SUMMARY REPORT	ABM University Health Board
Quality & Safety Committee	Date: 15th October 2015 Agenda item: 3.2

Subject	Nurse Documentation update
Prepared by	Helen Griffiths Head of Professional Standards and Practice Linda Bevan Head of Nursing Surgical Specialties
Approved & Presented by	Rory Farrelly Director of Nursing and Patient Experience

Purpose

The purpose of this paper, is to provide the Quality & Safety Committee with an update on the progress made and measures in place to improve and standardise nursing documentation across adult areas; excluding Mental Health and Midwifery.	Decision	✓
	Approval	✓
	Information	✓
	Other	

Corporate Objectives

Excellent Population Health	Excellent Population Outcomes	Sustainable & Accessible Service	Strong Partnerships	Excellent People	Effective Governance
✓	✓		✓	✓	✓

Executive Summary

Variable or poor standards of documentation have been a persistent theme highlighted by internal and external reviews undertaken by organisations such as Healthcare Inspectorate Wales. As a consequence, and following the publication of the "Trusted to Care Report" (May 2014), the Director of Nursing and Patient Experience requested that a full review of all nursing documentation be undertaken, with a view to streamlining and reducing duplication.

In September 2014, the Health Board introduced a streamlined integrated nursing assessment approach and related documentation. The new assessment approach reduces the need for every risk assessment to be completed for every patient, thereby reducing the volume of documentation that needs to be completed by nurses by up to 50% for some patients.

The new nursing assessment format and related documentation ensures that patients are assessed holistically to identify where further more detailed risk assessment and care bundles maybe required (see copy at **Appendix 1**). This not only reduces the volume of nursing documentation but ensures that the patient is only made subject to proportionate and appropriate assessments. The new assessment process also gives clear prompts to ensure that the nursing assessment fully informs a holistic care plan.

The new approach fits with the requirement set out by Mark Drakeford, the Minister for

Health and Social Services, for all health boards to introduce a new integrated assessment for older people
Key Recommendations
The Quality & Safety Committee is asked to note the information contained in this report and the progress made to date.
Assurance Framework
The Health Board Nurse Documentation Group will monitor progress, and will link closely with key recommendations from the All Wales Documentation group and update Nursing Midwifery Board on its progress.
Next Steps
• Roll out of nursing documentation in Singleton Hospital • Further roll out of the assessment documentation to Community Nursing

Corporate Impact Assessment	
Quality and Safety	Implementation will lead to improvements in the quality of Documentation and care we provide to patients.
Financial Implications	There will be no financial implications
Legal Implications	Compliance with NMC Code (March 2015) specifically in relation to good record keeping.
Equality & Diversity	All patients should have clear up to date documentation

MAIN REPORT		ABM University Health Board
Quality & Safety Committee.		**Date** : 22nd August 2015 Agenda :
Subject	Nurse Documentation update	
Prepared by	Helen Griffiths Head of Professional Standards & Practice Linda Bevan Head of Nursing Surgical Specialties.	
Approved & Presented by	Rory Farrelly Director of Nursing and Patient Experience.	

BACKGROUND

Variable or poor standards of documentation have been a persistent theme highlighted by internal and external reviews undertaken by organisations such as Healthcare Inspectorate Wales. As a consequence, and following the publication of the "Trusted to Care Report" (May 2014), the Director of Nursing and Patient Experience requested that a full review of all nursing documentation be undertaken, with a view to streamlining and reducing duplication.

A Documentation Group was established, jointly chaired by the Heads of Nursing for Surgery and Corporate Nursing with representation from all areas, with the exception of Maternity, Paediatrics and Learning Disabilities. It led on the review of documentation and the development of the new nursing assessment approach and documentation.

The Documentation Group now provides a scrutiny, monitoring and governance process for the use and development of nursing documentation. It links to the 'All Wales Documentation Group' established by the Chief Nursing officer for Wales, and has set up the following sub groups that are working on specific projects:

- Community Documentation group
- Care planning Group.

In the initial stages of the review it was found that nurses working on wards across ABMU hospitals were completing a large amount of documentation, for example a wide range of risk assessments, that were unnecessary given the patients presentation and care needs; hence they did not contribute to care plans or the provision of holistic care.

In September 2014, the Health Board introduced a streamlined integrated nursing assessment approach and related documentation. It was initially piloted across a number of ward areas in Morriston, Neath Port Talbot and Princess of Wales Hospital. A training pack and guidance was developed by Corporate Nursing to support the pilot study.

The aim of the new assessment approach is to reduce the need for <u>every</u> risk assessment to be completed for <u>every</u> patient; thereby reducing the volume of

documentation that needs to be completed by nurses by up to 50% for some patients. The new nursing assessment format and related documentation ensured that patients are assessed holistically to identify where further more detailed risk assessment and care bundles maybe required. This not only reduces the volume of nursing documentation but ensures that the patient is only made subject to proportionate and appropriate assessments. The new assessment process also gives clear prompts to ensure that the nursing assessment fully informs a holistic care plan (see copy at **Appendix 1**).

The approach and documentation ensures that information is collected from patients once, thus avoiding patients having to repeat information many times throughout their pathway. It also fits with the requirement set out by Mark Drakeford, the Minister for Health and Social Services, for all health boards to introduce a new integrated assessment for older people.

