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'Gaps, mishaps and overlaps'. Nursing documentation: how does it affect care?

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Abstract:	Abstract Introduction: Complete, accurate and relevant nursing documentation is essential for the multidisciplinary comprehensive geriatric assessment process which can improve older patient's outcomes following a hospital admission. Aims to understand older person nurses experiences of and attitudes to documentation. Methodology Semi- structured, in depth interviews of eight qualified nurses at an acute hospital trust. Interviews were analysed using the framework approach to identify key themes. Results Three overarching themes were identified: gaps, mishaps and overlaps. Gaps refer to information which was missing, inaccurate or inconsistent; mishaps refer to the consequences of these inaccuracies and inconsistencies and overlaps refer to the problem of duplications in recording of information. Discussion Older person nurses report many inconsistencies, omissions and duplications in their documentation. This has implications for how nursing contributes to the comprehensive geriatric assessment and the quality of care of older patients. Recommendations for practice New ways must be found to minimise and streamline existing documentation to ensure that records are complete, timely and person-centred. Nurses should be mindful that emerging digital

	technology systems do not create further problems. Ward nurses need to take greater control of development of documentation.

‘Gaps, mishaps and overlaps’. Nursing documentation: how does it affect care? (Word count 3901)

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Box 1. Keypoints

- Complete, accurate and relevant nursing documentation is essential for the multidisciplinary comprehensive geriatric assessment process which improves older patient’s outcomes following a hospital admission.

- Older person nurses express dissatisfaction with the amount and quality of documentation which is often inaccurate, inconsistent, repetitive and incomplete.

-Further work is required to streamline current systems, particularly in view of emerging digital methods of documentation to prevent further duplication and increased workload.

Abstract

Introduction: Complete, accurate and relevant nursing documentation is essential for the multidisciplinary comprehensive geriatric assessment process which can improve older patient’s outcomes following a hospital admission.

Aims to understand older person nurses experiences of and attitudes to documentation.

Methodology Semi- structured, in depth interviews of eight qualified nurses at an acute hospital trust. Interviews were analysed using the framework approach to identify key themes.

Results Three overarching themes were identified: gaps, mishaps and overlaps. Gaps refer to information which was missing, inaccurate or inconsistent; mishaps refer to the consequences of these inaccuracies and inconsistencies and overlaps refer to the problem of duplications in recording of information.

Discussion Older person nurses report many inconsistencies, omissions and duplications in their documentation. This has implications for how nursing contributes to the comprehensive geriatric assessment and the quality of care of older patients.

Recommendations for practice New ways must be found to minimise and streamline existing documentation to ensure that records are complete, timely and person-centred. Nurses should be mindful that emerging digital technology systems do not create further problems. Ward nurses need to take greater control of development of documentation.

Summary statement

Why is this research or review needed?

- There is a forecast increase in the numbers of older people in acute settings.
- Older patients often have complex healthcare needs requiring comprehensive geriatric assessment and a multidisciplinary team.
- Documentation in older person care acute settings must be of a standard that provides an accurate record of assessment, decision-making, care planning and treatment in order to ensure accurate communication between the multidisciplinary team of healthcare professionals.

• What are the key findings?

- Documentation in its present form is judged, by the nurses who use it, to be ineffective and in some cases, detrimental to good quality care.
- Nurses expressed a need to record information and felt it offered some form of protection.
- Nurses expressed dissatisfaction with the current system of documentation, deeming it to contain inaccuracies, omissions and duplication.

• How should the findings be used to influence policy/practice/research/education?

- New ways must be found to streamline documentation to ensure accurate and efficient communication in older person care.
- Nurses must be involved in the design, development and evaluation of documentation.

Box 2. Impact Statement

- This paper illustrates the difficulties with documentation older person nurses experience in the acute hospital.
- It shows that the volumes of paperwork which require completion combined with the workload of older person nurses results in inconsistencies, omissions and duplications, making it unfit for its purpose.
- It advises that documentation needs to be streamlined to make it appropriate for the communication of care of older patients between the multidisciplinary team.
- It advises that ward nurses need to be involved in the design, development and evaluation of documentation

Background

A high proportion of acute hospital beds are occupied by older people with figures from the Royal College of Psychiatrists reporting that two-thirds of NHS beds are occupied by people aged 65 years or older and an average district general hospital with 500 beds will admit 5000 older people every year (RCPsych, 2005). Many of these patients have multiple and complex problems compounded by treatments; poorer function and nutritional status; high levels of physical dependency; high prevalence of mental health needs and multiple co-morbidities; all of which require skilled, experienced nursing care which is found to be often difficult and time consuming to deliver in a compassionate way (Zekry et al, 2008; Glover et al, 2014; Goldberg et al, 2012). Staff caring for older people report feeling ill prepared to manage such complex health needs (Griffiths et al, 2014) with evidence of unacceptable variations in the quality of care and up to 77% of carers dissatisfied with the quality of care (Alzheimer's society, 2009; Whittamore et al, 2014; Bradshaw et al, 2014). Comprehensive geriatric assessment (CGA) involves the assessment of an

older person living with frailty over five domains (physical and mental health, functional ability, social support and environment), to inform a plan of care that improves patient outcomes (Welsh et al, 2014). There is evidence that use of CGA increases life expectancy and the ability to return home following an emergency admission to hospital (Ellis et al, 2011). It requires a multidisciplinary team approach supported by accurate and meaningful documentation to ensure the delivery of safe and effective quality care to older people.

