ABCDE

Back to Basics
Documentation

Laura Bayliss
Adult Nursing Lecturer
University of Bradford

Outcomes

- Development of Documentation
- Why Is it important?
- What do we write?
- How do we achieve this is an acute environment.

- Bad documentation can make good nursing look bad and can make bad nursing look even worse.
- Five years from now, you probably won't remember the patient you had yesterday. All you will be able to depend on is your notes.

Recap

What do we know about George…

A-E assessment

George is a 43year science teacher. He is 94Kgs and is normally fit and healthy with no underlying medical conditions. He developed a chest infection 3 weeks ago following a field trip with some students. At first he thought it was just a cold but eventually (2 weeks ago) did go to see his GP who prescribed oral antibiotics – the first course had no effect so a 2nd trip to see his GP resulted in a further course of oral antibiotics and a plan for Chest Xray if there was no improvement within a week. 2 Days ago George was increasingly breathless with a pyrexia and generally feeling unwell, he woke in the night with Rigors, his wife called 111 and was advised to take him to ED for assessment. After a 6 hour wait in ED he was admitted to the Medical Emergency Assessment Unit. His chest XRay showed apparent bilateral pneumonia, he was commenced on oxygen therapy, IV antibiotics & paracetamol. However his condition failed to improve, His fluid & oral intake had been poor for 2 – 3 days prior to admission and had diminished further since admission, his urine output was borderline at 0.5 ml.kg. His NEWs was 5 so Critical Care Outreach were called & suggested commencement of High Flow oxygen therapy & IV fluid bolus. There was some improvement however on review of his ABG's he was referred to Critical care and admitted for Level 2 care including CPAP, monitoring & observations. On admission to ICU he was commenced on IV fluids to support BP, his IV antibiotics & paracetamol continued – as yet a sputum sample had not been obtained. Arterial line inserted, he was commenced on CPAP 10/5 some improvement in his ABGs were noted but the ICU team were concerned for his condition……………………..

What does the NMC State?

- Standards that we must uphold
- Standards that the public expect

The Code

Professional standards of practice and behaviour for nurses and midwives

prioritise people

practise effectively

preserve safety

promote professionalism and trust

NMC Documentation

Principles of record keeping

1. helping to improve accountability
2. showing how decisions related to patient care were made
3. supporting the delivery of services
4. supporting effective clinical judgements and decisions
5. supporting patient care and communications
6. making continuity of care easier
7. providing documentary evidence of services delivered
8. promoting better communication and sharing of information between members of the multi-professional healthcare team
9. helping to identify risks, and enabling early detection of complications
10. supporting clinical audit, research, allocation of resources and performance planning, and helping to address complaints or legal processes.

NMC (2018) Documentation and record Keeping

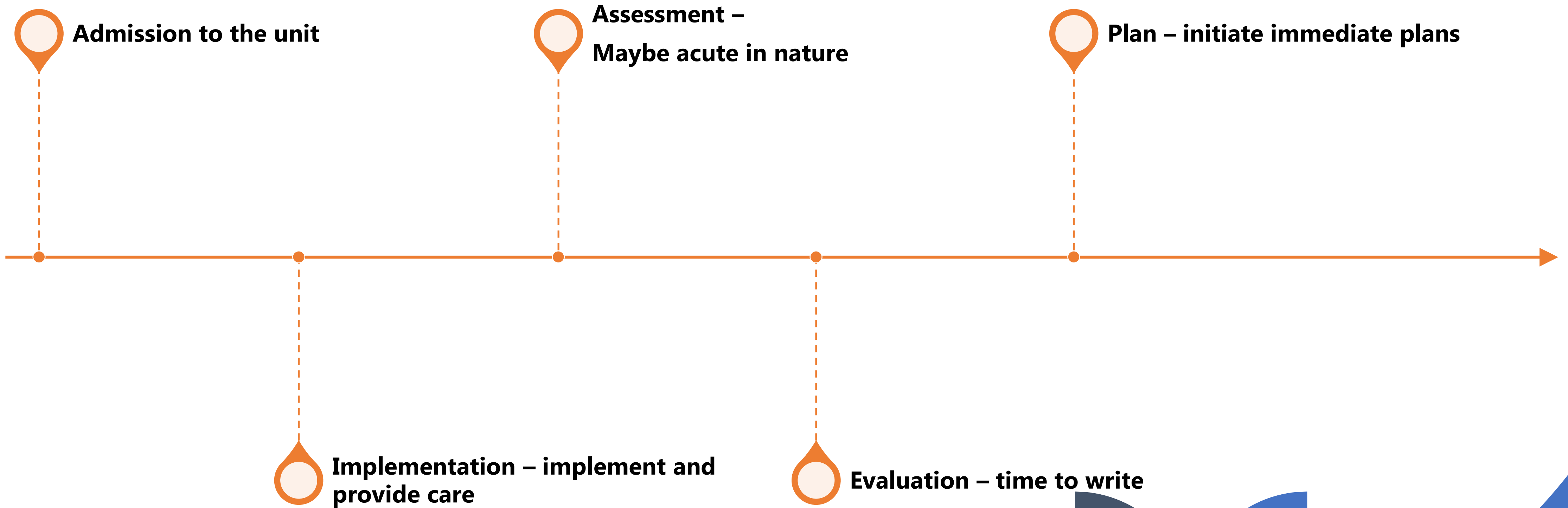
Roper and Logan

- Assess
- Plan
- Implement
- Evaluate

But how does this translate into Acute and critical care?

BACCN study Event 2023

Timeline of documentation



Standards

Standardisation of acute care documentation across settings

Provide a structured and systematic handover of the care that had been provided from the point of delivery.

