



Royal College
of Nursing

Documentation in colorectal and stoma care nursing

RCN guidance for nursing staff

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Contents

Introduction	2
1. The development of nursing documentation	3
2. Legal implications	5
3. Professional issues	7
4. Good documentation	8
5. Recording informed consent	10
6. Creating and using service records	11
7. Computerised records	12
Conclusion	13
References and useful websites	14
Appendix 1	16
Information which should be included in a patient's notes: an example data set	
Appendix 2	18
Summary of clinical nurse specialist documentation	
Appendix 3	19
Benchmarks for record-keeping, taken from <i>The Essence of Care</i>	

Introduction

During 2001, two nurses – members of the RCN Gastroenterology and Stoma Care Nursing Forum – attended formal enquiry hearings to account for their practice, after complaints were made about patient care. It's a situation many nurses will have encountered or been involved in at one time or another. These hearings involved a long process of sifting through documentation kept by the nurses themselves and by other multidisciplinary team members. Because they had kept such good records, both members were able to justify their actions and the quality of their decisions about care, often made many years before. Neither nurse, however, came away without facing some criticism.

To help other nurses who might face similar questioning in the future, the steering group of the RCN Gastroenterology and Stoma Care Nursing Forum decided to produce a *Report on Documentation for Specialist Colorectal and Stoma Care Nursing*, and this best practice guidance.

The guidance aims to minimise the risks that all nurses face every day when they document care. It sets out a range of issues you, as a nurse, need to consider, and highlights good practice points.

Keeping accurate and detailed records about a patient's care is part of your duty of care as a registered nurse. It is also the responsibility of your employer to set up overall systems of record-keeping which will enable you to work efficiently for your patients, and with other members of the multidisciplinary health care team across departments. You may be able to influence the development of more efficient systems in your team or workplace.

The principles set out here can help you and your team achieve a reasonable standard for documentation, until more research leads to better standardisation of documentation across organisations and health care in general. The Forum will review the guidance regularly, to help the on-going development of evidence-based guidelines, drawing on evidence from both legal precedent and professional guidance.

Following such guidance should improve the quality of care and the quality of mechanisms to support the delivery of care.

In all that we do in health care, we aim to provide our patients with a safer environment in which to be treated and cared for. Our nursing practice could be underpinned by the words of Aristotle:

You are what you repeatedly do.

Therefore excellence is not an act but a habit.

We hope this guidance will serve to generate best practice in nursing care and in its documentation.

1

The development of nursing documentation

The purpose of a nursing record is to act as a communication tool, reflecting the care of the patient, any related treatment decisions and a comprehensive account of the care given (Nursing and Midwifery Council (NMC), 2002a).

The quality of record-keeping is also a reflection of the standard of professional practice. Good record-keeping is the mark of a skilled and safe practitioner, while careless or incomplete record-keeping often highlights wider problems with an individual's practice (NMC, 2002b).

Nursing records

As nursing itself has developed, nurses' notes have also undergone various transformations: from narrative nursing notes, to the nursing process, to integrated pathways of care.

Documentation falls into two categories: documentation by exception and documentation by inclusion (Coleman, 1997).

- ◆ *Documentation by exception* means that standardised questions are asked, but only negative answers should be recorded as an exception. You might use this method when working to a care pathway where you only record items of deviance, for example.
- ◆ *Documentation by inclusion* produces a complete

and thorough patient record and if presented in court, appears as a complete record of events. This method can, however, be time consuming and increase the volume of paperwork. An example is notes made in nursing Kardex type records.