Introduction

Guidelines from the Nursing and Midwifery Council which is the nursing regulatory body of the United Kingdom, The Nursing and Midwifery Council (NMC, 2009) emphasize the importance of accurate record keeping. The Nursing and Midwifery Council code of conduct (NMC, 2015) states that nurses have a professional obligation to maintain clear and accurate records. However, there is a concern that an imbalance exists in the amount of time nurses spend on paperwork compared to direct patient care. A survey of 6387 members of the Royal College of Nursing found that 86% of nurses believed that non-essential paperwork had increased over the previous two years with 81% of them claiming that paperwork prevented them from spending time with patients (Sprinks, 2013).

A report commissioned into the failures in care at Mid Staffordshire NHS foundation Trust in England highlighted failures in communication between 2005-2008 (The Francis Report, 2013). One of 290 recommendations made by Lord Francis included that information systems must be designed by healthcare professionals and avoid 'unnecessary duplication' (Francis, 2013, p.111).

The amount of paperwork nurses must complete has increased over time with speculation that a million hours a week were spent completing paperwork in 2008 (Nursing Standard, 2008). Keenan et al (2008) highlight how current record keeping practices are failing to support nursing practice and stress the importance of developing solutions.

Systems of recording nursing documentation include computerised records. However, opinion as to whether this increases time spent or saves time have previously been mixed (Lee et al, 2002). For instance, a study by Moody et al (2004) assessed the attitudes of one hundred nurses towards electronic documentation and found that seventy five percent of nurses believed it to improve the quality of documentation. The same study found that seventy six percent of nurses assessed believed that the electronic format would lead to improvements in the safety of patient care (Moody et al, 2004). However, a study looking at the effect on nursing care of an electronic nursing documentation found that such a system may not necessarily lead to greater efficiency (Munyisia et al, 2012). Nevertheless, further research in this area is necessary as it is unclear as to whether the use of electronic nursing documentation improves the care of patients (Kelley et al, 2011).

The move towards capturing data at the bedside by recording patient observations using electronic hand held apparatus, such as smart devices, has the potential to grow with the possibility of recording nursing documentation and extra facilities such as photographing pressure ulcers to assess and evaluate care.

Complete, accurate, relevant and timely documentation is always important, but is particularly so in the care of older people. This is because of the complexities of care in such a client group, and the subsequent need for good communication between members of the multidisciplinary team who must work closely together to deliver care within the comprehensive geriatric assessment framework. Previous work into examining the use of documentation in older person care (Hardey et al, 2000) highlights the dynamic nature of nursing documentation.

This study aims to understand how documentation may affect the quality of care in one acute hospital trust in England by understanding the experiences of registered nurses towards the documentation used while working in older person care in acute hospitals wards.

A qualitative approach was adopted in order to strengthen the understanding of meaning a person gives to a situation without the need for statistical analysis (Rose, 1994). Thematic content analysis was used to allow the researcher to employ systematic means in an attempt to understand the perceptions of others (Burnard, 1991). This research attempts to answer the research question through qualitative means by interviewing registered nurses about their views of nursing documentation.

Methods

Study Design

An interview study analysed using the framework approach.

Sampling and Data Collection

Recruitment and data collection was completed in February 2015. The researcher was a registered nurse working as a Staff Nurse with years of experience caring for older patients in the acute hospital and was conducting the study towards a Master's Degree dissertation. The researcher aimed to interview only nurses she was not familiar with, on wards she had not worked on, but because of difficulties finding registered nurses who were able to take time out of their shift to be interviewed, an opportunistic sample was used. The interviewer did not work directly with six of the participants at the time of the interviews, but had previously worked with two of the participants. Participants were recruited from acute medical healthcare of the older person wards in a large acute Hospital Trust in England. These areas were chosen because of the multiple comorbidities found among the patient group; the use of the comprehensive geriatric assessment tool; and multidisciplinary team approach in such a setting. Registered nurses working for the trust were included. Agency nurses were excluded from the study because the researcher wanted views from nurses who were familiar with the documentation over a longer period of time than only one shift.
The matron of the unit was initially approached to discuss the research and was given information about the study. Following this all ward managers were sent letters inviting them to participate in the study and were asked for written permission for the researcher to access ward areas. Posters were displayed in clinical areas to inform nurses about the study. The nurse in charge approached nurses to be potential participants. The nurses decided if they wished to take part and were then introduced

to the researcher. Participants gave written informed consent and took part in a face to face semi structured interview. The interview guide was developed and piloted prior to use. Initially topics were selected from the literature and subsequent topics were added if they arose during the interview. Topics included: documents completed and how they directed care, what documentation helped with care and why, problems with documentation and time spent on documentation (box 3). Interviews were conducted in a quiet room on the ward. All interviews were audio recorded and field notes were made during the interview. The participants were reassured that privacy, confidentiality and identity would be protected.

Data Analysis

Box 3: Semi-structured interview questions

- Think about a patient you recently cared for, can you describe all the documentation you completed and how it directed the care you gave the patient.
- What helped with the care?
- What documentation did you think was beneficial?
- What do you think was not beneficial? Why?
- Can you give an example of how it did/didn't affect patient care
- Has documentation ever cause problems for you?
- Has documentation ever caused conflict between you and another colleague?
- How many hours a day do you spend on documentation?

Following interview, data were transcribed verbatim. In depth scrutiny of data meant the researcher was not only able to examine the content but also the structure, and speaking style of the participant (Mason, 1996) which allowed for analysis further than the literal sense of the data and to see the content and context in which it was gathered, namely the clinical area of qualified nurses. This allowed for the discovery of themes of which the researcher was then able to use framework analysis to summarise and classified the data (Ritchie and Spencer, 1994). Framework analysis is a flexible approach often utilised in health service research that allows all data to be collected and then analysed. The organisation of data within this approach involved a five stage process (Richie and Spencer, 1994). Firstly familiarisation with data involved constant comparison across the data to identify categories and themes. Transcripts are then coded to identify recurrent statements and expressed feelings which formed the basis of the thematic framework. Themes were then compared and contrasted between participants by indexing, charting and mapping to provide a detailed understanding and interpretation of the participants' experiences. The coding framework was developed by LC and agreed with SG, through regular meetings and discussions.

