While keeping good records is an essential professional and legal requirement of being a nurse, we all know that in reality it is a job that many of us — at one time or another — have put off for later. Good records promote continuity of care through clear communication; demonstrate the quality of care delivered; and provide the evidence necessary for any legal proceedings. Conversely, poor records have a negative impact on care delivery and clinical decision-making. Poor record-keeping can become a low priority for busy nurses and patient notes are often poorly maintained (Jefferies et al, 2010a). However, records provide evidence of our involvement with patients and should be completed after every consultation.

Poor record-keeping is one of the top five reasons for nurses incurring sanctions or even being removed from the NMC register (NMC, 2012), and we are increasingly being held to account for the standard of our records. Poor records are often reflective of poor practice and we need to remember that this link is often exploited in court to the detriment of the nurse in the witness box.

THE NEW CODE

The fact that record-keeping is integrated into all four professional standards in the new NMC Code of Conduct (prioritise people; practice effectively; preserve safety; promote professionalism and trust) (NMC, 2015), gives a clear indication as to its ongoing importance. Although record-keeping is often seen as an unwanted chore to be performed at the end of a shift, if we are to adhere to the four standards then the quality of record-keeping is something we all have to improve upon.

Prioritising people

When prioritising people it is imperative not only to gain informed consent — which the majority of us would do without thinking — but also to document that this consent has been obtained before any care is carried out. This is clearly stated in the Code. The type of consent, whether implied, verbal or written, is not the issue — what matters is the documented evidence of the consent having been gained.

Practice effectively

Practising effectively means that we should ensure the care we provide is based on the best evidence available. This use of evidence-based practice should also be explicitly recorded in patients’ notes.

Nurses’ verbal communication is generally good and most of us consider the different languages and/or communication requirements of our patients in a culturally sensitive manner. What is often less than successful is the documentation of these interactions between patient and nurse. The standard of ‘practising effectively’ requires us to be able to communicate clearly and effectively in English — there is also an implied necessity for a good standard of grammar and spelling, as well as an understanding of the difference between fact and opinion.

Records can also be an important communication tool, especially in the current climate of multiprofessional working and a good standard of nursing documentation facilitates continuity of care (Jefferies et al, 2010b), and enhances collaborative working. Keeping our colleagues informed of patients’ care helps to preserve their safety and improve risk management. For example, one of the documents shared across professional boundaries is the discharge summary. If these are completed accurately they...
facilitate a seamless transfer of care from hospital to community.

Preserve patient and public safety
The third standard highlights the need to preserve patient and public safety, working within the limits of our competence. But what does working within your competence actually mean? Let’s take a district nurse who identifies a patient who needs a referral to the mental health team. This referral must be based on an accurately documented assessment of the patient; this in turn will inform a smooth referral and assist the mental health team in their specialised assessment in a timely fashion.

We also need to be mindful of the ‘duty of candour’, a term taken from the Francis Report (2013) that obliges nurses to raise concerns immediately whenever a situation puts a patient or member of the public at risk. The professional duty of candour requires us to be open and honest in the care that we deliver to preserve safety.

Nurses are human and sometimes mistakes do happen, but the Code explicitly states that all situations of actual or potential harm need to be formally documented as part of the process of escalating the problem so that the appropriate action can be taken. This is particularly pertinent if you believe a patient is vulnerable and needs protection. Take the example of a patient with a leg ulcer who has had a dressing prescribed and applied by a district nurse. When the patient consequently develops a painful allergic reaction to the dressing, the nurse, rather than trying to cover up or ‘fix’ the mistake, should exercise the duty of candour and inform her colleagues so that the treatment can be discontinued and the incident documented and shared. The patient’s treatment can then be reassessed and a different approach taken.

Promote professionalism and trust
The final standard of the Code urges us to uphold the reputation of the nursing profession. Nurses who produce high-quality documentation demonstrate a personal commitment to the standards of practice and behaviour set out in the Code, thereby upholding the reputation of the profession.

SELF-DEFENCE
In an ideal world no nurse should
Contemporaneous: Right here... write now
- Nursing documentation must be completed as soon after the event as is possible; reliance on memory will not protect you in the witness box.

Continuity: Tell the story... ‘welcome to this patient’s journey’
- Produce an audit trail
- Remember to date and time (24hr clock) all entries. Identify your patient correctly on each side of the notes (copies of each side may need to be made).

Correct: Clear writing; clear message; clear communication; clear conscience
- Write legible, accurate and factual notes; do not express opinions unless you have the expertise to substantiate them
- Use only recognised and approved abbreviations

Claim: Your records; your pin... own your records
- Always include your name, designation and sign your entries
- If you make an error, own it — put a single line through the mistake and initial it

Candour: Discontinue; document; share and treat
- Preserve patient safety. Remember, record-keeping is an aspect of patient care and should not simply identify a problem, but also signify escalation and progression of care

Contain: Write safe; store safe
- Confidential and correctly stored records are paramount
- Remember, don’t just switch off the screen — log-off the computer
- Store all records according to local policies/procedures

Legal outcomes are not based on ‘truth’ but on ‘proof’ (Griffith, 2007), and we are all familiar with the old adage: ‘If it’s not written down, it didn’t happen.’

When writing in patients’ notes we need to bear in mind the possibility that the notes may later be used in court. Records are rarely neutral — they will either protect or condemn us professionally (see case study box).

There is a clash of cultures between health care and legal professionals, and community nurses need to be mindful of the need to protect themselves and their employers from potential fraudulent accusations.

**PROTECT YOURSELF**

As more aspects of nursing care move into the community, nursing teams are becoming increasingly busy. But remember, no matter how busy you are, lack of time is not a defence against litigation (Wood, 2010).

Community nurses need to develop a systematic, accurate and succinct approach to record-keeping, avoiding common inaccuracies in documentation (see examples in Tables 1 and 2). This will allow your records to withstand the scrutiny of the legal profession in a court of law. Remember when you chose nursing as a profession, you also chose law. In section 10 of the Code, there is a statement which clearly states the need to ‘keep clear and accurate records relevant to your practice’ (Table 3). Need we say more? **JCN**

**REFERENCES**


**Table 1:** The 6Cs of record keeping

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Of course it means...</th>
<th>But it also means...</th>
</tr>
</thead>
<tbody>
<tr>
<td>TWOC</td>
<td>Trial without catheter</td>
<td>Taken without consent</td>
</tr>
<tr>
<td>DNR</td>
<td>District nurse referral</td>
<td>Do not resuscitate</td>
</tr>
<tr>
<td>DOA</td>
<td>Date of admission</td>
<td>Dead on arrival</td>
</tr>
<tr>
<td>DOD</td>
<td>Date of discharge</td>
<td>Date of death</td>
</tr>
</tbody>
</table>

**Table 3:** What do good records show?

<table>
<thead>
<tr>
<th>Professional Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear decision-making processes</td>
</tr>
<tr>
<td>High standards of care</td>
</tr>
<tr>
<td>Evidence-based care</td>
</tr>
<tr>
<td>Clear channels of communication</td>
</tr>
<tr>
<td>Continuity of care</td>
</tr>
<tr>
<td>Evidence of adherence to policies and procedures</td>
</tr>
<tr>
<td>Ability to audit/track complaints</td>
</tr>
<tr>
<td>Professionalism in legal processes — furnishing the legal evidence of care</td>
</tr>
</tbody>
</table>

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