



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

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Abstract:	<p>Abstract</p> <p>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.</p> <p>Aims to understand older person nurses experiences of and attitudes to documentation.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

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

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3 **'Gaps, mishaps and overlaps'. Nursing documentation: how**
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14

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33 **Box 1. Keypoints**
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35 - Complete, accurate and relevant nursing documentation is essential for the
36 multidisciplinary comprehensive geriatric assessment process which
37 improves older patient's outcomes following a hospital admission.
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39 - Older person nurses express dissatisfaction with the amount and quality of
40 documentation which is often inaccurate, inconsistent, repetitive and
41 incomplete.
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43 -Further work is required to streamline current systems, particularly in view
44 of emerging digital methods of documentation to prevent further duplication
45 and increased workload.
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51 **Abstract**
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53 Introduction: Complete, accurate and relevant nursing documentation is essential for
54 the multidisciplinary comprehensive geriatric assessment process which can improve
55 older patient's outcomes following a hospital admission.
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3 Aims to understand older person nurses experiences of and attitudes to
4 documentation.

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6 Methodology Semi- structured, in depth interviews of eight qualified nurses at an
7 acute hospital trust. Interviews were analysed using the framework approach to
8 identify key themes.
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11 Results Three overarching themes were identified: gaps, mishaps and overlaps. Gaps
12 refer to information which was missing, inaccurate or inconsistent; mishaps refer to
13 the consequences of these inaccuracies and inconsistencies and overlaps refer to the
14 problem of duplications in recording of information.
15

16
17 Discussion Older person nurses report many inconsistencies, omissions and
18 duplications in their documentation. This has implications for how nursing
19 contributes to the comprehensive geriatric assessment and the quality of care of older
20 patients.
21

22 Recommendations for practice New ways must be found to minimise and streamline
23 existing documentation to ensure that records are complete, timely and person-
24 centred. Nurses should be mindful that emerging digital technology systems do not
25 create further problems. Ward nurses need to take greater control of development of
26 documentation.
27

28 29 30 Summary statement

31 32 **Why is this research or review needed?**

- 33
- 34 - There is a forecast increase in the numbers of older people in acute settings.
- 35 - Older patients often have complex healthcare needs requiring comprehensive
- 36 geriatric assessment and a multidisciplinary team.
- 37 - Documentation in older person care acute settings must be of a standard that
- 38 provides an accurate record of assessment, decision-making, care planning and
- 39 treatment in order to ensure accurate communication between the
- 40 multidisciplinary team of healthcare professionals.
41

42 43 44 • **What are the key findings?**

- 45
- 46 - Documentation in its present form is judged, by the nurses who use it, to be
- 47 ineffective and in some cases, detrimental to good quality care.
- 48 - Nurses expressed a need to record information and felt it offered some form of
- 49 protection.
- 50 - Nurses expressed dissatisfaction with the current system of documentation,
- 51 deeming it to contain inaccuracies, omissions and duplication.
52

53 54 55 • **How should the findings be used to influence** 56 **policy/practice/research/education?** 57

- 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

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3 older person living with frailty over five domains (physical and mental health,
4 functional ability, social support and environment), to inform a plan of care that
5 improves patient outcomes (Welsh et al, 2014). There is evidence that use of CGA
6 increases life expectancy and the ability to return home following an emergency
7 admission to hospital (Ellis et al, 2011). It requires a multidisciplinary team approach
8 supported by accurate and meaningful documentation to ensure the delivery of safe
9 and effective quality care to older people.
10

11 **Introduction**

14 Guidelines from the Nursing and Midwifery Council which is the nursing regulatory
15 body of the United Kingdom, The Nursing and Midwifery Council (NMC, 2009)
16 emphasize the importance of accurate record keeping. The Nursing and Midwifery
17 Council code of conduct (NMC, 2015) states that nurses have a professional
18 obligation to maintain clear and accurate records. However, there is a concern that an
19 imbalance exists in the amount of time nurses spend on paperwork compared to direct
20 patient care. A survey of 6387 members of the Royal College of Nursing found that
21 86% of nurses believed that non-essential paperwork had increased over the previous
22 two years with 81% of them claiming that paperwork prevented them from spending
23 time with patients (Sprinks, 2013).
24

26 A report commissioned into the failures in care at Mid Staffordshire NHS foundation
27 Trust in England highlighted failures in communication between 2005-2008 (The
28 Francis Report, 2013). One of 290 recommendations made by Lord Francis included
29 that information systems must be designed by healthcare professionals and avoid
30 'unnecessary duplication' (Francis, 2013, p.111).
31

33 The amount of paperwork nurses must complete has increased over time with
34 speculation that a million hours a week were spent completing paperwork in 2008
35 (Nursing Standard, 2008). Keenan et al (2008) highlight how current record keeping
36 practices are failing to support nursing practice and stress the importance of
37 developing solutions.
38

40 Systems of recording nursing documentation include computerised records. However,
41 opinion as to whether this increases time spent or saves time have previously been
42 mixed (Lee et al, 2002). For instance, a study by Moody et al (2004) assessed the
43 attitudes of one hundred nurses towards electronic documentation and found that
44 seventy five percent of nurses believed it to improve the quality of documentation.
45 The same study found that seventy six percent of nurses assessed believed that the
46 electronic format would lead to improvements in the safety of patient care (Moody et
47 al, 2004). However, a study looking at the effect on nursing care of an electronic
48 nursing documentation found that such a system may not necessarily lead to greater
49 efficiency (Munyisia et al, 2012). Nevertheless, further research in this area is
50 necessary as it is unclear as to whether the use of electronic nursing documentation
51 improves the care of patients (Kelley et al, 2011).
52

