ABCD – is a documentation framework to allow you to have up to date and accurate person centred records without duplication.

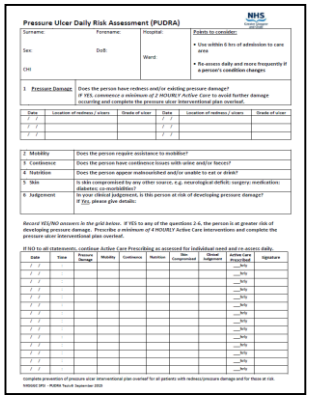
ABCD

A – abnormal results: hypotensive, pressure ulcer present, confusion

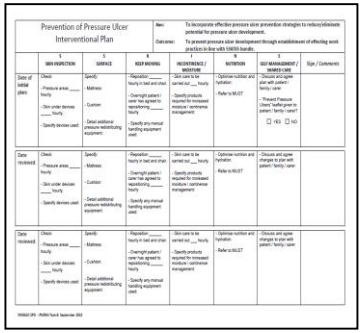
B – bedside charts: For example: **PUDRA, Care plans, Care rounds, Wound Assessment, Falls assessment, Bed rails assessment…all must be checked at each shift and updated if and when required.**

C – essential communication: document anything that needs communicated that is not captured in any other record

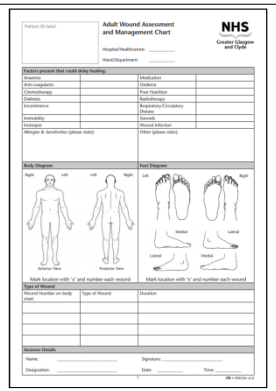
D – deviation: document any deviation from care plan for example pillows used as refusing Prolevo boots



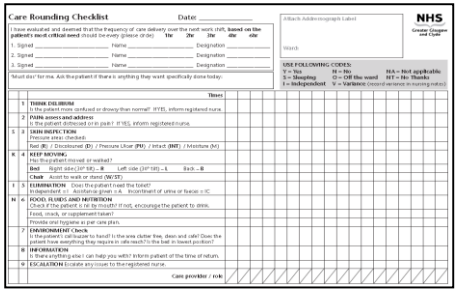
PUDRA



PUDRA care plan

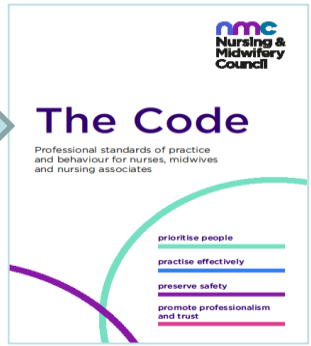


Wound chart



Care Rounds

Do not write *'bed end charts checked and updated'* **if you have not checked and updated**



10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

V.3 April 25