Government publications

Government white papers and publications on health care have had an impact on the development of nursing documentation:

- ◆ *Working for Patients* (1989) required health services to implement quality assurance schemes and audit care
- ◆ *Access to Records Act* (1990) gave patients access to their records, and has now been superseded by *The Data Protection Act*
- ◆ *The Data Protection Act* (1998) which covers access to people's records (see Section 2)
- ◆ *The Patients' Charter* (1992) promotes patients' rights and the standards of service they could expect. The Charter states, for example, that a patient has a right to 'access your health records, and to know that everyone working for the NHS is under a legal duty to keep your records confidential'
- ◆ *Making a difference* (1999) focused on strengthening the nurses', midwives' and health visitors' contribution to health care. As nurses develop new roles with added responsibilities, quality documentation and record keeping is fundamental as part of the audit process which demonstrates quality patient care
- ◆ *The NHS Plan: a plan for investment, a plan for reform* (2000) outlined a radical modernisation plan for the NHS in England and Wales, and led to similar modernisation plans for Scotland and Northern Ireland. Section 4.21 proposed the move towards electronic patient records, with patients holding a key (such as smart cards)

Good practice: documentation

- ◆ Guidance from documentation should meet standards set by the Nursing & Midwifery Council and the relevant department of health for your part of the UK.
- ◆ The use of a data set with free text space (see Appendix 1) should be used for any format of documentation.
- ◆ All notes should be contemporaneous and completed within 24 hours of interaction with a patient.

- ◆ *Your Guide to the NHS* (2001) stated as a core principle that ‘the NHS will respect confidentiality of individual patients and provide open access to information about services, treatment and performance’. It suggested that patients should be involved in planning their care and may have access to information including their medical records – so it is important that these documents are clear enough for patients to understand
- ◆ *The Essence of Care: patient focused benchmarking for healthcare practitioners* (DH, 2001) set out benchmarks for best practice in the provision of health care, and included benchmarks for record keeping (these are reproduced in Appendix 3).

Introduction of standards

Developments such as clinical governance and clinical effectiveness have led to greater use of professional and organisational standards, and these also inevitably impact on record-keeping. The NHS Executive (1998) suggests that the performance management of clinical effectiveness will require standards of record-keeping across organisations.

This responsibility is now part of the Commission for Health Improvement in England and Wales, covering the NHS, and the National Care Standards Commission for independent health care. Work is underway in Scotland to address the use of personal health information to support patient care and to implement the recommendations of the Confidentiality and Security Groups Report (Scottish Executive, 2003).

Clearly, these standards require record-keeping to become an integral and essential part of nursing care and of the care given by other members of the multidisciplinary team.

Good practice: good communication

- ◆ Every workplace should have a system for inter-disciplinary written communication which deals with dilemmas and potential concerns
- ◆ All colorectal and stoma care nurse specialists should have access to secretarial support.

2

The legal implications

There is an increasing emphasis on the rights of patients, and it is important that nurses understand their legal obligations and responsibilities in order to provide effective nursing. You are subject to the NMC *Code of Professional Conduct*, as well as the civil and criminal legal systems around the UK. You are also subject to the particular administrative policies of your employer.

Many legal and professional reports or inquiries considering aspects of care and professional practice refer to 'communicating effectively' and to demonstrating 'fitness for practice'. The Kennedy Report (*Learning from Bristol*, 2001) states: 'If a team does not work well together or if communication is poor the safety of the patient is compromised'. Clear, unambiguous documentation is a crucial component of any communication process.

The Health Service Commissioner (2000) commented that poor record keeping was a feature of many of the complaints that he investigated. The consequences of poor record keeping may result in:

- ◆ patient care being compromised
- ◆ the nurse and employer losing protection against negligence claims
- ◆ the nurse acting in contravention of the professional code of practice.

Records are an integral part of patient care and part of the 'professional duty of care owed by the nurse to the patient' (NMC, 2002). Potentially any record or report is a legal document, once a court requests sight of it – this can include nursing records, medical records, X-rays, pathology reports, records of telephone conversations with the patients or family, discharge letters and so on. When compiling a record, you must assume that it may be scrutinised later, either by a patient or a lawyer. There is no place in health records for meaningless expressions such as 'the patient had a good day'.