54 The move towards capturing data at the bedside by recording patient observations
55 using electronic hand held apparatus, such as smart devices, has the potential to grow
56 with the possibility of recording nursing documentation and extra facilities such as
57 photographing pressure ulcers to assess and evaluate care.
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4 Complete, accurate, relevant and timely documentation is always important, but is
5 particularly so in the care of older people. This is because of the complexities of care
6 in such a client group, and the subsequent need for good communication between
7 members of the multidisciplinary team who must work closely together to deliver care
8 within the comprehensive geriatric assessment framework. Previous work into
9 examining the use of documentation in older person care (Hardey et al, 2000)
10 highlights the dynamic nature of nursing documentation.
11

12
13 This study aims to understand how documentation may affect the quality of care in
14 one acute hospital trust in England by understanding the experiences of registered
15 nurses towards the documentation used while working in older person care in acute
16 hospitals wards.
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19 A qualitative approach **was** adopted in order to strengthen the understanding of
20 meaning a person gives to a situation without the need for statistical analysis (Rose,
21 1994). Thematic content analysis **was** used to allow the researcher to employ
22 systematic means in an attempt to understand the perceptions of others (Burnard,
23 1991). This research attempts to answer the research question through qualitative
24 means by interviewing registered nurses about their views of nursing documentation.
25

26 **Methods**

27 Study Design

28
29 An interview study analysed using the framework approach.
30

31 Sampling and Data Collection

32
33 Recruitment and data collection was completed in February 2015. The researcher was
34 a registered nurse working as a Staff Nurse with years of experience caring for older
35 patients in the acute hospital and was conducting the study towards a Master's Degree
36 dissertation. The researcher aimed to interview only nurses she was not familiar with,
37 on wards she had not worked on, but because of difficulties finding registered nurses
38 who were able to take time out of their shift to be interviewed, an opportunistic
39 sample was used. The interviewer did not work directly with six of the participants at
40 the time of the interviews, but had previously worked with two of the participants.
41 Participants were recruited from acute medical healthcare of the older person wards in
42 a large acute Hospital Trust in England. These areas were chosen because of the
43 multiple comorbidities found among the patient group; the use of the comprehensive
44 geriatric assessment tool; and multidisciplinary team approach in such a setting.
45 Registered nurses working for the trust were included. Agency nurses were excluded
46 from the study because the researcher wanted views from nurses who were familiar
47 with the documentation over a longer period of time than only one shift.
48 The matron of the unit was initially approached to discuss the research and was given
49 information about the study. Following this all ward managers were sent letters
50 inviting them to participate in the study and were asked for written permission for the
51 researcher to access ward areas. Posters were displayed in clinical areas to inform
52 nurses about the study. The nurse in charge approached nurses to be potential
53 participants. The nurses decided if they wished to take part and were then introduced
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3 to the researcher. Participants gave written informed consent and took part in a face to
4 face semi structured interview. The interview guide was developed and piloted prior
5 to use. Initially topics were selected from the literature and subsequent topics were
6 added if they arose during the interview. Topics included: documents completed and
7 how they directed care, what documentation helped with care and why, problems with
8 documentation and time spent on documentation (box 3). Interviews were conducted
9 in a quiet room on the ward. All interviews were audio recorded and field notes were
10 made during the interview. The participants were reassured that privacy,
11 confidentiality and identity would be protected.
12

13 14 Data Analysis

15 16 17 18 Box 3: Semi-structured interview questions

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

58 59 60 Ethics

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4 Research ethics committee approval was obtained (ethics reference number:
5 T17112014 SoHS 14109)
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10 Results

11 A total of eight nurses were interviewed. To demonstrate diversity of the sample
12 population, and to maximise the variety of responses, efforts were made to include a
13 wide variety of nurses from different backgrounds. These included male (n=2), female
14 (n=6), black and minority ethnicity (n=2), deputy sister or above (n=2), experience in
15 nursing over ten years (n=3). The figures do not add up because of diversity within
16 the interviewee population; for example experience did not equate with level of
17 seniority with one nurse in a senior position not having been qualified for many
18 months whereas one staff nurse had been qualified for over thirty years, and several of
19 the participants possessing more than one of the stated characteristics. The eight
20 interviews lasted between seven and sixty minutes.
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23
24 Analysis of the data found several common themes. Themes included issues around
25 time; amount of **documentation**; inaccuracies; surveillance; defensive practice. For the
26 purpose of this study will focus on three only. Firstly, gaps in information which
27 refers to information which was missing, inaccurate or inconsistent. Secondly,
28 mishaps refer to the consequences of these inaccuracies and inconsistencies. Thirdly,
29 overlaps refer to the repetition and duplications in written records.
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31

32 Gaps

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34 Inaccuracies in documentation were identified by participants including omissions, or
35 gaps, of essential information necessary for the delivery of safe care. Nurses spoke of
36 their frustration in systems that are incompatible leading to potentially problematic
37 situations
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41 *'...we don't have access to EDISS [electronic documentation system] so we*
42 *can't get next of kin and that's happened on a couple of occasions'*
43 *(participant 8)*
44

