Appendix 4

REGIONAL RECORD KEEPING INITIATIVE LITERATURE REVIEW

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NIPEC

Northern Ireland Practice and Education Council
for
Nursing and Midwifery

Regional Record Keeping Initiative

Literature Review

INVESTOR IN PEOPLE

CONTENTS

1.0 Introduction

The purpose of this discussion paper is to identify key themes arising from a literature review pertaining to the quality of nursing documentation and record keeping, to inform discussion between key stakeholders as they develop a project proposal to improve the quality of record keeping within the nursing profession in Northern Ireland and the development of regional nursing documentation.

2.0 Background

2.1 The written healthcare record has had a long history since the days when Florence Nightingale first put pen to paper. Nursing research relative to record keeping has demonstrated a tension between using a preferred model to articulate care that is planned and the reality of practice in any clinical environment[1]. It is now 28 years since Roper, Logan and Tierney[2] first penned their model of care which many nursing care plans are underpinned by, and it is widely accepted that this model no longer provides a suitable framework through which care might be assessed[1]. A study conducted by the Audit Commission in 1997[3] concluded that before a move towards electronic recording systems could be made efficiently, the manual systems currently in use required attention to standardise and unify the process. Integrated Care Pathways have been under discussion for quite some time also, seen as a method of linking up all the professions into one record and incorporating evidence based guidelines into practice[4].

2.2 The nursing process[5] promoted the principles of Problem, Aim, Action and Evaluate as a way of record keeping as well as a way of nursing patients and clients. Combining this method with the activities of daily living resulted in a record which was termed the 'nursing care plan'. The use of a problem solving approach to planning care results in documentation which can be lengthy, particularly for those clinical areas which use standardised care plans. Nursing is the only profession which looks at and uses care plans in this manner[1], which

are generally filed at the back of a patient's/ client's notes when the episode of care is complete.

2.3 From a patient/ client perspective the difficulties arising from separate note taking by professions can be grouped into issues around communication namely: similar questions are asked of the person repeatedly in the same episode of care by different personnel[6] [7]; problematic communication between professions[8]; duplication of information which may lead to inaccuracy[1]; physiotherapy/ specialist notes held separately which creates difficulties in A&E/ out of hours with vital pieces of care or history missing from the case note[1].

3.0 Purpose of Review

3.1 This review will examine the themes arising from recent literature (2003 – 2008) relative to improving the quality of nursing documentation in the first instance, although attention has been paid to the relevance of multidisciplinary notes, to inform the development of a proposal for a regional nursing documentation quality improvement project.

4.0 Methodology

4.1 Databases were searched through the interface Health On the Net Northern Ireland (HONNI). A number of searches were performed in three databases: British Nursing Index (BNI), Health Management Information Consortium (HMIC) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) with the following key search words: nursing records/ documentation, individualised care plans, information systems, person centred care/ patient centred care, patient records, multi-professional records, electronic records and medical records. This search was limited to 5 years which gave a total of 218 abstracts. A similar search was performed for text books producing three possible titles of which one was relevant, one had minimal relevancy and one is still in request at time of writing. It should be noted that midwifery was not included in the search, as the single Regional Hand Held Maternity Record is nearing completion within Northern Ireland at present and is therefore not under consideration.

4.2 Abstracts were scanned for relevancy and selected papers printed giving a total of 39 papers of which 22 were relevant. The main discussion points within the selected 22 papers were summarised and logged for thematic analysis (Appendix A). Summaries were then examined, main themes recorded and tallied for frequency (Appendix B). Of the 17 main themes identified, 7 occurred at a frequency of 3 or above and will be discussed in the body of this paper.

5.0 Main Discussion

5.1 *The Value and Purpose of Record Keeping*

5.1.1 The perception of nursing staff as to the value and purpose of documentation can predict some of the other factors that influence the quality of record keeping such as: when recording is completed and the time spent making a record; what information is recorded and the enthusiasm with which the task is completed[9]. In fact Pelletier et al[9] argued that record keeping is cited as a source of job dissatisfaction amongst nursing personnel.

