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RECORD KEEPING ERROR

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Abstract:
Medical record analysis is essential for medical and legal motive. Medical record carry detail concerning patients, analysis, medical and social history, lab testing-rays and evaluation complete by medical experts and health care provider. Nurses and other health care provider should keep accurate and proper record which are related to their practice.

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INTRODUCTION:

Record keeping Error:

Medical record analysis is essential for medical and legal motive. Medical record carry detail concerning patients, analysis, medical and social history, lab testing-rays and evaluation complete by medical experts and health care provider. Nurses and other health care provider should keep accurate and proper record which are related to their practice (NMC,2019).

Case Scenario:

22yrs old patient came in emergency at RHC Narang mandi with the complain of epigastric pain, vomiting, nausea and loss motion at 2:30 am. Patient received by on duty staff nurse, takes vital /signs and documented on emergency slip. Staff nurse called the on duty doctor to attend the patient. Duty doctor attend the patient and advised medicines on emergency slip. Staff Nurse administers medication as advised by on duty doctor. Patient was still uncomfortable and his condition becomes worse as compared to admission time. Patient's relatives create fuss about patient condition more badly during six hours .They claimed that Patient do not managed properly .During this situation, patient expired at 8:20 am. Case was reported to the chief executive by the patient relatives. The Patient relatives fight with on duty senior medical officer and push him from emergency. They don't accept patient's death. They don't receive death body Without any decision after one hour Medical superintendent was present at RHC for handling the current situation. He calls night staff to inquire the incident and claim for medical record. There was no record present except two line documentation on emergency register. There was no admission slip, no patient medication chart and no death certificate. Documentation on emergency Register is not a proper record for patient and health care provider at RHC level. Through this inquiry it was investigated that error of record keeping is a big mistake for the health care provider and doctors. Patient relatives insisted for postmortem report or terminate the SMO immediately. Medical superintendent handles the situation with his critical thinking and cools down the relatives. He Takes action and transferred the on duty doctor immediately and hold the salary for one month. Nurse received show cause notice against irresponsible behavior for the patient health. Proper record keeping is very necessary for health care provider .Error in record keeping is big mistake which is not for acceptable in health department .Make a plan for record keeping with proper file and all record should be attached . Secondly record saved by computer system.

DISCUSSION:

Nurses and health care provider are focus to increasing inspection concerning their record-keeping. As rule regulation such as the Human Right Act 1998 and the Data Protection Act 1998 has increased the description of, and entrance to, health records when patient are increasing ready to criticize about their health care. The patient records are sometimes essential suggestion before a court of law, or to explore a criticism at local institution level. Occasionally records may be demanded by professional leading forms when inspect claims associated to misconduct (Goonoo, Al-Talib et al. 2019)

Nursing is practice professions which play multiple roles and provide quality care, education, and counseling. Nursing is promotion protection and optimization of health care. The prevention from illness and injuries, and elevate the method of identification of disease and its treatment. Nursing records is very important part of nursing professions. Task of nursing professions is to provide care to the sick but also important part records keeping for all documents.(Ramjist, Coburn et al. 2018)

Good record keeping is a mark of the skilled and safe practitioner, yet allegations concerning shortcoming in nurse's record keeping.Good records keeping are best technique for better communication and promote patient care.

Nurses always should be aware steps for avoiding error in record keeping. First, if you spill something on the chart, don't discard notes in chart. Second, Wright copied on copy must mention. Third, don't scribble out chart Fourth, Avoid using error or wrong patient when making correction. Fifth, follow your facilities policy. Sixth, do not alter charting, it is a legal documents. Seventh, when mistakes happen, correct them immediately. Eighth, Draw a single line through mistakes writes the correct information next to the error. Sign and date document must. Ninth, don't color over mistakes. Tenth, never use correction fluid. (Adelman, Applebaum et al. 2019)

Doctor is responsible for the proper documentation and management of the patient. Medical record has progressed into a discipline itself. Through documentation and record keeping, a doctor can verify that the management is carried out appropriately. It is also very helpful in the evaluation of patient's management problems.(Joseph Thomas, 2009)

Clinical record is an important part of delivering

quality healthcare and good professional practice. Continuity of care and increased communication among different healthcare professionals is carried out properly through good clinical record keeping. Clinical record can also be used for investigating serious incidents patient's complaints and compensation cases. (Mathioudakis,A et al, 2016)

RESULTS:

The error of record keeping element was related with lower rate of unfavorable happens. Missing and error in recordkeeping also associated poor quality of patient care and patient information. The errors are common in health care system like surgical error, timing error, medication error, documentation error, and record keeping error. The record keeping error in case of death it creates multiple problems for the health care provider and health care system.

The reputation of health care system was also on risk because of this negligence. The patient and relatives has no positive response regarding health care system. Improvement of health care system is associated with proper record keeping like admission slip, medication chart, nursing notes, discharge slip, death certificate.

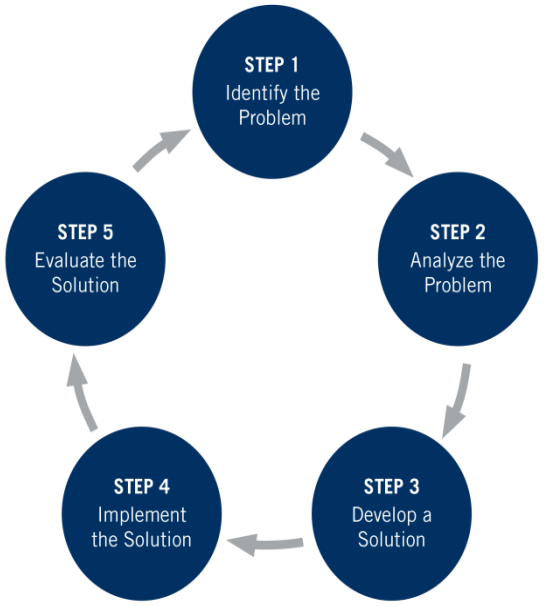
The error in record keeping due to high workload, long working hours, multiple and complex roles, non-nursing task.

Evidence-based stander and an electronic format for record keeping are necessary for standardization of recording patient information. This will improve the competence, readability, accessibility, accuracy, and exchange of patient information between health care provider and health care system. Batter registration of patient information will benefit the quality of the health care process will reduce the risk.

There is no proper check and balance at the peripheral health care system like rural health care center. Proper record keeping should be must at the RHC level.

Problem solving strategy is used to handle the problem occur in an organization.

1. Identify the problem
2. Analyze the problem
3. Develop solution
4. Implement the solution
5. Evaluate the outcome



According to problem solving strategy, firstly problem should be identified. Problem was error in record keeping at RHC Narang Mandi. Cause of the problem was that there was no proper system of record keeping. This causes a lot of problem many times. There was a need to develop a proper system of record keeping. Proper guidelines used to keep the patients record. It is responsibility of the head of the department to force the subordinates to follow the record keeping guidelines. It is important to evaluate the implemented strategies for batter outcomes.

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