Documentation

Developed by Joanne Purdue & Ally Kerr - Professional Officers, NSWNMA

Why is documentation so important?

Complaints

Ethics

Quality of care

Standards for Practice

Safety

Reduce risks

Nursing and midwifery - NSW

Nursing and Midwifery Council

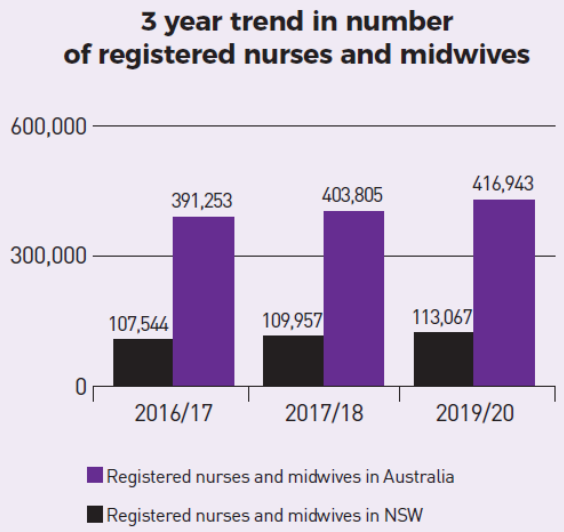
2018-19 Summary

NURSES AND MIDWIVES

113,067
Registered nurses and midwives in NSW

27%
of Australian nurses and midwives practise in NSW

0.7%
of NSW nurses and midwives had complaints made about them



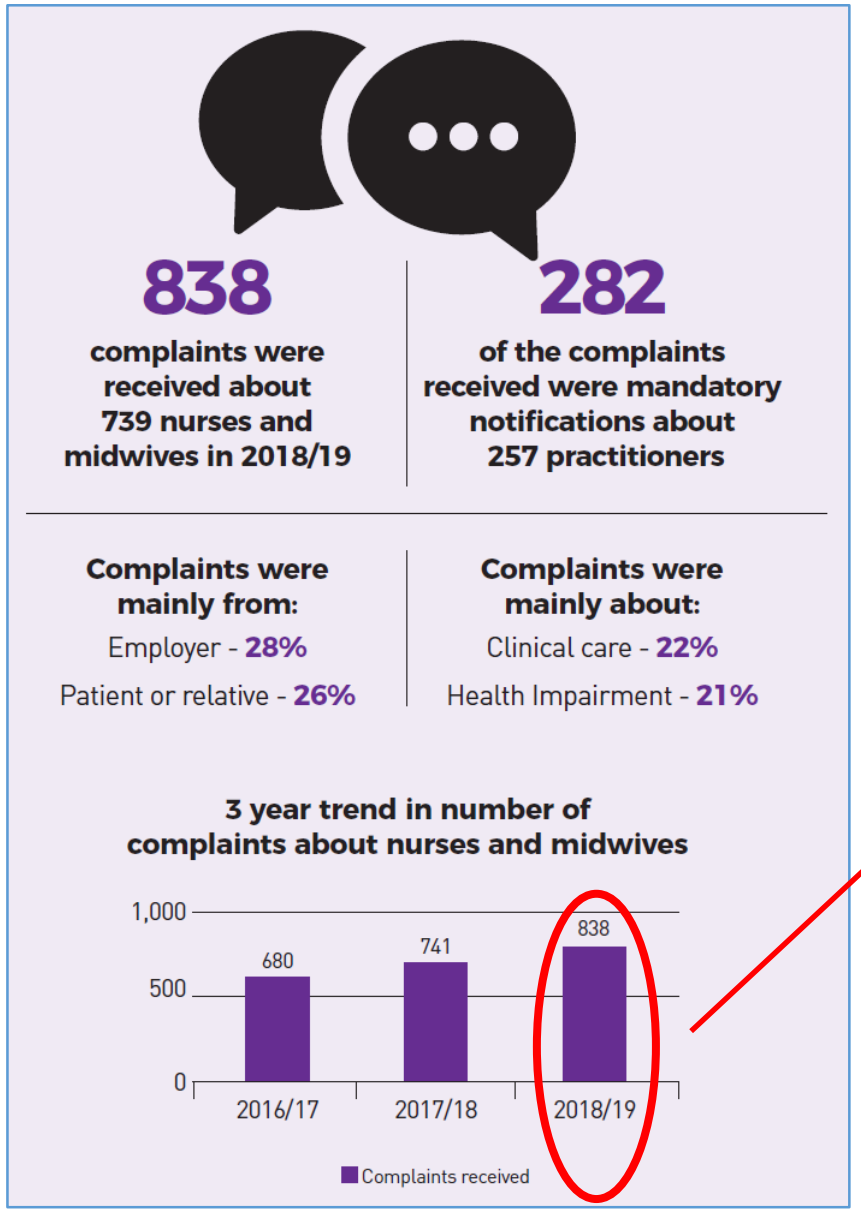
Nursing & Midwifery Council New South Wales

Nursing and Midwifery Council of NSW, **Annual Report 2019-2019**

Why is this such an important topic?