5.1.2 In a Norwegian project to look at the standards of written records within a mental health setting following the passing of legislation relative to health personnel records, Kalsen[10] found that a raised awareness of the importance of documentation in line with professional accountability sharpened the focus of practitioners across professions as to the need for improved standards. This encouraged ownership of quality improvement in collaboration with other professions which resulted in sustained improvement of standards of record keeping.

5.1.3 Vaz and Whitby[7] recognised the need to articulate the purpose of record keeping for nursing staff within a palliative care setting. They found that clearly defining the rationale and purpose of assessment raised awareness and refocused staff as to what should be recorded in their documentation.

5.1.4 With reference to multi-professional documentation, whilst nurses play a critical role in documenting the totality of patient's care due to their on-going presence with those in their care[11], there are not always shared views between professions as to what each one should be documenting[12]. In order for multi-professional notes to be recorded in a meaningful way, the value of what is recorded by all of the professions must be agreed at the outset of any project to streamline documentation. This issue has an interesting facet in another respect, in that nurses do not often value their own documentation when it stands alongside records of other professions such as medicine, the medical note being viewed as that to which the most importance is applied[13]. It is argued that this perception can then devalue the worth of the nursing note thus encouraging completion of records in a manner which is below the standard required. During an ethnographic study of nursing culture which focussed on a number of ward processes in a unit in Swansea, Philpin[14] found that nurses did place value around record keeping seeing the nursing note as a protection against litigation. It was suggested in this paper that the notion of devaluing this process originates in the fact that nursing historically was predominantly an oral profession.

5.2 *Issues Related to Time*

5.2.1 A theme occurring within literature linked to the perceived value and purpose of record keeping was that of the time at which notes were recorded on shift, also taking into account the length of time nurses spent in the process of documentation. The time that nursing notes were recorded was noted as opportunistic, as opposed to being a structured part of the working day, usually when direct patient care had ceased and in the time frame that was left before direct care commenced again[9 14]. Authors noted that recording also took place away from the patient, thereby not involving the patient in the process.

5.3 *Patient Awareness/ Inclusion*

5.3.1 This separate issue was raised in three papers, where the suggestion was made that giving patients the opportunity to read and contribute to their own documentation when appropriate, promoted collaboration in care, knowledge of treatment and prevented errors in records[1] [15]. The individual's awareness of the importance of a contemporaneous record of care was also an issue, many patients of the view that the nursing staff are 'just' writing and not, in fact, engaging in a vital component of their care[7]. Enabling staff to change their practices in terms of when and where documentation occurs in collaboration with patient education to raise awareness of the importance of record keeping was argued as a vital component for raising the quality of standards for documentation.

5.4 *Information Recorded*

5.4.1 The issue of the perceived underpinning purpose of records was often linked to the quality of what was recorded, one leading to the other. Often the historical culture, individual registrant mannerisms or understanding of what was important, linked to ward culture and influence of more experienced staff dictated the content of documents[10] [16]. The tendency to record medical treatments instead of nursing interventions was also noted[17] with many of the studies observing inaccuracies and insufficiencies in the information supplied, along with lack of evaluation and inclusion of professional opinion[18] [19]. Carpenito-Moyet[20] suggests that many nurses have been taught to write as much as possible, operating under a philosophy of 'it wasn't recorded it wasn't done', rather than accurately reflecting the status of the client/ patient and their ongoing treatment or care.

5.5 *Competence to Record*

5.5.1 Addressing the competence of nurses to complete records through a range of methodologies was a theme considered in a

number of the selected papers, and was irrespective of whether the discussion focussed on one profession or multi-professions. Internationally, some of the skills particular to health assessment or advanced assessment recording have been included in under-graduate programmes for nursing staff[21]. The competence to record correctly was seen as an important facet of maintaining high quality nursing documentation[7 22], training programmes cited regularly as part of a quality improvement initiative.