45 When gaps in documentation were found, assumptions were sometimes made that
46 care had been carried out for the patient. In such cases, nurses sometimes reported that
47 documentation had been completed retrospectively without full knowledge that care
48 had actually been done
49

50
51 *'...there's been a couple of times I've had to point out to health care assistants*
52 *when ...then maybe the skin bundle wasn't completed overnight and the care*
53 *assistants being told it should be done every 2 hours that they thought oh he*
54 *hasn't done it oh I might as well. I'll just fill it in for them overnight and I'm*
55 *saying you CAN'T really cos you're just making up that that he MIGHT have*
56 *done the care and gone home and forgotten to write it down...but you can't*
57 *just make it up (laughs)'* (participant 4)
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4 Further examples of gaps in the documentation emerged,
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7 *'...I just find those tick sheets with regards the post fall are just not filled out*
8 *correctly at all...and it it you're kind of left wondering well did anyone ring*
9 *the relatives?...'* (Participant 8)
10

11 while others described potentially dangerous gaps, or missing information, in the
12 documentation,
13

14
15 *'...the patient collapsed on the floor, we all went running there and then I got*
16 *to see what she came in with and there were NOTHING no no evidence of*
17 *what she came in for, NOTHING....'* (Participant 1).
18
19

20 Further evidence emerged of missing documentation despite simple systems in place,
21 such as a sticker to document in the medical notes when a patient has fallen,
22

23
24 *'the point is again...I am seeing it with the documentation and the instance*
25 *when I'm going back.... it's just not there...even simple things you know like the*
26 *stickers in the notes ...it's a sticker (laughs) stick it in the notes what...yeah it's just*
27 *yeah it's just missing...'* (Participant 8).
28

29 Missing and inaccurate documentation appeared to be problematic to nurses as it
30 created problems, or mishaps, which will now be discussed.
31

32 Mishaps 33

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35 Inaccuracies were reported within the documentation as regards peripheral cannulas.
36 Evidence emerged of nurses recommending completing accompanying documentation
37 prior to checking cannulas in an attempt to complete documentation that they knew
38 would be audited at a later date,
39

40
41 *'...someone told me it would be quicker if I filled in all the VIPS [a tool to*
42 *assess cannulas] at the beginning of the shift when I was doing the handover*
43 *and then look at them later on...'* (Participant 4)
44

45 And so led to a counterproductive and substandard service with patients receiving
46 inappropriate care and an increased risk of developing phlebitis,
47

48
49 *'...cos again I've quite often found cannulas that... someone's been that*
50 *they've been signing on for DAYS and on for DAYS and this persons going*
51 *this really hurting me this cannula ...'* (Participant 4)
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53 With one participant reporting documented care which appeared not to correspond
54 with the condition of the patient,
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3 *'... I check paperwork as a deputy sister role, checking that documentation is*
4 *done right and they've ticked something and haven't actually done it'*
5 (Participant 1).
6

7 One nurse expressed exasperation at the time needed to complete documentation with
8 no apparent effect on care,
9

10 *".....its time consuming, it's repetitive..."* (Participant 6)
11

12 Overlaps

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15 Finally, nurses expressed exasperation over the excessive amount of time it took to
16 complete paperwork which they felt was often repetitious, of no benefit and took them
17 away from the patient. This resulted in the omission of important information,
18 inaccuracy, duplication and potential safety concerns. Nurses described how staff
19 were unable to find the necessary information, despite information being recorded
20 numerous times,
21

22
23 *'... you're writing several, same bits of information in several different*
24 *places...'* (Participant 6)
25

26 *'...the doctor was asking me today to do a...a urine dip on a patient that had*
27 *already been done and documented...it obviously wasn't looked at closely*
28 *enough so you know there's an argument for like do you actually need any*
29 *paperwork if nobody looks at it?'* (Participant 5)
30

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33 *'...there is a vast amount of paperwork.....they've got reams and*
34 *reams...especially the care plans you see its just absolutely full of printed*
35 *word....'* (Participant 1)
36

37 With evidence of paperwork filed away and left unused,
38

39
40 *'...I do think some of the documentation we do is absolute ...waste of time...*
41 *as in like the care plans on admission because they're ... they're done..THEN*
42 *and I've not known one person or healthcare professional to look at them ever*
43 *AGAIN and they're just filed away'* (Participant 5)
44

45
46 One nurse appeared to be a deviant case in that she expressed her total satisfaction
47 with the documentation and initially did not have anything negative to say about it,
48 describing how she found the documentation important and helpful and how it made
49 her feel safe. On further probing, she revealed that the reason for this was that due to
50 being extremely busy she had previously omitted to record a patient's observations
51 following a patient fall despite having done them. As a result, she had subsequently
52 been reproached by the ward manager.
53

54
55 It is possible that the gaps, mishaps and overlaps with documentation may result in
56 actual harm to patients due to sub-optimal care delivery; however, documentation
57 may be protective to nurses if they need to demonstrate care delivery.
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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;

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3 Glover et al, 2014). They are also at risk of poor outcomes (Bradshaw et al, 2013).
4 Their care requires a comprehensive geriatric assessment (CGA) which involves a
5 multidisciplinary approach. The information nurses collect and record is
6 fundamental to the success of CGA as nurses are both the only healthcare profession
7 who are with the patient 24 hours a day and provide the most frequency and intimate
8 care, meaning they have access to information none of the other healthcare
9 professionals have. Accurate and timely written information is vital to the safe
10 delivery of care to this vulnerable group of patients.
11

