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Research for VISION 2020

We need good quality information to be able to carry out our eye care programmes in support of VISION 2020, to measure (and improve) our performance, and to advocate for the resources and support we need to succeed. Much of this information can be collected, analysed, and used as part of our daily work, as many of the articles in this issue show.

However, many of our questions can only be answered by dedicated research. With the outcomes of such a large amount of eye care research available internationally, we can be forgiven for thinking that no more research is necessary. Unfortunately, this is not so. For example:

• Treatment paradigms established by research in resource-rich areas may not be an appropriate basis for delivering care in resource-poor areas. We need to test them and see what works best.

• Health systems research, critical to inform our programmes and policies, is currently under-prioritised and under-resourced, and will not take place without more support.

• New evidence is needed to help us plan eye care because the patterns of eye disease are changing constantly, both due to an ageing population and due to changing lifestyles.

In addition, even when the appropriate research is available, there tends to be a gap between existing research and the actual use of evidence in the planning of blindness prevention programmes in the field; this is because research is often not easily accessible or not reported in a way that enables translation into actions.

Good research cannot take place without skilled staff and sufficient funding, but research often has to compete with eye care programmes for these resources. Therefore, we should be able to explain why we need to do research, why it is important, and how the outcomes of the research will support VISION 2020.

In September 2010, IAPB and the International Council for Ophthalmology jointly convened a workshop at the Lions Aravind Institute for...
Keeping good nursing records

In the busy working day of a nurse, with the many urgent demands on your time, you may feel that keeping nursing records is a distraction from the real work of nursing: looking after your patients. This cannot be more wrong! Keeping good records is part of the nursing care we give to our patients. It is nearly impossible to remember everything you did and everything that happened on a shift. Without clear and accurate nursing records for each patient, our handover to the next team of nurses will be incomplete. Needless to say, this can affect the wellbeing of patients.

In fact, the quality of our record keeping can be a good (or bad) reflection of the standard of care we give to our patients: careful, neat, and accurate patient records are the hallmarks of a caring and responsible nurse, but poorly written records can lead to doubts about the quality of a nurse’s work.

Another important consideration is the legal significance of nursing records. If a patient brings a complaint, your nursing records are the only proof that you have fulfilled your duty of care to the patient. According to the law in many countries, if care or treatment due to a patient is not recorded, it can be assumed that it has not happened. Poor record keeping can therefore mean you are found negligent, even if you are sure you provided the correct care – and this may cause you to lose your right to practise.

In short, the patient’s nursing record provides a correct account of the treatment and care given and allows for good communication between you and your colleagues in the eye care team. Keeping good nursing records also allows us to identify problems that have arisen and the action taken to rectify them.

In this article, we discuss how to be effective in your record keeping and how to maintain the high standards required.

Who is responsible for record keeping?

Anyone on the nursing team who provides patient care can contribute to record keeping. However, if you are a qualified or senior nurse supervising unqualified colleagues, you should assume responsibility for providing guidance on documentation.

What should go into a patient’s nursing record?

The nursing record is where we write down what nursing care the patient receives and the patient’s response to this, as well as any other events or factors which may affect the patient’s wellbeing. These ‘events or factors’ can range from a visit by the patient’s relatives to going to theatre for a scheduled operation.

If you are in any doubt about what to write down, it may be useful to ask yourself the following: “If I was unable to give a verbal handover to the next nursing team, or the next shift, what would they need to know in order to continue to care for my patients?”

You want to ensure that the patient’s care is not affected by the changeover of nursing staff.

How to keep good nursing records

The patient’s record must provide an accurate, current, objective, comprehensive, but concise, account of his/her stay in hospital. Traditionally, nursing records are hand-written. Do not assume that electronic record keeping is necessary.

Use a standardised form. This will help to ensure consistency and improve the quality of the written record. There should be a systematic approach to providing nursing care (the nursing process) and this should be documented consistently. The nursing record should include assessment, planning, implementation, and evaluation of care.