5.6 *Audit and Professional Supervision*

5.6.1 Also discussed, and occasionally in conjunction with the development of competence, was professional supervision and audit as methods to improve the quality of record keeping. Where audit occurred, the standards against which benchmarking took place were usually developed locally guided by national and international evidence[10 23]. It is noteworthy that where guidelines have been used to develop audit or benchmarking tools, they often included those of the Nursing and Midwifery Council[24] which are currently under review in light of the new Code[25]. Cheevakasemook et al[26] cited rolling audit as a method of continuous quality improvement for record keeping. Such evidence has prompted others to develop their own standards which in turn allowed the creation of simple tools for self assessment of record keeping standards. Quality improvement projects were often carried out in tandem with training and development programmes[7 10 23] where audit carried the clear responsibility of learning through measurement, and was not merely for use as a method of indicating quality. One study had included the use of the Plan-Do-Study-Act cycle[27] (PDSA)[7] to improve practice relative to recording of patient assessment linked to an audit methodology.

5.6.2 Professional supervision and the influence of other more senior members of staff were discussed as having both a negative and positive effect on the quality of record keeping. Bad record

keeping habits impacted through the example set by senior staff which was found to be a negative influence over the practice of less experienced registrants[10]. Conversely, professional supervision was found to be of benefit against prescribed standards for record keeping[28]. This included multi-professional supervision with pharmacy and medical colleagues to assist with record keeping skills [28 29 30]. One study looked at the learning and development linked to quality improvement through multi-professional group supervision where individuals were tasked with auditing and learning from 30 case records per month[31]. The value from this exercise was viewed as outweighing the time required to release staff for the period of time required.

6.0 Conclusion

6.1 From this literature review it is clear that there are many, diverse factors which influence the standard of record keeping within the nursing profession, most of which may be addressed appropriately in a manner which the evidence suggests, will lead to quality improvement. It is noteworthy that relatively few of the papers selected included the redesign of documentation per se, in fact most discussiohs concentrated on aspects of quality improvement. Nahm and Poston[32] however, in their study recorded an increase in patient satisfaction following the introduction of standardised documentation in an American hospital and Thompson and Wright[1] noted significant quality improvement in multi-professional record keeping following their project to develop a unified standardised record. The key areas of values and perception, purpose, determining what is recorded, competence to record, inclusion of the patient in recording, timing of and time spent recording, audit and professional supervision clearly, from the literature explored, have an influence over the quality of record keeping.

6.2 In order to inform development of a project proposal the following key issues are offered for discussion:

1. The priority or ranked importance of the 7 issues identified
2. The influence these issues have relative to the intended purpose of developing a single regional nursing documentation.