12
13 The findings raised a number of professional and ethical issues in that nurses were
14 reporting sub optimal and potentially unsafe care. In compliance with ethical
15 obligations of a researcher the researcher is in regular contact with the nursing
16 development team at the Trust to discuss the findings in order to raise awareness and
17 improve care. The findings can support future developments in regard to supporting
18 nurses to focus on efficient and effective completion of documentation.
19

20 21 Strengths and limitations

22
23 A registered nurse who understood nursing documentation and the acute care needs of
24 older patients living with frailty conducted the interviews and analysed the data.
25 However, the researcher was known to two of the participants and this may have
26 affected their answers to questions. Nevertheless, the researcher spent time reflecting
27 on their effect on the research by using a reflective diary and discussing issues with
28 the supervisor. The data are limited by coming from a single English National Health
29 Service hospital, but the hospital provides sole emergency medical services for its
30 local population, and is likely to be representative. The sample size was small, but
31 efforts were made to ensure a representative sample. The sample was registered
32 nurses in current practice who wanted to express their views on documentation.
33 Despite this a larger study may generate different findings.
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37 38 Recommendations for practice

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41 Complete and accurate nursing documentation is vital to the acute care of older
42 patients living with frailty, but the current system of documentation in this particular
43 setting was perceived to be counterproductive to safe and effective care and as such
44 needs to be extensively revised. One suggestion is a bespoke, generic manual with
45 core care plans for common conditions within each specialty to address the biological
46 nursing needs. This can be regularly updated with current evidence based practice
47 guidelines. Nurses can then prescribe care in the patients notes by detailing, for
48 example, 'care as per breathing care plan version 1.1, dated...' and cite which version
49 they are using with addendums as required for further personalised information
50 particular to each patient in order to tailor an individualised plan of care.
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54 A smaller document at the patients' bedside with details of what is most important to
55 them while they are in hospital and a completed 'this is me' form (Alzheimer's
56 society, 2015). Also asking the patient, 'what do I need to know about you as a person
57 to give you the best care possible?' (Johnston et al, 2015) which would result in a
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3 person centred care plan while providing evidence based care from a biomedical
4 viewpoint with the generic manual.
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6 This system will allow nurses to have more control over the planning of care as it can
7 be amended as required but will not generate large amounts of paperwork.
8

9
10 Streamlining documentation within organisations and ensuring compatibility of
11 different systems will ensure accuracy. This will help to prevent overlaps, repetition,
12 gaps and accidents or near misses through the absence of important information. Any
13 new systems of documentation should be researched to ensure they meet the needs of
14 patients and the multidisciplinary team working with them.
15

16 17 **Conclusion**

18 Documentation is vital to ensure good quality communication, and this is particularly
19 important in the acute care of older patients living with frailty.
20

21
22 Previous studies have shown that despite a need for efficient documentation in this
23 specialty, there still exists a lack of accuracy with nurses viewing documentation in a
24 negative light. This research supports previous work in this area as nurses feel there is
25 excessive documentation and it is often inaccurate, inconsistent, repetitive and
26 incomplete.
27

28
29 In view of the increased numbers of people needing care and a forecast global
30 shortage of nurses, new ways must be found to streamline and reduce the amount of
31 nursing documentation to support the delivery of quality care. The emergence of
32 electronic methods of documentation appears to present a unique opportunity to
33 develop a systematic way of record keeping which will streamline the process and
34 prevent repetition of information which has been shown by this study to be often
35 counterproductive to the process.
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3 **'Gaps, mishaps and overlaps'. Nursing documentation: how**
4 **does it affect care?** (Word count 3901)
5
6

7 Correspondence (anon)

8
9
10 E-Mail (anon)

11
12 Keywords: nursing documentation, paperwork, care plan, nursing process, audit,
13 comprehensive geriatric assessment, geriatric nurse, frailty, nurses, nursing.
14

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16 Conflict of interest None declared.

17
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21 Author details (anon)
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27 **Box 1. Keypoints**

- 28
29
30 - Complete, accurate and relevant nursing documentation is essential for the
31 multidisciplinary comprehensive geriatric assessment process which
32 improves older patient's outcomes following a hospital admission.
33
34 - Older person nurses express dissatisfaction with the amount and quality of
35 documentation which is often inaccurate, inconsistent, repetitive and
36 incomplete.
37
38 -Further work is required to streamline current systems, particularly in view
39 of emerging digital methods of documentation to prevent further duplication
40 and increased workload.
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46 **Abstract**

47
48 Introduction: Complete, accurate and relevant nursing documentation is essential for
49 the multidisciplinary comprehensive geriatric assessment process which can improve
50 older patient's outcomes following a hospital admission.
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52
53 Aims to understand older person nurses experiences of and attitudes to
54 documentation.
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3 Methodology Semi- structured, in depth interviews of eight qualified nurses at an
4 acute hospital trust. Interviews were analysed using the framework approach to
5 identify key themes.
6

7 Results Three overarching themes were identified: gaps, mishaps and overlaps. Gaps
8 refer to information which was missing, inaccurate or inconsistent; mishaps refer to
9 the consequences of these inaccuracies and inconsistencies and overlaps refer to the
10 problem of duplications in recording of information.
11

