Essentials of Documentation, Nursing audit, Nursing Research and Evidence Based Mental Health Nursing

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The Objectives

- To discuss the purposes, principles, and challenges of documentation
- To reiterate the guidelines for good practice in recording clinical practice
- To help the nurses to understand the methods of nursing audit and how to conduct nursing audit
- To clarify the differences between nursing audit and nursing research
- To instil the knowledge about the methods of nursing research and to analyse the chances of nursing research in their area of practice and
- To emphasise the concept of evidence based nursing and to find the way to overcome the barriers to evidence based nursing
Documentation

Documentation is communication regarding care of clients/patients and can be hand written or printed or stored in audio visual systems.

‘Documentation of care is synonymous with care itself’
- Ferrel K.G (2007)
Purpose of Documentation

- A means of communication
- Permanent record of patient care
- A means of professional responsibility and accountability
- Provides proof of practice and malpractice
- Is a legal document
- As a basis for evaluating the quality and appropriateness of health care provided
- Main source for research and evidence-based nursing practice
- Helps in planning and budgeting and
- Aids health care facilities in getting re-imbursement of services provided to clients
Principles of Documentation

- Be objective
- Be specific
- Be clear and consistent
- Record all relevant information including communication with other members of the health care team
- Respect confidentiality and
- Recording errors
Challenges of Documentation

- Shortage of staff
- Inadequate knowledge concerning the importance of documentation
- Shortage of materials for documentation and
- Numerous types of documentation requirements
Documenting consent to treatment

- The age of consent to treatment is 16 years
- Document the discussion and interactions with patients about planning care
- Consent to nursing care should be presumed
- Although written consent is not required for most nursing care, the procedure involving significant risk should be explained to patient and documented
- The agreement of the patient to the procedure should be documented
Documenting consent to treatment

- Nurses should obtain consent for procedures that they themselves will complete. Medical or other health care staff are responsible for obtaining consent for procedures or treatments that they will perform.

- Refusal of recommended procedure / treatment should be documented

- Any information or advice given to a patient about the possible consequences of such refusal should be documented
Legal consideration

- Use of records in criminal prosecutions
  - All information document should be factual and not based on summation
  - Comments with regard to third parties should always be documented as such

- Nursing Legal Claims
  - The statute of limitations
  - Storage of records
Use of records in nursing research

- Ethical approval

- Principles of privacy, confidentiality, and anonymity must be respected
Guidelines for documentation

- Clear
- Concise
- Complete
- Contemporary
- Consecutive
- Correct

- Comprehensive
- Collaborative
- Patient-centred
- Confidential
- Authentic
Guidelines for good practice in recording clinical practice
Guidelines for good practice in recording clinical practice

1. The quality of nurse’s record keeping should be such that continuity of care for a patient / client / family is always supported
2. All narrative notes are individualized, accurate, up to date, factual and unambiguous
3. All written records are legible
4. All entries are signed
5. All entries are dated
6. Entries in the records are in the chronological order
7. Documentation in the record is carried out as soon as possible after providing nursing care
Guidelines for good practice in recording clinical practice

8. All entries are timed, especially where the condition of the patient / client is changing or liable to change frequently
9. Abbreviations should only be used if drawn from a list approved by the healthcare facility
10. Accepted grading systems should only be used
11. Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated
12. A nurse / making referral consulting with another member of the healthcare team should clearly identify by name, the person in the record
13. All decisions to take no immediate action but review the situation later (‘wait and see’) should be documented
14. Any information, instruction or advice given, including discharge advice, by a nurse to patient should be documented
Guidelines for good practice in recording clinical practice

15. All written data in respect of a patient family should be kept in a designated area with a view to forming a complete single record

16. The patient’s name and record number (hospital number) should appear on every page of the record

17. Nurses should not, as a general rule, record or document care on behalf of someone else

18. The standard of record keeping of those under supervision in the clinical area

19. Regular audit is an integral part of maintaining quality records
Name: BBB

Finding of the Fitness to Practise Committee: Professional Misconduct.