Appendix A
Table of Document Summaries

Document	Summary
Carpenito-Moyet, L.J. (2009) *Nursing Care Plans and Documentation.* 5th Edition. Philadelphia. Lippincott Williams and Wilkins.	Text book with minimal relevance, main area for discussion around attributes of nursing documentation, relative to the purpose and focus, the accountability of the nurse for documentation and the link to client satisfaction that quality documentation has. Also mentions the misconception that recording a large amount of detail will appropriately capture what is needed.
Coward, R. (2008) *Information Governance in NHS Scotland: A Competency Framework.* Edinburgh, NHS Education for Scotland. (Consultation document).	Competency framework for all NHS staff dealing with issues such as freedom of information, data protection and confidentiality. Broad brush approach addressing issues on 4 tiers of knowledge and skills – foundation, intermediate levels 1 and 2 and 'advanced knowledge and skills'.
Davies, S., Priestly, M.J. (2006) A reflective evaluation of patient handover practices. *Nursing Standard.* 20, 21, 49-52.	This reflective account written by a student nurse, academically analysed the handover process and within that context the documentation which is used by individuals to inform those handing over. The literature review showed that the patient documentation is rarely referred to for handing over with information being recalled from memory. A template was developed for the handover process which gave brief details of the status of the patient which streamlined the information handed on.
Durkin, N. (2006) Using record review as a quality improvement process. *Home Healthcare Nurse.* 24, 8. 492-504.	This study looked at the value of study groups who were multi-disciplinary in essence and who reviewed 30 case records a month – the learning that came from completing the exercise was said to outweigh the release of time from the clinical area.
Granger, R. (2003) An introduction to England's integrated care records service. *British Journal Of Healthcare, Computing And Information Management.* 20, 10, 22-24.	Short paper on the introduction of an electronic record (which is still being worked on for the region of England). One issue addressed is the need to ask repeated questions from patients for each episode of care. Also requirement to repeat this information during one episode – an average of 13 times. Common problem for structuring electronic records is that there is no regional commonality, which, it is postulated, gives rise to ineffective sharing of information from one local system to another. The basis of the care record was to house all of the information relative to each patient in one place allowing a 'cradle-to-grave' record. (Piece in NHS confederation 15/12/08 states that project has reached a pivotal point in their development – possibility of major 'rethink' mentioned – now already 4 years behind schedule and on target for 2015.
Green, S.D. and Thomas, J.D. (2008) Interdisciplinary Collaboration and the Electronic Medical Record. *Paediatric Nursing* 34, 3: 225-240.	Nurses play the most critical role in documenting the totality of patients' care due to nurses' on-going presence with hospitalized patients (Langowski, 2005). This study surveyed 37 physicians on the relevance of nursing documentation within an electronic recording system in

Cont/d	the US. Key findings were that there were: *Incongruent views among physicians and nurses regarding pertinent patient data.* For successful nurse – physician collaboration to occur the required elements were: • Antecedents to changes in patient status • Documentation of changes in status • Nursing interventions performed in response to changes in status • Documentation of physician notification • Outcomes of interventions *Lack of nursing narrative.* • Summaries of incidents which occurred in the absence of the physician. *Lack of documented nursing observation of patients' psychosocial issues.* It is pertinent to note that these evaluations were based on a brief electronic record. Warning from the authors against reducing nursing documentation to mere checklists in an effort to reduce the workload of nursing staff. They are not advocating that this area should not be explored, merely refined to include information which is meaningful to the care setting and useful to aid patient recovery/ peaceful death.
Griffiths, P., Debbage, S. & Smith, A. (2007) A comprehensive audit of nursing record keeping practice. *British Journal of Nursing*. 16, 21: 1324-1327.	Cheevakasemook et al (2006) state that one way to ensure that high standards of record keeping are maintained is through continuous clinical audit, where areas of improvement may be identified (Dimond, 2005a). Local standards were developed using the guidance available from the NMC (2005), the NHS litigation authority (2006) and the Royal College of Physicians (2007). 19 criteria and 91 standards were established. The learning from auditing was that through the audit cycle documentation was improved – this was in tandem with an education programme based on the findings of the baseline audit. There appears to be the appointment of record keeping leads or champions within each clinical area also – although this is mentioned in passing only. The audit was to be rolled out to include other members of the MDT.
Hellesø, R. (2006) Information handling in the nursing discharge note. *Journal of Clinical Nursing*. 15: 11-21.	This study focuses on the information contained within the nursing discharge note in an effort to streamline for transfer to an electronic form. Ammenwerth et al (2001) stated that the use of structured forms to assist nursing documentation was a helpful pre-requisite for moving towards and electronic record. 3 phases of the nursing process are mentioned: nursing diagnosis, intervention, and outcome. Svennevig (2001) states that there is the use of a language function in recording which gives the record a personal slant or note depending on the viewpoint of the recorder. Study concluded that the language nurses use is not always accurate or helpful and also that a

