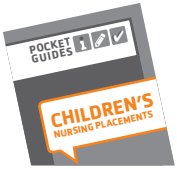
POCKET GUIDES
FOR NURSING AND HEALTH CARE

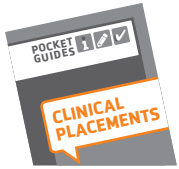
RECORDS AND RECORD-KEEPING

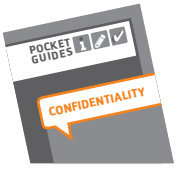
MARC CORNOCK

POCKET GUIDES
FOR NURSING AND HEALTH CARE

RECORDS AND RECORD-KEEPING





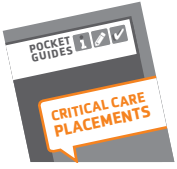


A unique series of pocket-sized books designed to help healthcare students

"All the information was clear and concise, this book is exactly what I was looking for." ★★★★★

"A great little guide. All the basic information needed to have a quick reference." ★★★★★

"A very useful, well-written and practical pocket book." ★★★★★



"Written by students for students. A must for any student about to head on placement." ★★★★

POCKET GUIDES
FOR NURSING AND HEALTH CARE

RECORDS AND RECORD-KEEPING

Marc Cornock
The Open University

ISBN 9781914962202
First published in 2024 by Lantern Publishing Ltd

Lantern Publishing Limited, The Old Hayloft, Vantage Business Park, Bloxham Road, Banbury OX16 9UX, UK
www.lanternpublishing.com

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Typeset by Medlar Publishing Solutions Pvt Ltd, India
Printed and bound in the UK

Last digit is the print number: 10 9 8 7 6 5 4 3 2 1

Contents

5 Practical aspects of health records

It is well known that there can be a disconnect between theory and the practice of healthcare. This chapter aims to reduce that disconnect in relation to record-keeping by discussing the common queries that arise with health records in practice.

The discussion in this chapter refers to both paper-based and electronic records, unless specifically stated.

5.1 Considerations when writing an entry in a health record

Chapter 4 considered how a healthcare practitioner knows if their record-keeping is of a sufficient standard and what they need to measure themselves against. If you are ever unsure of your record-keeping skills, you can either ask someone to review the entries you make or you can review the entries in the record made by others and compare them with yours.

5.1.1 The right record

The first consideration is to ensure that you have the right record for the right patient. You will need to verify the patient's details in the record.

5.1.2 Signing and initialling entries

So that everyone knows who has written what entry, in case clarification is needed at a later time, you should ensure that you sign or initial every entry. However, you should only use your initials if there is a record of initials against the

healthcare practitioners' names on a sheet within the health record. Initials can be particularly problematic to decipher some time after the event.

It is good advice to always sign your name whenever possible; this should ensure that there is no uncertainty that you wrote the entry.

5.1.3 Language and style of entry

How would you feel having to read out your entries in a court of law and being questioned on what they mean? Could you defend them? Are they clear or ambiguous?

The most effective way to write your entries is to consider how someone else might read them.

What would the patient think if they read them, or another healthcare practitioner, or your manager? Don't leave yourself open to misinterpretation – be clear in what you write and leave no room for doubt.

Also be clear and concise in what you write, keep it short and to the point without any waffle or extraneous material. Others have to understand what you are saying but, like you, are short of time so do not have the luxury of being able to read extensive entries each time.

5.1.4 Personalised entries

Don't be formulaic in your entries. That is, don't write the same thing entry after entry or the same for each patient in a group. Ensure that the entry means something and has something to say. There should be some analysis of the patient's progress or their response to care and treatment.

Entries should be personal to the patient and not just a standard set of words.

If you read an entry that said 'slept well' or 'no change since last visit' would you know what it meant? Would you be able to plan care for a patient based on these sorts of entries? An entry in a health record needs a reference point of some sort to be able to judge the patient's current condition against their previous condition to enable care to be planned.

5.1.5 Ink colour

This is not usually a problem with electronic records!

Black ink is the preferred colour because it photocopies the best, but it is not a legal requirement. Blue can become less legible once photocopied. Red does not photocopy at all well, with black and white copying.

Avoid non-permanent inks and pencils as these can be changed by someone else.

