RESULTS

A graph was produced at the end of each cycle to show which documentation had been fully completed. This was shared with staff via a report on the noticeboard and via junior sisters at monthly ward meetings. The total number of completed documentation sets possible for each cycle was 13.

Action cycle 1 (Fig 1)

After the first month, the best area showing full completion was the selection of care plans from a list included in the pack. The area needing most improvement was the discontinuation of care plans; only one set of documentation had care plans evaluated (n=13 sets).

The documentation consistently failed full completion owing to a lack of names and signatures on individual sheets. End of bed checks revealed that, while risk assessments were being completed in the booklet (seven of 13), the care delivered was not representative of other risk assessments that had taken place. For example, there were often bowel charts at the end of the bed that were not referred to elsewhere in the documentation.

Action cycle 2 (Fig 2)

We decided to reformat the care planning and evaluation document so that links required between “the plans selected” and evaluation required would be obvious.

By the end of the second month, there had been a vast improvement in the front checklist, ABCDE assessment checklist, nursing assessment checklist, risk assessment booklet, property form and multidisciplinary information sheet. One glaring omission was, again, the evaluation of care plans. This was also seen in use of bullet point lists in the notes that bore little relation to care planning on admission.

The process of systematic evaluation of care seemed to break down quite quickly after admission. Inconsistencies appeared immediately in the notes if the process had not been started properly.

Action cycle 3 (Fig 3)

Care planning was addressed in the first workshop to tackle the continuing trend for its discontinuation. As a result, the number of care plans evaluated increased from zero to eight out of 13 sets inspected.

While care planning evaluation improved, there was again a distinct mismatch in the care being delivered at the end of bed inspections. Intravenous infusions, pain charts and wound risk assessments were commonly in place but not mentioned in the care planning notes. This affected the continuity of day to day record keeping, which had deteriorated to a list of bullet points after three days’ stay (Box 2).

Three sets of documentation were virtually blank. We later identified that these had been started by a bank nurse; had these been completed, compliance would have been significantly better with each cycle.

Action cycle 4 (Fig 4)

We decided to include an example of how to evaluate care in the nursing entries as well as repeating the focus on care planning at the next workshop. There were also additions to the documentation on the basis of suggestions in the feedback book.

At the end of this final cycle, we decided to audit as many sets of notes as possible; 27 were available out of a possible 34. There was considerable improvement across all areas of documentation: signatures were on all pages and several sets contained a note to ask relatives if information was “pending”.

After the final cycle, a meeting was held to reflect on the project. Discussion with the senior sister helped to develop a new piece of documentation to assist with the day to day evaluation of care. In the end this was not implemented because we did not want to create more paperwork. Also, the work had become embedded and we did not want to disrupt what had already been completed. However, it was used for teaching sessions to show links within the care planning process, in an attempt to eradicate bullet point lists.

Workshops

Care planning was not well understood by nurses from overseas, who made up the majority of staff on the AMU. In addition, British nurses said they had “given up” trying to plan care because the process broke down so many times as so few nurses understood it. It also became evident from documentation entries that one nurse in particular consistently failed to evaluate patients’ care plans.

After the workshops, one-to-one teaching