12 Discussion Older person nurses report many inconsistencies, omissions and
13 duplications in their documentation. This has implications for how nursing
14 contributes to the comprehensive geriatric assessment and the quality of care of older
15 patients.
16

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

26 **Why is this research or review needed?**

- 27 - There is a forecast increase in the numbers of older people in acute settings.
- 28 - Older patients often have complex healthcare needs requiring comprehensive
29 geriatric assessment and a multidisciplinary team.
- 30 - Documentation in older person care acute settings must be of a standard that
31 provides an accurate record of assessment, decision-making, care planning and
32 treatment in order to ensure accurate communication between the
33 multidisciplinary team of healthcare professionals.
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40 **• What are the key findings?**

- 41 - Documentation in its present form is judged, by the nurses who use it, to be
42 ineffective and in some cases, detrimental to good quality care.
- 43 - Nurses expressed a need to record information and felt it offered some form of
44 protection.
- 45 - Nurses expressed dissatisfaction with the current system of documentation,
46 deeming it to contain inaccuracies, omissions and duplication.
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50 **• How should the findings be used to influence 51 policy/practice/research/education?**

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

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3 improves patient outcomes (Welsh et al, 2014). There is evidence that use of CGA
4 increases life expectancy and the ability to return home following an emergency
5 admission to hospital (Ellis et al, 2011). It requires a multidisciplinary team approach
6 supported by accurate and meaningful documentation to ensure the delivery of safe
7 and effective quality care to older people.
8

9 10 **Introduction**

11
12 Guidelines from the Nursing and Midwifery Council which is the nursing regulatory
13 body of the United Kingdom, The Nursing and Midwifery Council (NMC, 2009)
14 emphasize the importance of accurate record keeping. The Nursing and Midwifery
15 Council code of conduct (NMC, 2015) states that nurses have a professional
16 obligation to maintain clear and accurate records. However, there is a concern that an
17 imbalance exists in the amount of time nurses spend on paperwork compared to direct
18 patient care. A survey of 6387 members of the Royal College of Nursing found that
19 86% of nurses believed that non-essential paperwork had increased over the previous
20 two years with 81% of them claiming that paperwork prevented them from spending
21 time with patients (Sprinks, 2013).
22

23
24 A report commissioned into the failures in care at Mid Staffordshire NHS foundation
25 Trust in England highlighted failures in communication between 2005-2008 (The
26 Francis Report, 2013). One of 290 recommendations made by Lord Francis included
27 that information systems must be designed by healthcare professionals and avoid
28 'unnecessary duplication' (Francis, 2013, p.111).
29

30
31 The amount of paperwork nurses must complete has increased over time with
32 speculation that a million hours a week were spent completing paperwork in 2008
33 (Nursing Standard, 2008). Keenan et al (2008) highlight how current record keeping
34 practices are failing to support nursing practice and stress the importance of
35 developing solutions.
36

37
38 Systems of recording nursing documentation include computerised records. However,
39 opinion as to whether this increases time spent or saves time have previously been
40 mixed (Lee et al, 2002). For instance, a study by Moody et al (2004) assessed the
41 attitudes of one hundred nurses towards electronic documentation and found that
42 seventy five percent of nurses believed it to improve the quality of documentation.
43 The same study found that seventy six percent of nurses assessed believed that the
44 electronic format would lead to improvements in the safety of patient care (Moody et
45 al, 2004). However, a study looking at the effect on nursing care of an electronic
46 nursing documentation found that such a system may not necessarily lead to greater
47 efficiency (Munyisia et al, 2012). Nevertheless, further research in this area is
48 necessary as it is unclear as to whether the use of electronic nursing documentation
49 improves the care of patients (Kelley et al, 2011).
50

51
52 The move towards capturing data at the bedside by recording patient observations
53 using electronic hand held apparatus, such as smart devices, has the potential to grow
54 with the possibility of recording nursing documentation and extra facilities such as
55 photographing pressure ulcers to assess and evaluate care.
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3 Complete, accurate, relevant and timely documentation is always important, but is
4 particularly so in the care of older people. This is because of the complexities of care
5 in such a client group, and the subsequent need for good communication between
6 members of the multidisciplinary team who must work closely together to deliver care
7 within the comprehensive geriatric assessment framework. Previous work into
8 examining the use of documentation in older person care (Hardey et al, 2000)
9 highlights the dynamic nature of nursing documentation
10

11
12 This study aims to understand how documentation may affect the quality of care in
13 one acute hospital trust in England by understanding the experiences of registered
14 nurses towards the documentation used while working in older person care in acute
15 hospitals wards.
16

17
18 A qualitative approach **was** adopted in order to strengthen the understanding of
19 meaning a person gives to a situation without the need for statistical analysis (Rose,
20 1994). Thematic content analysis **was** used to allow the researcher to employ
21 systematic means in an attempt to understand the perceptions of others (Burnard,
22 1991). This research attempts to answer the research question through qualitative
23 means by interviewing registered nurses about their views of nursing documentation.
24