Consider the implications of poor documentation and communication including the transparency when care pathways change and patients move.

Write a systematic documentation of events for the care of George

What are the limitations of record keeping in acute care.

- Patient acuity
- Time
- Equipment
- Technology
- Systems
- Accuracy
- Illegible
- Poor handover
- Communication

Limitations to documentation in acute care.

- Nurse to patient ratio
- Urgent/acute situation
- Patient volume

How can we address this in terms of quality?

- Workforce approaches
- Workforce culture
- Quality improvement initiatives

Falk A et al (2022) Missed nursing care in the critical care unit, before and during the COVID-19 pandemic: A comparative cross-sectional study. *Intensive and Critical care nursing.* https://www.sciencedirect.com/science/article/pii/S0964339722000799

Quality of documentation

GPICS state that the documentation should be clear and reflect the care given

Bespoke enhanced training should be provided within trusts – due to distinct differences in the processes.

Dedicated workstation for each bedspace for all electronic documentation recording.

Appropriate number of spare workstations should also be available to facilitate ad hoc nursing care.

GPICs (2022) https://ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf

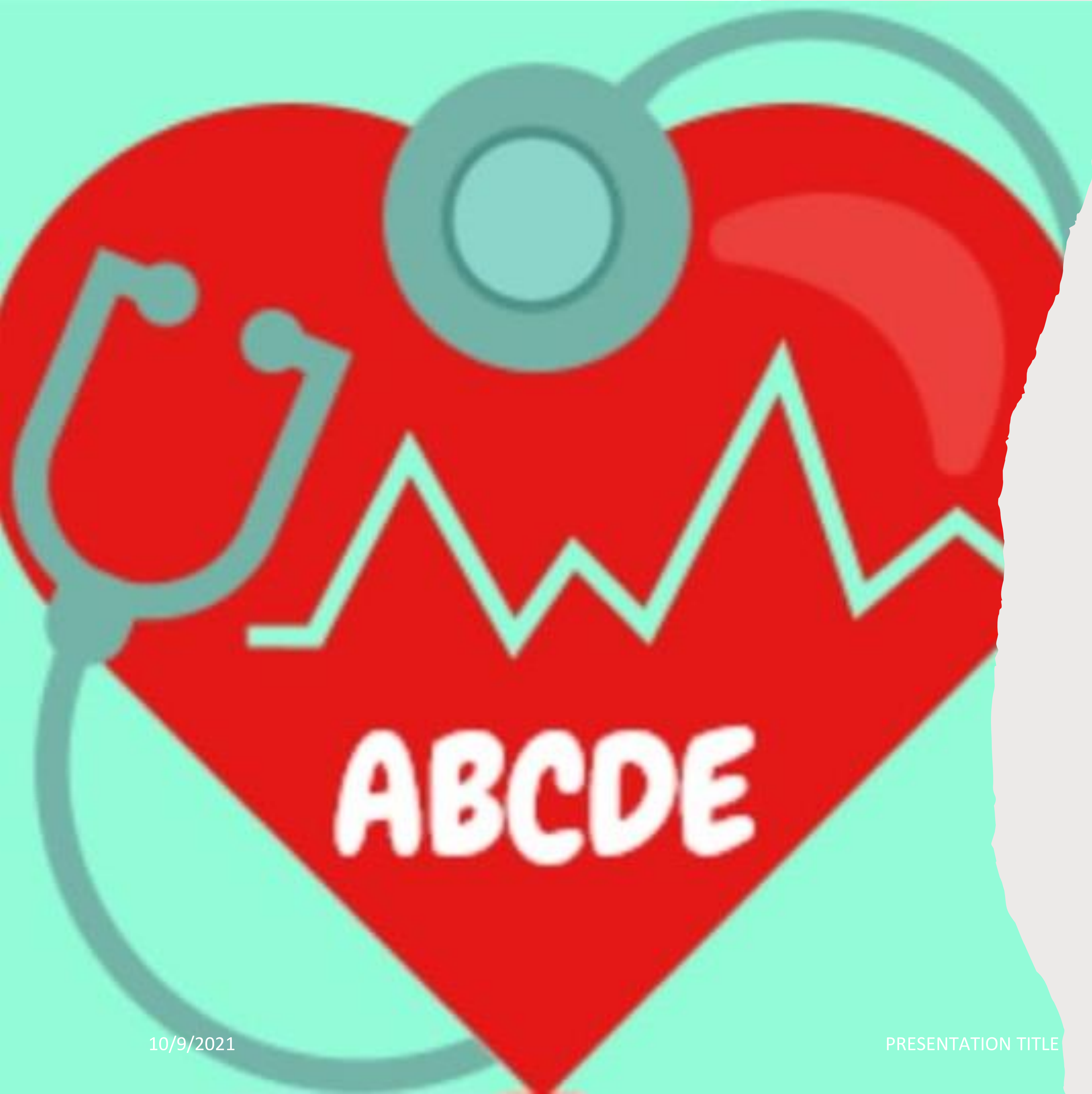
Summary

Development of Documentation
Why Is it important?
What do we write?
How do we achieve this is an acute environment.

Thank you

- Any questions?

l.r.bayliss2@bradford.ac.uk



References

- Holland, K and Roberts, D (2022). Understanding decision making in Nursing Practice. Sage.
- NMC (2018) The code of conduct.
- NMC (2018) Section 10. Record Keeping and documentation.
- GPICS (2022) Faculty of Intensive care medicine. https://ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf

Question

- How many principles of record keeping are listed by the NMC(2018) Record keeping and documentation?

1. 6
2. 9
3. 10