Security of records

There are important legal and ethical issues concerning the storage of and access to patient records. The NHSE Controls Assurance Standard, 2001 states:

'The Caldicott Committee recommended that NHS organisations should be held accountable through Clinical Governance procedures for continuously improving confidentiality and security procedures governing access to and storage of personal information'.

Guidance from the Department of Health for England (*For the Record: Managing NHS Records*, HSC 1999/053) clearly states that records: '*... must always be kept securely and when a room is left unattended, it should be locked.*' Guidance from Scotland also recommends supporting the recommendations of the Caldicott Committee.

There are particular concerns (for example, Frank-Stromberg *et al*, 2001) about confidentiality of patient records which are increasingly stored on computer – confidentiality is only as good as the electronic security programmed into computer software.

The Data Protection Act (1998) gives legal guidance governing the storage of and access to the data held about individuals, and your trust or employer should have developed a clear policy on security of patient records, which you and your team should be aware of.

Use of records in court

Although the main purpose of record-keeping centres around care of the patient, courts will place considerable reliance on records in any hearing. It is quite likely that any weaknesses or discrepancies will hamper a nurse who is required to give evidence in court and increase their vulnerability if cross examined – especially when there has been a considerable delay between the events recorded and the case coming to court.

With factors such as the growth of consumerism and higher expectations of medical technology, litigation has increased, and negligence cases of medical malpractice accounted for compensation of £373 million paid during 1999-2000 (National Audit Office, 2001). As their responsibilities and professional development grow, nurses too are involved and accountable.

If a nurse is involved in a claim of negligence, the court must establish that:

- ◆ the nurse owed a duty of care to the patient
- ◆ the nurse broke that duty of care by failing to act as a reasonable nurse
- ◆ the patient was injured as a result of the nurse's failure to carry out the duty.

The court can then quantify the level of harm and compensate the patient accordingly with cash.

In 1957, the Bolam case laid down the principle of how to judge a standard of care. This must be given as 'that of the reasonably skilled and experienced doctor as accepted by a responsible body of medical men skilled in that particular art' (*Bolam v Friern Hospital Management Committee*, 1957). The Wilsher case (*Wilsher v Essex AHA*, 1986) makes it clear that the standard of care required is that of the post *held* not of the post holder themselves (Tingle, 1988). These precedents are applicable to all post holders.

It's important to remember that a case could come to court many years after an incident of care. Negligence claims must be begun within three years of the date of the accident or alleged failure to act as a reasonable nurse. If the patient cannot know the exact date that the accident occurred – because its effects are not known immediately, for example – then the three-year time limit begins when a problem manifests itself and is diagnosed, following a visit to a GP for instance. In the case of a child the three-year time limit may begin when they reach 18 years old, their legal age of majority, which could be some years after the period of care in question.

3

Professional issues

In professional terms, documentation is as important as care: 'If it isn't documented, it didn't happen' (Calfee, 1996). A clear, accurate record of care is crucial to the delivery of care and to a patient's well-being.

The professional duty of care

High standards in documentation are part of your duty of care as a nurse. The Nursing and Midwifery Council (NMC, 2002) states that:

'The quality of your record-keeping is also a reflection of the standard of your professional practice. Good record-keeping is a mark of a skilled and safe practitioner, while careless or incomplete record keeping often highlights wider problems with the individual's practice.'

The NMC emphasises that your records must show evidence that you have understood and honoured your duty of care, taken reasonable steps to care for the patient and that, most importantly, any actions or omissions you've made have not compromised patient safety in any way.

Improving standards

Clinical governance standards are under constant review in all NHS trusts – we see this RCN guidance as contributing to that local, on-going process.

The Clinical Systems Group (CSG) report, *Improving clinical communications* (1998), made a number of recommendations, including:

- ◆ undergraduate professional education should be strengthened in areas of professional responsibility for recording adequate clinical records, including computer literacy
- ◆ record audits and feedback to staff are effective in improving record-keeping.

The profession needs more research on the development of better communication standards, such as common

templates, and especially on improving patients' understanding of their care and treatment. In the meantime, it is important that you follow your organisation's guidelines on record-keeping, or encourage the development of better systems within your workplace.