25 **Methods**

26 Study Design

27
28 An interview study analysed using the framework approach.
29

30 Sampling and Data Collection

31
32 Recruitment and data collection was completed in February 2015. The researcher was
33 a registered nurse working as a Staff Nurse with years of experience caring for older
34 patients in the acute hospital and was conducting the study towards a Master's Degree
35 dissertation. The researcher aimed to interview only nurses she was not familiar with,
36 on wards she had not worked on, but because of difficulties finding registered nurses
37 who were able to take time out of their shift to be interviewed, an opportunistic
38 sample was used. The interviewer did not work directly with six of the participants at
39 the time of the interviews, but had previously worked with two of the participants.
40 Participants were recruited from acute medical healthcare of the older person wards in
41 a large acute Hospital Trust in England. These areas were chosen because of the
42 multiple comorbidities found among the patient group; the use of the comprehensive
43 geriatric assessment tool; and multidisciplinary team approach in such a setting.
44 Registered nurses working for the trust were included. Agency nurses were excluded
45 from the study because the researcher wanted views from nurses who were familiar
46 with the documentation over a longer period of time than only one shift.
47

48 The matron of the unit was initially approached to discuss the research and was given
49 information about the study. Following this all ward managers were sent letters
50 inviting them to participate in the study and were asked for written permission for the
51 researcher to access ward areas. Posters were displayed in clinical areas to inform
52 nurses about the study. The nurse in charge approached nurses to be potential
53 participants. The nurses decided if they wished to take part and were then introduced
54 to the researcher. Participants gave written informed consent and took part in a face to
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3 face semi structured interview. The interview guide was developed and piloted prior
4 to use. Initially topics were selected from the literature and subsequent topics were
5 added if they arose during the interview. Topics included: documents completed and
6 how they directed care, what documentation helped with care and why, problems with
7 documentation and time spent on documentation (box 3). Interviews were conducted
8 in a quiet room on the ward. All interviews were audio recorded and field notes were
9 made during the interview. The participants were reassured that privacy,
10 confidentiality and identity would be protected.
11

12 Data Analysis

13 Box 3: Semi-structured interview questions

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

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37 Following interview, data were transcribed verbatim. In depth scrutiny of data meant
38 the researcher was not only able to examine the content but also the structure, and
39 speaking style of the participant (Mason, 1996) which allowed for analysis further
40 than the literal sense of the data and to see the content and context in which it was
41 gathered, namely the clinical area of qualified nurses. This allowed for the discovery
42 of themes of which the researcher was then able to use framework analysis to
43 summarise and classified the data (Ritchie and Spencer, 1994). Framework analysis
44 is a flexible approach often utilised in health service research that allows all data to be
45 collected and then analysed. The organisation of data within this approach involved a
46 five stage process (Richie and Spencer, 1994). Firstly familiarisation with data
47 involved constant comparison across the data to identify categories and themes.
48 Transcripts are then coded to identify recurrent statements and expressed feelings
49 which formed the basis of the thematic framework. Themes were then compared and
50 contrasted between participants by indexing, charting and mapping to provide a
51 detailed understanding and interpretation of the participants' experiences. The coding
52 framework was developed by LC and agreed with SG, through regular meetings and
53 discussions.
54
55

56 Ethics

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3 Research ethics committee approval was obtained (ethics reference number:
4 T17112014 SoHS 14109)
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8 Results

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10 A total of eight nurses were interviewed. To demonstrate diversity of the sample
11 population, and to maximise the variety of responses, efforts were made to include a
12 wide variety of nurses from different backgrounds. These included male (n=2), female
13 (n=6), black and minority ethnicity (n=2), deputy sister or above (n=2), experience in
14 nursing over ten years (n=3). The figures do not add up because of diversity within
15 the interviewee population; for example experience did not equate with level of
16 seniority with one nurse in a senior position not having been qualified for many
17 months whereas one staff nurse had been qualified for over thirty years, and several of
18 the participants possessing more than one of the stated characteristics. The eight
19 interviews lasted between seven and sixty minutes.
20
21

22
23 Analysis of the data found several common themes. Themes included issues around
24 time; amount of **documentation**; inaccuracies; surveillance; defensive practice. For the
25 purpose of this study will focus on three only. Firstly, gaps in information which
26 refers to information which was missing, inaccurate or inconsistent. Secondly,
27 mishaps refer to the consequences of these inaccuracies and inconsistencies. Thirdly,
28 overlaps refer to the repetition and duplications in written records.
29
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31 Gaps

32
33 Inaccuracies in documentation were identified by participants including omissions, or
34 gaps, of essential information necessary for the delivery of safe care. Nurses spoke of
35 their frustration in systems that are incompatible leading to potentially problematic
36 situations
37

38
39
40 *'...we don't have access to EDISS [electronic documentation system] so we*
41 *can't get next of kin and that's happened on a couple of occasions'*
42 *(participant 8)*
43

44 When gaps in documentation were found, assumptions were sometimes made that
45 care had been carried out for the patient. In such cases, nurses sometimes reported that
46 documentation had been completed retrospectively without full knowledge that care
47 had actually been done
48

49
50 *'...there's been a couple of times I've had to point out to health care assistants*
51 *when ...then maybe the skin bundle wasn't completed overnight and the care*
52 *assistants being told it should be done every 2 hours that they thought oh he*
53 *hasn't done it oh I might as well. I'll just fill it in for them overnight and I'm*
54 *saying you CAN'T really cos you're just making up that that he MIGHT have*
55 *done the care and gone home and forgotten to write it down...but you can't*
56 *just make it up (laughs)'* (participant 4)
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3 Further examples of gaps in the documentation emerged,
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6 *'...I just find those tick sheets with regards the post fall are just not filled out*
7 *correctly at all...and it it you're kind of left wondering well did anyone ring*
8 *the relatives? ...'* (Participant 8)
9