Complaints about nurses and midwives

Nursing and Midwifery Council (NMC) of NSW



11.5% increase from previous year

Nursing and Midwifery Council of NSW, **Annual Report 2019-2019**

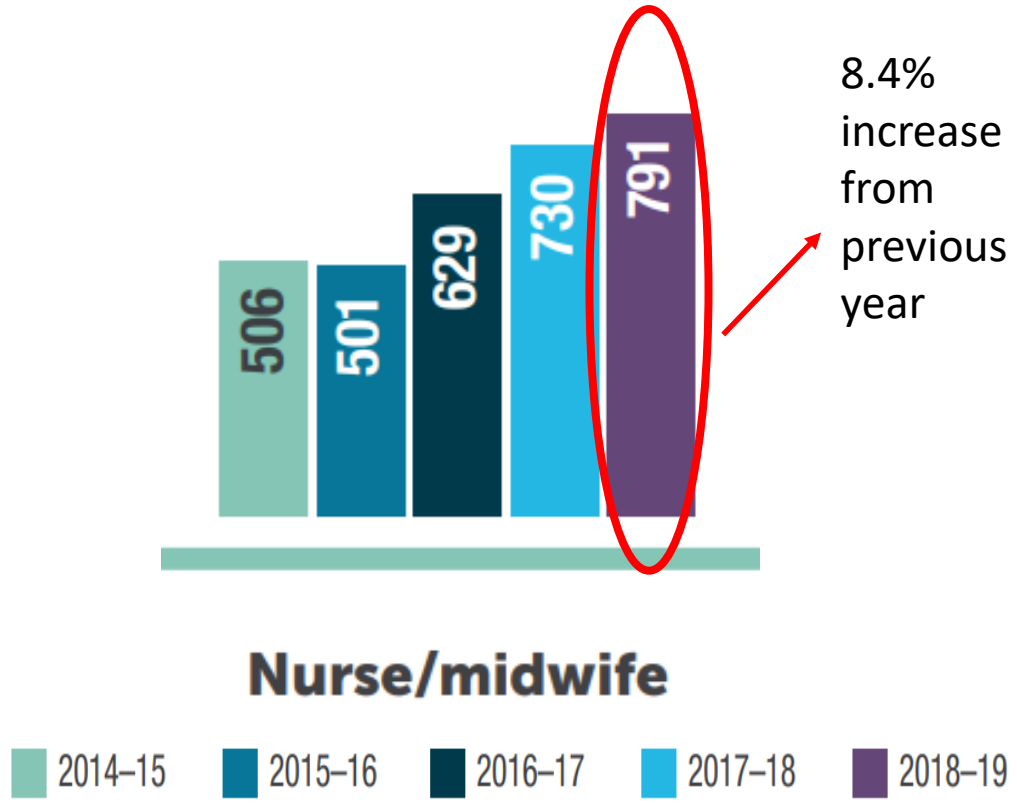
Why is this such an important topic?

Complaints about nurses and midwives

Health Care Complaints Commission (HCCC)

