Documentation and record keeping

by Susan Pirie

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Documentation and record keeping is an important aspect of healthcare practice and perioperative practice is no exception to this rule. For some time now, recording every activity or intervention that a patient receives has assisted with enhancing perioperative practice; equally, it has played a key part in resolving legal and professional incidents that have occurred. There are numerous national guidelines that uphold accurate record keeping as an intrinsic aspect to patient safety (DH 2006, HPC 2008, NMC 2008, Scottish Executive 2008, DH 2009). The intention of this article is to identify and discuss some of the more common errors associated with record keeping which may have a direct or indirect effect on practitioners’ misconceptions of using electronic record systems.

Definitions

It would seem appropriate firstly to consider what is meant by the terms documentation and record keeping. The Collins English dictionary (2003) defines documentation as ‘documents supplied as proof of evidence of something’. Records have been defined as ‘a document or other thing that preserves information’ (Collins English Dictionary 2003). Record keeping has been stated as ‘part of the professional duty of care owed by nurses to the patient’ (Dimond 2008).

Guidance for good record keeping

Having identified what is meant by the term record keeping, practitioners should be aware that the Nursing and Midwifery Council (NMC) consider that ‘good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow’ (NMC 2009). Given the importance of accurate documentation and records, practitioners should be aware of the guidance in Box 1 in relation to completing records:

Common errors in record keeping

Having established what a record is and how it should be completed, it may be helpful to consider some of the pitfalls and bad habits that can affect effective documentation and record keeping. These are particularly pertinent in the event that patient documentation needs to be reviewed in an adverse incident. Some of the more common errors can be found in Box 2.

Types of record

There is a wide range of records in the perioperative environment relating to the pre, intra and post operative periods of care. In the preoperative phase, records such as the checking of anaesthetic equipment and checking of controlled drugs as well as the anaesthetic record will be completed. The anaesthetic record will usually be completed by the anaesthetist or on some occasions by...
A record that begins with the preoperative phase and continues into the intra and post operative phases is the perioperative care plan

- All entries should be clear and legible
- Entries should be signed and if this is your first entry in a record, you should document your name and job title
- Records should be completed in line with local policy
- Entries should be accurate and the meaning of your entry should be clear to all individuals involved in the care of that patient
- Records should be factual and not based on opinion
- Practitioners should use their professional judgement to consider what information should be recorded
- The relevance of the information should be considered both in relation to the patient’s care and also to other healthcare professionals involved in caring for the patient
- Records should provide an account of the care given, any assessments that have been made as well as the requirements for ongoing care
- They should be able to provide a comprehensive but concise record of the care that has been given
- Patient records should identify any problems and how these have been resolved
- Where it is feasible and appropriate to do so, patients or their carer should be involved in the record keeping process
- Records should use appropriate language so that they can be easily understood by all who have access to them
- Records should not be altered or destroyed unless a practitioner has the authority to do so
- In the event that an entry in a patient record requires amendment, then this should be done without defacing the original entry which should still be readable
- Any alterations must be dated and signed and the practitioner undertaking the alteration must specify their name and job title
- Records should not be falsified in any way
- Records should always be readable, particularly if they have been photocopied or scanned

Patient details
- Ward checks prior to leaving for theatre
- Checks from the reception area on arrival in theatre
- Checks in the anaesthetic room and the positioning of monitoring equipment
- The position of the patient for the perioperative intervention or procedure and the aids that have been used to facilitate this position
- Skin integrity and condition, particularly around the diathermy site
- Information on the count
- The type of tourniquet used and the duration of use
- Details of specimens that have been taken
- Information on wound drains, dressings, catheters, stomas and plaster casts.

This is not an exhaustive list but will give an indication of some of the information that is required to be documented during a perioperative intervention or procedure.

Box 1: Guidance for good record keeping. Source: Nursing and Midwifery Council 2009

Box 2: Common errors in record keeping. Source: Dimond 2008
Documentation and record keeping

Continued

has been marked up on a white board in theatre. At the end of the operation, the accuracy of the count will be recorded in the theatre register and the perioperative care plan. The record will traditionally be made by the signature of the scrub and circulating practitioners who have performed the relevant count, and will not contain a record of the items utilised and incorporated into the count. Many perioperative departments have now introduced a system whereby the content of the count is recorded on paper as well as on a white board, so that a permanent record of the count is retained in the patient’s notes. This practice has had a significant impact on patient safety as it provides a clear record of all the items used in the count as well as identifying the practitioners who have been involved (APP 2007).

Decontamination records
Decontamination records are also kept to ensure compliance with tracking and traceability requirements. This is often a separate record in which both the tracking label for the tray and/or supplementary and the decontamination label detailing the autoclave and sterilisation data are placed. Again, this record is placed in the patient’s notes.

Records of implants or protheses
Many procedures involve the use of implants or prostheses and there are a number of regulations and recommendations that need to be complied with in relation to the recording of these items. Orthopaedic joint implants are now required to be logged centrally on the National Joint Registry database. There are a number of record keeping requirements that are linked to the Consumer Protection Act 1987 such as those listed in Box 4.

