

## **Writing Reports, Records or Recording in Patient Files**

Each member of staff will, at some time, be required to write in patient files, complete forms or write reports as part of their working day.

In some cases the format, method or content of the record is less important than the fact that a record has been made.

However, in most cases, the content of the report or record is absolutely vital. It will usually form part of a legally required document and may well be subject to scrutiny by a whole range of officers and inspectors.

Records and reports which are inaccurate, misleading, slanderous or simply wrong can result in legal action being taken against individuals and against the Company.

It is, therefore, in everyone's best interests that all our records are maintained to the highest of standards.

Over the next few weeks the standard of reporting and record keeping will be monitored closely to ensure that all staff are aware of their role and what is expected of them.

**There are two things that MUST happen on every report, record or entry:**

- 1. The date of the entry**
- 2. The signature of the person making the entry**

### **WHY?**

Because without these two things there is no way of knowing when the entry was made or who made it. We can guess at the date if it falls in a sequence and we may think we recognise the writing, but cannot easily prove it. As a result, the entry is not legally acceptable and would be discounted in a court of law. Legally, the situation would be regarded as though no entry had ever been made.

There are a range of other Do's and Don'ts

#### **Do's**

1. Always ensure that your entry is legible. You may think that your elegant script is neat, but may be difficult for others to decipher.
2. Ensure that you start each entry in patients reports on the next available line.
3. Start with the date in the left hand column
4. Write the main body of your report in the middle column
5. Sign your name in the right hand column.
6. Rule a line from the end of your final sentence to the end of the line. This indicates clearly that the report is ended and cannot be added to once you have finished.
7. If you find that you need to add to your report, start a new entry on a new line. There are no restrictions on how many times you can make entries in

daily reports.

8. If you make a mistake, rule a single line through the error and continue. If the error covers several lines, you may rule a diagonal line from both corners to indicate the extent of the error. Once deleted, you must sign and date the error / alteration, ensuring that the original entry can still be read.
9. Entries made by Support Staff must be countersigned by a qualified nurse.
10. The Nurse in Charge should pick two clients files each shift at random and check a selection of entries to ensure that they are of the standard required.

### **Don'ts**

1. Never scribble out an entry.
2. Never use TIPPEX or other forms of correction fluid
3. Always use a ruler or similar straight edge in entries
4. Never leave gaps between entries, this might be seen as allowing an opportunity for another member of staff to enter records retrospectively
5. Never make an entry in a report other than at the first available line for a new entry. Even if the entry is made late you must make it in the first available line and reference that it is in respect of an earlier report.
6. Never make comments of a personal nature, or comments which convey your opinion of a client. Subjective comments such as "I think that he is putting his illness on for our benefit" are not acceptable.
7. Never try to make medical or clinical observations or comments unless you are appropriately qualified to do so.

### **What Do You Write ?**

**You should always write the truth, you should never write your opinion.**

**The most important word in a patients daily report record is:**

**“APPEARS”**

#### **For example:**

1. David appears to be starting with a cold.
2. David is starting with a cold
3. David is unwell
4. David appears to be unwell.

All the above comments could be factual, all could be correct, but equally, No.2 and No.3 could be quite wrong as there may be other explanations for Davids symptoms. However, using the word “appears” allows for the possibility that there may be other causes of the symptoms observed which may come to light through further investigation or examination.

The important point is that the writer is not making a clear diagnosis or even saying that it is their opinion, they are reporting correctly and informing the reader.

There is a simple technique to writing in patient files. **You must be factual, brief and provide the reader with a clear understanding of what you are reporting.**

\*\*\*Remember\*\*\* - The next person reading these entries may well be **you** and you need to know what you are likely to be presented with.

Consider the following entry in patients notes:

**“Ted likes a drink”**

Does it mean:

- a. Ted likes tea?
- b. Ted likes to go to the pub?
- c. Ted is a happy social drinker?
- d. Ted has an obsessive compulsive disorder to drink?
- e. Ted is an alcoholic?

Clearly the potential implications are significant if the information is wrongly interpreted. Imagine the consequences of taking Ted to the pub if he is alcoholic, or the potential for disaster if Ted has an Obsessive Compulsive Disorder and was left, for example, in a bath of water, or shower unsupervised!

**Your reports must contain fact:**

- Ted slept from 3.00am to 6.45am
- Ted went to the gym at 10.00
- Ted refused to eat at lunchtime
- Ted took his morning medication

**You should avoid “Non-specific” comments such as:**

- Ted has slept today
- Has followed normal patterns of behaviour
- Ted was his usual self
- Wandering
- No goals today
- No therapy programme today

**Avoid too much “wordiology”**

- Ted rose early this morning and put on his lovely new slippers and went for a walk in the warm sunshine.
- Ted ate one piece of toast and then asked me if he should eat a second piece. I said that in my opinion, this would do his digestion no harm at all

### **Avoid the use of too much terminology and jargon**

- The radius of the laceration was laterally dissected by a profusion of abrasions at the periphery of the wound which exuded a corpulent amount of sloughy puss reminiscent of pineapple crème fraiche.

or, you could say:

“He has a cuts and bruises which are weeping.”