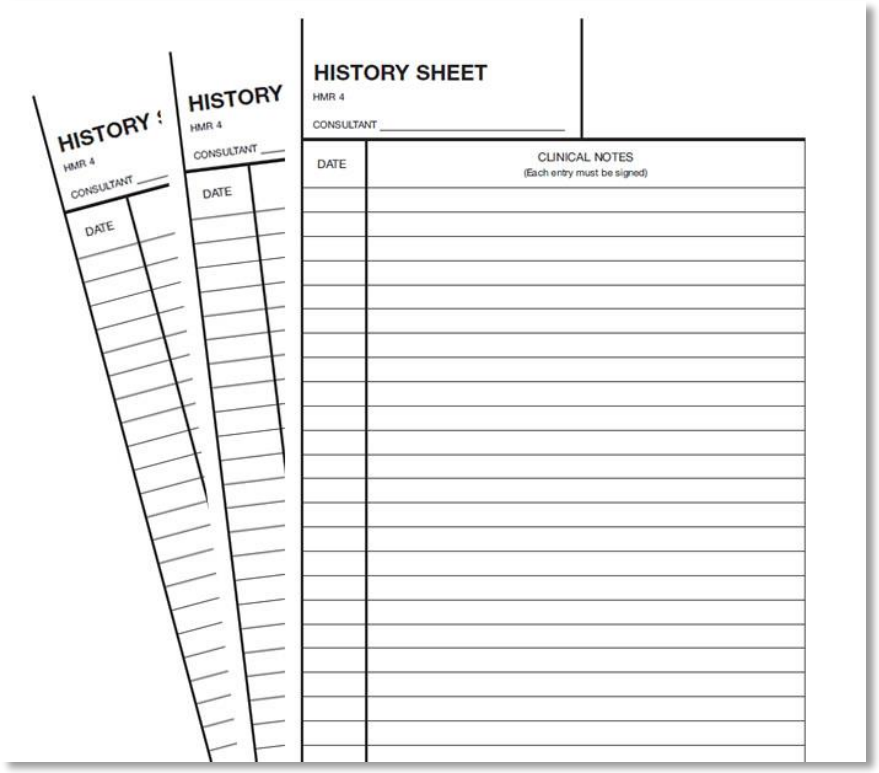
HEALTH CARE COMPLAINTS COMMISSION

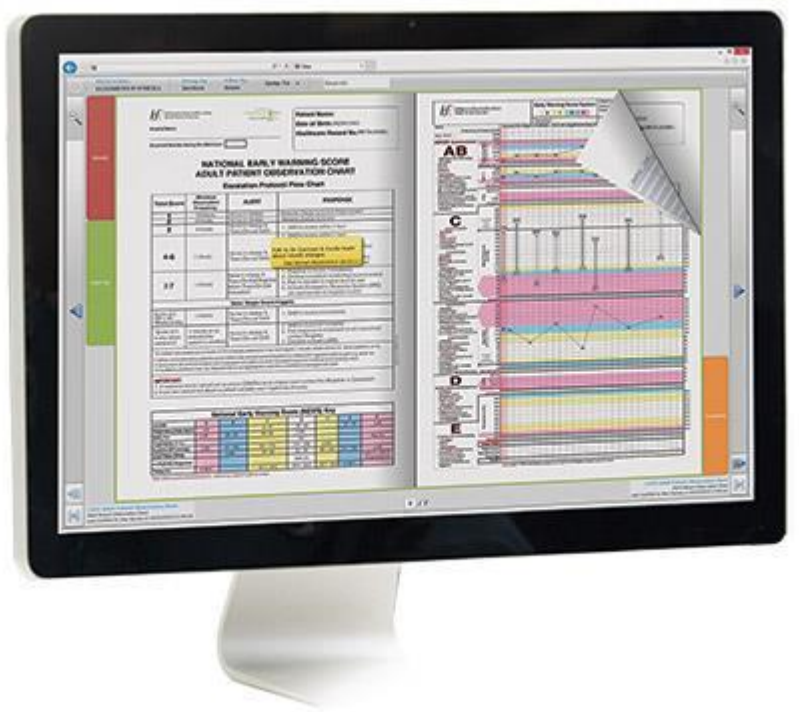
The proportion of complaints about assistants in nursing also increased in 2018-19 (from 6.0% in 2017-18 to 11.1%)