10 while others described potentially dangerous gaps, or missing information, in the
11 documentation,
12

13
14 *'...the patient collapsed on the floor, we all went running there and then I got*
15 *to see what she came in with and there were NOTHING no no evidence of*
16 *what she came in for, NOTHING....'* (Participant 1).
17
18

19
20 Further evidence emerged of missing documentation despite simple systems in place,
21 such as a sticker to document in the medical notes when a patient has fallen,
22

23 *'the point is again...I am seeing it with the documentation and the instance*
24 *when I'm going back.... it's just not there...even simple things you know like the*
25 *stickers in the notes ...it's a sticker (laughs) stick it in the notes what...yeah it's just*
26 *yeah it's just missing...'* (Participant 8).
27

28 Missing and inaccurate documentation appeared to be problematic to nurses as it
29 created problems, or mishaps, which will now be discussed.
30
31

32 Mishaps 33

34 Inaccuracies were reported within the documentation as regards peripheral cannulas.
35 Evidence emerged of nurses recommending completing accompanying documentation
36 prior to checking cannulas in an attempt to complete documentation that they knew
37 would be audited at a later date,
38

39
40 *'...someone told me it would be quicker if I filled in all the VIPS [a tool to*
41 *assess cannulas] at the beginning of the shift when I was doing the handover*
42 *and then look at them later on...'* (Participant 4)
43

44 And so led to a counterproductive and substandard service with patients receiving
45 inappropriate care and an increased risk of developing phlebitis,
46

47 *'...cos again I've quite often found cannulas that... someone's been that*
48 *they've been signing on for DAYS and on for DAYS and this persons going*
49 *this really hurting me this cannula ...'* (Participant 4)
50
51

52 With one participant reporting documented care which appeared not to correspond
53 with the condition of the patient,
54

55 *'... I check paperwork as a deputy sister role, checking that documentation is*
56 *done right and they've ticked something and haven't actually done it'*
57 (Participant 1).
58
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4 One nurse expressed exasperation at the time needed to complete documentation with
5 no apparent effect on care,
6

7 *“.....its time consuming, it’s repetitive...”* (Participant 6)
8

9 Overlaps

10
11 Finally, nurses expressed exasperation over the excessive amount of time it took to
12 complete paperwork which they felt was often repetitious, of no benefit and took them
13 away from the patient. This resulted in the omission of important information,
14 inaccuracy, duplication and potential safety concerns. Nurses described how staff
15 were unable to find the necessary information, despite information being recorded
16 numerous times,
17

18
19
20 *‘... you’re writing several, same bits of information in several different*
21 *places...’* (Participant 6)
22

23
24 *‘...the doctor was asking me today to do a...a urine dip on a patient that had*
25 *already been done and documented...it obviously wasn’t looked at closely*
26 *enough so you know there’s an argument for like do you actually need any*
27 *paperwork if nobody looks at it?’* (Participant 5)
28

29
30 *‘...there is a vast amount of paperwork.....they’ve got reams and*
31 *reams...especially the care plans you see its just absolutely full of printed*
32 *word.....’* (Participant 1)
33

34 With evidence of paperwork filed away and left unused,
35

36
37 *‘...I do think some of the documentation we do is absolute ...waste of time...*
38 *as in like the care plans on admission because they’re ... they’re done..THEN*
39 *and I’ve not known one person or healthcare professional to look at them ever*
40 *AGAIN and they’re just filed away’* (Participant 5)
41

42
43 One nurse appeared to be a deviant case in that she expressed her total satisfaction
44 with the documentation and initially did not have anything negative to say about it,
45 describing how she found the documentation important and helpful and how it made
46 her feel safe. On further probing, she revealed that the reason for this was that due to
47 being extremely busy she had previously omitted to record a patient’s observations
48 following a patient fall despite having done them. As a result, she had subsequently
49 been reproached by the ward manager.
50

51
52 It is possible that the gaps, mishaps and overlaps with documentation may result in
53 actual harm to patients due to sub-optimal care delivery; however, documentation
54 may be protective to nurses if they need to demonstrate care delivery.
55

