Reducing Paperwork Without Increasing Risk

Elaine Clark
Glasgow
Session Format

• 20 minutes debate
• 10 minutes ‘open floor’ discussion
• 20 minutes breakout groups discussing current practice and potential solutions
• 10 minutes feedback on solutions and final vote
GLASGOW FACTS

Charles Macintosh, inventor of the waterproof coat, lived and worked in Glasgow where, in 1824, he developed the first commercial manufacture of the waterproof material.

Alexander 'Greek' Thomson never visited Greece.

Glasgow is home to over 70 parks, with stunningly beautiful coastlines and mountains close-by.
ON THIS SITE
STOOD THE SURGICAL WARDS
IN WHICH FROM 1861 TO 1869
JOSEPH LISTER
SURGEON TO THE ROYAL INFIRMARY
AND REGNUM PROFESSOR OF SURGERY
IN THE UNIVERSITY OF GLASGOW
INITIATED THE METHOD OF
ANTISEPTIC TREATMENT
The Nursing Record is the Written Evidence of Nursing Practice!
TAPP 1990
TAPP 1990

• The Nursing Record is the Written Evidence of Nursing Practice!
• Remember- if it isn’t in the notes, it didn’t happen”
• RCN
You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

You must complete records as soon as possible after an event has occurred.

You must not tamper with original records in any way.
• You must ensure any entries you make in someone’s paper records are clearly and legibly signed, dated and timed.
• You must ensure any entries you make in someone’s electronic records are clearly attributable to you.
• You must ensure all records are kept securely
NO BLAME CULTURE

• REALLY???

• COMPLAINTS ON INCREASE

• IF IT ISN'T IN THE NOTES……
NEGLIGENCE and The LAW

- Careful and accurate records may assist if you are defending claims of negligence
- If they find shoddy records, they assume shoddy practice and are more inclined to go ahead with a claim
IMPROVEMENTS IN RECENT YEARS

• Unitary Notes for all staff
• Step in Right Direction
• Improves Communication
• Avoids Duplication
• Clarity of Information
• Ensures Team Working
SBAR

- WHO 2007 recommend SBAR as communication method, can be used by medics, nurses, untrained staff to give concise important information
- Improves telephone handovers
- Reduces time for shift handovers
- Reduces adverse outcomes
Move to Electronic Record

•Good Thing?
PROTECT YOUR REGISTRATION

• WE ALL WORKED HARD TO GET IT!

• DOCUMENTATION MUST BE
  • TIMELY
  • ACCURATE
  • COMPLETE
The Daily Telegraph
3,000 more patients have died needlessly in hospital

Daily Mail
£25,000 TO BE WON TODAY
Police probe 300 cases of ‘criminal neglect’

Express & Star
STAFFORD HOSPITAL SCANDAL: THE FRANCIS REPORT
Patients paid with their lives as hospital cut costs to hit targets
SACRIFICED

• Good record keeping is an integral part of nursing and midwifery practice, and is

• Essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. NMC
Evidence

• Nurses bear the large burden in documenting the care and progress towards goals.
• Considerable time spent doing this.
• Literature reveals tensions surrounding documentation including time spent, the number of errors, legal accountability, making them understandable to other disciplines (Keenan, et al 2008)
Nurses 'drowning in sea of paperwork'

- Nurses are "drowning in a sea of paperwork" and spend much of their working hours doing admin, a survey reveals.
- The poll by the Royal College of Nursing (RCN) found its members, who work for a combined 14.3 million hours a week, are being hampered by bureaucracy.
- Over four in five nurses (81%) said that having to complete non-essential paperwork prevented them from providing care.
Don’t believe me?

• Patient journey in Glasgow Royal Infirmary
Nursing ADL (tim 4 mins)
Intentional rounding (tim 2mins)
NEWS (tim 3 mins per entry)
Turning and skin (tim 3 mins)

<table>
<thead>
<tr>
<th>TIME</th>
<th>REPOSITIONING (USING CODES)</th>
<th>SKIN INSPECTION</th>
<th>ACTION TAKEN</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>L to D</td>
<td>Left Hip Non-</td>
<td>Reassess at</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blanching</td>
<td>next</td>
<td></td>
</tr>
</tbody>
</table>

Daily Repositioning & Skin Inspection Chart

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the person to reduce the risk of further damage, e.g. using the 20 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Individuals and any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required
- Encourage repositioning/mobilisation where possible
- Acutely ill people are seated out for no longer than 2 hours and returned to bed for no less than 1 hour

Reference: Best Practice Statement Prevention & Management of Pressure Ulcers March 2009
Swallowing (tim 4 min)

### Nursing Checklist for Swallowing

**Difficulty in Adults and Referral to Speech and Language Therapy**

**Refer to flowchart overview**

**NOTE:** Patients with a tracheostomy are subject to NHS GGC & Blackpool CCG Guidelines.

**Before making a fast track referral or carrying out the Water Swallow Test below, the patient MUST be able to:**
- Sit upright in a chair.
- Drink water without difficulty.
- Swallow saliva (swallowing saliva back is normal in patients.)