	structured record assisted the transfer of information.
Hutchinson, C. & Sharples, C. (2006) Information governance: practical implications for record-keeping. *Nursing Standard.* 20, 36. 59-64.	Discussion around what a health record is and agreement that there is no universal template for a contemporaneous record. Good tables as to the principles and standards articulated by the NMC and Essence of Care. Common mistakes in nurses' record keeping according to Dimond (2005) are: • Spelling mistakes • Inaccurate recordings • Missed information • Statements that identify a need but do not follow up with the action required or evaluation • Includes professional opinion or supposition (Taylor 2003)
Ismail, Z.F. et al. (2006) Improving safety for patients with allergies: an intervention for improving allergy documentation. *Clinical Governance: An International Journal.* 13, 2. 86-94.	This study looked at the possible reasons as to why allergies are not recorded correctly. Pharmacists had a significantly higher rate of recording allergies correctly. The conclusion of this and other studies like it was to locate a pharmacist in the A&E department for review and advice relative to all drug histories (Foreshaw, 2005). Whilst it was identified that this intervention would be a costly one, Fertleman et al. (2005) argued that such measures would lead to significant cost savings and a reduction in drug errors through improving patient safety. Also suggested is raising awareness multi-professionally relative to allergies.
Kalsen, R. (2007) Improving the nursing documentation: professional consciousness-raising in a Northern-Norwegian psychiatric hospital. *Journal of Psychiatric and Mental health Nursing.* 14: 573-577.	This article covers the journey of a mental health team to look at their nursing documentation after Norway brought in new legislation for health personnel (2001), increasing the demands for quality in nursing documentation. Interestingly this legislation required nursing notes to be an integral part of the patient medical record. This is in line with current thinking around professional documentation where a heightening of the importance of a written report makes the professions more aware of their accountability and responsibility (Bjørvell et al., 2003). The background to this project was through a request for teaching around documentation and legal responsibilities. The lecturer contacted, requested to work with staff to audit records made by the against documentation quality standards and then develop a tool which staff could use to self evaluate their recording. The professional standards used to benchmark were those of the NMC's Guidelines for Records and Record Keeping (2005). There was a slight difference arising from the setting of mental health – the records are seen as patient journals and the tone of 'parlance' from the nursing documentation is of consequence. Common issues were: • goals of care were too abstract and not easily measured • records were focussed on what an individual saw as important to record rather than what was actually important to record

	• recording had a hidden nursing plan which harked back to the days when mental health nursing was more about guard duty than recovery (Prior, 1993) • diagnostic systems adopted by senior members of staff were adopted by junior members of staff and repeated Findings were that raising awareness and ensuring ownership of the requirement to change practice meant sustained improvement.
Kenyon, E. (2003). Partnership in Care: The Implementation of a Model of Nursing Documentation. In Shaw, T. and Sanders, K. (Eds) *Foundation of Nursing Studies Dissemination Series*. Vol.1. no. 10.	Summary of a project to pilot documentation which allowed joint medical and nursing assessment in partnership with the parents and children within the unit. Resulted in a challenge to way of planning care and reported higher levels of communication, clearer definition of roles and greater inclusion of parents in the care of their child. Interestingly the project tried to encourage parents to make entries to the documentation but they were reluctant to do so. Questionnaire was used to ascertain the opinions of nursing staff within the directorate. 3 models of care were considered – Fawcett (1995), Neuman (1989), and Leininger (1991). A team working together developed documentation lifting elements of the three models to inform - this was also in conjunction of work with medical colleagues to identify the elements of a history which would be important. Subsequent audit after implementation showed positive outcomes – mainly related to partnership working with the parents of children.
Kramer, J.S. et al. (2007) Implementation of an electronic system for medication reconciliation. *American Journal of Health-System Pharmacy*. 64, 404-422.	Journal article outlining a project to implement an electronic record of medicines for admissions and discharges. Adverse drug reactions are responsible for 3-9% of hospital admissions in the USA (Peyiere et al, 2003). This system employed the skills of pharmacy and nursing to achieve accurate records of prescribed and non-prescribed medications taken by patients prior to admission. The study demonstrated the value of pharmacy led admission procedures and discharge – the reduction in drug prescription and therefore related budgets and both major and minor medication incidents reduced allowed the organization to fund a full time pharmacist for multi-professional ward rounds.
McCloskey, R. (2006) Documentation: Challenges and recommendations specific to long-term care. *Canadian Nursing Home*. 17, 3. 4-9.	Documentation most common reason cited by staff for overtime (Moody & Snyder, 1995). This article cites Pelletier et al (2005) frequently. Chronicles the difficulties arising from the increasing need for acute care within long term care facilities – patients discharged to care homes with more complex needs. Vloutilainen et al (2004) noted that staff were more likely to document medical treatments than their own observations. Writer comments that principles for record keeping are only of use when they are translated appropriately for the setting. <u>Perry & Potter (2001) Principles of documentation:</u> 1. Importance of application of policy and standards.