Ethics

Research ethics committee approval was obtained (ethics reference number: T17112014 SoHS 14109)

Results

A total of eight nurses were interviewed. To demonstrate diversity of the sample population, and to maximise the variety of responses, efforts were made to include a wide variety of nurses from different backgrounds. These included male (n=2), female (n=6), black and minority ethnicity (n=2), deputy sister or above (n=2), experience in nursing over ten years (n=3). The figures do not add up because of diversity within the interviewee population; for example experience did not equate with level of seniority with one nurse in a senior position not having been qualified for many months whereas one staff nurse had been qualified for over thirty years, and several of the participants possessing more than one of the stated characteristics. The eight interviews lasted between seven and sixty minutes.

Analysis of the data found several common themes. Themes included issues around time; amount of documentation; inaccuracies; surveillance; defensive practice. For the purpose of this study will focus on three only. Firstly, gaps in information which refers to information which was missing, inaccurate or inconsistent. Secondly, mishaps refer to the consequences of these inaccuracies and inconsistencies. Thirdly, overlaps refer to the repetition and duplications in written records.

Gaps

Inaccuracies in documentation were identified by participants including omissions, or gaps, of essential information necessary for the delivery of safe care. Nurses spoke of their frustration in systems that are incompatible leading to potentially problematic situations

> *'...we don't have access to EDISS [electronic documentation system] so we can't get next of kin and that's happened on a couple of occasions'* (participant 8)

When gaps in documentation were found, assumptions were sometimes made that care had been carried out for the patient. In such cases, nurses sometimes reported that documentation had been completed retrospectively without full knowledge that care had actually been done

> *'...there's been a couple of times I've had to point out to health care assistants when ...then maybe the skin bundle wasn't completed overnight and the care assistants being told it should be done every 2 hours that they thought oh he hasn't done it oh I might as well. I'll just fill it in for them overnight and I'm saying you CAN'T really cos you're just making up that that he MIGHT have done the care and gone home and forgotten to write it down...but you can't just make it up (laughs)'* (participant 4)

Further examples of gaps in the documentation emerged,

> *'…I just find those tick sheets with regards the post fall are just not filled out correctly at all…and it it you're kind of left wondering well did anyone ring the relatives?…'* (Participant 8)

while others described potentially dangerous gaps, or missing information, in the documentation,

> *'….the patient collapsed on the floor, we all went running there and then I got to see what she came in with and there were NOTHING no no evidence of what she came in for, NOTHING….'* (Participant 1).

Further evidence emerged of missing documentation despite simple systems in place, such as a sticker to document in the medical notes when a patient has fallen,

'the point is again…I am seeing it with the documentation and the instance when I'm going back…. it's just not there…even simple things you know like the stickers in the notes …it's a sticker (laughs) stick it in the notes what…yeah it's just yeah it's just missing… (Participant 8).

Missing and inaccurate documentation appeared to be problematic to nurses as it created problems, or mishaps, which will now be discussed.

Mishaps

Inaccuracies were reported within the documentation as regards peripheral cannulas. Evidence emerged of nurses recommending completing accompanying documentation prior to checking cannulas in an attempt to complete documentation that they knew would be audited at a later date,

> *'…someone told me it would be quicker if I filled in all the VIPS [a tool to assess cannulas] at the beginning of the shift when I was doing the handover and then look at them later on…'* (Participant 4)

And so led to a counterproductive and substandard service with patients receiving inappropriate care and an increased risk of developing phlebitis,

> *'…cos again I've quite often found cannulas that… someone's been that they've been signing on for DAYS and on for DAYS and this persons going this really hurting me this cannula …'* (Participant 4)

With one participant reporting documented care which appeared not to correspond with the condition of the patient,

> *'... I check paperwork as a deputy sister role, checking that documentation is done right and they've ticked something and haven't actually done it'* (Participant 1).

One nurse expressed exasperation at the time needed to complete documentation with no apparent effect on care,

> *''.....its time consuming, it's repetitive…'* (Participant 6)

Overlaps

Finally, nurses expressed exasperation over the excessive amount of time it took to complete paperwork which they felt was often repetitious, of no benefit and took them away from the patient. This resulted in the omission of important information, inaccuracy, duplication and potential safety concerns. Nurses described how staff were unable to find the necessary information, despite information being recorded numerous times,

> *'... you're writing several, same bits of information in several different places…'* (Participant 6)

> *'...the doctor was asking me today to do a…a urine dip on a patient that had already been done and documented…it obviously wasn't looked at closely enough so you know there's an argument for like do you actually need any paperwork if nobody looks at it?'* (Participant 5)

> *'...there is a vast amount of paperwork……they've got reams and reams…especially the care plans you see its just absolutely full of printed word….'* (Participant 1)

With evidence of paperwork filed away and left unused,

> *'...I do think some of the documentation we do is absolute ...waste of time... as in like the care plans on admission because they're … they're done..THEN and I've not known one person or healthcare professional to look at them ever AGAIN and they're just filed away'* (Participant 5)

One nurse appeared to be a deviant case in that she expressed her total satisfaction with the documentation and initially did not have anything negative to say about it, describing how she found the documentation important and helpful and how it made her feel safe. On further probing, she revealed that the reason for this was that due to being extremely busy she had previously omitted to record a patient's observations following a patient fall despite having done them. As a result, she had subsequently been reproached by the ward manager.

