



Record Keeping Manual

Candidate

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Company

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date

--	--	--	--	--	--	--	--

Important Copyright Notice

This training manual remains the intellectual property of E-cert Healthcare Training Limited

The Material featured in this workbook is subject to E-cert Healthcare Training Limited copyright protection unless otherwise stated; any breach of this may result in legal action. Any other proposed use of the E-cert Healthcare Training Limited material will be subject to copyright license from E-cert Healthcare Training Limited. The information enclosed is not to be used, leased or lent to anyone intending to use it for training purposes, neither is it to be stored on any retrieval system for a use at a later date.

© E-cert Healthcare Training Limited 2018

Learning Outcomes

- Understand what a record is and the different types and their purpose.
- Understand how to use reports and records appropriately.
- Be aware of the professional and legal responsibilities in maintaining accurate records.
- Know how and where to find the legal requirements when dealing with and managing personal information in your workplace (GDPR 2016)
- Understand the implications of good and poor recording keeping on client care.
- Understand potential errors and barriers to accurate record keeping.
- Know how to write reports and records that are understandable, relevant for the purpose, clear and concise, factual and checkable.

Complementary Manuals Available

- Medication
- Safeguarding Adults at Risk
- Malnutrition
- Fall Prevention
- Health and Safety
- Infection Control

Introduction

Record keeping is an essential part of health and social care and is part of the role and responsibilities of all care workers. As Law et al (2010), states record keeping remains the primary source of communication for all health care professionals therefore accuracy of records will have a profound effect on the overall quality of care the client receives.

If records are not completed accurately, communication between health professionals can break down resulting in poor care. Although there is no one method of record keeping, there are recognised principles and standards that can be used by all health professionals as a framework in maintaining accurate care records. Good and accurate record keeping is part of a carer's 'duty of care'; and is an important skill which needs to be performed with accuracy at all times.

Aim

The aim of this manual is to provide information on health documentation and record keeping and to gain an understanding of the standards required for accurate record writing.

Unit One

What are records and health care documentation?

Accurate record keeping plays a fundamental part in providing high quality health care. Firstly, because good standards of record keeping will contribute to improving client care and secondly accurate records will protect and safeguard the person completing the records by detailing what they have or have not done.

As a carer yourself it's vital you do not underestimate the contribution accurate record keeping plays in these areas as well as your ability to help in ensuring it is achieved. Records that are clearly presented, legible and which comprehensively describes the care given to your clients will enhance communication between the client, family and the health care team. There are many types of records used in health and social care, so it's important to discuss what is meant by the terms 'health record' and 'documentation'.

What is a health record?

Here are some examples of what health records are:

'A health record can be defined as a database or collection of dedicated information about a person which can be used to preserve evidence of the person's health care journey'.

'A health record is a collection of information that is unique to the individual client. It ensures that the client is correctly identified and that they receive the right treatment. This personal information can be recorded and stored in a number of formats: paper, scans, microfiche and computer (electronic).

The General Data Protection Regulation (GDPR) is a key piece of law introduced in the UK in May 2018 which as a carer you should have a good understanding of particularly in areas associated with your role and if you haven't received a full briefing from your Manager on your GDPR accountabilities you should ask for it now. This regulation was produced in order to consistently protect an individual's personal data stored either on computers or in an organised filing system and how it is used and managed. It states that information contained in a record should be known to the client, accessible, accurate, kept up to date and secure. The client also now has the right to be forgotten which includes the deletion of all data held on that individual. The regulation also maintains the principle that all staff who have access to this information have a legal duty to protect the confidentiality of the information.

A health record is defined as 'any electronic or paper information recorded about a person for the purpose of managing their health', these records will include medical and patient records, case notes, mental health notes and obstetric records.

General Data Protection Regulation (GDPR)

You are accountable for the way you manage and treat personal data of the people you care for and those who are clients of the business you work in. Your Manager or business owner is accountable for providing you with the training and understanding of the issues surrounding the general data protection act in the workplace, outlining the new regulation and includes what the changes mean, what is required to remain compliant for those who process personal data.

Below is a brief summary of what you should be expect to know as a minimum in terms of knowledge and understanding.

The European Commission has introduced the General Data Protection Regulation (GDPR) which will be implemented on 25th May 2018.

The regulation has mainly been implemented in order to:

- Force companies to be clearer on their data collection and usage
- Improve data protection and prevent data infringement
- Establish improved control and reactivity to prevent data leakage

These new regulations play an important role at a time when both the volume of data is increasing, and threats are growing at a similar rate.