Equipment related records
Another important area of documentation is less obvious to the perioperative practitioner, but remains important, and that is equipment related records. These records are often held outside the perioperative department as they are jointly managed with the estates department, medical physics or bioengineering departments, medical device companies or decontamination units. The content for these records can be found in Box 5.

- The specific implant or prosthesis, including the size
- The manufacturer of the implant or prosthesis
- The code number
- The batch and/or lot number
- The sterilisation date and/or date of manufacturer
- The expiry date of the implant/prosthesis
- Any amendments or adaptations that have been made.

In Scotland, the Scottish Patient Safety Alliance has instituted a similar system with the perioperative briefings where all team members introduce themselves and issues are discussed. As with the system in England and Wales, a surgical pause is initiated immediately prior to ‘knife to skin’ (Scottish Patient Safety Programme 2008).

Theatre registers
Theatre registers are another form of documentation that must be completed. The register will document the following:
- The patient’s name, date of birth, hospital number
- The procedure that has been completed, including the anaesthetic type
- The names of the anaesthetist(s) and surgeon(s) involved
- The name of the scrub and circulating practitioners involved in the count
- Details of any implants
- Details of any adverse incidents that have occurred (APP 2007, APP 2009).

Many perioperative departments no longer use a paper based register and record all of the above information on an electronic record. This knowledge has been gained from personal experience as a perioperative practitioner, by talking to other perioperative practitioners across the UK and by visiting perioperative departments where such a system is in use. This can cause concern to some practitioners, who feel that it is necessary for them to physically sign the register. However, it remains the responsibility of every practitioner, to ensure that records about the care they provide are
Care should be taken not only to record appropriate information, but also to ensure that appropriate and meaningful language is used.

Accurate and complete. Therefore an electronic register should be checked in the same way as a paper register and by acknowledging that the information is correct, this should act as confirmation that the record is correct in the same way that a signature on paper record signifies this. The NMC has published guidance in relation to the use of information management systems, which will include the use of electronic records (NMC 2009).

One element of electronic records that should be strictly adhered to is the confidentiality of passwords and smart cards. Smart cards are used by authorised staff to access the NHS electronic record, and are uniquely identifiable to the practitioner to whom they have been issued. Smart cards are currently being issued to staff in the writer’s trust, as a new electronic theatre record will be introduced early next year. The new system will require the use of smart cards in order to access the necessary records and to enter patient information in that record. Under no circumstances should these be divulged to or used by anyone else, nor should they be left in a system so that others may enter information or amend information that you have already entered (NMC 2009).

Legal implications

There are a wide range of legal implications in relation to the documentation of care and the record keeping requirements of healthcare practitioners. This article does not discuss all of these elements but gives a broad overview of the main requirements, including the definition of legal documents, the need for clarity and accuracy, the role of the Caldicott Guardian, and the retention periods for records. It also highlights some of the more important legislation relating to healthcare records. Practitioners who require information on consent should refer to national guidelines (DH 2001, DHSSPSNI 2003 and SEHD 2006).

What is a legal document?

In the first instance it is helpful to clarify and define ‘what is a legal document?’ The answer is somewhat complex as certain documents, such as patient’s case notes and theatre registers, are clearly defined as legal documents, whereas there is confusion over the status of many of the documents we use on a daily basis. Dimond (2008) has stated that a legal document is ‘any document requested by the court’ and goes on to identify some of the documents and records that may be requested. In the perioperative setting, any of the documents we complete, may be requested by the courts and so it is essential that all records are completed correctly. It is a known fact that poorly completed records will impact on the professional concerned in the event that they are questioned about documentation in a court of law (Dimond 2008), where they will be required to state the truth contained within the record, under oath in a court.

Implications of record keeping

Practitioners may wish to consider the implications of records in the case of Deacon v McVicar. In this case the patient alleged that there were a number of concerns relating to her care, particularly the removal of the Shirodkar suture, which needs to be removed as soon as labour has commenced, in order to prevent damage to the cervix. The patient did indeed suffer damage to her cervix and claimed that this was due to the failure of staff to attend to her promptly and that the perceived delay in removing the suture resulted in her injury. The defendants claimed that although the labour ward was busy, her care was not compromised. The judge concerned ordered that the records of other patient’s on the ward at the time of the incident should be disclosed to the courts in order that an assessment of the demands on staff at this point in time could be made (Dimond 2008).

It has been demonstrated above, that good record keeping is essential as the number of medical negligence cases continues to rise. Figures from the NHSLA Annual Report for 09/10 show that the total costs paid out in this period in relation to clinical negligence schemes was almost £787 million. It is the third year in succession that the figure has risen; £633 million and £769 million were paid out in 07/09 and 08/09 respectively (NHSLA 2010). It must be remembered that in medical law, if a care procedure has not been documented then it has not occurred (Wood 2010).