If the notes you are making are solely for your own use, will be destroyed by you and not form part of the patient's health record, you can use your own colour system, e.g. red for actions, green for information, and black for information to pass on to others.

However, that said, if you read notes from a few years back you will see that different coloured inks indicate different shifts, with red generally being a night shift. Alternatively, you may see that test results were written in a different colour to the main entry.

However, this is not as bad as military writing where certain colours were reserved for specific ranks – commanding officers wrote in red, their superiors wrote in green, with the

highest level commanders writing in purple. So if you received something written in purple ink, you did what it said!

5.1.6 Referring to other parts of the health record

If you need to refer to another document within the health record, ensure that it is clearly labelled so anyone reading your entry knows exactly which document you are referring to.

5.1.7 Jargon and abbreviations

Be very careful with jargon and abbreviations. Wherever possible avoid using them, or if you must, have a list of them at the front of the record.

Abbreviations are so often open to misinterpretation. For instance, most healthcare practitioners would use SOB to indicate 'shortness of breath', but would that be obvious to a patient or relative? The most common use of SOB in everyday life is often said to be 'son of a b****'. Remember that patients may request to see their health records, and you will be unlikely to be there to explain things to them.

Even within different specialities of healthcare practice abbreviations vary. For instance, is MS mitral stenosis or multiple sclerosis?

You also need to be careful not to inadvertently use offensive language or words which can be stigmatising; for example, it is a 'patient with diabetes' not a 'diabetic patient'. Generally it is best to use the words that the patient uses to describe themselves and their condition or illness.

If you do adopt the patient's own words, you may want to say that it is the patient's preferred words the first time you note it in the health record.

5.1.8 Electronic communications

If you send emails or text messages to your patients, perhaps as a follow-up or to remind them of forthcoming appointments or actions following a discussion, you should keep a copy of the email or text in the patient's health record, along with the date and time it was sent and the response received.

5.2 Time pressures

When discussing the codes of conduct in *Section 4.1.2* it was noted that the codes refer to entries being made in patient health records as soon as possible after the event.

'As soon as possible after the event' is open to interpretation but you should ensure that your entries are contemporaneous.

The longer the delay between the healthcare event or interaction and the writing of the entry, the more chance that something will be forgotten or missed in the entry.

Emergencies and the needs of other patients can mean that it is not possible for a healthcare practitioner to write an entry about an interaction until some time after the event. Although this is understandable in terms of time pressure, it must be recognised that health records are an essential element of healthcare practice and need to be maintained so that they fulfil their purpose.

However, it may be that the time pressure a healthcare practitioner faces is not actually a time pressure at all. Do all entries that are made in a patient's health record actually have to be written? It may be that entries should only be made when there is a clinical need for them and not just because it is the end of a shift.

5.3 Writing entries for colleagues

Your accountability is for your actions. You are judged on what you do. If you write an entry on behalf of another healthcare practitioner, are you absolutely sure that you will be able to record all the details accurately and in full?

If you sign an entry, you are saying that 'I did this'. If you ever write an entry on behalf of another healthcare practitioner, you would have to be very clear in that entry that it was written for someone else and be very clear who this was and why you are writing it.

The same applies to you asking someone else to write an entry for you.

However, if you are writing following an entry from another healthcare practitioner in relation to something you did together, you do not need to rewrite everything but do need to make a statement that you agree with what X said.

5.4 Changing an entry in a health record

Errors happen and need to be acknowledged.

If you ever write an entry in the wrong health record, cross it through and write 'written in error' and date and sign it.

If you make a mistake and need to correct it, just strike through the erroneous wording with a single line and write the correction, write the reason for the deletion and/or the correction and sign and date both parts.

Do not attempt to hide a previous entry or to alter something at a later time. Forensic electronic document analysis is excellent at knowing what was written initially and what the amendments are; paper-based entries can be analysed

to determine if something has been altered. It is perfectly legitimate to make an amendment once new information is available, so long as this is clearly stated as being an amendment with the reason and is dated and signed/initialled. Even if there is a valid reason to alter a previous entry, doing so can look suspicious so stick to the principles just stated.

5.5 Third party information

Be careful with third party information. If you are writing about something that you have been told and not what you have heard or seen yourself, it may be best to state where the information has come from by naming the source.

Notes

Notes