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Record keeping and documentation: a legal
perspective

by

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Introduction

All health care practitioners interact with health care records as part of their professional practice. In order for this aspect of their practice to be effective and safe for their patients, it is important that health care practitioners are aware of the legal & professional principles for effective record keeping and documentation, and appreciate the consequences of poor record keeping.

It is these principles that are the focus of this article.

Health care records

Health care records are an essential part of health care practice. They are part of the communication between the diverse members of a patient's health care team and allow for a patient's progress to be monitored, so that appropriate care and treatment can be provided.

A health care record includes anything that relates to the patient's health, including a specific episode in their health history. It may be episode based or a history detailing several episodes in one collection. It can include:

- Handwritten and electronic clinical notes
- Correspondence between health care professionals
- Laboratory reports e.g blood analysis
- Printouts and traces eg ECG
- X-rays, scans
- Consent forms

There are several reasons for health care records to exist. The most obvious is for the clinical benefit of the patient. However, there are also non-clinical reasons such as maintaining records for quality assurance/audit purposes; financial reasons such as ensuring that targets are met; and for commissioning purposes to ensure that the correct services are targeted at the correct population.

Whatever the reason for the creation of the health care record, it should allow the patient episode to be reconstructed entirely from the notes without the need to refer back to the health care practitioner and their memory of the events.

The rest of this article will concern itself with clinical health care records.

Why don't 'we' always keep 'good' records?

It is probably true to say that no health care practitioner sets out to make a 'bad' set of records. That said there are many sets of records that would not stand up to scrutiny.

From speaking with registered health care practitioners it is possible to identify some common reasons why health care records are not always kept to the required standard.

One of the most common reasons is that the health care practitioner is not aware of the purpose of a health care record or how they should be maintained and what needs to be recorded in them.

Some health care practitioners report that they do not have the time to record more than the very minimum of information because there are other demands on their time; they are too busy; they have too many patients to care for.

Some health care practitioners report getting interrupted when they are writing their entry in the health care record and are then distracted from completing it.

Others health care practitioners do not see the point of maintaining health care records as they believe that they know their patients and can report any findings or information that is needed. Others keep their records the way they have always done and do not see the need to change their practice, even if the health care record does not fulfil its purpose of allowing other health care practitioners access to the information they need to care for that patient.

What does a good health care record do?

The main purpose of a health care record is to allow the health care team to provide the best possible care for a patient. It does this by providing a full account of each episode of care and treatment the patient has received. By doing this it allows health care practitioners access to the information they need in order to care for and treat the patient.

Consequences of poor record keeping

If a health care record does not fulfil its function, as stated earlier, of allowing the patient episode to be reconstructed entirely from the notes there are several consequences that could occur as a result.

As one of the functions of a health care record is to provide a means for communication regarding a patient's health events, poor record keeping can hamper that communication: both with the patient and with other members of the health care team.

If tests that are ordered are not recorded, or the results not entered into the patient's health care record, tests may be repeated. This is wasteful in terms of time and resources as well as potentially harmful to the patient.

If the health care record is incomplete in terms of the patient's past health history, the patient's details regarding a specific condition may be missing, the patient's response to certain treatment may be lacking, previous symptoms and response to treatment may be imprecise. All of which may result in a delayed diagnosis or inappropriate treatment being given.

And, as a consequence of the above, patients may lose confidence in the ability of the health care practitioners looking after them.

Good health care records

In contrast to incomplete or poorly written health records, a good reliable health care record will:

Provide the information needed by all members of the health care team that they need in order to be able to provide care and treatment to the patient; and

Contain information regarding each health care episode that the patient has had.

This will allow the health care team to provide the best possible care and treatment to the patient.

The good health care record does this by:

- Identifying the patient and the person making the entry
- Being accurate in the information it presents
- Being clear and legible so that others reading the information are clear as to its meaning
- Establishing the timeframe, where possible use the 24 hour clock and allows date the entry including the year and the time.
- Providing information regarding tests and procedures that have been undertaken, including the findings and any action taken
- Identifies any diagnosis and decision-making
- Being comprehensive in including consultations with the patient
- Including any advice that has been given to the patient
- Specifying any information that has arisen from other sources
- Detailing arrangements for referrals and follow ups
- Being contemporaneous

Why should health care records be written contemporaneously?