A key factor of any organisation's GDPR compliance is staff awareness and education.

Some of the important aspects of GDPR that should be covered in all training sessions:

- Principles
- Key definitions
- Lawful bases for processing
- Individual rights
- Accountability and Governance
- International Transfers
- Personal data breaches
- Security

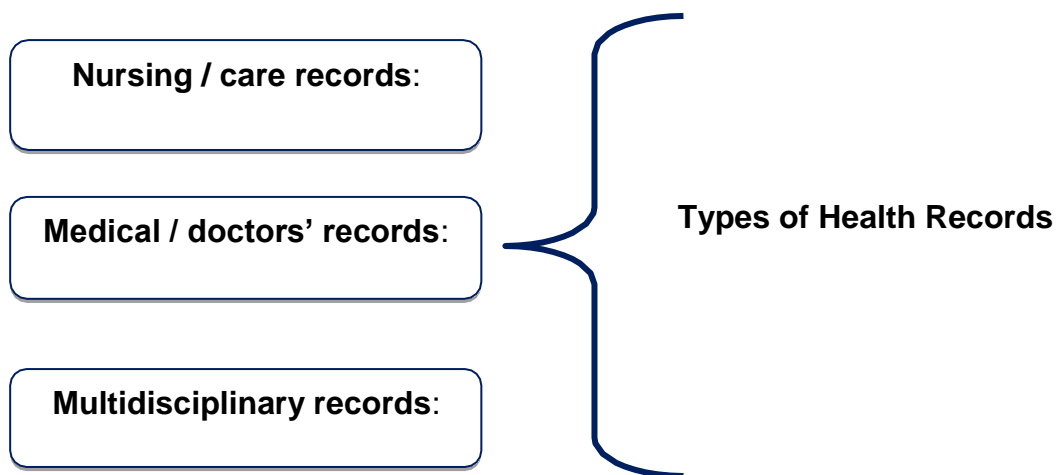
The data protection bill 2017 recognises that a health record is any record which:

- Contains personal medical or non-medical information relating to a person.
- Has been written or recorded by a health professional such a doctor, nurse or carer

Types of Health Records

While health and social care organisations are embracing developments in information technology, records / health documentation are found in a variety of formats and although there is a gradual use of electronic records, paper-based health documentation still remains widely used.

Evidence of health records / documentation can be found in health and social care settings as:



The writing of client's records remains an integral part of the care workers role and if it is accurate, timely and comprehensive it should reflect quality care. The professional body that regulates nurses and midwives, the Nursing and Midwifery Council (NMC 2010) states that record keeping is an essential part of safe and competent care for both nurses and carers

Accuracy in record writing should apply to all types and formats of records, regardless of how they are held, these can include the following examples:

- Clinical case records / operation records (Medical records)
- Social service case (Multidisciplinary records)
- Emails, letters, referral forms (Multidisciplinary records)
- Blood test results, X-rays (Medical records)
- Daily care notes, admission records (Nursing records)
- Risk assessment forms (Nursing / Care records)
- Accident reports and incident statements (Multidisciplinary records)
- Care charts, e.g. Food / weight charts (Nursing / Care records)
- Medication administration sheets (Medical / Nursing/ Care records)

Unit One Questions

1. If records are well written, legible and comprehensive what will be improved between care workers?

.....

.....

.....

2. Who inspects the standards of record keeping in health and social care establishments?

.....

.....

.....

3. Which regulation regulates how records must be stored and accessed?

.....

.....

.....

4. List two ways that health information can be recorded?

1.
2.

5. Name two examples of a health record or documentation you might see relating to nursing / care records

1.
2.

Suggested further reading for Unit One

***NMC (2009). Record keeping: Guidance for nurses and midwives.
www.nmc.uk.org***

General Data Protection Regulations

Department of Health (2010). Essence of care.www.dh.gov.uk.org

Unit 2

Functions of Health Records

There are many different types of records used in health and social care the ultimate goal of accurate record keeping is to maintain the safety of the client by protecting them from any potential mistakes in treatment or care.

For example, not recording the giving of a medicine to a client on a medication administration record could lead to the medicine being given again and overdosing the client.

‘Good record keeping is an integral part of nursing and midwifery practice and is essential to the provision of safe & effective care. It is not an optional extra to be fitted in if circumstances allow’ (NMC 2010).