	2. Factual reporting – objective reporting and not subjective (e.g. reporting that patient is anxious). 3. Adherence to standards for written entries
Müller-Staub, M. et al. (2007) Improved quality of nursing documentation: results of a nursing diagnoses, interventions and outcomes study. *International Journal of Nursing Terminologies and Classifications*. 18, 1. 5-17.	This article looks at an experimental review of the quality of nursing documentation following the implementation of NANDA, a nursing diagnosis system predominantly used in the USA, which according to the authors, has wide acclaim internationally. This is in conjunction with nursing interventions (NIV) and nursing outcomes (NOC). Based on this system where the problem is described, with the pertinent aetiology and corresponding signs, a coding can be used for nursing interventions (NIC) which is research based and recognised internationally (Oud, Sermeus & Ehnfors, 2005). There is also a list of corresponding outcomes which are again research based (Moorhead, Johnson and Maas, 2003a). The commentary on the nursing process can be summarised as: • Problems insufficiently described • Relations between nursing assessment and interventions lacking logical linkages • Nursing progress notes deficient These three issues result in uncertainty in the meaning of documentations, impaired information exchange and discontinuity of care (Bartholomeyczik, 2004). A systematic literature review of the use of nursing diagnoses (Müller-Staub et al, 2006) showed that whilst this form of coding was successfully used to identify problems, signs, symptoms and relevant aetiology were not recorded. This report pointed out the commentary that an underlying factor related to the mindset and education of nurses concerning the correct methods of documentation was required (Herr, Maas & Specht, 2000; Rivera & Parris, 2002). Bjoervell et al. (2002) found in a Swedish longitudinal study that there was significant qualitative improvement in documentation following training for registered nurses relative to the skills required for written records. Nahm and Poston (2000) also found an increase in both the quality of documentation and patient satisfaction following the introduction of standardised documentation in a US Hospital.
Oldfield, M. (2007) Case Study: changing behaviours to improve documentation and optimize hospital revenue. *Canadian Journal of Nursing Leadership*. 20, 1: 40-48.	This article helps explain why other US or Canadian articles are heavily weighted in favour of nursing diagnostics. These codes are used to secure revenue for the hospitals – they are paid against the diagnostic coding that is entered onto their systems. Thus any system which enhances the use of these codes allows and increases in their funding streams. Using broad principles applied to a coaching technique, registered nurses were seconded to review and advise clinicians regarding their documentation. They worked closely and corrected a small group until they no longer needed correction before moving onto the next group. This resulted in an average increase of $5k per patient for intensive care and $2.5 per patient within a

