

Importance of documentation care in nursing



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This scenario presents a number of problems to the staff nurse. In relation to the sphere of practice, as a D Grade Staff Nurse I have a senior nurse present on the ward, who will be in charge during the shift. This provides me with a source of support and experiential knowledge, and also someone with whom to liaise over any issues which arise. However, as a Registered Nurse I am responsible for my own practice, accountable for all aspects of nursing practice and therefore must act on everything pertaining to practice that should arise. In an ideal situation, the E Grade will act on any information or concerns I bring to her. If she does not, then it is my responsibility to act on these concerns myself. The NMC Code of Conduct (NMC, 2004) requires that all qualified nurses act in the best interests of their patients at all times. The NMC code of conduct also states that all nurses are accountable for their own practice, and must account for their own acts or omissions (NMC, 2004).

The focus of this analysis of the scenario is on documentation and the nurse. The nursing literature suggests that the completion of nursing documentation has been one of the most important functions of nurses, even from the beginning of the profession in the time in the time of Florence Nightingale (Cheevakasemsook et al, 2006). Documentation of nursing care is an important source of reference and communication between nurses and other health care providers (Martin et al, 1999). Documentation is a fundamental component of nursing activities such as assessment and care planning, according to the various models which have been designed for these functions (Nazarko, 2007). The importance of proper documentation may also be because it serves multiple and diverse purposes for nurses, for patients, and for the health profession, because current health-care systems

require that documentation ensures continuity of care, furnishes legal evidence of the process of care and promotes and facilitates the evaluation of the quality of patient care delivery (Cheevakasemsook et al, 2006).

In this instance, following handover, the first source of information to be checked will be the nursing records and care plans of each patient, as part of an individualised approach to care. The nursing records for Mrs Smith, for example, should provide the medical history and social history which will allow me to provide holistic nursing care. However, one of the problems with nursing documentation, as found in some empirical nursing studies, is that the complexity of nursing documentation does not always allow it to serve its many functions (Cheevakasemsook et al, 2006). However, the medical record is a legal document that tells the story of the patient's encounter with the nurse and other professional caregivers, and as such should provide a complete and accurate account of his condition and the care he received (Austin, 2006). Whatever the difficulties of the documentation processes concerned here, the documentation should have been complete and correct.

Documentation issues here include the improper recording of the administration of intravenous antibiotics. Given the strong nature of this medication, their specific nature and mode of action which can be tailored to the individual disease following culture and sensitivity tests, and the need to ensure they are given at the correct intervals, particularly as some such drugs can become toxic in larger doses, the proper recording of their administration is a vital part of the administration process. Bjorvell et al (2003) in a study of 377 nurses in Sweden found that nurses believed documentation to be fundamental to nursing practice, in particular, in <https://assignbuster.com/importance-of-documentation-care-in-nursing/>

promoting and ensuring patient safety. Protocols for the administration of intravenous medications exist, which, if followed, should promote safety.

For all medications that nurses give to patients, they must know indications, contraindications, dosage parameters and adverse reactions (Austin, 2006). Nurses must always ensure that the ordered medication is appropriate for the patient, and that the prescription is clear and legible (Austin, 2006). And once a nurse has administered a drug, they must monitor the patient for signs and symptoms of drug toxicity or other adverse reactions, and these monitoring activities must be fully documented, including any actions taken on notable findings and the patient's response to these interventions (Austin, 2006). This creates a record which demonstrates that the nurse met the prescribed standards of patient care when administering medication (Austin, 2006). Two qualified staff should have checked the drug dosage, route and timing, and the prescription against the patient identification band, and then recorded the administration of the antibiotics on the chart and in the patient records. Incomplete records in this instance could be suggestive of improper procedures in the administration of this medication, a serious issue which could lead to legal action and professional sanction, even dismissal and loss of registration (Austin, 2006).

Similarly, the issue of the blood transfusion error should be highlighted, because again patient safety is the fundamental point of nursing care. If proper procedures had been followed, this error could not have occurred. Administration of blood and blood products is subject to strict surveillance, and each Trust will have clear guidelines and protocols which govern and support this kind of activity. Checks should have been carried out on

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collection of the blood – the documentation should have been checked against the blood bag – patient name, number, blood group and type. The blood form, with the number of the blood bag, should have been checked properly. This should have been carried out by two qualified staff. The same checks should have been carried out at the bedside, checked against the patient notes and his identification band. Had the documentation been checked in this way, by two qualified staff, the wrong rhesus factor blood could not have been administered. This demonstrates how correct documentation supports safe nursing practice and facilitates patient safety as well as recording nursing actions.