Prideaux (2011) suggests that health records have many functions that are beneficial to both the client and health worker.



From you own experiences can you think of any functions that health records have in your workplace?

.....

.....

.....

.....

.....

Recording allows for the different stages of a client's care progress to be monitored and should provide evidence of the evaluation of care. From this information client care needs can be then adapted or changed if required.

Good record keeping also provides evidence of the actions of the care worker in supporting the client in meeting their health needs.

An example of which is in the scenario below.

Mr Glen Evans 79 lives in a care home; Due to arthritis he often has a poor night's sleep. He then gets tired during the day. His GP has already prescribed him pain killers to be taken at regular times during the day.

Using a pain assessment chart, his level of pain was recorded. From this assessment and information found in his care records and medication administration sheets, it was clear that his pain was not being controlled by the paracetamol and a medication review by his GP would be urgently needed.

For all those working in health and social care it's vital to recognise that health records have a very important legal and professional function. All records will be regarded as legal documents and can be called upon to be used as evidence in courts of law, at inquests and tribunals and for the purpose of official investigations.

Health records are very necessary in today's NHS and they have two main functions.

- The primary function of health records is to store important clinical information.
- The secondary function is to use the information in health records in an attempt to improve services / treatment delivered by the NHS such as accident and emergency care or the prevention of strokes in the UK.

Primary function	Secondary function
(Recording of clinical details by a health professional). These could include; Record of treatments. Any allergies Current medications Problems with any medications. History of health conditions. Previous illness / operations e.g. cancer, stroke, epilepsy Blood results, tests or x-rays. Personal details / life style information Name of GP/ Social worker etc	Using the information and data in NHS records to improve services. E.g. increase resources in staffing levels or improvements in waiting times for operations. To monitor the spread of, or risk from a particular disease, e.g. flu. Asthma, diabetes. To be used in the field of clinical research. E.g. medication treatments

Accurate health records should always give a factual account of what care has been given. Records, particularly risk assessments, should not only provide details of the actual care given but should provide clear information of why the decision was made to initiate this type of care.

Therefore, any decisions or the reasons behind care actions or changes in treatment must always be written in a person's record. This is very important for carers when demonstrating compliance with legislation; for example, the 'best interest' principles of the Mental Capacity Act (2005).

Records should also show if the client has declined any care or treatment and what alternatives have been offered to support the client following this decision.

During the day, carers observed that Mrs Peach hardly drank any fluid. It was noted that she often left most of her drink in the cup. Concerned about her lack of drinking, the carers decided to observe her fluid intake through the use of a fluid balance chart. However, they failed to record in her daily care notes that she frequently refused drinks offered to her especially in the evening.

Recording accurately that Mrs Peach was refusing to drink could have alerted the staff to investigate the reasons why she was refusing and enabled them to put in measures that would help in addressing any underlying problems or concerns.

In addition, this is a good example of how writing a full account of the refusal of Mrs Peach to drink and the subsequent actions then taken by the carers to monitor her fluid intake would have supported the care staff in the event of a complaint being made against them.

Good record keeping therefore should always clearly document the decisions and actions being taken by the care staff on behalf of the client.

Functions of records can also include:

- Good communication between health professionals.
- Observation charts, e.g. blood pressure, pulse, temperature.
- Risk assessments such as pressure sores, falls prevention.
- Monitoring health and safety e.g. accident books, food safety
- Evidence of daily care - daily record sheets, care plans.
- Decisions / choices / consent made by the client
- Outpatient clinic letters. Visits to other health professionals.
- Details of family input or decisions made on a client's behalf.

Suggested further reading

Taylor H (2003). An exploration of the factors that affect nurses record keeping. British Journal of Nursing. Vol 12, No 12, p-751-758.
The Mental Capacity Act 2005. www.doh.gov.uk

Unit Two

Questions

1. Complete the following quote from NMC guidance 'Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of

.....

2. Suggest two reasons why records might be required for legal evidence?

1.

2.

3. What is the primary function of health records?

.....

.....

.....

4. Give an example of a secondary function of health records.

.....

.....

.....

5. Name 2 reasons for making health records.

1.....

.....

.....

2.....

.....

.....

