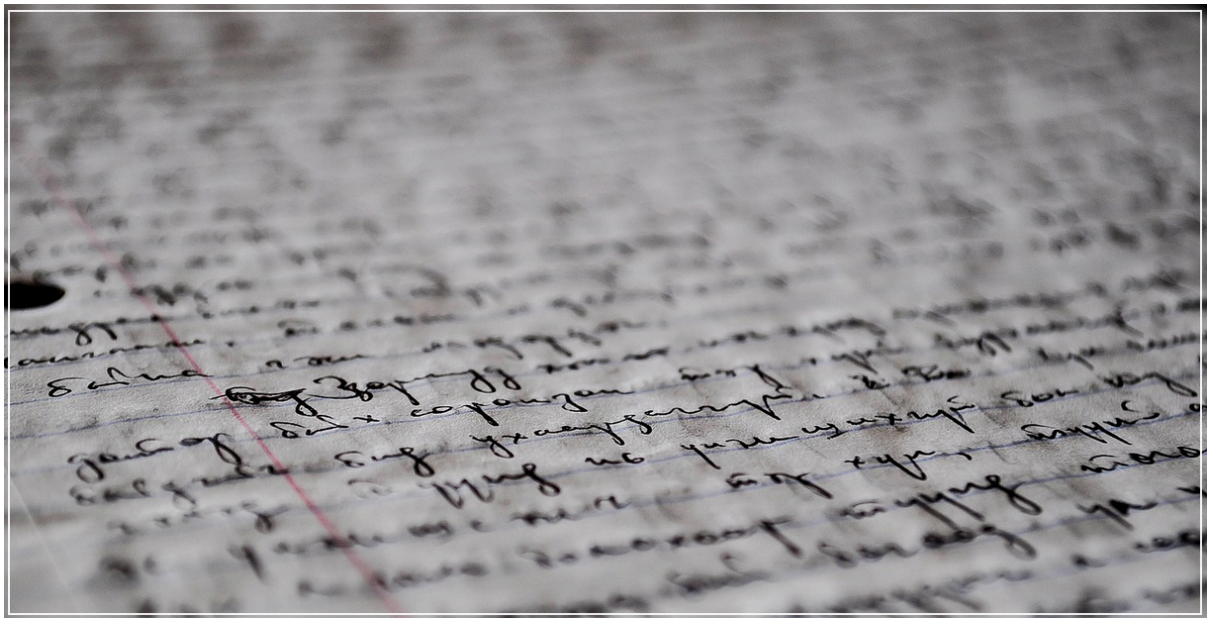

Documentation: do we communicate effectively?

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Note: the documentation examples I give here may be unacceptable in many organisations. Consult your own documentation policy for guidance. This reflection is intended to generate discussion and thinking about the way we currently do things.

Nursing documentation is often not read, until the shit hits the fan….and then it is read through with a fine-tooth comb.

At least this is my experience. Doctors seldom read our progress notes (of course, there are exceptions to this), and even we nurses tend to read the doctors notes far more than we read our own colleagues documentations.