This RCN best practice guidance will help you achieve a reasonable standard for documentation and will be reviewed regularly to keep up with the development of evidence-based guidelines.

4

Good documentation

When completing nursing documentation or setting up systems for patient records with your employer, you should bear in mind the points set out in this section, and follow the guidance.

The NMC states that your record-keeping must be able to demonstrate:

- ◆ a full account of assessment and the plan of care, as well as the care provided
- ◆ relevant information about the condition of the patient/client at any given time
- ◆ measures you have taken in response to patient needs
- ◆ evidence that you have understood and honoured the duty of care, that you have taken all reasonable steps to care for the patient and that any actions or omissions by you have not compromised patient safety in any way
- ◆ a record of any arrangements you have made for the continuing care of a patient/client.

As well as following the NMC's guidance, you and your team should also ensure that:

- ◆ records are written as soon as possible after an event has occurred

- ◆ record-keeping is logical and methodical
- ◆ records are formatted in such a way that access to patient information and essential data is straightforward and can be easily updated (Descombes & Harris 1999).

The perfect documentation system should achieve a balance, creating the most comprehensive and effective communication to benefit the patient, while also being time-efficient for their nurse. We have suggested an example data set for service records (see Appendix 1) which shows the level of detail for which you should strive.

The Clinical Systems Group 1998 report revealed many shortcomings in health care professionals' documentation. Its key findings included:

- ◆ few records made of decisions about planned care, and who is responsible for carrying out tasks
- ◆ specific advice or information given to patients rarely recorded
- ◆ nursing records left undated and unsigned.

You must ensure that these kinds of mistakes are not made by you or your team. The CSG also recommended that record audits and feedback to staff help improve record-keeping.

Language and length

Nurses tend to use imprecise language in their reports, because of a lack of a professional language and a lack

Good practice: records:

- ◆ should include dates and times
- ◆ should include accurate patient name, address and date of birth
- ◆ should include only objective and factual information
- ◆ should use only professional terminology but avoid using abbreviations (unless working to an agreed list of abbreviations)
- ◆ should include all phone calls and communications
- ◆ should be made in legible writing in black ink
- ◆ should not cover up errors – entries written incorrectly should be crossed out with a line, and 'Tippex' should not be used
- ◆ must have all entries signed.

of confidence in expressing clinical judgements and decisions (Brooks, 1998). They have yet to define how best to uncover and articulate their clinical focus, their concerns and actions in writing. Nurses' actions are typically described as compassionate, committed and caring – all qualities which are difficult to transcribe concisely.

Turnbull (2001) recommends that nurses adopt a concise way of writing simply by shortening sentences – Gunning and Kallan (1994) recommend an average sentence length of 15-20 words. To keep records concise and relevant, avoid jargon and keep situations in perspective.

Abbreviations

The *Essence of Care* benchmarking standard (DH, 2001) suggests that only 'agreed abbreviations are used'. The NMC (2002) discourages the use of abbreviations.

Using abbreviations can be dangerous because they can be misinterpreted. It's important that if they are used, it is to an agreed list. Such a list of abbreviations, established by each trust and attached to patients' notes, can help avoid misunderstanding and improve concise record-keeping. If used, they must be reviewed regularly. Some trusts already use such lists so check with your employer.

Good practice: using abbreviations

- ◆ Abbreviations may be used only if ratified by your employer
- ◆ Agreed lists of abbreviations must be reviewed regularly

5

Recording informed consent

It is a legal and ethical principle that health care professionals must obtain a valid, informed consent on every occasion when they want to initiate treatment or any other intervention, except in emergencies or where the law states otherwise. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

Whilst consent itself does not always have to be written, it is important that you record in writing, in the patient's notes, that you've given an explanation of the treatment to the patient, and obtained their informed consent.