Unit Three

Good and poor record keeping

In this unit the effects and consequences of good and poor record keeping will be discussed. Good record keeping will:

- Improve information sharing
- Support communication
- Be proof of care delivered
- Demonstrate best practice

Improve information sharing

Accurate record keeping allows for the sharing of information between all members of the health care team and should relate to the whole client. The complete needs of the client must be taken into consideration when planning their care requirements. This is called having a client centred approach to care and these care needs should include **P.I.E.S**

- The physical needs
- The intellectual needs
- The emotional needs
- The social needs

The following scenario will illustrate such a client centred approach.

Mrs Sinn Oe Cho is a new admission to the Meadow View care home. 6 weeks ago, while trying to get to the toilet at night she had a fall which caused a badly bruised wrist. She has lost confidence in walking without support of a carer and finds it difficult to cope at home. In agreement with Mrs Sinn Oe Cho, on admission a falls risk assessment was performed which identified several risk factors which could result in another fall. It was identified that she had not had her eyes tested for almost three years and had not had a GP medication review since her fall. In addition, she had not had an assessment of her walking and balance.

This information was accurately recorded and shared with her GP and members of the care team. The GP reviewed her and reduced her medication. She was referred for an eye test and to the community physiotherapist. At night, a commode was placed near her bed, and call bell placed within her reach. A night light was left on and the night staff made sure that she was checked on hourly. With the consent of Mrs Sinn Oe Cho her family was also informed of the actions taken.

Improved Communication

In the case of Mrs Sinn Oe Cho having the right information in her health records enabled the members of the care team to consult with each other, talk with her family and respond quickly and appropriately to meet her care needs. The process demonstrates how communication can be improved through accurate records.

Shows proof of care

Health records must show proof of care given as well as the health care worker involved in providing it. The record should clearly explain the reasons for the care or treatment provided to a client. This will allow health workers to quickly identify problems re-assess the client's needs and then plan to put measures in place that are better suited for the client.

Stevens & Pickering 2010 suggests that providing this proof or evidence is vital in maintaining continuity of care and avoiding errors in care. This has been well demonstrated in the scenario of Mrs Sinn Oe Cho where carrying out a falls prevention risk assessment identified several risk factors which could have caused her to fall again.

Following this assessment, the home's care staff were made aware, referrals made to the appropriate health professionals, and with the agreement of Mrs Sinn Oe Cho and her family, care interventions were put in place to prevent further falls.

Demonstrates best practice

A health record must always identify the care worker who has made the entry in the records. This information proves who has delivered the care to the client. Identifying the care worker who has written in the records makes them responsible and accountable for what they have written.

McGeehan 2007 states that written entries in records will be viewed positively as being completed by a skilled carer whereas a poor record could give the impression that the standard of the care worker is poor and therefore they may be viewed negatively. What would you think about the person who wrote this;

Susam dint feel rite this morning, says that she got gut ache or someting. She left most of her food, so I gave it to Bert, waste not want not!! but not sure how much she had drunk. I reckon she needs a no 2. She sould be put on a chart, none in notes trolly maybe matron could get some. I think she wet herslerf today after I dressed her, but she had no more clean pants so I had to put on a pair of Elsie. Elsie won't mind as she don't even know whether she has any on or not. Cn't find her bootom set of teeth?? Lost again in the laundry i bet. Suan up in day room now what fun!

Signed *joyce smith*

Fraser (2010) suggested that where a carer maintains neat and accurate records, it could be assumed that they will adopt the same approach to their care. If records are 'sloppy' and badly written, we may guess that the care being given is poor.

The benefits of good record keeping:

- Improved standards and continuity of care.
- Improved communication between care staff.
- Correct account of the delivery of care and how the care was planned.
- Alerts staff to problems and allows them to respond quickly.
- Show aspects of care that have not been done as well as those that have.

The risks of poor record keeping:

- Errors of treatment e.g. medication errors.
- Inaccurate care is given due to poor communication.
- Important vital signs observations not recorded e.g. blood pressure and so information not passed on to the person in charge or the Doctor.
- Risk to the health and safety of clients and carers e.g. failure to document moving and handling.
- Clients missing pre-booked outpatients' appointments or clinics.
- Poor morale / dissatisfaction from clients and their relatives.

Suggested further reading

McGeehan R (2007). Best practice in record keeping. Nursing Standard. vol 21, no 17 p -51-55

Griffith R (2007). The importance of earnest record-keeping. Nurse prescribing Vol 5, no 8 – p-363-6

Unit Three

Questions

1. List 3 reasons why the clients care would be improved because of good health record keeping

1.

2.

3.