### **Fact versus Opinion**

This is undoubtedly the most important aspect of report writing and entry making and the one area that most people get wrong most often.

It is a fact that I am bald.

It is opinion that says this is because I wore a safety helmet when I was a coal miner.

In other words, it is true, I am bald. It can be seen, photographed and touched. The cause of my baldness is not known and could be any combination of a number of differing causes which include:

- Genetic
- Through medication
- Medical condition
- Allergy
- Misuse of shampoo
- Allowing my dog to lick my head
- Wearing a safety helmet as a collier

## **What you can see, touch and photograph can be classed as fact.**

**Everything else falls into the categories of:**

- **Hearsay**
- **Opinion**
- **speculation**

**and should not be documented in patients notes.**

**Consider the following:**

George approaches you and says that Tony has told him that Fred has asked one of the staff for a cup of tea and staff told him to “sod off”. George says that he is now frightened.

Q. How do you document this?

R.

Q. Where do you document this?

R.

Q. Do you need to do anything else?

R.

From the example above, there is clearly a need to record and report the incident. A simple way to deal with this incident is to record in patients reports that:

“2.11.04 George has told me of an alleged incident which took place earlier. He told me that this has left him feeling frightened. Incident form completed (see file ref. 002). Nurse in Charge has asked staff to observe George discreetly for the next 48 hours (from 4.00pm today).” -----**Nigel**

- I have not identified other individuals in this report
- I have not stated that this event actually happened
- I have recorded the events as I know them and the follow up actions that have resulted.
- I have informed my colleagues and ensured that the direct request by the NiC has been documented for other staff to follow.
- I have not offered my opinion as to whether the incident occurred or tried to quantify how frightened (if at all!) George is.
- The record remains factual throughout.

**Alternatively, I could have written,**

“2<sup>nd</sup> Nov George flounced into the office in one of his moods again. He says that Tony has told him that Fred wanted a cup of tea and asked Terry for a cuppa. Terry told him to “sod off – I’m busy”. At the time Terry was rushed off his feet with photocopying some magazines and Fred should have asked Joyce who was

sitting down doing nothing. George says he is frightened now but this is just attention seeking behaviour that links with his paranoia. I've asked the RMN to give him some medication to quieten him down this evening. If he's doped up he wont be wandering all night.

Nigel – support worker”

**Which one is the most appropriate?**

**Which one do you recognise?**

**Which one is illegal?**

**Finally, The use of “foul” language or the description of “violence”.**

Providing we stick to the agreed rules about factual reporting, it is acceptable to record the text of conversation, threats, exclamations etc. in your records.

**For example:**

A report says:       ” **George was verbally abusive today**”.

What does that tell me?

Very little!

However, if I report that:       ”**George told me to piss off today**”,  
that gives the reader a clear insight into Georges behaviour and interpersonal skills at that time.

The recording of exactly what is said removes the element of “subjectivity” from my report. In other words, I may be deeply offended by George saying “piss off”, whilst for another member of staff it may be a totally accepted expression.

Also, in some parts of the country, local expressions may have differing meanings from those given in most dictionaries and may be used in every day speech whereas in other places they are considered rude or offensive.

An obvious example is the differing interpretations attributed to an “eraser”. It is usually referred to as a “rubber”, which has a totally different meaning if you have an American background.

Please take a couple of minutes to think of other words which might easily be mis-interpreted and which you might think twice about including in reports or records.

Add a few of the ones you can think of:

1.

2.

3.

4.

5.

**Please complete the following exercise.**

There are no “trick” questions, please take a few minutes to complete this page.

1. Why is the date and your signature important on records?
  
  
  
  
  
  
  
  
  
  
2. Who is responsible for what you have written? (It may be more than one person).
  
  
  
  
  
  
  
  
  
  
3. Who is liable for what you have written? (This is only one person!)

4. A report says that "Fred is a pain in the arse". Is that acceptable?
5. How could you write it more appropriately?
6. A report says "Fred has a pain in the arse". Is that acceptable?
7. How could you write it more appropriately?
8. A report says "Fred said to me "I have a pain in my arse". Is that acceptable?
9. Would you wish to change it?
10. You realise that you have just written an entry about John in Freds Daily records. Do you:
- A. Tear the page out and stick it in Johns file? Yes  No
- B. Scrub the entry using Tippex? Yes  No
- C. Use the dry wipe marker pen so that no one can see the mistake? Yes  No
- D. Rule a line through the entry, mark it as an error and sign it and date it? Yes  No
11. There are no new daily report sheets. Do you: (tick which ones you have seen!)

a. Photocopy some more Yes

b. Use the PC to locate the master copy and print some more Yes

c. Get a sheet of paper from the printer and use that. Yes

d. Use a piece of kitchen roll that is in the office. Yes

**12.** You return to the office to write your reports and find that your new black pen has gone missing and all that remains are some pencils, a green pen, a red pen and a blue felt tip. How would you write your report?

**13.** At the start of your shift, you read in the daily reports that George has “shown signs of aggression today”.

What does that mean and how would you interpret the information?

**14.** A daily report entry reads “George told me to “fuck off” and then threw a chair across the dining room in my direction as I approached with his lunch”.

What does this mean and how would you interpret the information?