Current consent policies stress the importance of making written advice (in the form of leaflets, for example) available to patients about their treatment options, to help them understand or remember more about what they have been told face to face (DH, 2001). However, some patients don't want detailed information. If you offer a patient additional information but they decline it, you should record this fact in the patient's notes (DH, 2001).

Good practice: documentation for clinics

- ◆ All patient interactions should be accompanied by a full set of patient notes.

6

Creating and using service records

Holding service records

Separate clinical records (known as service records) are often started about a patient when they are referred to a specialist department and to a colorectal or stoma care nurse. If these independent records are created and held by you or your department, it is important that service records are:

- ◆ in themselves a clear, accurate record of care. In Appendix 1 you will find a suggested data set for service records, detailing all the information you need to record
- ◆ linked in to the patient's other clinical records. If you, as a nurse specialist, hold separate records, you must disclose that these exist by flagging this on the trust/organisation's central clinical record for the patient. You can do this by using a sticker system, alert card or computer field, for example, which indicates where and by whom additional records are kept. If the patient is not otherwise a patient of your trust/organisation, you must inform their primary care physician

Good practice: service notes

- ◆ Colorectal and stoma care nurse specialists require and should maintain accurate service notes for safe and effective practice.
- ◆ Where it has been agreed that separate service records can be kept, these should be accessible to other members of the multi-disciplinary team and should be declared to the NHS trust/health care provider (using a sticker or alert card system) in the patient's main clinical notes
- ◆ Formats for service records should be locally agreed and may be in both written and/or computerised format. You may consider using self-duplicating notes (forms which allow multiple copies to be made in one go)

- ◆ made available to other clinicians in the multidisciplinary team. Whilst there is no specific law which prevents them seeing your patient without notes, an accurate record of the care you have provided will be crucial to them in delivering proper care
- ◆ kept in a confidential and secure environment.

A simple summary of what and how documentation should be kept is included in Appendix 2.

The *Essence of Care* (DH, 2001) states that all clinicians should contribute to a single, preferably multiprofessional, record. If service records form part of a computerised, central record, this process will become easier.

Providing extended services

Colorectal and stoma care specialist nurses often provide a broad range of services like telephone links and clinics, information and advice for many patients.

You can use service records, if they have sufficient detail to facilitate safe care (following the example data set in Appendix 1), to support your telephone advice and in informal out-patient interventions and /or community work.

If you are working in an extended practice role in out-patient clinics, however, the patient's full set of clinical notes and medical history should be available for the consultation.

Where you are holding clinics which are not supervised by medical practitioners, you must ensure that:

- ◆ documentation is kept following department/local guidelines
- ◆ patients must not be seen without full access to their clinical case notes
- ◆ appointments and advice given must be documented in patient's main case notes and copied to involved professionals from the patient's primary care trust.

Agreeing documentation guidelines

It is important that your employer agrees on the exact format of the independent service records you want to keep, so you must agree local guidelines on documentation.

7

Computerised records

As a result of the Kennedy report (*Learning from Bristol*, 2001) and of targets outlined in the NHS Plan, it is intended that all patient records are computerised by 2005.

Computerised records may resolve some problems of inaccuracy in manually held records (such as illegibility and poor spelling), but the principles of good record keeping in terms of content, clarity and accuracy of information will still apply. Data protection requirements on security and access to the data can be enforced through criminal law (Dimond, 2002).

Electronically held records are more easily accessible by all members of the multidisciplinary team and reduce the need for storage space. However, their success relies on the availability of electrical outlets and terminals or access points, and often suffers because staff do not have the necessary computer skills (Aitken & Catalano, 1994). To meet the demand for fully computerised records by 2005, employers will need to invest not only in computer hardware and software, but in accessible training for staff.

Good practice: security of records

- ◆ Service records should be kept in a locked office or cupboard at all times.
- ◆ Electronic records should only be accessible by a personal password issued to each staff member, which should never be shared.

Conclusion

This guidance was developed by the RCN Gastroenterology and Stoma Care Nursing Forum to ensure that the myriad of documents created in colorectal and stoma care specialist practice conform to, and support, best practice. The following are a summary of key points to remember.

