One Of The Important Duties In Phlebotomy Is Nursing Record Keeping

According to The State Archives and Records Authority of New South Wales (NSW State Archives and Records 2008), information is the primary organizational asset needed now and in the future, and good record-keeping can help people find the information they need. It can also help to promote information sharing and collaboration. If the information is accessible and trustworthy, it can be used to make more informed decisions and take appropriate action. Since health care is considered professional, caregivers need to document their work as they are completed, so as a phlebotomist. In medical care, record-keeping is important to both patients and nursing staff. There are many reasons for keeping medical records in health care, but two of them are more prominent than others: “Prepare a complete record of patient/customer journeys through the service; Provide ongoing care to patients/customers within and between services”. (Royal College of Nursing 2016) Record keeping is a critical and ethical responsibility for health care professionals. In this paper, the writer will critically discuss record-keeping, detail what is record keeping, the important value of the nursing records,s and the principles of record keeping.

Responsibility and skills a phlebotomist need

Some of the main responsibilities and skills required by blood collectors are as follows: Blood Collection—a phlebotomist will be the person who draws blood from the patient and marks the blood bottle and be responsible for bringing all blood samples to the local laboratory for testing. (phlebotomy training information 2017) Communication skill—Phlebologists must maintain a professional attitude with other health professionals and patients. For some patients who are afraid of blood collection, a friendly attitude, compassion, and reasonable use of conversation tactics can help patients relax and reduce tension. (Chron 2019) Infection control—various diseases, such as hepatitis, HIV, etc. can be transmitted through blood. Blood drawers must strictly follow the safety requirements to protect themselves and their patients. (phlebotomy scout 2019) Housekeeping—according to Chron (2019) that the phlebotomist is responsible for keeping their supplies and equipment in good condition, keep supplies in stock and organize them for easy access; Keeping the blood trays fully equipped and ready in case of a doctor orders a draw of blood elsewhere at the hospital. Record-Keeping—phlebotomists help keep patients and lab records up to date. They must mark the sample properly with the patient’s full name, date of birth and I.D. number, and other information such as the time and date of collection; They usually also need to enter information about blood samples and tests into the digital data entry system. (Chron 2019) Safety—the phlebotomist must be aware of needle injuries to avoid harm to themselves or their patients and to prevent the spread of blood-borne diseases. They need to keep hand hygiene and follow a sterile procedure. (Chron 2019)

Record and record-keeping

What is Record? In the medical field, nursing records are permanent written communication that records information related to a client’s health care management. It is the original written record of the observation and implementation of nursing measures by health professionals. Nursing

records are legal documents and have legal effects. (Jasleenkaur B. 2015) Record keeping refers to maintaining a person's activity history, as a financial transaction, by entering data in a ledger or journal, putting documents into files, and so on. In the medical field, record keeping is the act of organizing and recording information related to patient care. (Dictionary.com 2019) A good patient record includes detailed record details about patient care and the patient's response to the care. (study.com 2019) Different records retention methods were used in the health care environment. Some workplaces use handwriting records, some workplaces use computer-based systems, and many workplaces use both. According to the Nursing and Midwifery Board of Ireland (NMBI), the client records that an individual nurse, midwifery, or phlebotomist keep within a legal, ethical and professional framework should be clear, accurate, honest, and current. It means that they should be written as much as possible to the actual time of the event they describe.

The important value of nursing records is reflected in the following aspects:

- Communication - The medical staff can understand the patient's needs and the treatment and care process by reading to achieve mutual communication;
- Assessing patients - Information obtained from records such as admission assessments, hospitalization assessments, etc. can help identify patient needs, identify patient health issues, and develop targeted care plans;
- Investigation and research - Complete nursing records are important materials for nursing research and have reference value for retrospective research;
- Teaching Resources - A standard, complete nursing record allows health professionals to see the specific application of theory in practice and is the best material for teaching;
- Assessment - The nursing record reflects the quality, academic and technical level of a hospital's nursing service to a certain extent. It is an important information material for hospital nursing management, and also a reference for hospital-grade assessment and nursing staff assessment;
- Legal Basis - The nursing record is a legal document and is legally recognized evidence.

Legal issues in record-keeping

The content and processing of clinical records are strictly regulated by law, not only because they are the basis of high-quality patient care, but also because they are increasingly used in courts and are an important source of confidential personal information. (NCBI 2016) According to the Royal College of Nursing (2016), the UK health department has done two things about the legal aspects of keeping health record-keeping: Individuals working for health care organizations are responsible for what they write. Personally writing anything about their work as a health care worker becomes a public record. So you have to pay attention to what you write. For example, not only do you need to formally explain your records when a patient complains, but the patient can also request a copy of what you write through the Data Protection Act. (Royal College of Nursing 2016) There is also the question of whether health care assistants have the right to make the record and write down the care they provided to patients. In fact, as long as registered nurses represent this responsibility, health care assistants are qualified to carry out the activity and its documentation. In some countries, such as the UK, data security and data sharing laws can be very strict. The Royal College of Nursing has produced guidance on delegating record-keeping and countersigning records.

