Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Patient Safety Notification

Recording and Documentation in the Health Care Record

397

The number of incidents relating to recording and documentation in the Health Care Record (HCR) reported on NIMS in a three-month period in 2020

Examples of incidents relating to incomplete or absent documentation in the HCR:

- Absence of results of diagnostic tests
- Lack of documentation of injuries such as cuts and bruises
- Observations not recorded
- Incomplete patient history or absence of patient record during transfer of care
- No discharge letter
- No follow up arrangements or careplan documented

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Advice for enhancing best practice of recording and documentation in the HCR

Falling short of the required standards for documentation practice within the HCR can have serious consequences for the care provided to the service user. This may result in the disruption of continuity of care, incorrect decisions regarding treatment, unnecessary diagnostic tests being performed or wrong site surgery. The Clinical Risk Unit in the State Claims Agency has noted the frequent occurrence of incidents relating to recording and documentation in the HCR and has prepared the following advice.

Risk Considerations

A number of risk factors have been identified which may contribute to shortfalls in the required standards for recording and documentation in the HCR:

- Illegible hand writing or misunderstood dictation
- Transcriptional errors e.g. “hypo-” instead of “hyper-”
- Documenting note in wrong HCR
- Misuse of “copy and paste” functions in the electronic health record
- Using non-approved abbreviations in the HCR
- Not making notes during or soon after interaction with the service user, resulting in reliance on memory, which can lead to omission of information
- Lack of standardised process for discharge documentation and follow-up arrangements
- Use of multiple electronic systems that are not integrated, resulting in missed episodes of care
- Insufficient or absent training for health and social care professionals on good documentation practices

References:

1. *Kommer, C.G. (2018) Good documentation. JAMA, 320 (9), pp 875-876. doi:10/1001/jama.2018.11781*
2. *Schaeffer, J. (2016) ‘Poor Documentation: Why it Happens and How to Fix it’. For The Record, 28(5), pp 12*
3. *Health Service Executive (2011) Standards and Recommended Practices for Healthcare Records Management. Health Service Executive (HSE)*
4. *Health Service Executive (2010) Code of Practice for Healthcare Records Management: Abbreviations. HSE*

Advice for Safe Practice

- Practise in accordance with **national policy, standards and professional guidance**
- Use a **standardised approach / process** for documentation at **transitions of care** e.g. discharge, and transfer of care between practice settings
- Ensure notes are **contemporaneous** by allowing **sufficient time** to document while with, or soon after interaction with, the service user
- Only use **approved HSE abbreviations** (see Ref 4 below)
- Implement an **Electronic Healthcare Record** system, where possible
- Ensure **electronic service user information platforms** are compatible and are **integrated**, where possible
- Audit the documentation processes to ensure practice complies with **national policy, standards and professional guidance**
- Provide appropriate **training** on good documentation and recording practices for **all health and social care professionals**

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