2. In the scenario of Mrs Sinn Oe Cho why is it important that information about her risk of falls is recorded?

.....

.....

.....

3. List 3 ways in which poor record keeping may affect the client in your care?

1.

2.

3.

4. What could your impression be of the person who has produced badly written record notes containing mistakes and errors?

.....

.....

.....

5. What do the letters P.I.E.S refer to in client centered care?

P.....

I

E

S

Unit Four

Legal and professional issues

Ensuring good records is a serious aspect of care and is the professional responsibility of all carers. Therefore, they should have an understanding of the most important laws which are associated with health records

General Data Protection Regulation (GDPR)

From 25 May 2018, most processing of personal data by organisations will have to comply with the General Data Protection Regulation. (GDPR)

The Data Protection Bill 2017

Information stored in any way, whether on paper or computer must be confidential and secure. People have the right to see their own records.

Freedom of Information Act (2005)

This allows a person to request information from a public body such as the NHS.

The Care Quality Commission (CQC)

The CQC is the body which regulates and inspects care providers. Guidance on meeting the record keeping requirements of the Health and Social Care Act 2008 can be found in their publication 'Essential Standards of Quality and Safety' which can be found at www.cqc.org.com

CQC: Regulation 20- Outcome 21 (Records)

People's personal records must be accurate, fit for purpose, held securely and remain confidential.

What is written in care records is the responsibility of the person who has made the record. No one else can be held responsible for it. Carers should not write care records on behalf of any other carer. Carers must keep up to date with relevant best practice guidelines, policies and processes for completing health records within their own working environment (A nominated person or data controller will be in charge of this in your company and should be able to give you a full copy of their policies and procedures and complete comprehensive training in line with the guidelines and your role). This is because any carer could be summoned to court to give evidence in relation to what took place during that period of care (Dimond 2008).

For how long should health records be kept?

As has been previously discussed all care workers are legally accountable for what they have written in health records, they also need to remember that all clients need to be aware of what records we keep of them and why from the start of any client relationship, whatever we write in a record and be able to request to view any records of their personal data themselves. For these reasons all entries need to be clear, intelligible, factual, and free of demeaning statements and value judgements.

Health records must always meet the legal requirements set by the General Data Protection Regulation and Freedom of Information Acts. Currently;

- GP records are kept for 10 years after the death of a client.
- GP records relating to children are kept until they are 25 years old.
- Maternity records are also kept for 25 years.
- Mental health records are kept for 20 years.

The accuracy of records written by carer is crucial when defending the carer practices either in a malpractice law suit or investigation. Cases may be won or lost based on the quality of documentation.

Accurate record keeping can be seen as a 'shield' in defending health professionals against legal action. In law courts, poor records mean poor defence, while no records mean no defence (Smith & Field 2011).

Barriers to Good Record Keeping

The reasons why care staff are not able to write accurate health records remains a point of debate but the most common barriers to record keeping appear to be the following:

- Workload pressures resulting in lack of time to complete the records.
- Staff may not consider record keeping such a high priority compared to the client care.
- Staff view writing records as a chore.
- Too many distractions and unexpected events.
- Lack of staff training, directives, supervision or support
- Lack of resources, paperwork, forms.
- Staff may have a fear of making mistakes, punishment, breaching clients' rights, possible litigation.
- IT system knowledge gaps and system breakdowns.

Professional Issues

Duty of Care

All care providers have a duty of care to their clients. This means they must aim to provide high quality care to the best of their ability. If you are unable to achieve this then you must always report to the manager and explain the reasons why you are unable to do so.

Accountability

The principle of accountability applies to all health care providers. To be protected from legal action if things go wrong you must be able to show that you were following appropriate guidelines, policies and procedures, and the law. Evidence of this should be found in the records you create.

You are individually accountable for the care you provide and the consequences of your working practices.

Registered nurses are accountable under the NMC's code of professional conduct, and carers are accountable for their own work under their workplace policies.

Confidentiality

The information stored in a client's health records is highly confidential; therefore, carers must ensure that it is only ever shared with appropriate people directly involved in the care of the client. Your workplace should have policies and procedures for information sharing and maintaining confidentiality and you should be trained in all areas of client personal data care.

Computer records must be protected and there must be systems for identifying exactly who accessed information. All companies should have an effective process for managing password protection/security and the access levels for all individuals. There must also be a clear policy on reporting any breaches of your systems if or when it happens.