- ◆ Keeping accurate and detailed records about care is part of a nurse's professional duty of care.
- ◆ It is important to keep accurate records which could be used in court, should a nurse be involved in a negligence case, to demonstrate what actions the nurse took and why.
- ◆ All records must be kept in a confidential and secure environment.
- ◆ Specialist nursing documentation must be a true and accurate reflection of total patient care and experience. The Forum recommends a data set for service records which is set out in Appendix 1.
- ◆ Service records, if they have sufficient detail to facilitate safe care, may be used for telephone advice, especially in informal out-patient interventions and /or community work. However, if colorectal and stoma care nurses are working in extended practice roles in out-patient clinics, the patient's full clinical notes should be available for the consultation.
- ◆ Any nurse specialist holding separate records should ensure disclosure of those records to the NHS trust/health care provider's central records system, by indicating in the patient's main clinical record where (and by whom) additional records are kept.
- ◆ All documentation must be available to members of the multidisciplinary team on request.
- ◆ Nurses' employers must agree with the form of documentation they are using.

The Forum will continue to review and update this guidance following service developments (such as increasing computerisation of patient records) and legal precedents, to inform the ongoing development of nursing documentation.

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Useful websites

Commission for Health Improvement (CHI)	www.chi.nhs.uk/
Care Standards Commission	www.carestandards.org.uk/
Department of Health	www.doh.gov.uk/
Department of Health & Social Security Northern Ireland	www.dhsspsni.gov.uk/
National Institute of Clinical Excellence (NICE)	www.nice.org.uk/
National Audit Office	www.nao.gov.uk/
Nursing & Midwifery Council	www.nmc-uk.org/
NHS Scotland	www.show.scot.nhs.uk/
NHS Wales	www.wales.nhs.uk/
Scottish Intercollegiate Guidelines Network	www.sign.ac.uk/

Appendix 1:

Information which should be included in a patient's notes: an example data set

Baseline demographics

NHS Number
 Hospital No
 Name
 Address
 Telephone
 Contact person in case of emergency
 Partnership status
 Date of Birth
 Occupation
 Religion
 Ethnicity
 General Practitioner and telephone number
 Consultant
 Past medical history : relevant
 Allergies
 Medication
 Date of first contact - who and where
 Source of referral
 Reason for referral
 Disabilities
 Literacy
 Presenting symptoms: including bowel habits now and previous, bleeding
 Diet/fluids
 Patient and family understanding of disease and treatment
 Diagnosis awareness explained by...{NAME}
 Histologically proven (use Potential v. Definitive histology)
 Relevant Investigations and results
 Information relating to consent for examination should be documented
 Chaperone refusal should also be included

Checking the patient's understanding

- a. Patient account and feedback of consultations so far
- b. Understanding of the findings of investigations / surgery / histopathology
- c. Understanding of what is involved in illness and/or treatment

Use of Multi-media resources: specify

(e.g. if tapes are used to record a patient consultation the person retaining the tape is responsible for its safety)

Departmental contact numbers for the patient:

Proposed treatment

Risks and benefits explained:

Wounds +/-infection

Bleeding

Skin problems

Medical: e.g. anastamotic leak, thrombosis

Sexual function: present and future expectations

Preparation for stoma

- a Stoma siting, and use of photographs and diagrams should patient agree
- b Siting - always with patient approval (some recommend signed consent for this. This point needs further investigation / research)
 - Any abnormalities should be documented (scars, arthritis etc)
 - Where marked - why if any deviations
- c Competent person / nurse name who marks the site
- d Recording the siting
- e Assure patient involvement where possible and record if "patient's best preferred site"
- f Description of siting (eg waistband or skin crease), anatomical problems
- g Shown appliance(s).

