ARTHUR COX

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Conquering Record-Keeping for Healthcare Professionals

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While it may not be a healthcare professional's most exciting task, keeping good records is good professional practice and makes sense. Good healthcare records protect patients, staff and you, now and in the future.

Keeping good healthcare records does not need to be an ordeal. Here are our top tips for taking the sting out of record-keeping.

MAKE SURE YOU:

» ***Keep content relevant.*** Notes on a healthcare record should include details of the patient's relevant history, examinations, discussions with the patient, continuous observations, consultation with other professionals, treatment given, recommended treatment, care plans and risk assessments. Think about the information you would need to know if you just started your shift and had to treat the patient: this is what you need to record.

» ***Present the notes well.*** Write your notes legibly. Always include the date and time of the note. This is particularly important when amending notes or making retrospective notes. Make sure to sign any entry you make on the notes.

» ***Record notes in the same place.*** Make sure that healthcare records are recorded in the same place i.e. on a patient's hard copy chart or electronic file. Do not record notes in log books or on pieces of paper which can be easily lost.

DO NOT:

» use generic language or vague terms (e.g. "slept well") unless they are specific to the patient's issues / requirements;

» criticise the patient or their family; or

» record anything you cannot stand over.

In summary: stick to the facts!

FREQUENTLY ASKED QUESTIONS

Why do we need to keep records?

There are many reasons to keep good healthcare records, not least to safeguard the best interests of the patient:

» ***Professional obligation:*** The Codes of Ethics of many professional regulatory bodies (e.g. the Medical Council, the Dental Council, the Nursing and Midwifery Board of Ireland) impose obligations on professionals to keep accurate and up to date records for all patients. Fitness to practise proceedings against professionals often involve allegations of a failure to maintain accurate or complete healthcare records.

- ***HIQA requirement:*** The Health Information and Quality Authority (HIQA) requires providers of healthcare services to have effective arrangements for the management of healthcare records. HIQA's National Standards for Safer Better Healthcare say that patients can expect that healthcare workers will record their information accurately and keep the records safe and up to date.
- ***Employer and insurance Requirements:*** Many professional indemnity insurers, as well as employers, require professionals to meet certain standards of record-keeping. Familiarise yourself with relevant employment and insurance policies and review them regularly.
- ***Protection against legal action:*** Healthcare records are crucial if a complaint is made about the patient's care, or an inquest is necessary or a legal claim is made. In these situations, records may be provided to the patient, a court, a review/investigation team or a coroner. They will rely on the contents of the records, along with any other evidence given. You may have to give evidence several years after you cared for the patient. If you have kept good records, you will have a clear and accurate record of what happened. This may prove invaluable to you. Keeping good records now is a gift for the future.
- ***Patients' rights:*** Patients have certain rights to access information held about them. These rights are set out under the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 2014. If their healthcare records are well-kept and accurate, the patient will benefit from gaining access to them. You will also be in a much better position to answer any questions a patient may have if the notes can be easily reviewed.

CAN I CHANGE A HEALTHCARE RECORD?

Yes. A healthcare record needs to be accurate and contain the most up to date information, so do not shy away from making amendments that are necessary in your professional opinion.

To amend a healthcare record, put a line through the original note and write your new note. Do not use tippex or other correction fluid. You should ensure that it is still possible to read the original entry. Sign the alteration and insert the date and time it was made. You should also explain why you have made the amendment.

HOW DO I RECORD AN ADVERSE EVENT IN HEALTHCARE RECORDS?

In general, best practice suggests that you should complete an incident report form. Make sure you are familiar with the specific form your employer requires you to complete. The form should be filled out on the day of the incident and it must describe the incident and identify all the people involved. All those involved should sign the completed form.

A detailed description of the incident should also be noted in the patient's chart (making it clear that it is recorded after the event). More than one note may be recorded on the chart e.g. by different healthcare professionals.

Check your employer's policy on adverse events so that you are familiar with it if there is an adverse event.