It is possible that the gaps, mishaps and overlaps with documentation may result in actual harm to patients due to sub-optimal care delivery; however, documentation may be protective to nurses if they need to demonstrate care delivery.

Discussion

This research reveals that nurses working with older patients living with frailty find current documentation time consuming to complete and sometimes unnecessary to the delivery of care, resulting in gaps, mishaps and overlaps of information.

The recording of contemporaneous and confidential nursing documentation exists to protect the welfare of the patient and is integral to ensuring high standards and continuity of care, good communication, and accuracy and as such allows for audit to maintain standards while demonstrating the professional and legal duty of care to the patient (NMC, 2005). This research illustrates how the current system of nursing documentation is perceived by nurses to be counterproductive to safe and effective care. It is a legal and professional requirement of nurses on the Nursing and Midwifery Council professional register in the United Kingdom to maintain clear and accurate records in order to deliver safe and effective care to patients (NMC, 2015). This resonates with the interviewed nurses who expressed a need to record information.

However, the findings also support findings in earlier literature. For example, Mason (1999) found that nurses viewed care plans negatively and the majority of documentation had no apparent influence on care. A mixed methods study of nursing documentation complexities (Cheevakasemsook, 2006) showed poor completion of documentation, disruption, incomplete and inappropriate charting. A literature review by Burt et al (2014) found a lack of specificity in care plans and care planning with insufficient evidence of the effect on outcomes and on factors that affect benefit to patients. An observational study of transactions between nurses and patients (Airdroos, 1991) showed that care was found to be lower quality when care plans were used. Broderick and Coffey (2013) in a qualitative descriptive study of 56 records of nursing documentation of older people in care homes found many records to be incomplete and that the structure of documentation can be an obstacle to person centred care. Research involving interviews, observations and an assessment of documentation showed that only 40% of nursing care was actually documented and an increase in nurse workload correlated with a decrease in the amount of documentation written (De Marinis et al, 2010). All of which were supported by the participants' comments in the interviews.

A meta synthesis of 14 qualitative research reports showed that the structure of documentation and organisational presuppositions may prevent recording of individualised patient care (Karkkainen et al, 2005). This research adds to the body of knowledge in that it concurs with these findings and offers a contemporaneous viewpoint from registered nurses in current practice, the pace and intensity of which has accelerated in recent years.

The implication of these findings is particularly important for the hospital care of older patients living with frailty. These patients have high levels of cognitive impairment from dementia or delirium which can result in problems of communication. They have multiple co-morbidities, functional problems, behavioural and psychiatric problems and many are reaching the end of life (Goldberg et al, 2012;

Glover et al, 2014). They are also at risk of poor outcomes (Bradshaw et al, 2013). Their care requires a comprehensive geriatric assessment (CGA) which involves a multidisciplinary approach. The information nurses collect and record is fundamental to the success of CGA as nurses are both the only healthcare profession who are with the patient 24 hours a day and provide the most frequency and intimate care, meaning they have access to information none of the other healthcare professionals have. Accurate and timely written information is vital to the safe delivery of care to this vulnerable group of patients.

The findings raised a number of professional and ethical issues in that nurses were reporting sub optimal and potentially unsafe care. In compliance with ethical obligations of a researcher the researcher is in regular contact with the nursing development team at the Trust to discuss the findings in order to raise awareness and improve care. The findings can support future developments in regard to supporting nurses to focus on efficient and effective completion of documentation.

Strengths and limitations

A registered nurse who understood nursing documentation and the acute care needs of older patients living with frailty conducted the interviews and analysed the data. However, the researcher was known to two of the participants and this may have affected their answers to questions. Nevertheless, the researcher spent time reflecting on their effect on the research by using a reflective diary and discussing issues with the supervisor. The data are limited by coming from a single English National Health Service hospital, but the hospital provides sole emergency medical services for its local population, and is likely to be representative. The sample size was small, but efforts were made to ensure a representative sample. The sample was registered nurses in current practice who wanted to express their views on documentation. Despite this a larger study may generate different findings.

Recommendations for practice

Complete and accurate nursing documentation is vital to the acute care of older patients living with frailty, but the current system of documentation in this particular setting was perceived to be counterproductive to safe and effective care and as such needs to be extensively revised. One suggestion is a bespoke, generic manual with core care plans for common conditions within each specialty to address the biological nursing needs. This can be regularly updated with current evidence based practice guidelines. Nurses can then prescribe care in the patients notes by detailing, for example, ‘care as per breathing care plan version 1.1, dated…’ and cite which version they are using with addendums as required for further personalised information particular to each patient in order to tailor an individualised plan of care.

A smaller document at the patients’ bedside with details of what is most important to them while they are in hospital and a completed ‘this is me’ form (Alzheimer’s society, 2015). Also asking the patient, 'what do I need to know about you as a person to give you the best care possible?’ (Johnston et al, 2015) which would result in a

person centred care plan while providing evidence based care from a biomedical viewpoint with the generic manual.

This system will allow nurses to have more control over the planning of care as it can be amended as required but will not generate large amounts of paperwork.

Streamlining documentation within organisations and ensuring compatibility of different systems will ensure accuracy. This will help to prevent overlaps, repetition, gaps and accidents or near misses through the absence of important information. Any new systems of documentation should be researched to ensure they meet the needs of patients and the multidisciplinary team working with them.

Conclusion

Documentation is vital to ensure good quality communication, and this is particularly important in the acute care of older patients living with frailty.

Previous studies have shown that despite a need for efficient documentation in this specialty, there still exists a lack of accuracy with nurses viewing documentation in a negative light. This research supports previous work in this area as nurses feel there is excessive documentation and it is often inaccurate, inconsistent, repetitive and incomplete.

