was carried out in the clinical environment to emphasise the principles of care planning (Leach, 2008). This meant that nurses on night duty would not be excluded if they could not attend the daytime workshop.

The workshops provided dynamic discussions where issues relating to documentation were raised. The activities of daily living assessment evolved as a direct result of suggestions from these sessions. The discussion enabled a greater understanding of the links and importance of the process. Moreover, it seemed the process would fail if each part was not adequately completed.

Feedback book
Comments showed compliance with the process and a willingness to engage to make documentation easier:

“Needs documentation hole punched please,”
as well as staff trying to make links between nursing charts and nursing assessment:

“Medical early warning scores should be added to the ABCDE assessment,”

“Add: put the patient’s name above their bed on the front checklist please,” and

“Add wristband as well please.”

Some anxiety about the lack of handover was also evident, together with the realisation that care happens 24 hours a day. Concern regarding inconsistencies in the quality of documentation between nursing staff was evident:

“What do we do if the documentation has not been completed by the admitting person?”

Other comments did not suggest changes to the process or content, but did suggest there had been an improvement:

“I think it is easy to use,” and

“I think it is good.”

**DISCUSSION**

**Nursing documentation in medical records**
The documentation of too much unfocused nursing information made it difficult to find decisive information (Tornval and Wilhelmson, 2008). For example, requested investigations resulted in the emphasis on decisions and the patient’s progress being masked. Of equal concern was the omission of information, such as a patient’s transfer date and time, acute deterioration, care that had been discontinued and new care that had commenced (Gunningberg et al, 2009).

The most commonly noted omissions, observed from a mismatch between care at the bedside and that documented in medical notes, were IV infusions (commenced a few days into the patient’s stay, when new cannulas were inserted) and problems with bowel function. Often a bowel chart at the end of the bed would be noted, but nothing documented in the integrated medical record to demonstrate the patient’s progress.

Entries in the records were not always up to date, which was representative of what care was being delivered at the bedside; for example, changes to a regimen of care were not represented (NMC, 2009; Wong, 2009). The care planning process was also a concern; care planned using care planning documentation was not evaluated consistently in the medical records (Leach, 2008). Nurses documented “bullet point lists of functional care/comments”, which were disconnected from the care planned and without a goal (Box 2). It was difficult to establish whether this was because their knowledge of care planning was lacking or the practice of care planning had been eroded through changing documentation practices in the trust.

**Nursing documentation**
When initially inspected, documentation was considered to be of poor quality; notes were often misaligned, barely decipherable and photocopied. There was no AMU standard for completing assessments and the overall admission process; this has been rectified (Lees, 2009).

New staff nurses were left to their own devices to decide what assessments to complete; as such, they may never have known the correct core nursing assessments and admission process (Leach, 2008). Core nursing admission assessments,