Not only should the mistake be rectified, the doctor in charge of the patient informed and summoned to examine the patient, and ongoing observations be carried out to ascertain if there are any side effects from the administration of the blood, but all of this should be clearly documented. Further, it should also be documented how this mistake occurred, through an examination of the documentation pertaining to the error and the actions of those who administered the blood. All medically relevant facts related to an incident should be recorded in the medical records, according to the Trust and ward policies and protocols (Austin, 2006). A critical incident reporting form should also be completed, according to Trust policy, in order to ensure that risk management are informed and actions can be taken to prevent such occurrences in the future. Thus, such a form should also be completed for the perceived drug error. The NMC code of conduct states that nurses should act to identify and minimise risk to the patient or client (NMC, 2004), and this applies to the action taken in the current situation and the potential

protection of all clients in the future, in the avoidance of future errors of a similar nature.

Another error which relates to documentation is the issue of the patient who was discharged inappropriately. It is understandable that the relative should be distressed and should be dealt with sensitively and apologetically. Liaison with management, risk management and any hospital or Trust agencies which deal with patient complaints should commence immediately. The most important issue here is to address the error, and not to question whether or not the error took place. It obviously did, because the patient arrived home in that state, and the usual discharge protocols cannot have been adhered to. If they had been, the discharge documentation should have been complete, and would have been communicated with the receiving district nursing team. The nurse plays a unique and pivotal role in discharge planning, as a key member of a multidisciplinary team (Fielo, 1998) role. If, as Bull and Roberts (2001) suggest, a proper discharge occurs in stages, and can be characterised by involvement of all team members within interacting circles of communication, then this discharge error should not have taken place at all. Therefore, any work done to address this error must examine where communication processes failed, and the documentation here should provide the evidence of where this failure occurred.

Communication is fundamental to discharge planning, both between nurse and patient and between professionals across the divide between hospital and community services (Fielo, 1998), and so the documentation here should have been both individualised and comprehensive, functioning both as a record and as a communication tool. Effective discharge planning is also a

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vital link for continuity of care (Bull and Roberts, 2001), and so the failure of this process will lead to negative impact for the patient and their carers.

Similarly, patient and carer participation is important in discharge planning (McLeod, 2006; Bull and Roberts, 2001). Research by Cleary et al (2003) demonstrates that consumers want information on medication, treatment, awareness of their rights and opportunities to participate in decision making. The nurse engaging in discharge planning also needs to take into account the needs and capabilities of carers (Qualey, 1997).

The failure of the discharge planning process in this case therefore has a number of complex effects and may be shown to have failed in a number of key areas. It is also imperative that nurses value the social aspects of patient care and that this is seen as an integral part of the discharge process (Atwal, 2001). There are some ways in which this could be improved, and a close examination of what went wrong might highlight ways in which this could be avoided in future cases. The discharge documentation may need to be adapted to better reflect the processes and knowledge involved (Reed, 2005). This might ameliorate relationships between the acute and community sectors (McKenna and Keeney, 2000), and may prevent these errors occurring in the future. It might also be necessary, from the evidence of the available documents relating to the case, and from the ward rota, to identify who failed to properly discharge the patient so they can be engaged in education and development activities to develop their competence in this area. The documentation used should have served to enhance the ability to deal with this difficult situation (Sollins, 2007) by providing the family with the answers to their questions about what went wrong.

Cheevakasemsook et al, (2006) in their study found that complexities in nursing documentation include three aspects: disruption, incompleteness and inappropriate charting. Of these, this scenario shows occurrences of incomplete documentation, whereby the documentation related to discharge planning has not been completed. Related factors that influenced documentation comprised: limited nurses' competence, motivation and confidence; ineffective nursing procedures; and inadequate nursing audit, supervision and staff development functions (Cheevakasemsook et al, 2006). These findings suggest that complexities in nursing documentation require extensive resolution and implicitly dictate strategies for nurse managers and nurses to take part in solving these complicated problems (Cheevakasemsook et al, 2006). These are learning points to take forward into future professional development and practice. However, the more immediate needs would be to address the problems associated with these failures. The nurse must act to redress the balance and to minimise, for example, the potential litigation which may arise from this unfortunate situation. The family are likely to make a formal complaint, and, depending on how this has affected the discharged patient, may even take legal action for compensation. In this instance, the incomplete discharge documentation demonstrates that the required nursing care did not take place (as there is no evidence of it in the records). Therefore, legally, the nurse taking care of this patient will be liable for the errors that have occurred.

There are other issues to be considered, taking the wider view, in perhaps understanding why such errors occurred and how they can be avoided in subsequent cases. Hyde et al (2005) highlight the limitations of the forms of

documentation (and the forms of communication which characterise that documentation) within nursing practice. They suggest that this nursing documentation depicts the domination of reductionist medical models, utilising scientific rationality in linguistic and communication forms, rather than reflecting the holistic nature of nursing practice (Hyde et al, 2005). Therefore the documentation may be at odds with the autonomy of the patient, bringing up issues of control and power, where the documentation may serve to exert and maintain the power of the nurse or the medical profession rather than support the wellbeing of the patient (Hyde et al, 2005). Professional autonomy on the part of nurses demands a degree of mature clinical and ethical judgement in emergent and complex situations, and it is the documentation, if correctly completed, which should also signpost this process of judgement and decision making. But if the documentation is difficult to complete, onerous or time consuming, it may be that it detracts from the quality of patient care and the easy recording of this, rather than supporting it. Documentation provides the legal protection nurses require in modern healthcare practice (Frank-Strombourg et al, 2001). Educating nurses about the principles of documentation and the importance of implementing risk-reduction practices may help guard against liability and ultimately improve patient care (Frank-Strombourg et al, 2001). Perhaps developing better charts and records, in liaison with all staff, might also ameliorate the situation.