In view of the increased numbers of people needing care and a forecast global shortage of nurses, new ways must be found to streamline and reduce the amount of nursing documentation to support the delivery of quality care. The emergence of electronic methods of documentation appears to present a unique opportunity to develop a systematic way of record keeping which will streamline the process and prevent repetition of information which has been shown by this study to be often counterproductive to the process.

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‘Gaps, mishaps and overlaps’. Nursing documentation: how does it affect care? (Word count 3901)

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Box 1. Keypoints

- Complete, accurate and relevant nursing documentation is essential for the multidisciplinary comprehensive geriatric assessment process which improves older patient’s outcomes following a hospital admission.

- Older person nurses express dissatisfaction with the amount and quality of documentation which is often inaccurate, inconsistent, repetitive and incomplete.

-Further work is required to streamline current systems, particularly in view of emerging digital methods of documentation to prevent further duplication and increased workload.

Abstract

Introduction: Complete, accurate and relevant nursing documentation is essential for the multidisciplinary comprehensive geriatric assessment process which can improve older patient’s outcomes following a hospital admission.

Aims to understand older person nurses experiences of and attitudes to documentation.

Methodology Semi- structured, in depth interviews of eight qualified nurses at an acute hospital trust. Interviews were analysed using the framework approach to identify key themes.

Results Three overarching themes were identified: gaps, mishaps and overlaps. Gaps refer to information which was missing, inaccurate or inconsistent; mishaps refer to the consequences of these inaccuracies and inconsistencies and overlaps refer to the problem of duplications in recording of information.

Discussion Older person nurses report many inconsistencies, omissions and duplications in their documentation. This has implications for how nursing contributes to the comprehensive geriatric assessment and the quality of care of older patients.

Recommendations for practice New ways must be found to minimise and streamline existing documentation to ensure that records are complete, timely and person-centred. Nurses should be mindful that emerging digital technology systems do not create further problems. Ward nurses need to take greater control of development of documentation.

Summary statement

Why is this research or review needed?

- There is a forecast increase in the numbers of older people in acute settings.
- Older patients often have complex healthcare needs requiring comprehensive geriatric assessment and a multidisciplinary team.
- Documentation in older person care acute settings must be of a standard that provides an accurate record of assessment, decision-making, care planning and treatment in order to ensure accurate communication between the multidisciplinary team of healthcare professionals.

• What are the key findings?

- Documentation in its present form is judged, by the nurses who use it, to be ineffective and in some cases, detrimental to good quality care.
- Nurses expressed a need to record information and felt it offered some form of protection.
- Nurses expressed dissatisfaction with the current system of documentation, deeming it to contain inaccuracies, omissions and duplication.

• How should the findings be used to influence policy/practice/research/education?

- New ways must be found to streamline documentation to ensure accurate and efficient communication in older person care.

- Nurses must be involved in the design, development and evaluation of documentation.

Box 2. Impact Statement

- This paper illustrates the difficulties with documentation older person nurses experience in the acute hospital.
- It shows that the volumes of paperwork which require completion combined with the workload of older person nurses results in inconsistencies, omissions and duplications, making it unfit for its purpose.
- It advises that documentation needs to be streamlined to make it appropriate for the communication of care of older patients between the multidisciplinary team.
- It advises that ward nurses need to be involved in the design, development and evaluation of documentation

Background

A high proportion of acute hospital beds are occupied by older people with figures from the Royal College of Psychiatrists reporting that two-thirds of NHS beds are occupied by people aged 65 years or older and an average district general hospital with 500 beds will admit 5000 older people every year (RCPsych, 2005). Many of these patients have multiple and complex problems compounded by treatments; poorer function and nutritional status; high levels of physical dependency; high prevalence of mental health needs and multiple co-morbidities; all of which require skilled, experienced nursing care which is found to be often difficult and time consuming to deliver in a compassionate way (Zekry et al, 2008; Glover et al, 2014; Goldberg et al, 2012). Staff caring for older people report feeling ill prepared to manage such complex health needs (Griffiths et al, 2014) with evidence of unacceptable variations in the quality of care and up to 77% of carers dissatisfied with the quality of care (Alzheimer's society, 2009; Whittamore et al, 2014; Bradshaw et al, 2014). Comprehensive geriatric assessment (CGA) involves the assessment of an older person living with frailty over five domains (physical and mental health, functional ability, social support and environment), to inform a plan of care that

improves patient outcomes (Welsh et al, 2014). There is evidence that use of CGA increases life expectancy and the ability to return home following an emergency admission to hospital (Ellis et al, 2011). It requires a multidisciplinary team approach supported by accurate and meaningful documentation to ensure the delivery of safe and effective quality care to older people.

Introduction

Guidelines from the Nursing and Midwifery Council which is the nursing regulatory body of the United Kingdom, The Nursing and Midwifery Council (NMC, 2009) emphasize the importance of accurate record keeping. The Nursing and Midwifery Council code of conduct (NMC, 2015) states that nurses have a professional obligation to maintain clear and accurate records. However, there is a concern that an imbalance exists in the amount of time nurses spend on paperwork compared to direct patient care. A survey of 6387 members of the Royal College of Nursing found that 86% of nurses believed that non-essential paperwork had increased over the previous two years with 81% of them claiming that paperwork prevented them from spending time with patients (Sprinks, 2013).

A report commissioned into the failures in care at Mid Staffordshire NHS foundation Trust in England highlighted failures in communication between 2005-2008 (The Francis Report, 2013). One of 290 recommendations made by Lord Francis included that information systems must be designed by healthcare professionals and avoid 'unnecessary duplication' (Francis, 2013, p.111).