Bowel preparation and routine pre-op prophylaxis (TEDS + anti-embolism)

Consent statement

Proposed treatment

Document if patient refuses visit and /or information

Other agencies involved:

Other clinical nurse specialist (state who)

Oncology:

Palliative care:

Social worker:

Support group:

Dietician:

Consultant:

Physiotherapy:

Peri-operative period

Actual treatment – dated

Stoma type

Operation described verbally and written (leaflet with a tick box will do – must be dated)

Patient feedback /understanding

The admitting nurse is to provide the documentation which will be available for all ward staff to use, for example at weekends/nights

Post-operative period

Continue with list under peri-operative period, plus...

For patients with stoma:

Stoma management

Appliances - choice

Disposal of used appliances

How to obtain appliances and prescriptions

Nutrition

Wound complications

Further treatment options

Discharge

Follow-up appointments

Notify district nurse

Notify community stoma care nurse (if separate service)

General practitioner letter

Exemption certificate

Back to work

Emotional support

Voluntary support organisations

Travel

For patients without stoma:

Bowel management

Nutrition

Complications and what to do

Wound complications

Further treatment options

Discharge

Follow-up appointments

Notify district nurse

General practitioner letter

Emotional support

Voluntary support organisations

Nursing evaluation(s):

Date

Time of contact

Place

Who present

Time spent

Tel/Home/Clinic/Ward

By whom

Diagnosis: known, told by..., explained by...

Post-discharge – home visit and/or clinic

Shared information between acute and primary care sectors

Examination of stoma

Stoma function / Check stoma supplies (if necessary)