**FAST TRACK REFERRALS TO Speech and Language Therapy (SALT) FOR SWALLOWING ASSESSMENT**

If making an immediate referral for a SALT Swallowing Assessment, tick marks(s) below.

- Patient is reported to have one of the following:
  - A history of more than one episode of upper GI tract infection.
  - Evidence of aspiration (Hegazin test) or abnormal swallowing seen on endoscopy.
  - Patient has rapid and/or forced oral intake and is experiencing swallowing difficulties.
  - Patient has no known swallowing problem (e.g., requiring modified diet) but is reported by caregivers as having problems.

**Nurse signature:**

**Date:**

---

### Water Swallow Test

**Part 1.** Give patients 1-5 tablets of water. Score “yes” if any of the questions below get a positive answer.

If answer is “no” to all of Part 1, proceed directly to Part 2.

**Does the patient show any signs of the following? (Tick Yes or No)**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 1 &gt; 12 hours</th>
<th>Day 2</th>
<th>Day 2 &gt; 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Choking</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Change in voice</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Part 2.** Give patients milk or coffee, and observe if they aspirate. Proceed as Part 1.

**Does the patient show any signs of the following? (Tick Yes or No)**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 1 &gt; 12 hours</th>
<th>Day 2</th>
<th>Day 2 &gt; 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Choking (hesitantly swallowing)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Change in voice (hoarse and/or raspy)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Documentation outcomes of Water Swallow Test:**

- **Yes:** Day 1, Day 2
- **No:** Day 1, Day 2
- **NA:** Day 1, Day 2

**Date/time:**

**Signature:**

---

**Patient details:**

Please cross out below.
Urinary Catheter (tim 2 min)
Food chart (tim 1 min per entry)

<table>
<thead>
<tr>
<th>Day 1 (Date)</th>
<th>Day 2 (Date)</th>
<th>Day 3 (Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
</tr>
<tr>
<td>Mid-morning</td>
<td>Mid-morning</td>
<td>Mid-morning</td>
</tr>
<tr>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>Mid-afternoon</td>
<td>Mid-afternoon</td>
<td>Mid-afternoon</td>
</tr>
<tr>
<td>Evening meal</td>
<td>Evening meal</td>
<td>Evening meal</td>
</tr>
<tr>
<td>Bedtime</td>
<td>Bedtime</td>
<td>Bedtime</td>
</tr>
</tbody>
</table>

Please record all food and drink taken on this chart daily - e.g. 1 bowl porridge, 1 slice brown bread, 1 cup of tea with milk and sugar, 6 spoonfuls of soup, half portion of fish etc.

Special Instructions:
Moving and handling (tim 5 min)

<table>
<thead>
<tr>
<th>Patient's Details</th>
<th>Nurse</th>
<th>If Patient is totally independent, tick here and go to date box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Build</td>
<td></td>
<td>Problems with comprehension, balance, co-ordination (specify)</td>
</tr>
<tr>
<td>Obese</td>
<td>Tall</td>
<td></td>
</tr>
<tr>
<td>Above average</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Weak</td>
<td>Short</td>
<td></td>
</tr>
<tr>
<td>(specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of falls</td>
<td></td>
<td>Handling conditions e.g. disability, weakness, pain with bones, injuries (specify)</td>
</tr>
<tr>
<td>High</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Into Bath or shower</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Toileting</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Walking</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Move up/down bed</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sit up over side of bed</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transfer to/from trolley (or bed etc.)</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other instructions</th>
<th>Manual support</th>
<th>Assistance</th>
<th>Instruction</th>
<th>Supervision</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Manual support</td>
<td>Assistance</td>
<td>Instruction</td>
<td>Supervision</td>
<td>Independent</td>
</tr>
</tbody>
</table>

---
Swallow (tim 4 min)
### Daily Summary of Fluid Balance

<table>
<thead>
<tr>
<th>Date</th>
<th>Oral</th>
<th>I.V.</th>
<th>Other</th>
<th>Total</th>
<th>Urine</th>
<th>Gastric</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
</table>

### Routine Urine Chart

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Colour</th>
<th>pH</th>
<th>SG</th>
<th>Protein</th>
<th>Sugar</th>
<th>Albumin</th>
<th>Leukocytes</th>
<th>Blood</th>
<th>Nitrite</th>
<th>pH</th>
<th>Leukocytes</th>
<th>Lumps</th>
<th>Lumps Hemat</th>
<th>Lumps Leuk</th>
<th>Lumps @</th>
<th>Lumps @</th>
</tr>
</thead>
</table>

### Stool Chart

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Colour</th>
<th>Consistency</th>
<th>Abnormalities</th>
<th>F.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-ve</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+ve</td>
</tr>
</tbody>
</table>
Canulae Chart (tim 3 min)
Diabetic Chart (tim 2 min per entry)
GMAWs (tim 5 min)
VTE (tim 4 min)
MRSA (tim 2 min)

