Self-audit helped increase nurses' knowledge and understanding of documentation

Using self-audit to improve nurses' record keeping

In this article...
> Why standards of record keeping need to be improved
> How one trust used self-audit to improve documentation
> Benefits for nurses' practice of this kind of project

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Abstract Walker S (2012) Using self-audit to improve nurses' record keeping. *Nursing Times;* 108: Online issue.
The Documentation Improvement Project used self-audit as a tool to improve clinical documentation on a low-secure unit. All nurses demonstrated increased confidence and knowledge by the end of the project.

Documentation is a crucial aspect of nursing care, both to facilitate continuity of care and to form a record of care provided. However, nurses are not always confident in fulfilling this responsibility.

This Documentation Improvement Project (DIP) was undertaken on a busy low-secure unit providing high-quality assessment, treatment, care and rehabilitation in a secure and therapeutic environment for people with serious mental illness and associated forensic history. It was initiated after a routine audit revealed a serious deterioration in the quality of documentation over the previous six months.

Education methods such as targeted teaching sessions, sharing of Nursing and Midwifery Council (2009) standards and individual supervision were not addressing this problem satisfactorily. Although it was clear from supervision and team meetings that nurses could recount the requirements of good documentation, in practice they were not carrying it out consistently.

Pfeffer and Sutton (2000) argued that knowing what to do does not necessarily precipitate change, and that a clear barrier to turning knowledge into action is the belief that talking about a change actually manifests that change with no extra effort. I decided to test whether the gap between knowledge and action could be bridged using self-audit, enabling staff to change their practice once they could clearly see they were not meeting NMC standards.

Background

Locally, for the previous two years, almost every action plan resulting from a serious adverse event had contained recommendations about improving standards of documentation and communication in the clinical area. This is echoed nationally and is a challenge for learning and development teams across the NHS.

Kolb's (1984) learning cycle is based on the premise that the more staff reflect on a task, the more they will have the opportunity to modify and refine their efforts. Inspired by this, Swenson (1997) asserted that the logic of this cycle is that small improvements made by many will constitute major improvements over time; this formed part of the project's philosophy.

The Department of Health's (2002) policy implementation guide for low-secure units dedicated a whole chapter to documentation, highlighting the importance of having adequate and effective information systems.

Aims

The aims of the project were to:
» Improve documentation in line with NMC guidelines;
» Improve patient care by ensuring records are up to standard;
» Enable reflection on issues affecting standards of documentation;
» Improve nurses' confidence with documentation issues;

5 key points

1 Serious adverse events have demonstrated the need to improve standards of documentation and communication

2 A barrier to turning knowledge into action is the belief that talking about a change manifests that change with no extra effort

3 Self-audit can improve standards of documentation considerably and increase nurses' knowledge and confidence

4 This project could be used as a continuous improvement package for all clinical staff

5 Self-audit can deliver an improvement in practice at no extra cost

A self-audit can help nurses see whether they are meeting documentation requirements
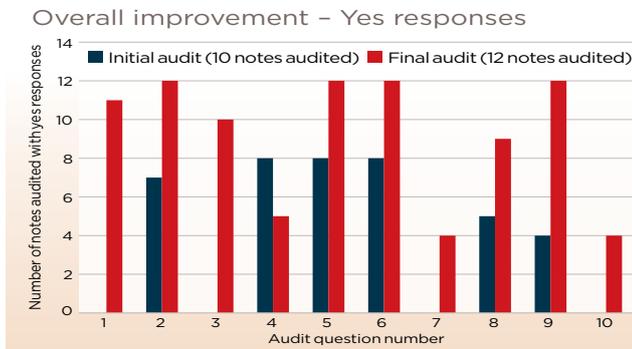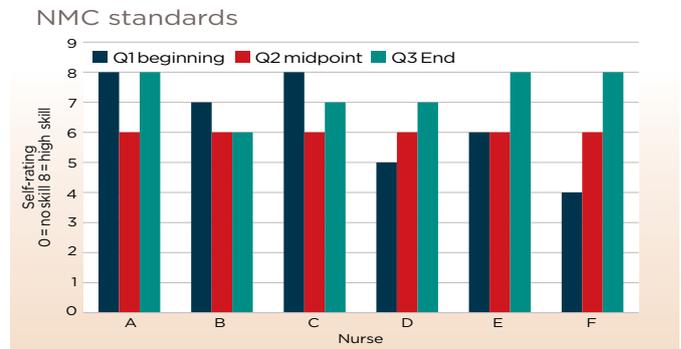
FIG 1. **YES RESPONSES IN THE TWO AUDITS**

Overall improvement – Yes responses

FIG 2. **SKILL LEVELS RELATED TO NMC GUIDELINES**

NMC standards

» Enable greater knowledge about nurses' approach and understanding of documentation;
» Allow performance management of staff who do not raise their standard of practice.

