Introduction

Report writing and recordkeeping are an integral part of your work as a nurse or midwife. Patient records, particularly the written reports of healthcare personnel, form the greater part of a patient’s record, and fulfil three major roles.

1. Firstly, they provide a contemporaneous and ongoing account of the patient’s care and treatment. In that role, they provide you with essential information about the patient’s current health care status and care given.

2. Secondly, they provide a record of prior health care treatments and care given and as such provide a benchmark for future health care decisions.

3. Thirdly, they are utilised for teaching, quality and research purposes.

In addition, patient records can be required as evidence in court in civil or criminal legal proceedings, and in coronial inquests.

When the situation arises, the health authority, hospital, or an individual health practitioner may be served with a subpoena requiring them to produce the relevant records.

Patient records in legal proceedings

When required to be produced, patient records are utilised as follows:

Civil proceedings

In civil proceedings they may be examined for evidence to support an allegation of negligent treatment, of treatment not given, or a failure of clinical practice standards.

Criminal proceedings

In criminal proceedings a patient’s record may be used to establish evidence of an alleged criminal assault and the nature and extent of the injury, as well as the record made by the treating health professionals of the patient’s account of the circumstances of the alleged assault at the time the patient presented.

For example, this evidence can be critical in circumstances of alleged sexual assault where the first place the victim presented for help was the emergency department of the hospital.

In such circumstances the words used by the victim as to the circumstances of the alleged assault and the injuries sustained may be crucial evidence in determining the extent of the criminal charges that may follow.
Coronial inquests

In coronial inquests they will be examined by the Coroner to assist in determining the manner and cause of death in that they may contain evidence of the patient’s deterioration and any evidence of clinical treatment errors or adverse events that may have caused or contributed to the patient’s death.

Effective documentation

The key document that summarises your documentation requirements as a health care professional is PD2012_069 ‘Health Care Records – Documentation and Management’.

If you have not already, you should review this document and ensure you are familiar with the content.

Reading patient records

One key requirements of the policy is that you must be aware of current information about the patient under your care, including reviewing entries in their health record where appropriate.

It is very important that you read your patient's records thoroughly and regularly.

While clinical handover will provide some information, the written record will often provide a more extensive overview, and may provide information that was forgotten during handover, or did not seem relevant but later proves critical.

While the policy PD2012_069 sets out parameters for all NSW Health records, there is no standard format for proper report writing. There are different techniques or models of documentation used in hospitals and health care facilities. For example:

- Progress notes
- Charting by exception
- Problem-oriented medical records
- Clinical and critical pathways
- Clinical care plans
- eHealth records

In some hospitals or health care facilities, computerised record systems (eHealth records) are becoming more commonplace, although most still use handwritten records.

How to ensure good quality records

Whatever recordkeeping systems are in place, there are matters that are common to all that should be borne in mind when engaging in the task of recordkeeping.

- Reports should be accurate, brief and complete.
- Reports should be legibly written.
• Write objectively. Record what you see, not what you think you see.

• Write report entries at the time the relevant incident occurs. This is known as contemporaneous reporting. Your memory will always be better.

• Only use accepted NSW Health abbreviations.

• If you use medical terminology in reports, ensure you know the exact meaning.

• If you make an error, draw a line through the incorrect information and initial it, and continue.

• Always check the name on the record before adding an entry.

• Integrated recordkeeping in the patient’s records is essential. There should be one source of information for all patients.

• Make sure the patient’s name and identifying number are on every sheet of the patient record before making an entry on the sheet.

• And finally never, ever, write an entry in a patient record on behalf of another nurse or midwife.

Conclusion

Remember that courts place great value on written evidence. Keeping a complete and accurate written record will protect you in any future legal proceedings.

Nursing and midwifery has had a strong oral tradition, and reliance has often been placed on the clinical handover. However, remember that judges will rely on written evidence, especially when witnesses have poor recollection of events.

When nurses’ charts and times have been tendered in courts and tribunals, and have been found to be inaccurate, the nurse witness’ credibility has suffered as a consequence.

Privacy and Confidentiality

Remember also that the information in a patient’s health care record is confidential. Disclosure of this information is only permissible under certain conditions.

In NSW, the relevant legislative provisions in relation to the privacy of health care records is found in the Health Records and Information Privacy Act 2002.

While it may not be necessary for nurses and midwives to be overly familiar with that legislation, it is important that you be aware that there are regulatory provisions in place and that your hospital or health service would have clear policy directives that are based on those regulatory provisions. That latter document is one you should be very familiar with.

You would consider information about you to be private and confidential, and would want people to respect your privacy and confidentiality; and this is the same respect you must give to your patients.
The key policy document for NSW Health employees is the Privacy Manual. If you have not already, read and become familiar with this document.

The following points are important to remember in relation to confidentiality:

Firstly, you are only permitted to use or divulge patient information on a ‘need to know’ basis in the course of performing your work, unless you have prior written authority from the health service authority, or delegate, to divulge the information.

There are some exceptions, for example, notification of child abuse and notifiable diseases to the appropriate authority.

The patient’s medical record is a confidential document, the contents of which should only be divulged in the course of your working duties unless prior authorisation from the health service executive (or delegate) has been obtained, or you are required by law to report certain information.

Accessing your own medical record in hard copy or electronic format is a breach of confidentiality.

You must only use the NSW Health electronic systems to perform your work and not to gain access to patient information for personal use.

Conversations about patients must not be conducted in the presence of, or be overheard by, those not entitled to know the information in the performance of their duties.

Likewise, you must not disclose confidential information about a patient outside your work environment either in conversation or by any form of social media.

Disclosure of patient information over the phone should be limited and undertaken in accordance with NSW Health policy.

Ultimately, it is your individual professional responsibility to maintain confidentiality when you have access to, or knowledge of, confidential patient information.

The importance of observing patient confidentiality and the confidentiality of patient records cannot be overstated.

All health care professionals owe a duty of care to their patient that includes a duty of confidentiality.

If that duty of confidentiality is wrongfully breached, the patient may sue the health professional for damage that may flow to him or her as a result of the release of the confidential information.

As a health professional and a member of the front-line treatment team, nurses and midwives become privy to confidential and often sensitive information about the patients they care for.
It is imperative that patients feel confident that the information they give will be kept secure and not be divulged without their consent.

Obviously, if a patient does consent to divulging their personal information, that obligation is overridden, but only to the extent that the patient has consented.

As always, there are exceptions to the above provisions. For example, mandatory reporting of notifiable diseases or suspected child abuse. As well, regulatory provisions also allow a chief health officer of a state or territory to release certain disease epidemiological data.

What is important in this area is that, as a nurse or midwife, you are aware of your duty of confidentiality and familiarise yourself with the hospital and NSW Health policy relating to this issue - particularly given the ever increasing demand by a variety of agencies seeking to acquire and store information of a personal and sensitive nature about individuals.