Nurses need to keep it on the record

Undoubtedly, the challenges faced by community nurses are on the rise due — but not limited to — several factors: the NHS being under severe financial scrutiny; the drive for a seven-day service; policies that mean more care is being delivered in the community setting; and rising patient numbers resulting in less time available to spend with each patient. Coupled with a reduction in recruitment which means that there still aren’t enough nurses in the profession, this is a potent mix of factors that has contributed to a creaking NHS.

But while we quite rightly focus on the effect this may be having on the quality of patient care, we must also look at how nurses themselves could be at risk. The fact that we are under pressure to see more patients invariably means the amount of time spent with each individual decreases and it is easy to see where standards could slip — particularly with documentation not being as thorough and detailed as it could be.

RECORD KEEPING

One of a nurse’s main duties, and one for which they are held entirely responsible, is documentation, whether this is patient consultation notes or a care plan. Healthcare professionals are constantly reminded of the importance of documentation and how it underpins skilled and safe practice. In short, the way you maintain your records is the hallmark of your professional conduct, providing evidence of high quality patient care.

However, due to time pressures — feeling rushed to see the next patient or trying to fit-in just one more consultation at the end of a busy shift — it is easy to envisage how a nurse could just make a quick entry into the patient notes even though they know this should never happen. We have all done it at some point, but this is where, as nurses, we are potentially putting ourselves at risk.

If there are any questions over the care received by a particular patient, the documentation is the first thing that is looked at. If the notes aren’t clear and the investigator has to question or guess why the patient received certain care or underwent a particular procedure, the notes may be indefensible and increase the chance of a claim being made against the trust and/or the practitioner. In some cases, this can have severe financial and professional consequences for those involved.

CASE IN POINT

Through my role as clinical director of a nursing recruitment company, I recently supported an advanced practitioner through legal proceedings. The nurse in question was wrongly accused of inappropriate behaviour towards a patient and the documentation was central to the defence. Unfortunately, the omission of one sentence in the notes allowed a stronger legal case to be made against the nurse. The reason given for the omission was lack of time at the end of a busy shift.

Luckily, the nurse was found not guilty, but the trauma caused by the allegation should serve to remind us all that in the eyes of the law ‘if it isn’t written down, it didn’t happen’. Accurate documentation is synonymous with good practice and is therefore vital should there be a complaint about your work. Don’t put yourself at risk even if time is against you.

The vital role of documentation within practice is explored further in a recent article in the Journal of General Practice Nursing, ‘Learning zone: record keeping — essential to good practice’. It covers standards, how you can safeguard yourself and how your employer can assist. When it comes to nursing practice and the law, what you write is almost as important as what you do.

Alex Munro is a registered nurse with a background in unscheduled care as a nurse practitioner. He is the co-founder and clinical director of Hallam Medical, the primary care recruitment specialist.
Community Nurses...

...Join Our Community

0844 335 0395
recruitment@hallammedical.com
www.hallammedical.com

Together, we are brilliant