## MRSA Screening

**Hospital:**

**Ward:**

**Date:**

### A. Clinical Risk Assessment (CRA) - for patients >23 hours

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the patient ever had a previous positive MRSA result?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has the patient been admitted from a care home/institutional setting or another hospital?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Does the patient have a wound/ ulcer or invasive device which was present prior to admission?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If "Yes" to any question or if the patient is within (or admitted to) a High Impact Specialty* complete section B (*Not known = "No")

* Orthopaedics / Vascular / Renal / Critical Care (please circle)

### B. MRSA Swabs taken (✔):

- **Nose**
- **Penile**
- **Patient refused**

---

[Image of MRSA screening form]

---
### Bedrail Risk (tim 5 min)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem:</th>
<th>Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risk Factors:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bedrail Assessment:***

1. **Patient Type:** [ ] Bedbound
2. **Position:** [ ] Sitting
3. **Risk:** [ ] Low
4. **Assessment:** [ ] Bedrail needed

**Bedrail Options:***

- [ ] Regular
- [ ] Extended

**Bedrail Considerations:**

- [ ] Falls
- [ ] Mobility

**Bedrail Instructions:**

- [ ] Secure bedrail
- [ ] Monitor patient

**Bedrail Records:**

- [ ] Date
- [ ] Time

---

**NIHSS Care Bedrail Risk Assessment:**

- [ ] Bedbound
- [ ] Falls
- [ ] Mobility

---

**Bedrail Details:**

- [ ] ID
- [ ] Age
- [ ] Sex

---

**Care Provider:**

- [ ] Date
- [ ] Time

---

**Bedrail Summary:**

- [ ] Date
- [ ] Time

---

**Bedrail Comments:**

- [ ] Additional notes

---

**Bedrail Approval:**

- [ ] Signed
- [ ] Dated

---

**Bedrail Keywords:**

- Fall prevention
- Mobility support
- Bedrail necessity

---

**Bedrail Contact:**

- [ ] Name
- [ ] Phone

---

**Bedrail Instructions:**

- [ ] Secure bedrail
- [ ] Monitor patient

---

**Bedrail Resources:**

- [ ] Hospital guidelines
- [ ] Patient education

---

**Bedrail Recommendations:**

- [ ] Regular bedrail
- [ ] Extended bedrail

---

**Bedrail Follow-up:**

- [ ] Date
- [ ] Time
### Falls Risk (tim 4 min)

#### Nursing Interventions

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Risk Assessment</strong></td>
<td>Identify high-risk patients and monitor regularly.</td>
</tr>
<tr>
<td>2. <strong>Environmental Modifications</strong></td>
<td>Remove tripping hazards and ensure safe pathways.</td>
</tr>
<tr>
<td>3. <strong>Medication Management</strong></td>
<td>Adjust medications to prevent dizziness and sedation.</td>
</tr>
<tr>
<td>4. <strong>Physical Therapy</strong></td>
<td>Strengthen muscles to reduce fall risk.</td>
</tr>
<tr>
<td>5. <strong>Wear Anti-Slip Socks</strong></td>
<td>Ensure patients wear appropriate footwear.</td>
</tr>
<tr>
<td>6. <strong>Use of Assistive Devices</strong></td>
<td>Use grab bars, railings, and walk辅助等。</td>
</tr>
<tr>
<td>7. <strong>Regular Monitoring</strong></td>
<td>Perform daily assessments and interventions.</td>
</tr>
</tbody>
</table>

---

**Note:** Always consult with medical professionals for specific recommendations and patient care plans.
Wound Assessment (tim 5 min)
LCP (tim 5 min)
Time in Motion

- 64 mins if all paperwork complete
- Current ratio of 1 nurse to 7
- Approx 80 admissions daily
- 1 nurse 7.4 hours of 12 hour shift on paperwork assuming 7 patients
- Does not account for transfers or new admissions
How did we get to this?
Staffing

- Rafferty 2007 reports 26% higher mortality in hospitals with poorer nurse:patient ratio
- Kane 2007 96 studies in meta-analysis. Review concluded an association between higher nurse:patient ratio and lower rate of hospital mortality and adverse patient events
- 30,000 patient safety incidents related to staffing in England and Wales (NPSA 2009)
- 90% of these in acute sector settings
• “too few staff”
• Robert Francis
• Feb 2013
Impact on nursing

• Feel “stretched to limit”
• Report insufficient time to deliver care properly
• Higher levels of stress which impairs functioning (Bell 2006)
• Not refreshed and rested
• Less professional development/updates (Ball and Pike 2009)
Unregulated Care Staff

• Cheap alternative
• Untrained
• Unregulated
• Robert Francis QC, chairman of the public inquiry into the failings at Mid Staffordshire NHS Foundation Trust, recommended a registration system for healthcare support workers.