that a standard universal record might emerge to meet the information needs of all practitioners and adhering to basic principles is recommended (Charles et al 2000).

Records should provide factual, current, comprehensive and consistent information about the assessment and care of patients (NMC 2002). Records should be written chronologically and dated and signed by the practitioner in a manner that cannot be erased, and is legible on photocopies. In addition, the Guidelines for Records and Record Keeping state that abbreviations and jargon must not be used and records should be written, whenever possible, with the involvement of the patient (NMC 2002).

The Access to Health Records Act 1990 gives patients the right to view and receive written records. This legal proceeding could be prevented if records are written with the patient’s active participation. However, it is not always possible or appropriate for nurses to involve patients in record keeping. For example, if a community nurse visits an older patient where elder abuse is suspected, the patient needs to be protected and the nurse needs to document the findings. In such exceptional circumstances the NMC (2002) suggests that a supplementary record could be made.

Writing accurate records not only ensures quality of practice but also safeguards the nurse by providing evidence of his or her professional ability (Dion 2001). Records can be used as evidence before a court of law or regulatory body. The approach adopted by courts of law to record keeping tends to be that ‘if it is not recorded, it has not been done’ (NMC 2002). For this reason, the NMC’s (2002) guidelines recommend that professional judgement is used to decide what is relevant and what should be recorded, even when there is no change in the patient’s condition.

Documenting patient care is extremely important in the community setting as nurses usually visit patients alone, sometimes with long periods between each visit. The only way that the nurse can legally communicate the care that has been delivered is by writing effective records. Nursing records are usually held by the patient, enabling information to be shared easily between visiting practitioners. Ultimately, however, the record remains the property of the primary care trust. Access to the record can be requested at any time, enforced by law, if necessary, and health professionals are not liable if the record is lost (Health Visitors Association 1991). Nurses are responsible for maintaining records and are accountable if documentation is not accurately completed and informative. Tingle (2002) believes that nurses are not learning from
Increasing documentation and time pressures.

Information several times, in different places, nurses are often required to record the prescribing medication for a patient, community keeping (Dion 2001). For example, after bureaucratic system associated with record keeping are exacerbated by the record keeping is an obstacle to improving accurate records, which is an ongoing area of concern. The NMC (2002) guidelines aim to provide clarity but general ambivalence towards record keeping is an obstacle to improving documentation.

Other problems associated with effective record keeping are exacerbated by the bureaucratic system associated with record keeping (Dion 2001). For example, after prescribing medication for a patient, community nurses are often required to record the information several times, in different places, increasing documentation and time pressures.

Duplication of records is necessary to provide legal protection for nurses working as part of the primary healthcare team.

Improved record keeping

The NHS Modernisation Agency is trying to improve record keeping by outlining indicators for best practice in the Essence of Care document (Department of Health (DH) 2003). Benchmarks of best practice are recommended to improve the quality of record keeping such as access to current health care, integration of records across professional and organisational boundaries, lifelong records, high quality practice and security and confidentiality (DH 2003). The need for patients to have a single, lifelong, integrated multiprofessional record is emphasised. However, information technology software will be required for this change to occur. Although an exciting prospect, this process will be extensive and may take some time to implement (Dion 2001).

Conclusion

Even with these resources, patient records will still need to be clear, accurate and comprehensive so that care can be communicated effectively and records are legally valid. The basic principles advocated by the NMC (2002) should be adhered to and documenting care with the patient’s involvement is best practice. Records should be subjected to audit as a quality control measure, and it is important that the results of these audits are disseminated to enhance evidence-based nursing. Time constraints will continue to be an issue as the role of the district nurse develops but it is anticipated that ambivalence will become less of a barrier to effective documentation as bureaucracy is reduced. Patient safety is paramount and record keeping will remain a fundamental aspect of nursing care.

References