Following the audit results previously mentioned, we shared the NMC (2009) standards with the team via email and ward newsletter and undertook educational reflective discussion as part of the fortnightly qualified nurse meeting. We then created a self-audit tool using these standards and questions from the trust audit as a guide.

Method

The self-audit period was set for six months. Using the self-audit tool, the clinical manager carried out an audit of all patients' notes at the beginning and end of the study. During this time three more patients were admitted to the unit and one was discharged, so there was some variation in the notes audited.

Nurses were asked to complete a self-audit – comprising 10 questions – of their named patients' notes only, on a weekly basis. This meant no nurse had to audit more than two sets of notes for a week at a time. We also devised a questionnaire so nurses could reflect on and self-assess their:
» Knowledge of NMC record-keeping standards;
» Approach and understanding in dealing with documentation issues;
» Ability to challenge others about documentation.

The nurses were also asked to give their views on problems with documentation, using free text. They completed the questionnaire at the beginning, middle and end of the project.

The audit process included:
» Initial audit using self-audit tool of all notes by clinical manager;

» Self-audit completed weekly by nurses;
» Initial questionnaire for nurses;
» Repeat of questionnaire at three months by nurses;
» Repeat of audit using self-audit tool at six months by clinical manager, and of questionnaire by nurses;
» Regular supervision of all nurses involved in the study from individual supervisors.

Participation was mandatory for staff nurses as the standard of documentation had fallen; all concerned accepted this could have dangerous results. Mandatory participation was a pilot measure to see whether the issue could be addressed in this way.

Box 1 shows the questions asked on the self-audit tools. All had "yes"/"no" answers, with the ideal answer being "yes". We created these questions using the NMC (2009) guidelines as the standard and gave each question a score of 1 for a "yes" and 0 for a "no", making the maximum score 10 at the beginning of the project and 12 by the end (reflecting the increase in patient numbers). We used the audit results with the self-audit tool at the beginning and end of the process to measure any changes.

Nurse participation

Ten staff nurses undertook the project; of these, one left the trust after 14 weeks, one joined the project at week three and two did not take part despite agreeing to do so at the beginning.

The rationale behind the self-audits was not to analyse nurses individually, but observe the effect on staff nurses' practice as a whole. There were, however, some interesting points from nurses' individual self-audits. One of these referred to the question on access to electronic records. Although several nurses did not have access to the system themselves, as named nurses it was their responsibility to ensure

BOX 1. **QUESTIONS ON AUDIT TOOL**

1. Are all entries dated, timed and signed with names printed after the signature?
2. Are the patient's details recorded clearly on each page?
3. Do note entries make reference to specific care plans?
4. Are non-registered staff entries countersigned?
5. Are all entries free of subjective opinion, jargon, abbreviation and offensive comments?
6. Are any alterations or deletions initialled and still legible?
7. Are all care plans dated at the time of writing and reviewed weekly?
8. Is there evidence that care plans have been written with the patient and is there evidence of an attempt to gain patient consent and signature?
9. Are all risk events that have happened during the week recorded on the risk history?
10. Is the last review recorded on electronic records?

the information was entered onto the system by someone. Despite being aware of this, the nurses concerned did not always fulfill this responsibility; this had to be raised in supervision with them.

Audit results

The initial audit confirmed the hypothesis that there was much documentation work to do. However, the final audit showed improvements in all but one category. Fig 1 compares the results of the two audits.

Question 7 showed some improvement on re-audit but not a sufficient amount, prompting discussion and a system change within the department; the guidance stated that care plans should be