	hospital setting. The discussion lists a very interesting side effect of the project which was the competitive nature of the medics who normally did not do anything which was not financially rewarded. Because they were being scored on a regular basis they tried to 'out-do' colleagues and other departments which meant that the competition dynamic promoted excellence. Before long the project team had medics ringing them asking if they could take part too! Gold stars were given for achievement and some colleagues featured in the hospital newsletter.
Pelletier, D.,. Duffield, C. and Donoghue, J. (2005) Documentation and the transfer of clinical information in two aged care settings. *Australian Journal Of Advanced Nursing.* 22, 4: 40-45	Observational study of documentation habits of nursing staff in two settings found that: - *recording took place when opportunity arose as opposed to a structured part of the nurse's day* - *recording took place when patient care had ceased* Debate takes place relative to: - importance not being placed appropriately, documentation being seen as necessary 'evil' - more comprehensive records are required now because of the extended roles of nursing and midwifery - nursing documentation bears out the effectiveness of treatment by medical staff and AHP staff - record keeping can be a source of job dissatisfaction multiple modalities and forms of documentation
Philpin, S. (2006) 'Handing over': transmission of information between nurses in an intensive therapy unit. *British Association of Critical Care Nurses: Nursing in Critical Care.* 11, 2: 86-93.	This study was an ethnographic study of the nursing culture within an ITU in Swansea. The study focused on a number of processes within the ward and documentation was a by-product of the observation phase. The researcher noted that the completion of nursing notes was generally undertaken during a 'lull' of nursing activity. The purpose of the nursing note was highlighted – that of an account of the patient's status and also to note was the nurse has done during the shift. This author noted the value of the nursing documentation to nurses themselves. Street (1992) and Allen (2001) both noted a devaluing of nursing notes on the part of nursing staff when compared with other documentation such as medical notes. In Philpin's study this was not found to be the case; however there was a sense of the records being there to protect the 'backs' of the nursing staff. It is suggested that nursing has been traditionally an oral profession and this is where the devaluing originates.
Pothier, D et al. (2005) Pilot study to show the loss of important data in nursing handover. *British Journal of Nursing.* 14, 20: 1090-1093.	This study was a quasi-experimental approach to studying the behaviours of nurses during handover and the amount of information relative to patient care which is inaccurately transferred or not transferred at all. Three methods were studied – verbal, written and a pro-forma for transfer of information. The pro-forma was found to be the most accurate for the

	transfer of information. The study did not stipulate how frequently the handover 'sheet' was completed i.e. daily etc. but that there was more than one copy for a single episode demonstrating that a refreshing of information was completed.
Powell, J. (2006) Sharing electronic health records. *Informatics in Primary Care*. 14, 1; 55-57.	Paper published some time after the initiation of the electronic records system pilots and roll out. Short article documents the fact that there are concerns regarding the accuracy of patient records. Some of the issues are around the sharing of information to other facilities – the information is held on a central database. 31 patients were polled to give guidance on sensitive issues – there were a wide range of issues which they did not want held centrally including mental health records. 10/31 found pieces of their records which were incorrect, including one incorrect drug sensitivity. This study recommended actually giving patients their own notes to read to uncover inaccuracies. Study was limited because it was a small study with patients who were acutely unwell or distressed excluded.
Rushforth, H. (2008). Reflections on a study tour to explore history taking and physical assessment education. *Nurse Education in Practice*. 8, 31-40	Paper discusses the policy context relative to nurses taking advanced health assessment commenting on the current literature which states that this can make important enhancements to care delivery (Rushforth et al., 2000; Kinley et al., 2002).in America these skills are taught at pre-reg level already (Jarvis, 2002). Writer was conducting a study tour to gain insight into the teaching elements of other countries for advanced health assessment practice. Otherwise, discussion not relevant except to mention that mental health assessment is highlighted as an area for consideration.
Thompson, D. & Wright, K. (2003) *Developing a Unified Patient Record: A Practical Guide*. Abingdon, Radcliffe Medical Press.	Book detailing the issues of creating a unified record. The approach used was that of keeping the patient central to the development process, as opposed to the professions and their requirements from the record. Also looked at the timeframe of the record, with the commencement of the collection of information within A&E – the record merely carried forward into the ward environment to continue. The assessment tool was based on the Barthel assessment – a validated clinical tool for assessing physical function. The plan of care is guided by evidence based protocols and plans of care which are standardised and also on care guidelines which are developed when the need arises for individual plans. There are a series of quite complex daily, weekly and hourly records of care which amount to tick boxes against fields of experience or clinical condition. The patient is assessed as having needs within six areas of care -: hygiene, pressure area care, mobility, intake, communication and discharge. Reporting is by exception. There is quite a high level of collaboration with the patient, the record having sections which require a daily discussion with the patient as to how they feel. There is also a part of their record on which they may write themselves or their relatives – there are suggestions as to what they might write which include concerns or issues or questions they