56 Discussion

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3 This research reveals that nurses working with older patients living with frailty find
4 current documentation time consuming to complete and sometimes unnecessary to the
5 delivery of care, resulting in gaps, mishaps and overlaps of information.
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9 The recording of contemporaneous and confidential nursing documentation exists to
10 protect the welfare of the patient and is integral to ensuring high standards and
11 continuity of care, good communication, and accuracy and as such allows for audit to
12 maintain standards while demonstrating the professional and legal duty of care to the
13 patient (NMC, 2005). This research illustrates how the current system of nursing
14 documentation is perceived by nurses to be counterproductive to safe and effective
15 care. It is a legal and professional requirement of nurses on the Nursing and
16 Midwifery Council professional register in the United Kingdom to maintain clear and
17 accurate records in order to deliver safe and effective care to patients (NMC, 2015).
18 This resonates with the interviewed nurses who expressed a need to record
19 information.
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22 However, the findings also support findings in earlier literature. For example, Mason
23 (1999) found that nurses viewed care plans negatively and the majority of
24 documentation had no apparent influence on care. A mixed methods study of nursing
25 documentation complexities (Cheevakasemsook, 2006) showed poor completion of
26 documentation, disruption, incomplete and inappropriate charting. A literature review
27 by Burt et al (2014) found a lack of specificity in care plans and care planning with
28 insufficient evidence of the effect on outcomes and on factors that affect benefit to
29 patients. An observational study of transactions between nurses and patients
30 (Airdroos, 1991) showed that care was found to be lower quality when care plans
31 were used. Broderick and Coffey (2013) in a qualitative descriptive study of 56
32 records of nursing documentation of older people in care homes found many records
33 to be incomplete and that the structure of documentation can be an obstacle to person
34 centred care. Research involving interviews, observations and an assessment of
35 documentation showed that only 40% of nursing care was actually documented and an
36 increase in nurse workload correlated with a decrease in the amount of documentation
37 written (De Marinis et al, 2010). All of which were supported by the participants'
38 comments in the interviews.
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42 A meta synthesis of 14 qualitative research reports showed that the structure of
43 documentation and organisational presuppositions may prevent recording of
44 individualised patient care (Karkkainen et al, 2005). This research adds to the body of
45 knowledge in that it concurs with these findings and offers a contemporaneous
46 viewpoint from registered nurses in current practice, the pace and intensity of which
47 has accelerated in recent years.
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50 The implication of these findings is particularly important for the hospital care of
51 older patients living with frailty. These patients have high levels of cognitive
52 impairment from dementia or delirium which can result in problems of
53 communication. They have multiple co-morbidities, functional problems, behavioural
54 and psychiatric problems and many are reaching the end of life (Goldberg et al, 2012;
55 Glover et al, 2014). They are also at risk of poor outcomes (Bradshaw et al, 2013).
56 Their care requires a comprehensive geriatric assessment (CGA) which involves a
57 multidisciplinary approach. The information nurses collect and record is
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3 fundamental to the success of CGA as nurses are both the only healthcare profession
4 who are with the patient 24 hours a day and provide the most frequency and intimate
5 care, meaning they have access to information none of the other healthcare
6 professionals have. Accurate and timely written information is vital to the safe
7 delivery of care to this vulnerable group of patients.
8

9
10 The findings raised a number of professional and ethical issues in that nurses were
11 reporting sub optimal and potentially unsafe care. In compliance with ethical
12 obligations of a researcher the researcher is in regular contact with the nursing
13 development team at the Trust to discuss the findings in order to raise awareness and
14 improve care. The findings can support future developments in regard to supporting
15 nurses to focus on efficient and effective completion of documentation.
16

17 Strengths and limitations

18
19 A registered nurse who understood nursing documentation and the acute care needs of
20 older patients living with frailty conducted the interviews and analysed the data.
21 However, the researcher was known to two of the participants and this may have
22 affected their answers to questions. Nevertheless, the researcher spent time reflecting
23 on their effect on the research by using a reflective diary and discussing issues with
24 the supervisor. The data are limited by coming from a single English National Health
25 Service hospital, but the hospital provides sole emergency medical services for its
26 local population, and is likely to be representative. The sample size was small, but
27 efforts were made to ensure a representative sample. The sample was registered
28 nurses in current practice who wanted to express their views on documentation.
29 Despite this a larger study may generate different findings.
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34 Recommendations for practice

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37 Complete and accurate nursing documentation is vital to the acute care of older
38 patients living with frailty, but the current system of documentation in this particular
39 setting was perceived to be counterproductive to safe and effective care and as such
40 needs to be extensively revised. One suggestion is a bespoke, generic manual with
41 core care plans for common conditions within each specialty to address the biological
42 nursing needs. This can be regularly updated with current evidence based practice
43 guidelines. Nurses can then prescribe care in the patients notes by detailing, for
44 example, 'care as per breathing care plan version 1.1, dated...' and cite which version
45 they are using with addendums as required for further personalised information
46 particular to each patient in order to tailor an individualised plan of care.
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50 A smaller document at the patients' bedside with details of what is most important to
51 them while they are in hospital and a completed 'this is me' form (Alzheimer's
52 society, 2015). Also asking the patient, 'what do I need to know about you as a person
53 to give you the best care possible?' (Johnston et al, 2015) which would result in a
54 person centred care plan while providing evidence based care from a biomedical
55 viewpoint with the generic manual.
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3 This system will allow nurses to have more control over the planning of care as it can
4 be amended as required but will not generate large amounts of paperwork.
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6 Streamlining documentation within organisations and ensuring compatibility of
7 different systems will ensure accuracy. This will help to prevent overlaps, repetition,
8 gaps and accidents or near misses through the absence of important information. Any
9 new systems of documentation should be researched to ensure they meet the needs of
10 patients and the multidisciplinary team working with them.
11

12 13 14 **Conclusion**

15
16 Documentation is vital to ensure good quality communication, and this is particularly
17 important in the acute care of older patients living with frailty.
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20 Previous studies have shown that despite a need for efficient documentation in this
21 specialty, there still exists a lack of accuracy with nurses viewing documentation in a
22 negative light. This research supports previous work in this area as nurses feel there is
23 excessive documentation and it is often inaccurate, inconsistent, repetitive and
24 incomplete.
25

26 In view of the increased numbers of people needing care and a forecast global
27 shortage of nurses, new ways must be found to streamline and reduce the amount of
28 nursing documentation to support the delivery of quality care. The emergence of
29 electronic methods of documentation appears to present a unique opportunity to
30 develop a systematic way of record keeping which will streamline the process and
31 prevent repetition of information which has been shown by this study to be often
32 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