INTRODUCING IMPROVED NURSING DOCUMENTATION ACROSS A TRUST

AUTHORS Kim O’Connor, BSc, RGn, is head of practice development; Therese Earl, RGn, is professional development nurse; Petra Hancock, BSc, RGn, is practice facilitator; all at Barking, Havering and Redbridge Hospitals Trust.


This article describes how staff training and stakeholder engagement were used in a pilot to streamline nursing documentation and ensure its successful roll-out over an NHS trust. The paper-based documentation will be followed by electronic documentation. This is a summary: the full paper and reference list can be accessed at nursingtimes.net.

Nursing documentation within Barking, Havering and Redbridge Hospitals Trust (BHRT) was a concern for senior nurses. Complaints and investigations were leading to indefensible claims due to a lack of thorough documentation and accountability. There was a range of problems related to record-keeping, while each of the trust’s four hospital sites had its own format for nursing documentation.

Three main issues needed to be addressed:

- Inadequate nursing systems needed to be replaced;
- Poor staff performance in planning and evaluating care;
- Lack of patient involvement by nurses planning and documenting care at the patient’s bedside.

Existing internal and external documentation was researched and draft revisions were designed. Particular consideration was given to the accountability of the person completing the document, clarity, time spent on completion, duplication of information, relevance and ease of use. Models of record-keeping were also reviewed. This highlighted the Gloucester Patient Profile (GPP) (Gloucester Royal NHS Trust, 2000) as a useful model. Two hospitals using the GPP were visited to evaluate it.

Drafting of new charts

The steering group agreed that the trust’s model of record-keeping should be in keeping with Essence of Care (Department of Health, 2003) and familiar to nursing staff. It was agreed that the Activities of Daily Living model (Roper et al, 2002) was the simplest and most effective to satisfy these criteria. The following five charts were designed:

- Patient admission record;
- Patient observation record;
- Daily patient progress record;
- Patient plan of care;
- Fluid balance chart.

Key timings

When the pilot started a consultation process took place to inform staff about the project. This included three drop-in days on each main site, when staff could view chart prototypes and discuss the process with members of the practice development team. Information was also disseminated at a range of meetings and events. A number of amendments were made to the proposed documentation as a result of this process, and supplementary charts were identified as necessary.
These included the following:
- Two supplementary patient observation charts – a neurovascular chart for trauma, head injury, orthopaedic and neurological patients, and an obstetric observation chart;
- A pressure ulcer management chart and a wound management chart.

Training
A variety of training methods were used, including ward-based groups, one-to-one support, seminars and patient involvement using charts and presentations. Once the documentation arrived, training was provided intensively on one ward per week. Additional support was available on a drop-in basis or on request.

Feedback and support
Many forums were held during the pilot to update staff groups and inform them on areas in which the documentation might be used. Matron and sisters’ meetings together with feedback from the pilot wards were informative and led to developments of the documentation. Nurse education and practice development meetings also raised issues and discussed developments of the pilot.

The matrons provided constant constructive feedback and support for the project. They assisted with the ongoing review and questioning of staff on the documenting and planning of care and gave ad hoc training to students and to new or temporary staff where necessary.

Specialist nurses assisted with specific training, including pain, nutrition, diabetes and infection control. The nursing directorate secretaries, support services department and ward clerks in the pilot areas also gave strong support. Feedback came from many sources, including:
- Supernumerary sisters’ meetings;
- Specialist nurse forums;
- Individual nursing staff;
- Feedback books.

All feedback was noted and incorporated into the project and chart redesign.

Stakeholder engagement
The project team wanted to guarantee evaluation of the charts and, before redesign, liaised with every specialty and potential area where they would be used. Two stakeholder events were held to ensure interested parties could give their views. Anomalies were identified and solutions offered. The project team also contacted areas where staff representatives had been unable to attend to ensure all relevant views were heard.

RESULTS
All senior staff members involved were clear about the aims of the pilot. This ensured that they all felt supported through the new documentation process and that the focus was on planning care.

The support team gave direction and ensured that any issues that arose were tackled immediately. Feedback from the pilot sites was constructive and informative and allowed the project team to adjust the documentation accordingly. The pilot highlighted that both nursing students and supervised practice nurses require clear guidelines during their training. These directives will ensure a clear, defined method of documentation throughout the ward team.

IMPLEMENTATION
A 12-month roll-out began in January 2006, with site-based focus and training within the ward area. It was recognised that the project team needed to continue and that cascade training, resource packs and ward ownership had been cost-effective so no additional funding for nursing posts would be needed, providing the supernumerary ward sister project was implemented in all wards.

The documentation has now been reproduced in an electronic format, which complements the Connecting for Health patient record. The system aims to replicate the flow and process undertaken by nursing staff and will capture the same information as the paper documentation.

BHRT plans to produce care standards to ensure equality in care delivery. These could be based on the GPP, then broadened to incorporate all clinical skills. This would provide a benchmark for care delivery and comparison. The trust has developed 70 care standards that correlate with the new documentation. These comply with the model for Essence of Care, enabling staff to plan care using common references. Care is planned individually and focuses on patients’ perceived needs as well as assessments.

**REFERENCES**


**IMPLICATIONS FOR PRACTICE**

- The revised documentation means that information is documented immediately and in clearly defined places on the charts. Staff no longer have to stay at the end of shifts due to difficulty of accessing notes.
- Knowledge of developing care plans in preparation for discharge has increased, which has led to earlier discharges. Nurses’ contact with patients has increased as they are documenting care with the patients, which has led to greater job satisfaction for the nurses, while patients have shown less frustration about their care.
- The documentation has facilitated handling of complaints and the clinical governance department is using it to demonstrate that issues are being addressed.
- Documentation is only as good as the nurses who complete it and it is important to ensure systems are in place to support managers when accountability issues occur.
- Ward teams must ensure that all patient care is documented effectively. This could be facilitated by implementing the supernumerary sister role within the ward areas.