The literature demonstrates unequivocally that nurses are the professionals that patients have the most interactions with in the hospital environment (Williams, 1997). The work and competence of the nursing staff is therefore

perhaps the most significant factor in determining quality of patient care (Williams, 1997), and so it is vital to ensure that nurses record their practice accurately so that their competence can be audited, and the effectiveness of their practice evaluated. If, as suggested, evidence-based practice is now at the heart of nursing care (DOH, 2001), then documentation will also allow the implementation of evidence based practice, through care protocols and pathways, and through auditing processes and reflective practice which reviews care against the available evidence. Martin et al (1999), in their research of nursing documentation activities, found that good nursing documentation supported the implementation of evidence-based practice. This takes us back to the quality of the documentation processes, and it may be that they are under development - towards evidence-based care pathways or the like, or this kind of thing may need implementing.

Utilising alternative modes of documentation may also enhance practice and recording behaviours. Lee (2006) in a study of one computerised documentation system in practice, found that nurses generally viewed the content of the computerized nursing care planning system as a reference to aid memory, a learning tool for patient care, and a vehicle for applying judgement to modify care plan content. This suggests that such tools may do more than simply streamline nurses' work (Lee, 2006). It may be that using a computerized care plan system can also enhance nurses' knowledge, experience and judgement of descriptions of patient problems and care strategies (Lee, 2006). It is my opinion that it may also serve to minimise the kinds of errors that have occurred in the assignment scenario.

The nature of the documentation (ie the content and structure) may therefore need to be changed. O'Connor et al (2007) show how new, streamlined nursing charts improved planning and evaluation of care and served promote patient involvement in the care and documentation processes. In reference to the discharge planning incident in particular, this might be an area to develop within the clinical area.

One innovation which supports this is that described by the NHS (2007) in *The Essence of Care*, which was launched in February 2001, as providing a toolkit to help practitioners to implement a structured approach to sharing and comparing practice, through principles of clinical governance, enabling them to identify the best and to develop action plans to remedy poor practice. This would appear to be a key activity in the longer term to develop from the learning points contained within this problematic scenario. These kinds of benchmarks and guidelines can provide useful guidance, in association with other activities such as evidence-based care pathways and protocols, to develop more streamlined and effective practices.

Another point of action is the need to carry out specific empirical research into this area. In a systematic review of research literature to test the hypothesis that care planning and record keeping in nursing practice has no measurable effect on patient outcomes, the authors were unable to identify any robust studies for review (Moloney and Maggs, 1999). This suggests that the potential effects of documentation failures cannot be fully evaluated, anticipated or described without future research. This also underlines the need to ensure the highest possible standards of care are both implemented

and fully documented throughout every stage and component of nursing practice.

This analysis shows that documentation serves a number of purposes within nursing practice. It records care, demonstrating and communicating what procedures were carried out, when, and why. It rationalises clinical decisions and evaluates clinical and nursing actions. It also allows the direction and planning of care. It provides legal proof that nurses have followed proper protocols and procedures for the administration of medicines and blood products, for the implementation of medical and nursing orders, and in particular supports complex activities such as discharge planning. Lack of proper documentation can indicate that proper procedures were not carried out. Poor documentation can lead to confusion and to patient compromise, whereby a patient may not receive the medication required, or may erroneously receive an overdose. Similarly, the blood error could have had significant consequences, and should not have occurred, given the nature of the procedures involved, and the clear links between safety and existing documentation. These errors point to either a lack of competence in basic nursing procedures, or a lack of care on the part of the staff who made them.

Documentation would also have supported the D grade nurse here when dealing with the problems. The discharge planning errors could have been dealt with more effectively if the documentation had been complete. This would be their primary source of information when dealing with a patient complaint and a complaint from a district nursing colleague. The expectation on all parts that such records will be complete and will answer the questions raised by all parties places the responsibility firmly on the nurse to ensure

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they properly fulfill this vital part of their role. Nurses can engage in proper documentation of the errors and incidents noted so that they are appropriately and comprehensively dealt with now that the errors have been identified, and so can meet all the professional requirements of their role within this situation (NMC, 2004). And all staff can learn from these incidents, and be included in processes of research, improvement and development to implement better documentation and care practices in the future.

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