HCCC Annual Report 2018-2019

Paper VS electronic



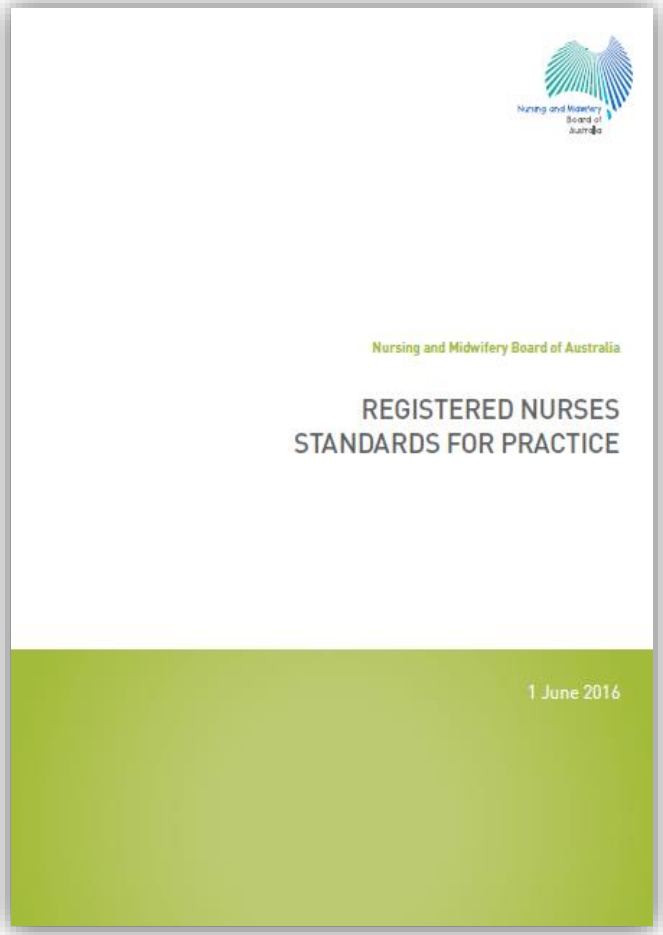


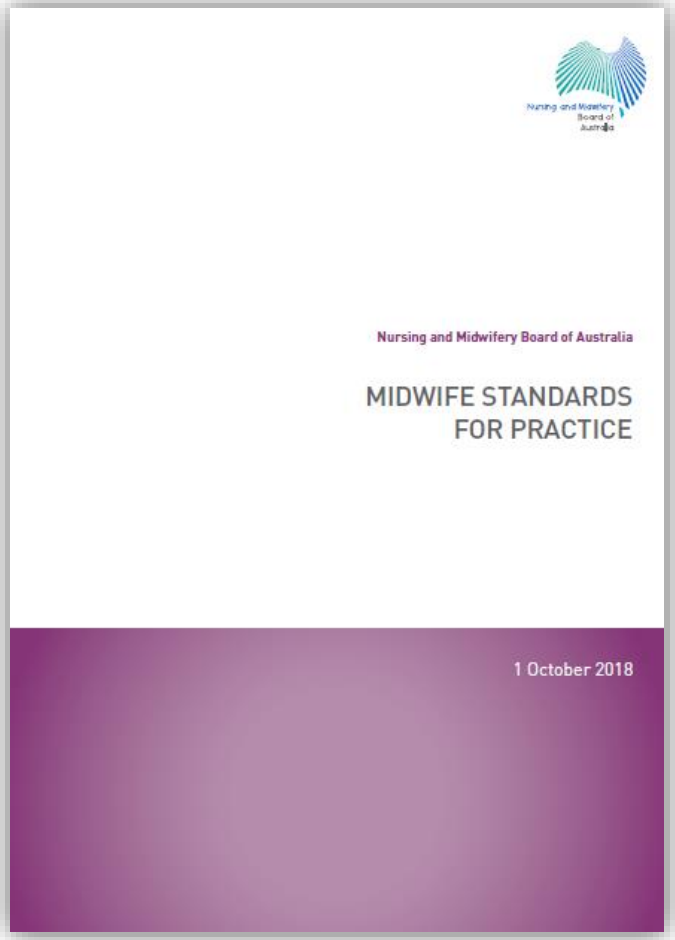
Documenting patient care

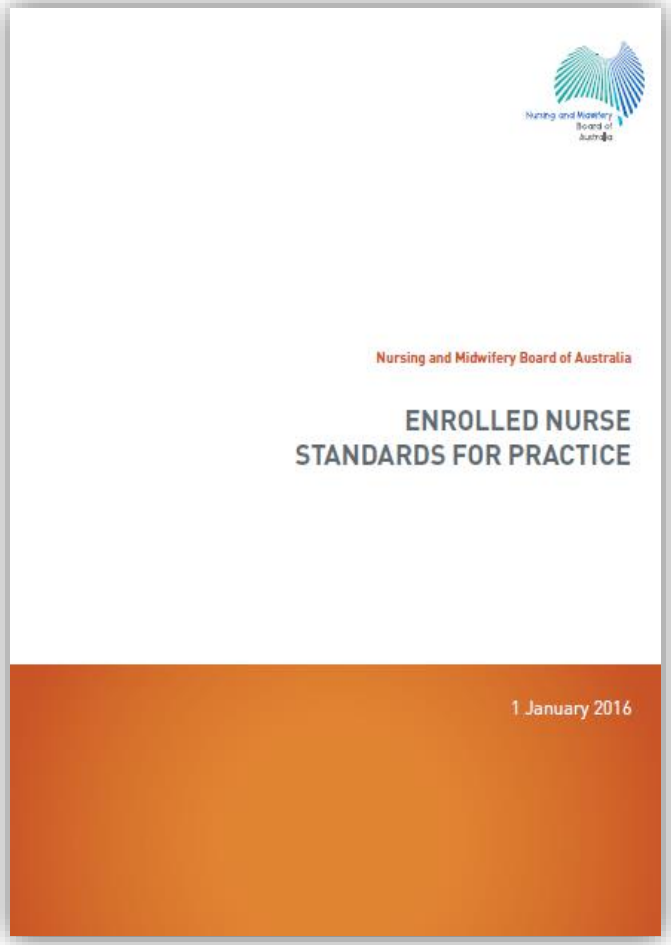
- Documentation is the basis of communication between healthcare professionals
- Documentation provides **evidence of decision making** and of the **care planned**, as well as **evidence of critical thinking** and **professional judgment**
- Documentation is used as evidence for reviews of health care delivery, professional conduct and investigations
- Documentation informs education, research, prevention programs and policy development

➢ **DOCUMENTATION IS INTEGRAL TO SAFE PATIENT CARE!**

Standards for Practice







NMBA Standards for Practice – RN, Midwife, EN

The Importance of Documenting

Nursing and Midwifery Board of Australia Standards for Practice: RN

Standard 1: Thinks Critically and analyses nursing practice

- 1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations

Standard 5: Develops a plan for nursing practice

- 5.3 Documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes

Standard 7: Evaluates outcomes to inform nursing practice

- 7.3 Determines, documents and communicates further priorities, goals and outcomes with the relevant persons.

The Importance of Documenting

Nursing and Midwifery Board of Australia Standards of Practice: EN

Standard 7: **Communicates and uses documentation to inform and report care**

- 7.1 collects data, reviews and documents the health and functional status of the person receiving care accurately and clearly.
- 7.3 uses a variety of communication methods to engage appropriately with others and documents accordingly.
- 7.4 prepares and delivers written and verbal care reports such as clinical handover, as part of multidisciplinary healthcare team.

The Importance of Documenting

Nursing and Midwifery Board of Australia Standards for Practice: Midwifery

Standard 5: Develops a plan for midwifery practice

- 5.4 Documents, evaluates and modifies plans to facilitate the anticipated outcomes.

Competent Practice

Nurses and midwives will be held accountable for the care they provide – if it's not documented, did it happen?