That Mr. BBB, being a registered nurse, while employed as a Staff Nurse at X Hospital, in respect of the care afforded to a patient in his care (the “Patient”):

On or around 20 June 2011:
- failed to administer insulin to the Patient, in a timely manner and/or at all;
- failed to take and/or record the Patient’s blood glucose levels in circumstances where he knew or ought to have known that this was required; and/or
- failed to carry out and/or arrange any or any adequate patient assessment following his failure to administer the insulin referred to above;
- failed to report adequately or at all his failure to administer the insulin referred to above;

On or around 23 and/or 24 June 2011:
- failed to administer insulin to the Patient, in a timely manner and/or at all;
- failed to record that the insulin referred to above, had not been administered in a timely manner and/or at all;
- failed to take and/or record the Patient’s blood glucose levels in a timely manner and/or at all when he knew or ought to have known that this was required;
- failed to carry out and/or arrange any or any adequate patient assessment following his failure and/or delay with respect to the administration of the insulin referred to above;
- failed to report adequately his delay in administering the insulin referred to above;
- made a record at or around 23.00 that “due insulin” had been given when he knew or ought to have known that this was not the case;
- wrote the initials of another nurse, Ms X, in the Insulin Medication Record when he knew or ought to have known that this was not appropriate;
- altered the Insulin Medication Record by crossing out Ms X’s initials when he knew or ought to have known that this was inappropriate and/or when he knew or ought to have known that he should have initialed this alteration;
- Failed to act in the best interests of the Patient and/or put the health and/or welfare of the Patient at risk.

Sanction: Pursuant to Section 41(1) of the Nurses Act, 1985, Mr. BBB was censured in relation to his professional conduct.
Finding of the Fitness to Practise Committee: Professional Misconduct

That you, being a registered nurse, while employed as a staff nurse at X Hospital:

In respect of a mediastinoscopy carried out on a patient, “Mr X”, on or around 5th May 2011, when you were the designated “scrub nurse”:

- Failed to adhere to X Hospital “Care and Preservation of Specimens - Guideline”
- Failed to ensure appropriate care and/or management and/or preservation of the specimen(s) removed from Mr X.
- **Failed to ensure that the specimen(s) were documented** in the specimen log book;
- On one or more dates after 5 May 2011, told Ms. A, Clinical Nurse Manager 3, and/or the X Hospital Investigation Team that no specimens were taken when you ought to have known this to be untrue;
- Failed to act in the best interests of Mr X.

**Sanction:** Pursuant to Section 41(1) of the Nurses Act, 1985, Mr. was censured in relation to his professional conduct.
Think!

- Have you ever witnessed any documentation error?
- How did you manage the situation?
- Is there any suggestions or views?
‘Nursing audit is a process of collecting information from nursing reports and other documented evidence about patient care and assessing the quality of care by the use of quality assurance programmes’
Purposes of audit

- Evaluating nursing care given
- Achieves deserved and feasible quality of nursing care
- As stimulant to better records
- Focuses on care provided and not on care provider
- Contributes to research
Methods of nursing audit

- Retrospective review
- Concurrent review
Methods to develop audit tool

1. Define patient population
2. Identify a time framework for measuring outcomes of care
3. Identify commonly recruiting nursing problems presented by the defined patient population
4. State patient outcome criteria
5. State acceptable degree of good achievement
6. Specify the source of information
7. Design and type a of tool
Points to consider

I. Quality assurance must be a priority
II. Those responsible must implement a program not only a tool
III. A co-ordinator should develop and evaluate quality assurance activities
IV. Roles and responsibilities must be delivered
V. Nurses must be informed about the process and the results of the program
VI. Data must be reliable
VII. Adequate orientation of data collection is essential
VIII. Quality data should be annualized and used by nursing personnel at all levels
Audit as a tool for quality control

- Outcomes audits
- Process audit and
- Structure audit
Advantages of nursing audit

- Can be used as a method of measurement in all areas of nursing
- Seven functions are easily understood
- Scoring system is fairly simple
- Results easily understood
- Assess the work of all those involved in recording care
- Maybe an useful tool as part of a quality assurance program in areas where accurate records of care are kept
Disadvantages of nursing audit

- Appraises the outcomes of the nursing process, it is not so useful in areas where the nursing process has not implemented.
- Many of the components overlap making analysis difficult.
- Is time consuming.
- Requires a team of trained auditors.
- Deals with large amount of information.
- Only evaluates record keeping. It only serves to improve documentation not using care.
Differences Between Audit and Research