The amount of paperwork nurses must complete has increased over time with speculation that a million hours a week were spent completing paperwork in 2008 (Nursing Standard, 2008). Keenan et al (2008) highlight how current record keeping practices are failing to support nursing practice and stress the importance of developing solutions.

Systems of recording nursing documentation include computerised records. However, opinion as to whether this increases time spent or saves time have previously been mixed (Lee et al, 2002). For instance, a study by Moody et al (2004) assessed the attitudes of one hundred nurses towards electronic documentation and found that seventy five percent of nurses believed it to improve the quality of documentation. The same study found that seventy six percent of nurses assessed believed that the electronic format would lead to improvements in the safety of patient care (Moody et al, 2004). However, a study looking at the effect on nursing care of an electronic nursing documentation found that such a system may not necessarily lead to greater efficiency (Munyisia et al, 2012). Nevertheless, further research in this area is necessary as it is unclear as to whether the use of electronic nursing documentation improves the care of patients (Kelley et al, 2011).

The move towards capturing data at the bedside by recording patient observations using electronic hand held apparatus, such as smart devices, has the potential to grow with the possibility of recording nursing documentation and extra facilities such as photographing pressure ulcers to assess and evaluate care.

Complete, accurate, relevant and timely documentation is always important, but is particularly so in the care of older people. This is because of the complexities of care in such a client group, and the subsequent need for good communication between members of the multidisciplinary team who must work closely together to deliver care within the comprehensive geriatric assessment framework. Previous work into examining the use of documentation in older person care (Hardey et al, 2000) highlights the dynamic nature of nursing documentation

This study aims to understand how documentation may affect the quality of care in one acute hospital trust in England by understanding the experiences of registered nurses towards the documentation used while working in older person care in acute hospitals wards.

A qualitative approach was adopted in order to strengthen the understanding of meaning a person gives to a situation without the need for statistical analysis (Rose, 1994). Thematic content analysis was used to allow the researcher to employ systematic means in an attempt to understand the perceptions of others (Burnard, 1991). This research attempts to answer the research question through qualitative means by interviewing registered nurses about their views of nursing documentation.

Methods

Study Design

An interview study analysed using the framework approach.

Sampling and Data Collection

Recruitment and data collection was completed in February 2015. The researcher was a registered nurse working as a Staff Nurse with years of experience caring for older patients in the acute hospital and was conducting the study towards a Master's Degree dissertation. The researcher aimed to interview only nurses she was not familiar with, on wards she had not worked on, but because of difficulties finding registered nurses who were able to take time out of their shift to be interviewed, an opportunistic sample was used. The interviewer did not work directly with six of the participants at the time of the interviews, but had previously worked with two of the participants. Participants were recruited from acute medical healthcare of the older person wards in a large acute Hospital Trust in England. These areas were chosen because of the multiple comorbidities found among the patient group; the use of the comprehensive geriatric assessment tool; and multidisciplinary team approach in such a setting. Registered nurses working for the trust were included. Agency nurses were excluded from the study because the researcher wanted views from nurses who were familiar with the documentation over a longer period of time than only one shift.
The matron of the unit was initially approached to discuss the research and was given information about the study. Following this all ward managers were sent letters inviting them to participate in the study and were asked for written permission for the researcher to access ward areas. Posters were displayed in clinical areas to inform nurses about the study. The nurse in charge approached nurses to be potential participants. The nurses decided if they wished to take part and were then introduced to the researcher. Participants gave written informed consent and took part in a face to

face semi structured interview. The interview guide was developed and piloted prior to use. Initially topics were selected from the literature and subsequent topics were added if they arose during the interview. Topics included: documents completed and how they directed care, what documentation helped with care and why, problems with documentation and time spent on documentation (box 3). Interviews were conducted in a quiet room on the ward. All interviews were audio recorded and field notes were made during the interview. The participants were reassured that privacy, confidentiality and identity would be protected.

Data Analysis

Box 3: Semi-structured interview questions

- Think about a patient you recently cared for, can you describe all the documentation you completed and how it directed the care you gave the patient.
- What helped with the care?
- What documentation did you think was beneficial?
- What do you think was not beneficial? Why?
- Can you give an example of how it did/didn't affect patient care
- Has documentation ever cause problems for you?
- Has documentation ever caused conflict between you and another colleague?
- How many hours a day do you spend on documentation?

Following interview, data were transcribed verbatim. In depth scrutiny of data meant the researcher was not only able to examine the content but also the structure, and speaking style of the participant (Mason, 1996) which allowed for analysis further than the literal sense of the data and to see the content and context in which it was gathered, namely the clinical area of qualified nurses. This allowed for the discovery of themes of which the researcher was then able to use framework analysis to summarise and classified the data (Ritchie and Spencer, 1994). Framework analysis is a flexible approach often utilised in health service research that allows all data to be collected and then analysed. The organisation of data within this approach involved a five stage process (Richie and Spencer, 1994). Firstly familiarisation with data involved constant comparison across the data to identify categories and themes. Transcripts are then coded to identify recurrent statements and expressed feelings which formed the basis of the thematic framework. Themes were then compared and contrasted between participants by indexing, charting and mapping to provide a detailed understanding and interpretation of the participants' experiences. The coding framework was developed by LC and agreed with SG, through regular meetings and discussions.

Ethics

Research ethics committee approval was obtained (ethics reference number: T17112014 SoHS 14109)

Results

A total of eight nurses were interviewed. To demonstrate diversity of the sample population, and to maximise the variety of responses, efforts were made to include a wide variety of nurses from different backgrounds. These included male (n=2), female (n=6), black and minority ethnicity (n=2), deputy sister or above (n=2), experience in nursing over ten years (n=3). The figures do not add up because of diversity within the interviewee population; for example experience did not equate with level of seniority with one nurse in a senior position not having been qualified for many months whereas one staff nurse had been qualified for over thirty years, and several of the participants possessing more than one of the stated characteristics. The eight interviews lasted between seven and sixty minutes.