Suggested further reading

Beech M (2007). Confidentiality in healthcare: conflicting legal and ethical issues. Nursing Standard. Vol 21, no 21, p-42-46
Casey A & Wallis A (2011). Effective communication: Principle of Nursing Practice E. Nursing Standard. April 13. Vol 25, no 32, p-3537.
Unison (2011). Unison duty of care handbook. Unison. www.unison.org.uk

Unit Four

Questions

1. Name any two laws/regulations that relate to health records that carers need to be aware of?

1.

2.

2. Name the CQC regulation which applies to the monitoring of standards of records in health and social care establishments.

.....

.....

.....

3. Who is accountable for what is written in a client record?

.....

.....

.....

4. How many years after the death of a person must a GP keep their health records before disposing them?

.....

.....

.....

5. Suggest a reason why carers' record keeping might be poor.

.....

.....

.....

Unit Five

Principles of Good Record Keeping

As discussed in other units, care workers have a duty to ensure that all entries in clients' records are accurately written. However, as there is no comprehensive, universal standard for record keeping, what should good accurate recording consist of and what are the principles of good record keeping for a care worker to follow? In its document record keeping: Guidance for nurses and midwives, the NMC (2010) provide a template on the principles of good record keeping.

NMC (2010): Principles of good record keeping: style and content

1. Clear, legible handwriting must be used.
2. All entries must be signed by the person writing them.
3. Use a full signature unless policies allow for the use of initials.
4. Entries should include the date and time using the 24-hr scale
5. Records must contain information which is factual, accurate, relevant and comprehensive.
6. Risk assessments must identify potential risks and outline actions taken.
7. Records must communicate effectively at all times.
8. Do not alter or destroy records unless authorised to do so.
9. Amendments must be signed and dated. Original entries must be clear and readable.
10. Clients / significant others should be involved in the record keeping process.
11. Avoid medical jargon, language must be understood by all.
12. Records should be readable when photocopied or scanned. Use black ink
13. Sarcasm or humorous abbreviations should not be used. Use authorised abbreviations only
14. Records must never be falsified or tampered with.
15. Black ink should be used at all time
16. Don't use correcting fluid, cross through errors with a single line, sign and date.
17. Records must be held securely.
18. Entries must be written in chronological order and as soon as possible after the episode of care / activity.

The introduction of a structured framework using the mnemonic R.E.C.O.R.D F.A.C.T will provide care workers with a set of principles for good record keeping that can be applied when completing health documentation.

Principles of Accurate Record Keeping R.E.C.O.R.D F.A.C.T

- (R) **Responsibility.** All entries made in records should be accurately dated, timed and signed with the full signature. In written records the person's name and job title should be printed alongside the first entry. Initials should only be used when indicated by local policy.
- (E) **Errors.** Errors made in records should not be erased or hidden. White correcting fluid should not be used. Instead the error should be scored out with a single black line with 'Error' written over it, signed and dated.
- (C) **Comprehensiveness.** Entries made in records should be comprehensive and communicate effectively all aspects of the health journey e.g. assessments, reviews, future plans, on-going care and treatments.
- (O) **Original.** Original handwriting should be legible and understandable and the meaning should be clearly identifiable.
- (R) **Readable.** Records that need to be photocopied or scanned must be readable. All entries should be made using black indelible ink.
- (D) **Don't diminish.** Entries in records should not use abbreviations to convey information unless they are specified in local policy.
- (F) **Factual.** All entries should be made without the use of meaningless phrases, irrelevant speculation or opinions. Offensive and subjective statements should not be used.
- (A) **Accurate.** All information contained in records should be accurate, based on professional judgement and never falsified. Records are never neutral, they will either support or condemn.
- (C) **Consistent.** All information should be consistent and written in order of occurrence (Chronological order).
- (T) **Timing.** Entries made in records should be written at the time of the event or as soon as possible afterwards (Contemporaneous

Dimond (2008) identified some common errors found in record keeping that care workers need to be aware of when completing care records and documentation. These include:

- Times and dates omitted,
- Illegible handwriting, poor spelling and inappropriate abbreviations.
- Use of correcting fluid and covering up of errors
- Records of phone calls (e.g. to social services) that omitted the name of the recipient (e.g. social worker).
- No signature.
- Absence of information about a client. Omission of date of medical reviews, records of tests.
- Delay in completing the record; sometimes more than 24 hours elapsed before the records were completed.
- Records completed by someone who did not undertake the care.
- Inaccuracies of name, date of birth and address.
- Unprofessional terminology, e.g. 'what a weight!!'.
- Meaningless phrases, e.g. 'off his legs this morning'.
- Opinion mixed up with facts e.g. 'the client should go on a diet'.
- Subjective, not objective comments e.g. 'strange behaviour today, he's not right'.
- Using hearsay e.g. information gained from family members or visitors.