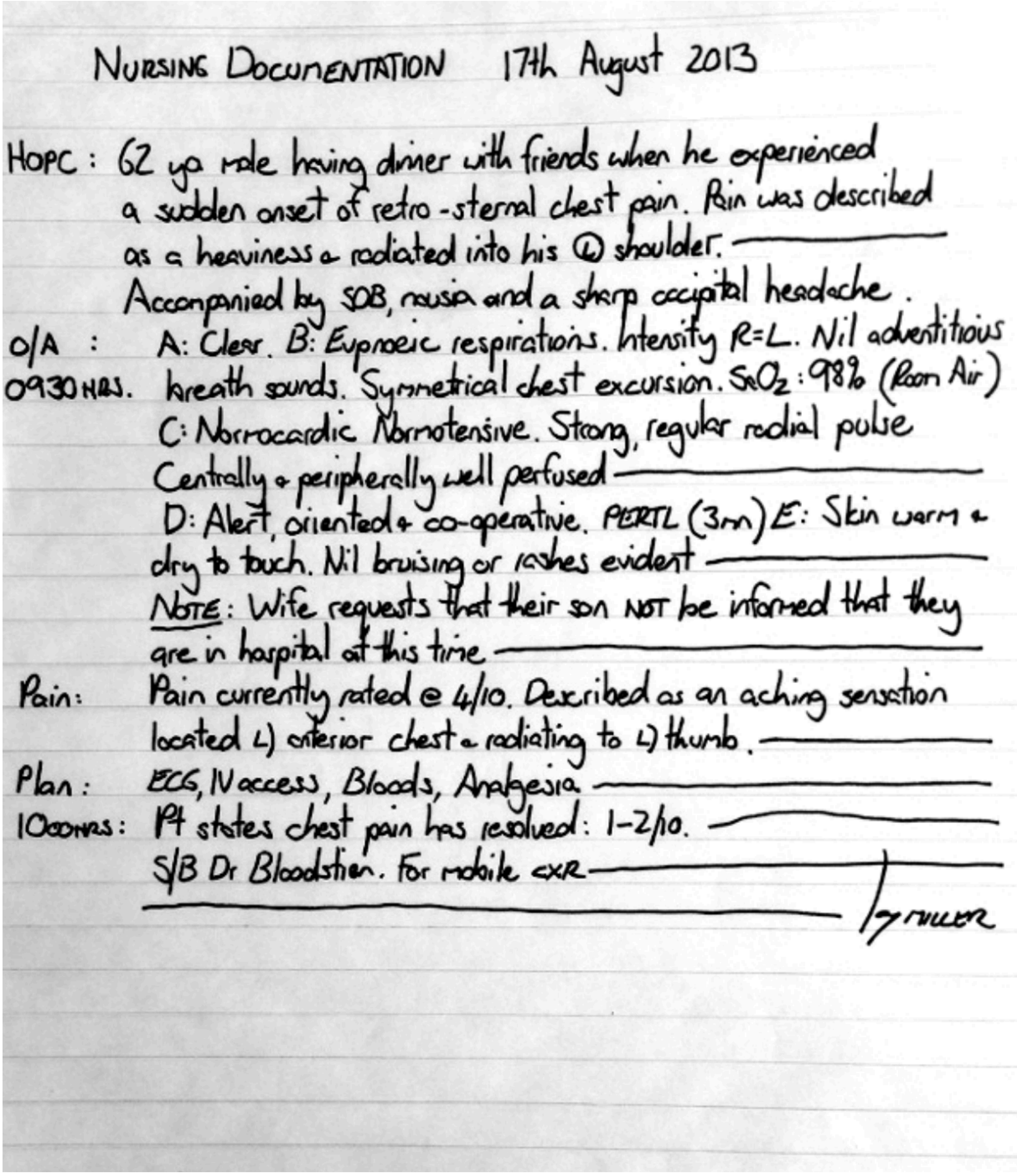
But when something goes wrong it is inevitably the nursing notes that come under scrutiny.
It is our documentation that is expected to provide the most meaningful measure of the standards met in care delivery for the patient.

So as nurses, we tend to try to reflect both some sort of narrative of the patient's journey through the health system as well as an objective record of interventions, care plans and issues.

So, we document, but do we communicate?

Many units/departments are transitioning to largely electronic record keeping applications, but many of us are still using hand written nursing notes.
I was taught that the correct way to document my notes was to ensure there were no empty spaces or breaks in my writing (presumably so that nobody can retrospectively tamper or change the notations).
The feeling is very much……you know: give your care to the patient….but give your notes to the judge.

So, a typical nursing progress notes entry might look like this.



NURSING DOCUMENTATION 17th August 2013

HOPC: 62 yo male having diner with friends when he experienced a sudden onset of retro-sternal chest pain. Pain was described as a heaviness & radiated into his (L) shoulder.
Accompanied by SOB, nausia and a sharp occipital headache.