Analysis of the data found several common themes. Themes included issues around time; amount of documentation; inaccuracies; surveillance; defensive practice. For the purpose of this study will focus on three only. Firstly, gaps in information which refers to information which was missing, inaccurate or inconsistent. Secondly, mishaps refer to the consequences of these inaccuracies and inconsistencies. Thirdly, overlaps refer to the repetition and duplications in written records.

Gaps

Inaccuracies in documentation were identified by participants including omissions, or gaps, of essential information necessary for the delivery of safe care. Nurses spoke of their frustration in systems that are incompatible leading to potentially problematic situations

> *'...we don't have access to EDISS [electronic documentation system] so we can't get next of kin and that's happened on a couple of occasions'* (participant 8)

When gaps in documentation were found, assumptions were sometimes made that care had been carried out for the patient. In such cases, nurses sometimes reported that documentation had been completed retrospectively without full knowledge that care had actually been done

> *'...there's been a couple of times I've had to point out to health care assistants when ...then maybe the skin bundle wasn't completed overnight and the care assistants being told it should be done every 2 hours that they thought oh he hasn't done it oh I might as well. I'll just fill it in for them overnight and I'm saying you CAN'T really cos you're just making up that that he MIGHT have done the care and gone home and forgotten to write it down...but you can't just make it up (laughs)'* (participant 4)

Further examples of gaps in the documentation emerged,

> *'…I just find those tick sheets with regards the post fall are just not filled out correctly at all…and it it you're kind of left wondering well did anyone ring the relatives?…'* (Participant 8)

while others described potentially dangerous gaps, or missing information, in the documentation,

> *'….the patient collapsed on the floor, we all went running there and then I got to see what she came in with and there were NOTHING no no evidence of what she came in for, NOTHING….'* (Participant 1).

Further evidence emerged of missing documentation despite simple systems in place, such as a sticker to document in the medical notes when a patient has fallen,

'the point is again…I am seeing it with the documentation and the instance when I'm going back…. it's just not there…even simple things you know like the stickers in the notes …it's a sticker (laughs) stick it in the notes what…yeah it's just yeah it's just missing… (Participant 8).

Missing and inaccurate documentation appeared to be problematic to nurses as it created problems, or mishaps, which will now be discussed.

Mishaps

Inaccuracies were reported within the documentation as regards peripheral cannulas. Evidence emerged of nurses recommending completing accompanying documentation prior to checking cannulas in an attempt to complete documentation that they knew would be audited at a later date,

> *'…someone told me it would be quicker if I filled in all the VIPS [a tool to assess cannulas] at the beginning of the shift when I was doing the handover and then look at them later on…'* (Participant 4)

And so led to a counterproductive and substandard service with patients receiving inappropriate care and an increased risk of developing phlebitis,

> *'…cos again I've quite often found cannulas that… someone's been that they've been signing on for DAYS and on for DAYS and this persons going this really hurting me this cannula …'* (Participant 4)

With one participant reporting documented care which appeared not to correspond with the condition of the patient,

> *'… I check paperwork as a deputy sister role, checking that documentation is done right and they've ticked something and haven't actually done it'* (Participant 1).

One nurse expressed exasperation at the time needed to complete documentation with no apparent effect on care,

> *''.....its time consuming, it's repetitive…'* (Participant 6)

Overlaps

Finally, nurses expressed exasperation over the excessive amount of time it took to complete paperwork which they felt was often repetitious, of no benefit and took them away from the patient. This resulted in the omission of important information, inaccuracy, duplication and potential safety concerns. Nurses described how staff were unable to find the necessary information, despite information being recorded numerous times,

> *'... you're writing several, same bits of information in several different places…'* (Participant 6)

> *'...the doctor was asking me today to do a…a urine dip on a patient that had already been done and documented…it obviously wasn't looked at closely enough so you know there's an argument for like do you actually need any paperwork if nobody looks at it?'* (Participant 5)

> *'...there is a vast amount of paperwork……they've got reams and reams…especially the care plans you see its just absolutely full of printed word….'* (Participant 1)

With evidence of paperwork filed away and left unused,

> *'...I do think some of the documentation we do is absolute ...waste of time... as in like the care plans on admission because they're ... they're done..THEN and I've not known one person or healthcare professional to look at them ever AGAIN and they're just filed away'* (Participant 5)

One nurse appeared to be a deviant case in that she expressed her total satisfaction with the documentation and initially did not have anything negative to say about it, describing how she found the documentation important and helpful and how it made her feel safe. On further probing, she revealed that the reason for this was that due to being extremely busy she had previously omitted to record a patient's observations following a patient fall despite having done them. As a result, she had subsequently been reproached by the ward manager.

It is possible that the gaps, mishaps and overlaps with documentation may result in actual harm to patients due to sub-optimal care delivery; however, documentation may be protective to nurses if they need to demonstrate care delivery.

Discussion

This research reveals that nurses working with older patients living with frailty find current documentation time consuming to complete and sometimes unnecessary to the delivery of care, resulting in gaps, mishaps and overlaps of information.

The recording of contemporaneous and confidential nursing documentation exists to protect the welfare of the patient and is integral to ensuring high standards and continuity of care, good communication, and accuracy and as such allows for audit to maintain standards while demonstrating the professional and legal duty of care to the patient (NMC, 2005). This research illustrates how the current system of nursing documentation is perceived by nurses to be counterproductive to safe and effective care. It is a legal and professional requirement of nurses on the Nursing and Midwifery Council professional register in the United Kingdom to maintain clear and accurate records in order to deliver safe and effective care to patients (NMC, 2015). This resonates with the interviewed nurses who expressed a need to record information.