- Nurses and midwives should consider their records as the most credible source as to **their judgment and critical thinking**, in relation to the care they provided.
- If the adequacy of care provided to patient's is under scrutiny, the **health record** is considered one of the most detailed and **reliable sources of evidence**

Risk Assessment

Clinical risk assessment are specific assessments that are used to **measure levels of risk** for certain situations, procedures and outcomes

- Pressure injury, falls prevention and other risk assessments are all part of the **Accreditation and National Safety and Quality Health Service Standards (NSQHS)**
- Should be **filled out on admission** so clinical pathways and nursing care plans can meet the needs of the patients
- Reviewed and updated when needed every shift

6 common mistakes of documenting

→ Failing to record pertinent health or drug information

→ Failing to record nursing action

→ Failing to record that medications have been given

→ Recording in the wrong chart

→ Failing to record changes in the patient's condition or drug reactions

→ Writing illegible or incomplete records

Report writing

Report Writing

Reports must be a *contemporaneous* record of events which have taken place.

Contemporaneous → **'existing at or occurring in the same period of time'**

But WHY?

A. More likely to be an accurate account of events, and

B. More weight is given to contemporaneous notes than notes that are written a long time after an event

Report Writing

'Real time' progress notes: nursing documentation written in a timely manner during the shift

- Records are not legal documents until tendered and admitted into evidence
- Accurate statement of fact (objective); or Statement of clinical judgement relating to:
  - Care
  - Observation
  - Assessment
  - Diagnosis
  - Management /treatment

Shift Assessment

S **Subjective**: reports what the patient says

O **Objective**: records what the nurse observes

A **Analysis**: identifies a nursing diagnosis

P **Plan**: describes nursing interventions

I **Implementation**: records how those actions were carried out

E **Evaluation**: reports the actual patient response and outcome

Objective VS Subjective

What is OBJECTIVE?