Principles of Record-keeping

Patient records are permanent records of care provided by health professionals. Failure to fully record important patient information on the medical record is the negligence of the caregivers. There are general principles that health professionals and authorized care assistants must follow to ensure the records do their job, whether it is handwriting or electronic system input, can be summarized by stating that anything you write or enter must be functional, accurate, complete, current organized and confidential. (RCN 2016) These principles are explained in detail as follows: Functional means that record information about the customer and their care must be valid. It is a true portrayal of a series of nursing activities carried out by health professionals to patients. It records the whole process of a patient's treatment, nursing care and reflects the evolution of the patient's condition. Accuracy means that customer or patient records must be reliable. In order to give confidence to health team members, information must be accurate. (Jasleenkaur B. 2015) Complete means that the information in the record entry or report should be complete, containing concise and comprehensive information about patient's care, or any event that occurs within the jurisdiction of the administrator. Current means that any recorded incidents should be updated as soon as possible; provide up-to-date information on patient care and status. Delays in recording or reporting can lead to serious omissions. (Lydia N 2018) Organization means that health professionals convey information in a logical format or sequence. When members of the health team are arranged in the order in which they appear, they will have a better understanding of the information. (Jasleenkaur B. 2015) Confidentiality is a principle that cannot be ignored. According to The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (2014), the caregivers are legally and ethically obligated to keep information about the client's illness and treatments confidential. If these principles being followed properly, the contribution to record-keeping will be valuable.

There are some more things that need to pay attention to when recording: the caregiver's record-keeping quality should ensure that continuous care for patients is always supported, and any jargon, witticisms, or derogatory words should not appear in the record. (NMBI 2014) In case the patient might want a copy of the record, the content of the record should be accurate and understandable; Focus on facts, not speculation; Abbreviations cannot be used on documentation to transfer, discharge, or external referral letters. (RCN 2016) Delete or change is scored by a single line followed by the signature (plus name in capitals) and counter-signature, if appropriate; date and time of correct entry, no scraping, sticking or painting methods shall be used to cover up or remove the original handwriting. (RCN 2016) While doing corrections, don't mark or change anything written by someone else, or change anything that wrote before. Never write any patient or colleague about an insult or derogatory. (Health Service Executive 2019) Always follow the principles described in the written communication section and keep in mind to report to the responsible registered nursing staff when finding something important in working with patients. Write it into the patient/customer's record. Always report first and then record.

According to the Royal College of Nursing (2016), health services need to maintain good patient care written record for three main reasons: First, continuous and safe care and treatment can be carried out no matter which employee is on duty; Second, to record the care that has been given to the patient/client; Third, when the patient/client complains about the care they receive, make sure that an accurate record is used as "evidence". Since the level of actual participation in written medical records varies from workplace to workplace, it is important to understand the

expectations in the workplace and ensure compliance with the rules.

Nursing records should be written on the basis of facts, correctness, and consistency, be as close as possible to the time when the care provided or events occur; write simply and clearly, if typing in a computer, try to avoid mistakes, if written by hand, write clarity, when specific events and situations occur, insert dates and times as accurately as possible to invalidate and express personal opinions. Avoid making any judgment or personal insults, write the observation into the report. Remember, as part of the health care team, it’s the health professional’s responsibility to ensure that everything written about patients/clients is confidential and that no one is authorized to access them. This is considered an important issue of confidentiality.

Disadvantages of poor record-keeping

Incomplete and untimely records: Health professionals are busy completing various treatments and daily nursing work, the changes of patients illnesses and nursing activities can not be recorded in time, the medical records are often retrospectively recorded before the end of the work, this resulting in the phenomenon that the medical records are omitted, not timely or even not recorded, which distorts the value of nursing records. When medical disputes occur, no favorable evidence can be provided. Phlebotomists need to complete high-intensity collection work in a short time, with a heavy task and a compact working rhythm. It is one of the important reasons why blood collectors can't input and submit the information of specimens correctly when they are busy with their work. Otherwise, if the blood collector has not been trained in place, and the relevant knowledge has not been updated in time, it resulting in inaccurate or incomplete information about the specimen. Defects in the authenticity of nursing records: In order to improve the surface quality of the medical records and to cope with the examination, the unimplemented nursing measures are fictitious in the nursing record. For example, oral care for patients three times a day in the records, but only once in practice. Such substantive issues require good supervision by clinical managers. For phlebotomists, incorrect identification of specimens resulting in unnecessary repetition of tests or other investigations. This misuses medical professionals and prolongs the length of hospitalization. More serious, it may lead to an incident. (hcpro.com 2019) According to NCBI (2016), incomplete documentation in patient’s clinical records may lead to increased legal costs, inaccurate statistical databases, and also lead to poor patient care by other medical team members who take over. That's why every organization should ensure accurate and complete clinical records.

Conclusion

A recording is an important part of nursing practice and has clinical and legal significance. Good quality records are associated with improved patient care, and poor documentation is considered to be the cause of poor quality care. Regardless of the form of medical records, good clinical record preservation should ensure the continuity of care and strengthen communication between different health professionals. Maintaining high-quality records and reports has direct and long-term benefits for all health care professionals. A good medical record can reduce the time of repeated blood tests, avoid giving an inaccurate diagnosis or inappropriate prescription treatment, and benefit patients greatly. In addition, good clinical record keeping can help to make decisions for individual patients and save time for those who need it most. Finally, poor clinical records can have a profound impact on patients' lifelong health. Therefore, never forget the importance of the responsibility to share information and the

obligation to protect patient confidentiality.

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