Reducing time spent on ritualistic documentation with an A,B,C,D approach

A review of what and how nurses are documenting care provided to ultimately reduce incidence of avoidable pressure ulcer categorisation due to poor documentation

Heather Hodgson, Lead Nurse Tissue Viability & Sean Chambers, Senior Charge Nurse NHS Greater Glasgow and Clyde

Record only the abnormal or deviation from care plan
Entries on other records do not need to be duplicated
Free up time by recording only what you have to
Look at care rounding chart before recording care carried out
Ensure bedside charts all updated
Care plan must be checked and updated
Time will be saved if you only document what is required and not duplicate

A	Abnormal results and observations	Only abnormal results and observations should be recorded and what has been done to address the abnormality for example – patient developed pressure ulcer on heel, referral made to podiatry.
B	Bedside charts	The main focus for the registered nurse is ensuring that the bedside charts are up to date and reflect the care that has been delivered on that shift, The Care Rounding Chart must be checked and any gaps in care rectified.
C	Essential communication	Only essential communication for the clinical team needs to be recorded.
D	Deviation from care plan	Only deviation from care plan needs to be recorded, but it is essential that the care plan is updated and is person centred.

Situation

•Documentation is an integral part of a registered nurse's day. The 'writing up' in a patient's notes can account for at least 10% of a nurse's time and in a 30 bedded ward this can equate to around eight hours of registered nurse time.

•Whilst undertaking case note reviews, as part of the process of determining why a pressure ulcer occurred, it is apparent that up to 100% of what is documented in nursing notes is ritualistic recording and not required since the information recorded is recorded elsewhere, or recording the norm, so essentially double recording for example 'medicines as charted' 'observations as charted' 'catheter patent and draining well'. However the documentation at the bedside, in particular care rounding charts are not completed adequately.

•The gaps in care rounding has led to numerous hospital acquired pressure ulcers being categorised as avoidable. Since the care has not been recorded as being delivered there is also the possibility that the care has not actually been delivered leading to pressure damage.

Background

•Registered nurses and HCSWs participated in two informal focus groups where patient records were randomly selected and examined to determine what was actually written and why some content was included for example 'medicines as per kardex' the other areas explored was 'care as per care plan' and 'care as per care rounding' as findings from red day reviews have identified that this is documented without the registered nurse actually checking the care plan or care rounding charts.

•Outcome of the focus groups revealed the following:
•Up to 45 minutes were spent by each nurse, each shift documenting in the continuation sheet.
•Up to 100% of what was recorded was recorded elsewhere or not required.
•There was a realisation that the process was ritualistic.
•Opportunity to save time was identified.
•Realisation to only record what is required and not duplicate.

Action

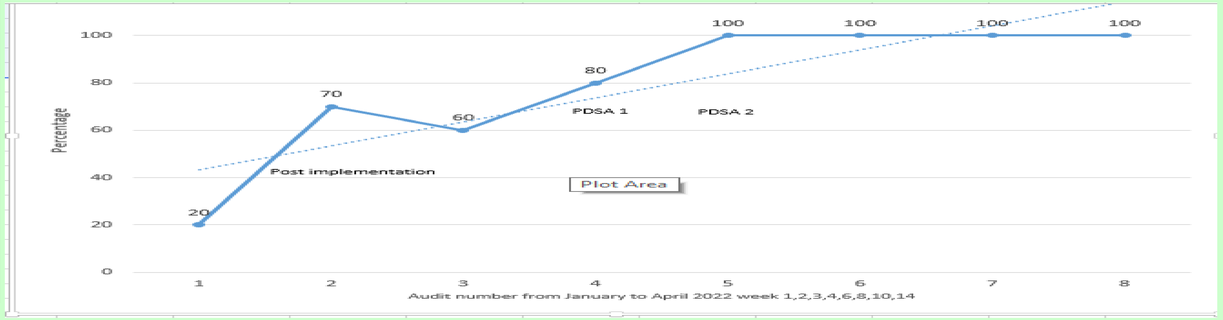
There needs to be a change in what and how registered nurses are documenting and the registered nurses need to recognise that they have the responsibility to ensure that the care prescribed in care rounding is delivered, this is often the responsibility of health care support workers and students and registered nurses focus on documenting in the nursing continuation sheet of which up to 100% is unnecessary. To address this a test of change was required and a redesign what and how nursing interventions are recorded.
The main goals of this test of change being:
Stop ritualistic documentation
Efficient and effective use of the registered nurse's time
Good quality bedside documentation that actually reflect the care that was carried out
Reduction of hospital acquired pressure damage developing and/or being classified as avoidable due to incomplete documentation
The test of change aim was to achieve this by supporting nurses to undertake an ABCD approach as described below:

Unannounced audits of ten sets of notes were undertaken randomly at different times of the day over a fourteen week period. To ensure continuity it was the same person – Lead Nurse for Tissue Viability that undertook the audits.

Two PDSA cycles were completed during the process to enhance communication about the project in particular with visiting, bank and agency staff not familiar with the project.

The results are displayed in the run chart below.

After the two PDSA cycles the ward maintained a rate of 100% of the documentation met the standard required.



Recommendations

Registered nurses must **REFLECT** on how much time they are dedicating to documentation and reflect on what and why they are documenting and avoid duplication.

Acknowledgements

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