**Audit**
- Is not randomised
- Compare actual performance against standards
- Conducted by those providing the service
- Usually led by service providers
- Does not involve investigation of new treatments, but evaluates the use of current treatments

**Research**
- May be randomised
- Identifies the best approach and then sets the standards
- Not necessarily provided by those providing the service
- Usually initiated by the researchers
- Involves comparators between new treatments and placebos
<table>
<thead>
<tr>
<th>Audit</th>
<th>Research</th>
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<tbody>
<tr>
<td>Involves review of records by those entitled to access them</td>
<td>Requires access by those not normally entitled to access them</td>
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<tr>
<td>Ethical consent normally not required</td>
<td>Must have ethical consent</td>
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<td>Results usually not transferable</td>
<td>Results must be generalizable</td>
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<td>Hypotheses used to generate the standard</td>
<td>Testable hypothesis generated</td>
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<td>Compares performance against the standard</td>
<td>Present clear conclusions</td>
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Discuss

- Develop a sample audit tool and discuss how this will benefit your practice
Nursing Research

‘Nursing research is systematic inquiry designed to develop trustworthy evidence about issues of importance to the nursing profession, including nursing practice, education, administration, and informatics’

- Polit and Beck (2008)
Purposes of research

- Basic and applied research
- Research to achieve varying levels of explanation
- Research purposes linked to Evidence-Based Practice
  - Identification
  - Description
  - Exploration
  - Explanation
  - Prediction and Control
  - Treatment, therapy, or intervention
  - Diagnosis and assessment
  - Prognosis
  - Prevention of harm
  - Aetiology or causation
  - Meaning and processes
Exercise

- What is your view about research in nursing?
- Is it essential to give importance to nursing research? Why?
- Have you participated or facilitated any nursing research in your area of practice?
Evidence – Based Practice in Nursing

Evidence Based Nursing (EBN) is a ‘process by which nurses make clinical decisions using best available evidence, clinical expertise, and patient preferences in the context of available resources’

- DiCenso et al. (1998)
Evidence Based Nursing is:

- Building on process of research use, but more encompassing
- More specific than term ‘best practice’
- Not fostering rigid adherence to standardized guidelines
- Recognizing the role of clinical expertise
- A state of mind!
Purposes of EBN

- Fuelled by accrediting bodies, professional organizations, third party payers
- Potential to improve quality, reduce variations in care
- Focus on practices that result in best possible outcomes at possibly lower cost
- Provides a way to keep pace with advances
- Potential to narrow the research-practice gap
- Impacted by perception that published research is not relevant to practice
- Provides a means to answer problematic clinical practice issues
- Potential to improve individual bedside practice; supports/improves clinical decision making skills.
Levels of Evidence Hierarchy

- Level 1: formal, open, clinical randomised-controlled trials
- Level 2: case controlled trials (comparisons made but not randomised)
- Level 3: observational studies (including surveys and questionnaires)
- Level 4: anecdotal evidence (including independent user comments and reviews)
- Level 5: methodological verification and validation studies
EBN Process

- Identify a practice issue
- Formulate an answerable question
- Search for best evidence
- Critically evaluate the evidence and clinical relevance
- Make recommendations
- Apply to clinical practice
- Evaluate impact / effectiveness / outcomes
Barriers to EBN

- Lack of knowledge about EBN
- Lack of knowledge about library and online resources
- Inconvenient / inaccessible library / internet
- Misperceptions or negative views of research
- Devotion to traditional care
- Overwhelming patient care load
- Voluminous amounts of literature
- Difficult patient care situations
- Organizational constraints
- Inadequate information in pre-licensure nursing program and
- Laziness / lack of motivation / burnout
Solutions to overcome the barriers

- Educational emphasis in nursing schools and hospitals
- Administrative support and encouragement
- Time to think through patient care situations
- Time to critically appraise studies and implement findings
- Clearly written, well-done research reports
- Library and internet access in the clinical area
Reflection

- Where do you stand in EBN?
- How can you advance your area of practice?
ONLY YOU CAN DO IT!

Nurses dispense comfort, compassion, and caring without even a prescription.

—Val Saintsbury

www.mightynurse.com

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Thank you!

All the best