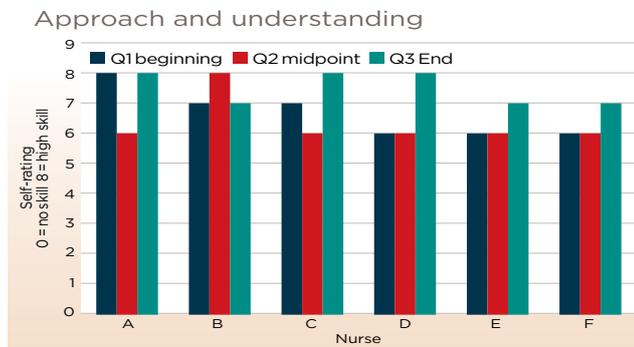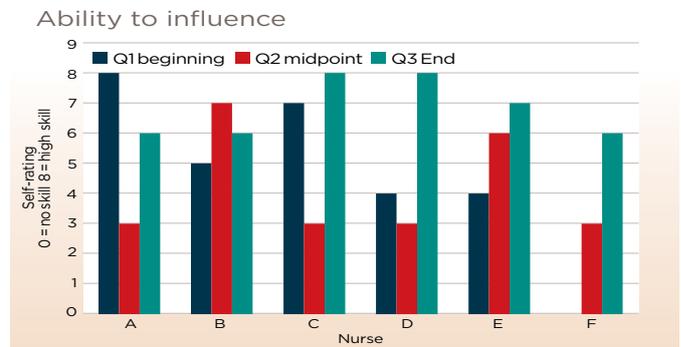## FIG 3. APPROACH TO AND UNDERSTANDING OF DOCUMENTATION

Approach and understanding

FIG 4. ABILITY TO INFLUENCE COLLEAGUES

Ability to influence

reviewed weekly, but in mental health rehabilitation settings these often do not change weekly or even monthly, so weekly review was unnecessary. We therefore decided monthly review was sufficient.

Question 4 was the anomaly in that not only was there no improvement but there was a decrease in the number of "yes" responses at re-audit. It was suggested this may have been affected by a combination of understaffing, high use of bank staff, difficulties in persuading junior staff to complete paperwork and time constraints. Relating to this last point – the staff nurse on duty on each shift is responsible for countersigning all entries by junior staff.

Questionnaire results

Although eight nurses participated in the whole project, only six completed all three questionnaires, due to staff turnover, so only these six have been included. Figs 2-4 are divided into the questionnaire categories in which nurses were asked to assess themselves; the six nurses are labelled A-F, with the three responses shown together for each nurse. The maximum score nurses could give themselves was eight, indicating they thought they had a high level of skill – "0" indicates no skill at all.

Fig 2 shows ratings of skill level in relation to NMC recordkeeping guidelines. It is interesting to note – although difficult to hypothesise why – that all nurses considered themselves to be at level 6 at the midway point of the project.

Fig 3 shows nurses' approach to, and understanding of, documentation. Fig 4 shows their perceived skill in influencing colleagues on documentation.

Themes

At the end of the questionnaire nurses could add free text to share what they saw as the main obstacles and challenges to good documentation in practice. The themes that became clear were:
» Time constraints;
» Managing resources.

This was particularly apparent in terms of when it was best and who was best placed to write the notes. One nurse noted on all three questionnaires that the main barrier to good documentation is waiting to write the notes at the end of the shift instead of updating them as time progresses. That this was done indicates that, although the problem had been identified and a potential solution put forward, the staff nurse had not evidently put this solution into practice. Perhaps this is an example of Pfeffer and Sutton's (2000) assertions about the belief that talking about something will be enough to constitute change.

Another nurse said there may be an assumption that once something is verbally handed over, the requirement to document may not seem like a priority. All nurses said low staffing levels and pressure of work interferes with good documentation. At a time when most patients were well into their recovery programme and often needed escorting in the community, these were very real issues for staff during the project.

Conclusion and recommendations

There was a significant improvement in the standard of documentation on the unit after the project. At the initial audit there was only a 40% "yes' response rate; this rose to 76% after the project, indicating that standards had increased considerably.

One of the two members of staff who failed to take part in the project was performance managed while the other has since left the trust. Despite the perceived difficulties about asking staff to complete more paperwork and the time pressures that staff highlighted, most staff members were extremely conscientious about participating and could see the potential benefits to patients.

Following the pilot project we have made the following recommendations:
» DIP could be used as a continuous improvement package for all clinical staff – although it has been piloted in an adult mental health setting, the learning is transferable across areas;
» A feedback process should be devised to ascertain whether patients see an improvement in their care after the DIP process is completed;
» A free-text question should be added to the end of the audit tool: what action will you take this week to change any "no" answers to "yes"?
» Further review of influencing others is needed, particularly around countersigning unregistered staff entries.

Overall, DIP has delivered an improvement in practice at no extra cost and resulted in improved levels of documentation for all patient notes concerned. In addition, all the outcomes have been met.

We have reviewed and adapted the project in light of electronic record keeping often being used; a rehabilitation unit in the same trust is currently using this adapted version. **NT**

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