Use of Abbreviations

It is not normally good practice to use abbreviations as they can be misunderstood; however, some may be useful as long as they are easily recognisable and agreed by your employer.

HCA, BP, Temp, SW, Physio, DNAR, UTI, MDT, RN, CD, MCA, DOA, BO, BD, IVI, BB, NBM.

B	O	U	D	B	B	R	T	B
B	B	W	T	D	M	H	D	M
P	H	Y	S	I	O	C	C	I
T	E	M	P	D	N	A	R	V
A	o	D	M	B	N	N	U	I

Once you have found the abbreviations can you explain their full meaning by completing the following table.

Abbreviation	Full Meaning
HCA	
BP	
Temp	
SW	
Physio	
DNAR	
UTI	
MDT	
RN	
CD	
MCA	
DOA	
BO	
BD	
IVI	
BB	
NBM	

Conclusion

Accurate record keeping is an essential part of health and social care and is the responsibility of all care workers. Good standards of record keeping will improve the

quality of client care and should be seen as the documented evidence of the care provided.

This manual has discussed issues surrounding record keeping, in particular its effects on the client and the role of care worker. The manual offers a framework for care workers to develop their knowledge and skills ensuring their record keeping is in accordance with current best practice.

Suggested further reading

Griffith R & Tegnah C (2008). Law and professional issues in nursing. Learning Matters. Exeter.

Law L, Akroys K, Burke L (2010). Improving nurse documentation and record keeping in stoma care. British Journal of Nursing. Vol 19, No 21. P-1328-1333.

Unit Five

Questions

1. As there is currently no universal standard for record keeping, what can the care worker follow to ensure their records are accurate?

.....

.....

.....

2. Can you list 3 principles of good record keeping?

1.
2.
3.

3. Why is it not normally good practice to use abbreviations?

.....

.....

.....

4. Can you describe 3 common errors that can be found in health records

1.
2.
3.

5. Complete the words which make up the principles of accurate record keeping

R.....

E.....

C.....

O.....

R.....

D.....

F.....

A.....

C.....

T.....

Abbreviation

HCA
BP
Temp
SW
Physio
DNAR
UTI
MDT
RN
CD
MCA
DOA
BO
BD
IVI
BB
NBM

Full Meaning

Health Care Assistant
Blood pressure
Temperature
Social worker
Physiotherapist
Do not attempt resuscitation
Urinary tract infection
Multidisciplinary team
Registered Nurse
Controlled Drug
Mental Capacity Act
Date of admission
Bowels open
Twice daily
Intravenous Infusion
Bed bath
Nil by Mouth

References:

- Dimond B (2008). Legal aspects of nursing (5th edition). Pearson Education Ltd. Harlow. England
- Fraser J (2010). Keeping midwives out of court. Practising Midwife. Vol 13, no 3, p-36-37
- Nursing & Midwifery Council (2010). Record Keeping: Guidance for nurses and midwives. NMC. London.
- Owen K (2005). Documentation in nursing practice. Nursing Standard vol 19, no 32, p-48-49
- Prideaux A (2011). Issues in nursing documentation and record –keeping practice. British Journal of Nursing. Vol 20, No 22. P-1450-1454.
- Smith B & Field L (2011). Nursing care: An essential guide for nurses and healthcare workers in primary and secondary care. Pearson. London.
- Stevens S & Pickering D (2010). Keeping good records: a guide. Community Eye Health Journal. Vol 23, no 74, p- 44-45
- General Data Protection Regulations
- The data protection bill 2017

Further reading:

- Hoban V (2005). For the record. Nursing Times. vol 101, no 27, p- 20-22.
- Ingram P & Lavery I (2009). Clinical skills for healthcare assistants. Wiley Blackwell. Chichester
- Woods C (2003). The importance of good record keeping for nurses. Nursing Times vol 99, no 2, p-26-27

Endacott R & Conway N (2009). Principles of good recording keeping. In Clinical nursing skill, core and advanced (eds Endacott R, Jevon P, Cooper S,)Oxford University press. Oxford.