Not influenced by emotions, opinions, or personal feelings – **based in fact**, **measurable** & **observable**.

What is SUBJECTIVE?

Open to greater interpretation based on personal feeling, emotion, aesthetics, etc.

We should only be writing objectively other then when told by another party.
E.g. patient stated…….

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
Patient appears drunk.	Patient smells strongly of alcohol, with unsteady gait and slurred speech.

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
Patient is cold.	Pt has temperature of 35C and is shivering. Skin feels cold to touch, with capillary refill of >3 seconds.

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
Good circulation to feet.	Feet are warm and well perfused. Capillary refill is <3 seconds, with strong pedal pulses.

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
Patient slept well, nil complaints.	Patient observed at regular intervals; when observed, pt was resting in bed with eyes closed.

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
IVF continues.	Normal Saline running @ 120ml/hr via R) hand IVC.

Objective VS Subjective

SUBJECTIVE	OBJECTIVE
IVC insitu.	IVC Day 2 – no signs of infection, dressing intact.

What should I document?

- Your assessment
- Change in a patient's condition
- Any concerns & your action
- Follow up – required or needed?

Keep all entries;

- Factual
- Accurate
- Complete
- Timely

Report Writing

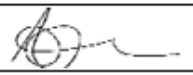
A reliable record must be…

- → Complete and current
- → Able to demonstrate it has not been tampered with
- → Available when required
- → Organised in a consistent manner that aids retrieval of information (legibly written)
- → **Signed by author, with the name and designation printed** (if paper) **or logged in appropriately**
- → Written as a chronological record of actions and events
- → **Contemporaneous: as close to the time of event as possible (not end of shift)**

Report Writing

- Failure to provide an accurate, honest and timely account of the care provided negatively impacts the credibility of the health practitioner
- Also impacts the health practitioners ability to rely on the record during testimony
- Poor documentation can contribute to findings of negligence
- **Late entries should be rare, not a normal part of nurses practice.** If late entries are required, they need to be identified as such.
- Attempts to falsify the record to hide the fact the entry took place sometimes after the encounter, is poor practice.

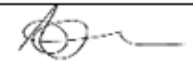
Example – report writing

22/05/2019	1300hrs	Pt SOOB in chair for morning. Obs normal. Assisted with ADLs. Mobilising-----
		with 1 x assist. Nil complaints ATOR.  (ANURSE, RN) ----------

- Any issues with this report?
- What could be improved?

Example – suggested improvement

Any better? Would you change anything else?

22/05/2019	1300hrs	Pt sitting out of bed in chair this morning. Minimal assistance required for ------
		ADLs - required assistance to wash and dry lower limbs, otherwise ----------
		independent. Pt has an unsteady gait – mobilising with walker and stand-by
		assistance. ----------  (ANURSE, RN)

Example – report writing

22/05/2019	2100hrs	Pt has history of alcohol use ++. Appears drunk and was aggressive to staff.
		Security called and pt now settled. Resting in bed ATOR. For OT tomorrow –
		to be NBM from midnight for same. ---------- (ANURSE, RN)

- Any issues with this report?
- What could be improved?

Example – suggested improvement

- Any better? Would you change anything else?

22/05/2019	2100hrs	At ~ 2000 hrs, pt observed to have an unsteady gait, slurred speech and smelt
		strongly of alcohol. Pt was using abusive language and shaking his fists. -------
		Advised pt this behaviour is not tolerated, and that I would be calling security.
		Security attended at 2015. At this time observations taken – between the
		flags. Security remained on ward to 2045; no further issues with behaviour.
		Pt currently resting in bed with eyes closed. Request for on-call JMO to r/v pt
		as concerns about potential alcohol use and interaction with medications. Pt
		awaiting r/v. Pt is for OT tomorrow – to be nil by mouth from 2400. ----------
		---------- (ANURSE, RN)

Report Writing – in summary

In Summary

- *Write objectively*, not subjectively (facts, not opinions)
- Provide information and *evidence of decision making* (based on documented events and information)
- First hand (direct) observations
- Actions and outcomes
- *Document contemporaneously*

References

Nursing and Midwifery Council (NMC) Annual Report
https://www.hpca.nsw.gov.au/council-annual-reports-201819

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https://www.hccc.nsw.gov.au/Publications/Annual-reports/Default

Nursing and Midwifery Board of Australia:
http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx