Answer Guidance

# Chapter 18: Record-keeping and documentation

## Activity answer guidance

Ask your students to read these activities before class. In class, discuss their responses to the activities.

### Activity 18.1

Discuss with your fellow students why you think it is important to keep good records about the people that you care for as a health professional

How do these records help guide your care?

#### Answer guidance:

*You have been asked to discuss with fellow students and consider why it is important to keep good records about the patients you care for. You might consider the following as examples: to ensure joined-up interprofessional care, to ensure care is timely, to ensure treatment is necessary and follows the correct guidelines, to ensure patients do not fall through the gaps in our care, to ensure the patient has a good experience and care is person-centred, to aid communication, to aid patient safety, to ensure care is cost-effective, to reduce complaints, to reduce error and risk, to be accountable in line with the NMC code of conduct, to ensure care is legal and ethical, for example, consent is given, to ensure medication is given correctly, post-operative instructions are followed, incidents are reported and discharges are done correctly.*

### Activity 18.2

What types of records are used in relation to patients?

Make a list of the various types of records you have seen or are aware of in clinical practice.

#### Answer guidance:

*You are likely to have come across a large number of documentation in clinical practice such as care plans, admission and discharge forms, treatment plans, drug charts, observation sheets, behavioural assessments, investigation reports, capacity assessments, behavioural plans, safeguarding reports, documentation for detention under the Mental Health Act, epilepsy charts, incident/accident reports, etc. Remember as a student nurse you will also have many records that need completing.*

### Activity 18.3

What do you feel are the main principles of accurate record-keeping? Consider areas such as safety, practicalities, key information, storage, language, and legal and ethical considerations.

In relation to each of the four fields of nursing, what additional considerations would you need to make? For example, consider children or people with learning disabilities, dementia, or mental health needs.

#### Answer guidance:

*Some of the main principles of accurate record-keeping are that they need to be factual, understandable, secure, identify risks and proposed actions, logical, confidential, signed and dated, and in line with local policy and national guidance (see NMC 2015 Code, section 10 in particular)*

*Additional considerations—these may centre on making information from various records accessible for those with disabilities. For example, the use of technology, visual and hearing aids, translation services, communication aids, and bespoke storage and security measures. Children may need a parent or carer to explain matters and those with disabilities may have an advocate to support them in providing information, ensuring confidentiality, and keeping patient-held records safe and secure.*

### Activity 18.4

When you are next in practice, look at a patient’s record of the care and then answer the following questions:

 If you did not know the patient, would the record accurately inform you of what they were like, what treatments they had received and how they responded?

 If possible, look at different patient groups—children, older people, people with learning disabilities, etc.—and repeat this exercise.

#### Answer guidance:

*You have been asked to review some care records in practice and see if they accurately inform you of what the patient is like. Things that might be included would be an accurate admission with history taking and assessment, including medical, social, and medication history. There would be a complete assessment of activities of daily living, relevant risk assessment tools completed, vital signs, and regular care plan entries updating you on the care implemented and evaluating its effectiveness.*

### Activity 18.5

Considering the patients you have been involved in caring for, think about the advantages and disadvantages of them holding their own records. For the purpose of this activity, think of paper records only.

#### Answer guidance:

*Allowing patients to hold their own records enables them to be equal and active participants in their own care, it also encourages a culture of openness and transparency. It does mean patients can easily get an update on their care and can feedback if they believe something has been missed. However, it also means that patients may see upsetting information before they have been verbally updated e.g. worrying test results. They also may not have the knowledge to understand complex medical information or jargon, which may lead to anxiety and misunderstandings regarding their condition and care plan.*

### Activity 18.6

Some records use statements that are difficult to determine the exact meaning of.

Spend a couple of minutes with some of your fellow students thinking about what each of the following mean; note down what they mean to you and then compare the answers with those of your colleagues:

 poor dietary intake

 diarrhoea

 satisfactory fluid intake

 slept well.

#### Answer guidance:

*Documentation should be objective—the SMART acronym is useful here- specific, measurable, achievable, realistic, timed. So, for example, “the patient is mobile with support” is not clear, but “the patient was able to walk from their bed to the bathroom with the aid of a Zimmer frame and two staff for standby support.”*

*A poor dietary intake might mean they are nil by mouth, are post-operative and have a plan to build up their intake, have nausea and vomiting or stomach pains, are being fed enterally instead, is malnourished, or simply didn’t like the options at mealtime this afternoon!*

*Diarrhoea is often attributed to loose or soft stools on one occasion- what number on the Bradford stool chart is the patient scoring and how many times have they had their bowels opened today, have you sent a sample?*

*What is a satisfactory fluid intake? Are they post-operative or on a fluid restriction? Are they able to top their drink up independently or do they need help?*

*One of the worst statements is “the patient slept well”! Did they actually sleep well, or did they just appear to sleep well because you didn’t speak to them? Did they try to sleep well but were woken at regular intervals for observations and nursing interventions? Do they normally sleep well at home in comparison? Do they sleep flat in bed or propped up with pillows, or even in a chair? Hospitals are notoriously noisy, and it is very rare that patients do actually sleep very well in the hospital!*

### Activity 18.7

Access this article: Baillie, L. Chadwick, S., Mann, R. and Brook-Read, M. (2012) ‘Students’ experiences of electronic health records in practice’, British Journal of Nursing, 21(21): 1262–9:

Reflect on the students’ experiences in the study and your own experiences of electronic records to date.

#### Answer guidance:

*The study found that students perceived the benefits of Electronic Health Records for care delivery as better information availability and quality of record keeping. Their concerns related to practical and logistical issues, and difficulties in adjusting to electronic systems. Are your experiences similar? There is no right or wrong answer as everyone’s experiences will vary.*

## Case study answer guidance

### Case study 18.1: Claire and Ian

Consider each of the situations below:

 What decision did the professional conduct committee reach and what sanction do you think was applied?

The stories of Claire and Ian are based on true cases, and the actual outcome is online, so don’t look at this until you have judged for yourself!

#### **Claire**

Claire has been a health visitor for 20 years and was an adult nurse prior to that. She has worked in many inner-city locations within the UK and has a great deal of experience in caring for families in deprived areas.

She was reported to the professional conduct committee because it was alleged that:

  She removed patients’ records and kept them in her car and at home.

 Her records lacked detail and were partially or wholly illegible.

 Records were unsigned.

 Records contained no evidence of the action taken by her; for example, she failed to record when a child had been made subject to a child protection plan.

This was the second time Claire had been reported to the professional conduct committee. She had been subjected to the supervision of practice orders following her previous offence.

#### **Ian**

Ian has been a mental health nurse for two years. He has worked since he completed his nursing programme within a small community team in a rural location. He was reported to the professional conduct committee because he was alleged to have:

 incorrectly made an entry relating to patient B inpatient A’s notes, then removed the page, photocopied the page, and replaced the page in patient B’s notes

 then destroyed the original entry.

Now that you have judged the cases, go online and find out the outcomes for Claire and Ian.

#### Answer guidance:

*Claire was removed from the register. The fact that this was a second offence, following previous supervision of practice order was taken very seriously, as she had not changed her original behaviour, despite being provided with support and guidance.*

*Ian was subject to the supervision of practice order and had to undertake a course on record keeping.*

### Case study 18.2: Mrs. Mary Davies

Mrs. Mary Davies is a 60-year-old woman with mild learning disabilities who has been admitted to a general ward after a road traffic accident. She suffered an injury after hitting her head on the steering wheel while coming home after a night out on the town. The car she was driving crashed into a tree and she was later found to be over the drink-drive limit. Mary is from a close-knit community and is very assertive in expressing her needs. She did not really want to be admitted to the hospital but her family insisted that she stay in for at least one night. The other patients did not take to her as they felt she was too overbearing. She woke early in the morning with a headache and a painful shoulder and neck. She made her way to the nurses’ station to complain to the nurses about the noise from the other patients keeping her awake. There was a difference of opinion over who was making the noise as the other patients complained about Mary’s behaviour. Mrs. Davies insisted on being moved to another ward or side room. There was a shortage of beds that day and patients were waiting to be admitted from the Accident and Emergency department and other hospitals. At breakfast, Mary did not like the breakfast and threw it on the floor still complaining about her pain. The Duty doctor was called and Mary was prescribed a muscle relaxant and stronger analgesia on regular prescription for the next 24 hours instead of her required milder analgesia. She went off to sleep later that afternoon. Staff nurse, Peter Williams was on duty from 8 to 4.30 pm.

Compare and contrast entries A and B regarding the above case study and decide which one most meets the NMC (2015) code guidance on record keeping. Make a note of both good and bad points.

Entry A

|  |  |  |
| --- | --- | --- |
| **Date** | **Comments** | **Signature** |
| 2/10 | The patient got up in a foul mood and was very abusive to staff. There was no good reason for this or why she threw her dinner over the floor other than she has a learning disability. The other patients dislike her and have asked me to move her off the ward as she scares them. In the afternoon she was given her pain meds as she was still very moody and not at all remorseful for her actions.  | ƒƒ |

Entry B

|  |  |  |
| --- | --- | --- |
| **Date** | **Comments** | **Signature** |
| 2/10/130500 Hours0900 Hours1230 Hours1600 Hours | Mrs. Davies awoke at 0430 hours and got out of her bed and walked to the nurses’ station. She alleged that she had been woken up by two of the patients snoring and that “they were doing her (she used F word) head in.” She also stated that she wanted to be moved to a (she used F word) side room so that she can get some sleep. It was explained to her that there were no free side rooms at present and she would have to wait until one became available but that would be dependent on other patients’ needs.At approximately 0830 hours Mrs. Davies threw her breakfast plate, full of food onto the floor shouting that her (she used the F word) head was killing her. The duty doctor was called at 0900 hoursThe duty doctor arrived at 1200 hrs midday and prescribed Ibuprofen 400 mg and Diazepam 2 mg every 8 hours a day after examining her (see medical notes for full account). He felt that Mrs. Davies had a neck spasm due to the accident and also poor sleeping posture although she insists it was due to the noise made by two other patients. These two patients blamed Mrs. Davies for the noise and disruption in the ward. At 1430 hours she has given her medication of Ibuprofen 400 mg and Diazepam 2 mg (see drug chart for full prescription details).At approximately 1500 hours Mrs. Davies rested on her bed, appeared pain-free, and eventually went off to sleep. | Susan HarriesNight sisterPeter WilliamsStaff nursePeter WilliamsStaff nursePeter WilliamsStaff nurse  |

#### Answer guidance:

*You should have noticed that entry A was not very good in terms of accuracy, errors, and providing a personal opinion. There were no times provided and just two letters in terms of staff identification. The most concerning aspect was the negativity towards Mrs. Davies by the nurse making the entry? It was very one-sided, personalised and seemed to imply that Mrs. Davies was not very popular and was very troublesome possibly due to her learning disability. If you contrast this entry with entry B then a more balanced approach has been adopted. Dates, times, and the individual nurse making the entry are clearly identifiable. The events are put into order and a number of entries are made during the span of the nurse’s shift. The nurse Peter Williams has provided factual information and has resisted the temptation to take sides and give an opinion. He has also included swear used but has stopped short of the actual spelling out of the full term. Some clinical areas insist on this and others do not and are content for just an F word was spoken. There is an assumption that everyone knows what F word was spoken. However, even with this entry, you are left wondering what other care has been provided other than the incidents and visits from the doctor. For example, did Mary have another breakfast or drink? Was she seen by a physiotherapist or pharmacist?*

*Considering the reason Mary was admitted to the hospital was due to a car accident, would you know if this was Mary’s usual behaviour or could it be a sign of a head injury? Both record entries do not tell us what observations had been undertaken or her current neurological status. There is also no indication of any other care she actually received besides what has currently been recorded. Both records fail to identify any pain assessment despite the fact Mary complains that her head is “killing her.” Can you tell from these records Mary's problems and responses to interventions? Finally, as Mary has a known learning disability, there is no recorded evidence that her capacity to make decisions has been assessed.*

*Remember that if it is not recorded it is deemed not to have taken place*.