	would like answered about their stay in hospital. There is a chapter in the book relative to sustaining change. This project took place with no additional funding with the exception of one practice development nurse to project manage the development process. A significant help was the raising of awareness of the staff, the commitment and drive of the PD nurse, extensive piloting and readjustment of the records and regular audit to show and monitor improvement.
Tulloch, A., et al (2007) Admission and discharge practices: High Dependency Unit Audit Outcome. *Contemporary Nurse*. 24: 15-24.	This study primarily looked at the criteria for admission to and discharge from an HDU in Australia in order to provide a protocol. Another discovery from the study was that documentation was poorly competed – if completed at all.
Vaz, H. & Whitby, A. (2006) Nursing admission assessment documentation (NAAD): A quality improvement project. *Nursing Monograph 2006*. 20-24.	Problem was identified relative to documentation in palliative care setting. Issues were also detailed relative to assessments being repetitive and patients being required to give similar answers to a number of health care professionals during their stay. (Issue about reading information carried in notes first). This article chronicles the journey of a project managed to correctly assess and intervene in bad practice to increase the quality of practice. This covered five areas – 1. the paper work 2. patient education as to the importance of the assessment 3. staff documentation competencies 4. the rationale for assessment – staff awareness of the importance 5. time practicalities PDSA cycle was used to implement new ways of working and a patient focus group tested an initial form, discussing the approach to completing the form. Interestingly the team used a screening tool for depression as a part of their assessment form. Monthly audits monitored the implementation phase, but gave no information as to the efficacy of the documentation.

Appendix B

Themes From Selected Papers.

Theme	Summary of theme	Inclusion in papers
Use of care protocols	The use of care protocols to guide care-planning in documentation where organisationally agreed protocols are cited in a record.	1
Reporting by exception	Written records made only when treatment and care other than that planned was given.	1
Use of record keeping links/ leads	One project structure included and relied on, personnel identified as a multi-professional link within each organisation that would champion good record keeping principles and act as a resource/ communication conduit.	1
Multiple modalities of record keeping templates	Recognition of the multiple templates used for record keeping and the difficulties in attempting to standardise.	1
Review of model of documentation	Description of the need to review the model under which care was prescribed for relevance and currency. This included the acknowledgement that the models the organisations were using were no longer fit for purpose.	2
Repetition of questions for patients during assessment	Identification of repetition of questioning during assessment by numerous health care professionals and the anxiety this causes to patients/ clients.	2
Value of streamlining records prior to implementation of electronic record systems	Description of the value of streamlining record templates to one single template which is a necessary project prior to the introduction of electronic models of record keeping.	2
Increased accuracy of pharmacy led drug histories during assessment	Introduction of pharmacists into history taking for medications. One project found the savings from drug errors and mis-prescribed medications enough to fund a pharmacist for A&E permanently.	2
Link to and importance relevant to handover	Description of the use of documents during handover – the fact that information is very often recalled from memory and not given directly from the notes. This information was also found to be inaccurate.	2
Significance of historical influences over record keeping	Description of how historical perceptions or influences can direct what is recorded regardless of what is known as required to be recorded. Example given was from a mental health setting where historically	2

	nursing staff were custodians for the clients. Records demonstrated references to the whereabouts of the clients as opposed to the evaluation of treatments or care. Also with this theme was a discussion on how the perceptions of more experienced staff and in some cases bad habits in record keeping can heavily influence newly qualified staff.	
Time of recording taking place	Discussion in paper	3
Patient awareness of importance/ inclusion in process	Discussion in paper	3
Professional/ multi-professional supervision as a method of quality improvement for record keeping	Discussion in paper	4
Competence to complete assessment/ documentation	Discussion in paper	6
The content of what is documented	Discussion in paper	8
Value of audit as a method of quality improvement and trigger for training	Discussion in paper	8
Staff awareness of the importance/ value placed on record keeping	Discussion in paper	9

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