Examination of wound

Reinforce information

Diet and general condition

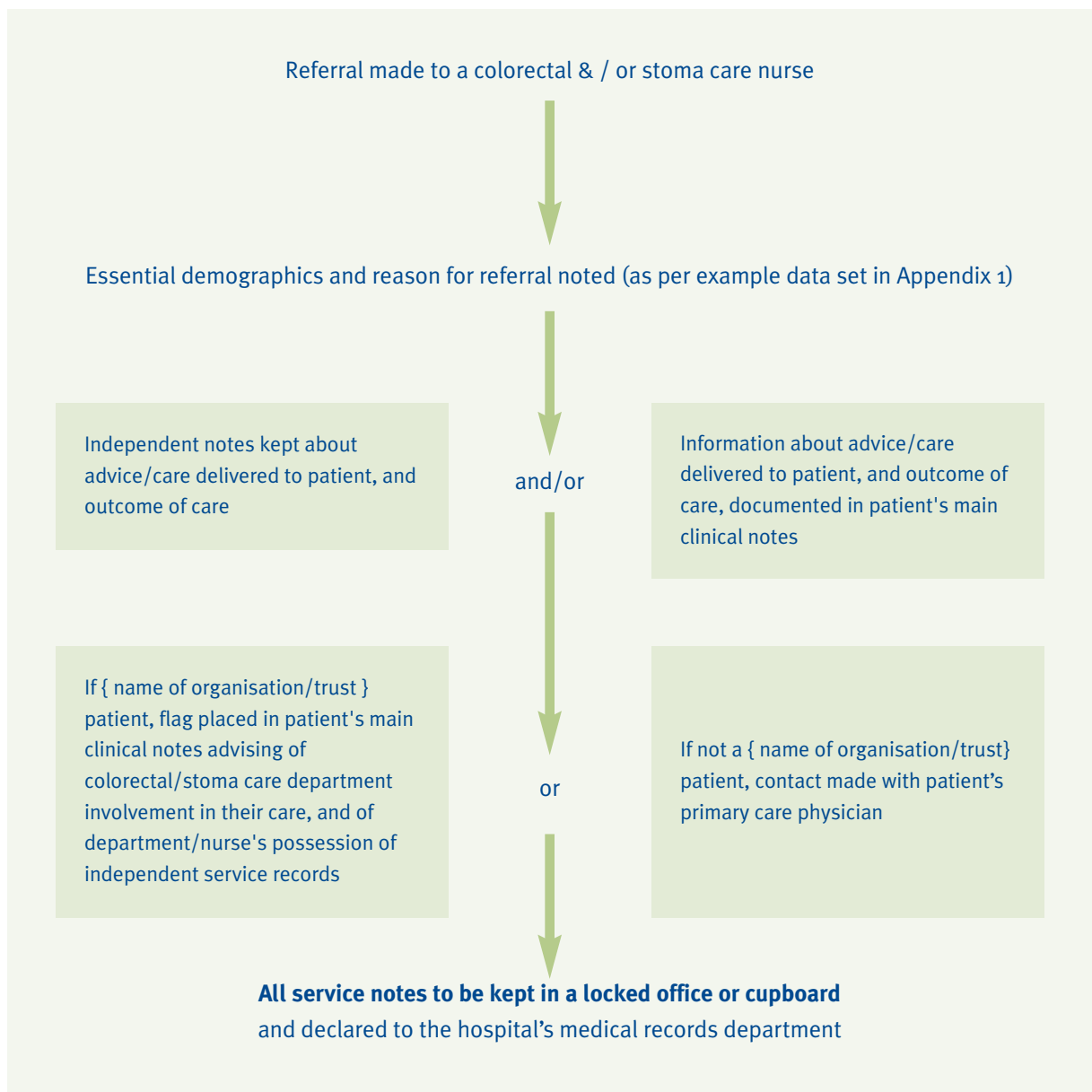
Emotional support

Is patient involved in a research trial? (eg national chemotherapy trial, infection audit, colorectal cancer audit)

Review of care date and/ or open access stated

Appendix 2:

Summary of clinical nurse specialist documentation



Appendix 3:

Benchmarks for record keeping, taken from *The Essence of Care*

Benchmarks set out in *The Essence of Care*, produced in 2001 by the Department of Health for England, are focused on meeting patients' and clients' needs and are guided by, but not dependent upon or limited by, the examples of legislative and government guidance shown in *italics*. The benchmarks of best practice identified are applicable to any health care setting and within any health care delivery system.

All records must be legible, accurate, signed with designation stated, dated, timed, contemporaneous, be able to provide a chronology of events and use only agreed abbreviations.

A health record is defined in Section 68 (2) Data Protection Act 1998

- (a) *consists of any information relating to the physical or mental health or condition of an individual and*
- (b) *has been made by or on behalf of a health professional in connection with the care of that individual*

Health Service Records support:

- ◆ patient care and continuity of care
- ◆ evidence-based clinical practice (For the Record HSC 1999/053).

Agreed patient-focused outcome:

Patients benefit from records that demonstrate effective communications which support and inform high quality care

Indicators/information highlighting concerns which may trigger the need for benchmarking activity:

Patient satisfaction surveys
 Complaints figures and analysis
 Critical incident analysis
 Documentation audit
 Information technology and information
 Management systems audit
 Litigation / Clinical Negligence Scheme for trusts
 Information technology and management training records
 Educational audits / student placement feedback
 Information technology expenditure
 Commission for Health Improvement (CHI) reports

	Factor	Benchmark of best practice
1	Access to current health care records	Patients/clients are able to access all their current records if and when they choose to, in a format that meets their individual needs
2	Integration – patient / professional partnership	Patients/clients are actively involved in continuously negotiating and influencing their care
3	Integration of records – across professional and organisational boundaries	Patients/clients have a single, structured, multiprofessional / agency record which supports integrated care
4	Holding life-long records	Patients/clients hold a single, lifelong, multi-professional / agency record
5	High quality practice – evidence-based guidance	Evidence-based guidance detailing best practice is available and has an active and timely review process
6	High quality practice	Patients/clients records demonstrate that their care follows evidence based guidance or supporting documents describing best practice, or that there is an explanation of any variance
7	Security / confidentiality	Patients/clients records are safeguarded through explicit measures with an active and timely review process

Taken from Department of Health (2001) *The Essence of Care. Patient focused benchmarking for healthcare practitioners*, page 160 (www.doh.gov.uk/essenceofcare)



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