How important are nursing records?

Introduction

Nursing records remain one of the most important communication tools for the multi-professional healthcare team. These records must provide an accurate and comprehensive report of the care planned and decisions made, as well as the treatment and care delivered to the patient. When considering the statistics reported by the SA Nursing Council (SANC), the prevalence of poor nursing care reported is notable, with 410 cases of a total of 899 professional conduct cases involving poor nursing care being reported. This represents 46% of the cases.¹

Total patient care constitutes both the hands-on physical care provided, as well as the recording thereof, followed by monitoring of the response and condition of the patient. Poor recordkeeping plays a role in all of these cases. Let’s consider one of them.

The case study

A neonatal unit had three nurses on night duty (two professional nurses and one enrolled nursing auxiliary), responsible for 14 ill patients. The mother of baby F informed the nurses at 24h00 that the baby’s abdomen was distended and hard. Two registered nurses had already checked on the infant, and were of the opinion that there was no reason for concern. Notes were made at 23h50, indicating no abnormalities. The next instance of a record being kept was at 05h30, when the baby collapsed. This last recording indicated that the baby’s abdomen was distended and that secretions were leaking from the baby’s mouth. The infant was turned over onto her abdomen, resuscitated and the doctor called. Resuscitation was unsuccessful, and the baby died at 06h30.

In the written incident report, information appeared that had not been reported in the baby’s records. This incident report also contained numerous mistakes that were subsequently corrected. The corrections were not dated, and the reason given was that these mistakes were the result of the nurses having to write the report up without the patient’s records. The mistakes were subsequently identified and corrected after receiving the records back from the doctor.

The SANC Professional Conduct Committee indicated that the fact that no recordings were made on the condition of the baby, as reported by the mother at 24h00, clearly indicated that an assessment was not carried out, or if performed, was inadequate. The nurses were negligent in failing to keep a clear and accurate record of all the actions performed on baby F. This led to an error of judgement occurring, with the result that medical assistance could not be summoned promptly.

The nurses were found guilty on two charges:

• They negligently failed to appropriately assess and diagnose the condition of the patient, baby F.
• They negligently failed to keep a clear and accurate record of all acts performed in connection with this patient.

The sentence was suspension from practising as a nurse for one year, suspended for three.²

Discussion

If the situation is considered, a few areas can be identified that may have contributed to this sad outcome. While the above record of the hearing does not provide much information on the baby’s condition, the condition of the baby could have been the reason for her death, even in ideal circumstances. From the investigation, it appeared that there was clearly a shortage of staff, and perhaps even a lack of appropriate skills needed to care for very ill neonates. Both of these are often cited as reasons why nurses do not take the time to record their observations and interventions. Under such circumstances, it is crucial that meticulous records are kept to ensure that nurses keep track of their patient’s progress, or this case, her lack of progress and deterioration.
Could the records have made a difference?

In terms of the sanctions by the SANC Professional Conduct Committee, applying the basics of recordkeeping could have prevented at least one of the sanctions, namely that they negligently failed to keep a clear and accurate record of all acts performed in connection with this patient.

The fundamental and basic rules in incident report writing are:

• To always record all observations, actions taken and progress reports, because these constitute the only proof that these actions were indeed taken.
• To be factual and only write what you saw and did; never what you think might have happened.
• Not to write an incident report without the patient’s file at hand to guide you. While it is important to write any incident report as early as possible to ensure that all of the details are fresh in the mind, do not be pressurised to write a report “quickly”. It is not possible to remember the exact details or chronological order of events without consulting the patient’s file.
• To correct inaccurate notes in a proper manner.

Could the baby’s death have been prevented?

It is not possible to know if the baby’s death could have been prevented, but based on the poor recordings on the progress of the baby’s condition, it appears that a proper observation and assessment of the baby was not performed. If it had been done, it was not recorded, and in any court of law or at a hearing, this equates to never having been performed at all.

According to the verbal evidence provided during the hearing, an assessment was made at 24h00 after the mother expressed her concern, but the two nurses determined that there was no reason for concern. Notes were not made to this effect. Based on the available records, it appears that the nurses did not return to re-assess the infant’s condition. Even if they had returned, there was no record to indicate that they had done so. And yet, the additional information provided in the incident report implies that they observed more than what had been written up in the baby’s records.

However, this extra information did not provide an overview of the baby’s progress. If any observations made during the night had been written down, any deterioration or changes would have alerted the nurses to the fact that their patient was not doing well and that they needed to call the doctor.

Nurses are taught to recognise the signs of physiological compensation in very ill patients. These changes often occur subtly from hour to hour, but by reviewing the charted observations, a clearer overall picture then emerges of a deterioration in the patient’s condition. In this case study, it appears that the baby was denied the right to proper observation and adequate intervention and care. For this reason, it is not surprising that the SANC came to the conclusion that an assessment had not been performed at all, or that an inadequate assessment was carried out by the nurses, which led to an error in judgement.

What about staffing shortages?

The general shortage of nurses has an impact on the quality of care that is provided to patients. But it cannot be used as an excuse. As advocates of the patient and her right to quality care, did the nurses submit a memorandum or report to management to indicate that they were short staffed? Management must be kept informed of poor working conditions which impact on a nurse’s ability to provide quality care. Factual information needs to be provided which describes the situation effectively. This should be given regularly and copies of all memoranda submitted kept. When statistics are used, it is important to interpret these to explain why the numbers are problematic.

What about the mother’s concern?

In addition to their own ability to observe, the nurses had been alerted by the baby’s mother that something was wrong with her. The information at our disposal indicates that the nurses did not heed the concerns of the mother. Why is it that we so often do not listen to parents’ pleas that there is something wrong with their child? As nurses and midwives, we should be more sensitive and must listen and observe more accurately. According to the ethic of care, nurses do not have to like anyone with whom they have contact, but they have to acknowledge them, listen to them and respond to them. And yet as nurses, we are often said to be rude and uncaring. Patients and their families are not responsible for the staffing shortage. Therefore, they should not bear the brunt of our frayed tempers because the hospital management has not provided optimum conditions for patient safety and well-being.

References