The clarity of information in records is essential (Dimond 2008). Care should be taken not only to record appropriate information, but also to ensure that appropriate and meaningful language is used. Care should be taken in relation to the use of abbreviations, for example ESR may relate to erythrocyte sedimentation rate or electronic staff record, a confusion that has occurred in the writer’s workplace. Similarly the need for accuracy in what has been recorded has been highlighted earlier in the text, particularly in documentation that is used by the multidisciplinary team. Document retention periods

The retention periods of documents vary enormously and there are specific legal guidelines for some perioperative documents. Some of these requirements can be found in Box 6

Accountability

It is often the case that there is a degree of confusion amongst staff over the level of accountability that healthcare practitioners hold, and a common misconception is that only registered practitioners are accountable. In relation to professional accountability, this is an accurate assumption as it is only the practitioners who are regulated by a professional body that are held accountable to that organisation. However, it should be remembered that everyone regardless of professional status has a legal duty of care to each other. In addition, all employees are accountable to their employer who will expect them to work within the policies and protocols of their organisation.

Registered nurses and operating department practitioners are regulated by the Nursing and Midwifery Council and the Health Professions Council respectively.
order to maintain their registration, registrants are required to work within the guidance provided in the code or standards of these organisations. Registered nurses must comply with ‘The Code: Standards for conduct performance and ethics for nurses and midwives’ (NMC 2008); operating department practitioners are required to comply with the guidance in ‘Standards of conduct, performance and ethics’ (HPC 2008). The requirements of these bodies can be found in Boxes 7 and 8 respectively. Keep clear and accurate records

In addition, the NMC has provided further guidance for registrants in the document ‘Record Keeping Guidance for Nurses and Midwives’ (NMC 2009). This document provides a greater insight into these requirements and provides further guidance on the knowledge requirements that registrants should be familiar with. The Health Professions Council guidance for accurate record keeping is contained within the document ‘Standards of conduct, performance and ethics’ (HPC 2008); it can be found in Box 8.

Conclusion

This article provides an overview of some of the main requirements relating to professional standards of documentation and record keeping and identifies some of the documentation that requires completion in perioperative practice. It is anticipated that this article will provide a resource to practitioners who can then extend their knowledge further by reflecting on their own and their organisation’s practice in relation to these issues. It is hoped that the further reading list may be of assistance to them in this process.

References

Association of Anaesthetists of Great Britain and Ireland 2008 Information Management: guidance for anaesthetists London, AAGBI
Association for Perioperative Practice 2009 Safeguards for Invasive Procedures Harrogate, AIPP
Association for Perioperative Practice 2007 Standards and Recommendations for Safe Perioperative Practice Harrogate, AIPP

Box 6: Guidelines for retention of perioperative documents. Source: Department of Health 2009

- All records pertaining to children and young people should be retained until the patient’s 25th birthday or until 8 years after death
- If treatment is concluded when the patient was aged 17 at the conclusion of treatment, then records must be kept until the patient is 26 years of age
- Controlled drug documentation should also be kept for specific periods of time, and advice on these retention periods should be sought from the pharmacy department as it is probable that the retention and storage of these drugs will be within their domain
- Endoscopy records must be kept for a period of 8 years or in accordance with guidance on records for children if paediatric patients have been treated within these records
- These records must also include sterilix endoscopy disinfector traceability strips and the traceability strips for PEG/stents that are used in endoscopy
- Joint replacement records need to be kept for 10 years
- Operating theatre lists should be kept for 4 years if they are only available in a paper format, and paper copies of electronic theatre lists should be kept for a minimum of 48 hours
- Operating theatre registers should be kept for a minimum of eight years if they relate to adults only
- Operating registers with details of paediatric cases should be kept in line with the recommendations for children and young people
- Obstetric operating theatre registers or those that contain obstetric patient records, should be kept for 25 years after the birth of the child
- Records that contain batch information on products should be kept for 10 years
- Refrigerator temperature records should be retained for a period of one year, although records relating to the products stored within a refrigerator should be kept for the life of the products i.e. until the expiry date
- Photographs that are printed and placed in the patient’s notes should be retained in line with the retention period relevant to the patient
- Recovery room records need to be retained for a minimum of 8 years

Box 7: Keeping clear and accurate records. Source: Nursing and Midwifery Council 2008

- You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been.
- You must complete records as soon as possible after an event has occurred.
- You must not tamper with records in any way.
- You must ensure that any entries you make in someone’s paper records are clearly and legibly signed, dated and timed.
- You must make sure that any entries you make in someone’s electronic records are clearly attributable to you.
- You must ensure that all records are kept securely.
It can be seen therefore that these two documents provide clear guidance in relation to the keeping accurate records. Source: Health Professions Council

**Box B: Keeping accurate records. Source: Health Professions Council 20**

It can be seen therefore that these two documents provide clear guidance in relation to the standards of documentation and record keeping that registrants are required to comply with.

**You must keep accurate records**

Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services. You must complete all records promptly, if you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries.

You have a duty to make sure, as far as is possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user.

You must protect the information in records from being lost, damaged, accessed by someone without appropriate authority, or tampered with. If you update a record you must not delete information that was previously there, or make the information difficult to read. Instead you must mark it in some way (for example, by drawing a line through the old information).

Further reading

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