‘Documentation is vital and research will ensure systems are effective’

When I started nursing in the 1980s, the focus was on ‘hands-on’ care and establishing a relationship with patients. As a student, I became adept at completing documentation including the Kardex as well as bath and bowel books, which were sufficient for our needs then. Care plans were seen as an optional extra to be completed in our ‘spare time’. I quickly realised the potential of emerging systems of documentation that would improve the quality of nursing care, such as developing a tool to detect older patients at risk of malnutrition.

Times have changed from the simple Kardex system. The NHS is much different compared with how it was 30 years ago. It is vital we continue to deliver and document safe, individualised care to the increasingly high turnover of older patients with complex multiple comorbidities. We rely on accurate, reliable and streamlined systems to communicate, especially in view of the multidisciplinary team infrastructure in acute older person care. I have gone from using a few pages to record nursing notes to entering patients’ details and observations onto an electronic hand-held device – and my feelings have also evolved.

My small-scale qualitative research project completed for a Master’s degree in advanced nursing explored nurses’ perceptions of how and where nursing documentation supports the quality of patient care (Charalambous and Goldberg, 2016). I conducted semi-structured, in-depth interviews with eight nurses caring for older people in the acute care setting.

Participants described the complexities of nursing documentation, including the amount they had to complete, the potential for inaccuracies, and both its benefits and challenges as a means of managing care. The positive outcome of this research is that more is known about the practicalities of current documentation systems, and how we can improve. Since the research data was collected, the use of electronic systems have been introduced and well-received by staff. Signs of illness – particularly sepsis – are more easily detected, and the system allows for the smooth escalation of treatment to senior colleagues and critical care outreach teams with remote access to details.

My personal opinion is that nursing documentation will continue to evolve and, when implemented effectively, can provide a valuable tool for care and improvement across care boundaries. Primary healthcare, community care and maternity services support the idea of patient-held records – an excellent, empowering ideology. However, these record-keeping systems could be problematic in other settings, as patients who are frail and acutely unwell (who often also have delirium and cognitive impairments) need extra support.

Although my research had limitations in terms of sample size and cross-sectional design, it is vital that further research is undertaken in areas that directly affect the health and wellbeing of patients. In this way, steps can be taken to improve our practice and most effectively support high-quality documentation. Using research as a tool to discover ways of improvement allows us to find solutions by informing and evaluating the impact of documentation and streamlining existing systems for the benefit of both patients and staff. NT

Liz Charalambous is registered nurse and PhD student, University of Nottingham

References