However, the findings also support findings in earlier literature. For example, Mason (1999) found that nurses viewed care plans negatively and the majority of documentation had no apparent influence on care. A mixed methods study of nursing documentation complexities (Cheevakasemsook, 2006) showed poor completion of documentation, disruption, incomplete and inappropriate charting. A literature review by Burt et al (2014) found a lack of specificity in care plans and care planning with insufficient evidence of the effect on outcomes and on factors that affect benefit to patients. An observational study of transactions between nurses and patients (Airdroos, 1991) showed that care was found to be lower quality when care plans were used. Broderick and Coffey (2013) in a qualitative descriptive study of 56 records of nursing documentation of older people in care homes found many records to be incomplete and that the structure of documentation can be an obstacle to person centred care. Research involving interviews, observations and an assessment of documentation showed that only 40% of nursing care was actually documented and an increase in nurse workload correlated with a decrease in the amount of documentation written (De Marinis et al, 2010). All of which were supported by the participants' comments in the interviews.

A meta synthesis of 14 qualitative research reports showed that the structure of documentation and organisational presuppositions may prevent recording of individualised patient care (Karkkainen et al, 2005). This research adds to the body of knowledge in that it concurs with these findings and offers a contemporaneous viewpoint from registered nurses in current practice, the pace and intensity of which has accelerated in recent years.

The implication of these findings is particularly important for the hospital care of older patients living with frailty. These patients have high levels of cognitive impairment from dementia or delirium which can result in problems of communication. They have multiple co-morbidities, functional problems, behavioural and psychiatric problems and many are reaching the end of life (Goldberg et al, 2012; Glover et al, 2014). They are also at risk of poor outcomes (Bradshaw et al, 2013). Their care requires a comprehensive geriatric assessment (CGA) which involves a multidisciplinary approach. The information nurses collect and record is

fundamental to the success of CGA as nurses are both the only healthcare profession who are with the patient 24 hours a day and provide the most frequency and intimate care, meaning they have access to information none of the other healthcare professionals have. Accurate and timely written information is vital to the safe delivery of care to this vulnerable group of patients.

The findings raised a number of professional and ethical issues in that nurses were reporting sub optimal and potentially unsafe care. In compliance with ethical obligations of a researcher the researcher is in regular contact with the nursing development team at the Trust to discuss the findings in order to raise awareness and improve care. The findings can support future developments in regard to supporting nurses to focus on efficient and effective completion of documentation.

Strengths and limitations

A registered nurse who understood nursing documentation and the acute care needs of older patients living with frailty conducted the interviews and analysed the data. However, the researcher was known to two of the participants and this may have affected their answers to questions. Nevertheless, the researcher spent time reflecting on their effect on the research by using a reflective diary and discussing issues with the supervisor. The data are limited by coming from a single English National Health Service hospital, but the hospital provides sole emergency medical services for its local population, and is likely to be representative. The sample size was small, but efforts were made to ensure a representative sample. The sample was registered nurses in current practice who wanted to express their views on documentation. Despite this a larger study may generate different findings.

Recommendations for practice

Complete and accurate nursing documentation is vital to the acute care of older patients living with frailty, but the current system of documentation in this particular setting was perceived to be counterproductive to safe and effective care and as such needs to be extensively revised. One suggestion is a bespoke, generic manual with core care plans for common conditions within each specialty to address the biological nursing needs. This can be regularly updated with current evidence based practice guidelines. Nurses can then prescribe care in the patients notes by detailing, for example, ‘care as per breathing care plan version 1.1, dated…’ and cite which version they are using with addendums as required for further personalised information particular to each patient in order to tailor an individualised plan of care.

A smaller document at the patients’ bedside with details of what is most important to them while they are in hospital and a completed ‘this is me’ form (Alzheimer’s society, 2015). Also asking the patient, 'what do I need to know about you as a person to give you the best care possible?’ (Johnston et al, 2015) which would result in a person centred care plan while providing evidence based care from a biomedical viewpoint with the generic manual.

This system will allow nurses to have more control over the planning of care as it can be amended as required but will not generate large amounts of paperwork.

Streamlining documentation within organisations and ensuring compatibility of different systems will ensure accuracy. This will help to prevent overlaps, repetition, gaps and accidents or near misses through the absence of important information. Any new systems of documentation should be researched to ensure they meet the needs of patients and the multidisciplinary team working with them.

Conclusion

Documentation is vital to ensure good quality communication, and this is particularly important in the acute care of older patients living with frailty.

Previous studies have shown that despite a need for efficient documentation in this specialty, there still exists a lack of accuracy with nurses viewing documentation in a negative light. This research supports previous work in this area as nurses feel there is excessive documentation and it is often inaccurate, inconsistent, repetitive and incomplete.

In view of the increased numbers of people needing care and a forecast global shortage of nurses, new ways must be found to streamline and reduce the amount of nursing documentation to support the delivery of quality care. The emergence of electronic methods of documentation appears to present a unique opportunity to develop a systematic way of record keeping which will streamline the process and prevent repetition of information which has been shown by this study to be often counterproductive to the process.

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Liz Charalambous Amendments for 'Gaps, mishaps and overlaps paper 24.09.2016

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Page:line	comment	action
8:19&21	- suggested saying 'was' rather than 'will be'	'will be' changed to read 'was' in both places
10:25	suggest 'amount of documentation' as a theme rather than just 'amount'	Wording changed from 'amount' to 'amount of documentation'

All changes highlighted in red