O/A: 0930 HRS. A: Clear. B: Eupnoeic respirations. Intensity R=L. Nil adventitious breath sounds. Symmetrical chest excursion. SaO2: 98% (Room Air)
C: Normocardic. Normotensive. Strong, regular radial pulse. Centrally & peripherally well perfused
D: Alert, oriented & co-operative. PERTL (3mm) E: Skin warm & dry to touch. Nil bruising or rashes evident
NOTE: Wife requests that their son NOT be informed that they are in hospital at this time

Pain: Pain currently rated @ 4/10. Described as an aching sensation located L) anterior chest & radiating to L) thumb.

Plan: ECG, IV access, Bloods, Analgesia

1000HRS: Pt states chest pain has resolved: 1-2/10.
S/B Dr Bloodstien. For mobile CXR

Tyrmer

Now, I’m not so concerned about content here (and don’t even get started on my spelling), but rather the overall perceptual connection between the reader and this set of notes.

It is based on a legal or organisational-centred design.

It is pretty much a block of dense text.

It certainly does not convey much information on initial inspection.

There is no indication if the information on this page is important or mundane.
You are going to have to wade right in and work hard to find anything useful.

I am not a lawyer, or a manager, or an auditor…so if I turn the page and see this, I am not engaged, and will keep looking for something to easily tell me what I want to know (often this is why I default to the doctor's notes, because they seldom document in this way).

OK. Now, compare the first example with this one.
Exactly the same information, but presented with a little more visually ordered design:

Ian Miller

NURSING DOCUMENTATION 17th August 2013.

HOPC: 62yo male having dinner with friends when he experienced a sudden onset of retro-sternal chest pain. Pain was described as a 'heaviness' + radiated into his Ⓛ shoulder.
Accompanied by SOB, nausia and a sharp occipital headache.

O/A : A: Clear.
[0930 HRS] B: Eupnoeic respirations. Intensity R=L. Nil adventitious breath sounds. Symmetrical chest excursion. SaO_2: 98% (Room Air)
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E: Skin warm + dry to touch. Nil bruising or rashes evident.

Pain: Pain currently rated @ 4/10. Described as an aching sensation located L) anterior chest + radiating to L) thumb.

PLAN:
- ☑ ECG
- ☑ IV access 18fr R) c.fossa
- ☑ Bloods: FBC UEC COAGS VBG
- ☑ Analgesia: IV opioids (as charted)

*NOTE: Wife requests that their son NOT be informed that they are in hospital at this time

[1000 HRS] Pt states chest pain has resolved: 1-2/10.
S/B Dr Blookstien.
For mobile CXR.

Byruer.

Did you get more out of this?

The information is set out to communicate information. **It pushes information out to the reader rather than requiring them to pull it out of the page.**

It is user-centred and contains information cues, hierarchical organisation, emphasis and style and the use of space to improve accessibility to the information.

With a little thought I am sure we could think of many other ways to improve the communication quality and redesign of our documentation.

For example:

- Use of colour.
- Use of standardised symbols to flag topics or themes.
- Use of ‘tags’ to group themes or information topics.
- Use of page/paragraph links to jump forwards or backwards to relevant information.
- Use of both subjective and objective narratives that are identified as such.

This format may not stand up to the medico-legal requirements, but surely we have a far greater requirement to ensure that there is high-quality communication of information between ourselves and other healthcare professionals?
Surely we no longer need to use dense blocks of ink. What is really important to our patients is that we communicate effectively.

What about the move to electronic notes?

Are computer driven documentation systems really designed effectively to communicate information?

Well, I kinda like handwriting my notes. It is like a personal seal on the care I have given to my patients. It is a little craft to reflect the art and science of my work.

Despite this, I have no illusions that hand written notes will soon be obsolete in most hospitals.
And there are certainly many advantages to maintaining data this way (lets just hope doctors don’t get to design their own fonts!).

But even with electronic record keeping, are we still communicating?
Is information presented in an accessible, user-friendly, visually engaging and contextual format?
Is the record of our care easy to get in and easy to get in and out?

What do you think?