As a health care record is a means of communication regarding a patient and their health event to the whole health care team, it is important that anyone coming into

contact with the patient has the correct and up-to-date information available to them. The sooner a health care record is updated the sooner other members of the health care team will have access to the relevant information for their aspect of the patient's care and treatment.

If a record is updated contemporaneously with the events it portrays, the less likely it is that investigations and their results will be overlooked and that referrals and follow up requirements will be missed.

It can be argued that recording an event contemporaneously saves time as it means that the health care practitioner will not have to keep referring to their notes or refreshing their memory to record the event.

Making a record at the time of the event means that it is more likely to be done and not forgotten. Delays in recording the event, making errors in the recording due to forgetting important details or making an inadequate record of the event can all lead to harm for the patient.

When making an entry in a health care record beware of:

- Incomplete entries – if an entry is incomplete other members of the health care team may not realise that they do not have all the pertinent information for their aspect of the patient's care and treatment.
- Drug doses – ensure these are accurate and ensure that decimal points are in the correct place and the correct unit of dose is used.
- Subjective statements – you should be recording facts regarding the patient, their health event and the care and treatment you have provided. Everything recorded by you should be objective. Do not use derisive or insulting language about the patient or your colleagues. It is sometimes necessary to record the patient's subjective statements such as their indication of how much pain they are in, this should be recorded as being from the patient and where possible using the patient's own words.
- Ambiguous entries – ensure that your writing is clear and there is no ambiguity as to your meaning.
- Be very wary of abbreviations and other forms of shorthand when writing in a patient's health care record. This is especially so with TLAs. Don't know what a TLA is? It is a Three Letter Acronym. What one person thinks is commonplace may not be for another.

Some examples of issues with abbreviations and TLAs:

Some are unclear - UBI (unexplained beer injury), not useful if you are unaware of what it means.

Some can have alternative meanings

Ca – cancer or calcium

IUD – intrauterine device or intrauterine death

GU – genito-urinary or gastric ulcer

MS – mitral stenosis or multiple sclerosis

Whilst many of these can be contest specific if the reader is not aware of the context it is not always possible to determine what was meant by the abbreviation.

Corrections and alterations

No-one is infallible and we all make mistakes, what marks out a professional health care practitioner is how they deal with that mistake.

Do not be tempted to alter an entry in a health care record after the event without acknowledging that this is the case. If in doubt remember that audit trails can be investigated very thoroughly and forensic analysis can be undertaken and it is amazing what forensic analysis can determine and uncover. Forensic investigation is able to determine if an entry has been amended either in hard form or on a computerised record.

If a record is found to be altered without this fact being acknowledged this increases the health care practitioner's vulnerability to disciplinary proceedings and any evidence by them being seen as being unreliable.

To prevent this from being a possibility, whenever making an amendment or alteration to an entry in a health record:

- Always date and time the amendment
- Provide the reason for amendment (e.g. at patient request, written in error)
- Sign the amendment
- Place the amendment as close as possible to the entry that needs amending or clearly indicate the entry that is being amended and the one that is the amendment.

Ensuring professional practice

Ensure that any information you record in a patient's health care record is

- Accurate
- Contemporaneous
- Chronological
- Factual

- Succinct

Good record keeping is a mark of the skilled and safe practitioner. Your standard of care will be judged by the quality of your record keeping; careless or inadequate record keeping suggests your standard of care is the same.

Conclusion

This article commended with the statement that health care records are an essential part of health care practice. It is hoped that the need for accurate record keeping can be seen, and that all health care practitioners should be capable of making notes that are accurate and complete. Poor health care records can be dangerous for the patient and damaging to the career of the health care practitioners; as they can result in disciplinary action being taken by their employer and their regulator (such as the Nursing and Midwifery Council or Health and Care Professions Council).