Following development of the nursing document template, a cost benefit analysis was undertaken on the use of photocopying, materials and nursing resource, and it was agreed to move to a pre-printed booklet format for the documentation. The procurement and ordering for this is now managed within each of the Delivery Units, at ward level.

The ultimate aim is to move to electronic patient recording and the hard copy document and assessment format was developed with this in mind. Corporate Nursing is currently working closely with the information and communication colleaguesto move towards this.

CURRENT SITUATION & ACHEIVEMENTS

Currently the new nursing assessment documentation is being used across all assessment and ward areas in the following hospital sites:

- Morriston Hospital
- Princess of Wales Hospital
- Neath Port Talbot Hospital

Meetings have taken place with the Senior Nursing team within Singleton Hospital with a view to implement the documentation on the wards imminently.

The Draft Community Nursing Documentation has been agreed and pilots are in place.

Findings from audits undertaken in April 2015 have shown that the standard of completion is varied. There are a number of key themes identified which need to be addressed which include;

- Completion of the information sharing section of the documentation.
- The recording of Advanced decisions /Do not attempt cardiopulmonary resuscitation
- Cultural & Spiritual preferences.

Further expectations are that audits will continue on a weekly basis by the Ward Sisters, and monthly by the Lead Nurses. A Health Board wide peer review will also be undertaken in September. This will be led by the Documentation Group.

NEXT STEPS

The Health Board is committed to improving the quality of nursing. The quality and appropriateness of nursing documentation will be monitored via the Health Board's Documentation Group. There will be a need for ongoing regular audit to ensure continuous improvement and achieve full compliance across all areas. Further actions and discussions will include the move towards electronic documentation as well as looking as the possibility of all disciplines writing in one Medical record

RECOMMENDATIONS

The Quality & Safety Committee is asked to note the information contained in this report and the progress made to date.

ABERTAWE BRO MORGANNWG

Integrated Nursing Assessment

Addressograph

Consultant

Directorate		
Department / Speciality		
Assessor (Print Name)		
Assessor (Signature)		
Date/time		**EDD**

Date/time	Ward	Transfer Sheet Completed	EDD

SIGNATURE SHEET

If document is to be faxed or photocopied please add addressograph here.

Please ensure you have signed the signature sheet below.
Full Name, Signature and initials required.

Full Name (print)	Designation	Signature	Initials	Date

Record Additional Bolt On below

Name of Bolt On	Date commenced	Date Completed

Title Name Permanent address: Post Code:	Tel: Mobile: Email: DOB: Age: M / F	Social Service No: NHS Number Hospital Number: Care Co-ordinator:

Preferred name:	**1st Language:** **Preferred language:**
Does the individual wish to speak Welsh? YES / NO	**If YES, link with Welsh speaking member of staff**
Occupation:	**Is a Translator required: Yes / No**
Ethnic Origin:	**Cultural / Spiritual Preference / Religion:**

Current Address: (if different from above) **Post Code:** **Tel No:**	**Preferred Method of Contact:** **Home Phone:** **Mobile Number:** **Email:**

Next of Kin: **Tel No:**	**Preferred Contact:** **Tel No:**
Please indicate who to contact in emergency: Next of Kin / Preferred Contact:	Wishes to be contacted 24 hours YES / NO

GP Name and Address: **Telephone:**	**Are You Registered with a Dentist?** **YES / NO**

Marital/Partnership Status:	
Extra Communication Needs: YES / NO If YES what support is required? **Do you have Learning Difficulties? YES / NO** **Has a Learning Difficulties Traffic Light Assessment been completed? YES / NO** **Do you have a support worker / Care Coordinator? YES / NO** **If YES, Contact details for Support Worker / Care Coordinator**	
Any known Allergies: YES / NO	
Allergy:	**Adverse Reaction:** **Action Needed:** **EPI Pen: YES / NO** **With the patient: YES / NO**
Date and Place of Completion:	**Name and Designation:**

If document is to be faxed or photocopied please add addressograph here.

ISSUES RELATING TO CONSENT

Cognitive Ability

Do you have concerns about the person's capacity to engage in this assessment?	YES / NO
Are there concerns about the person's cognitive abilities i.e. are they confused?	YES / NO
Is this permanent	YES / NO / NOT KNOWN
Is this a temporary state	YES / NO / NOT KNOWN
Is there a Lasting Power of Attorney / Court Appointed deputy for Welfare	YES / NO
Is there a Lasting Power of Attorney / Court Appointed deputy for property and financial affairs	YES / NO
If YES, has it been seen?	YES / NO

Consent

Has the reason for this assessment been discussed with the individual and/or their carer if applicable?

YES / NO

If NO, give reason:

Does the individual or their representative consent to this assessment / referral? YES / NO

If there are concerns refer to the Mental Capacity Act Code of practice

Information Sharing

I understand that the information recorded on this form is required and will be of importance in decisions regarding my future help and support needs. I consent to the sharing of this report with relevant agencies on a need to know basis for the purposes of planning any care and support I may require and I understand that this information will be stored on relevant written and electronic records in line with Health Board and Local Authority Data Protection Policies.

I agree to the display of relevant information in clinical areas? YES / NO

Is there anybody you would not want to share this information with? YES / NO
Who:

Individuals / Representatives Signature: Date

Has the patient made a valid & applicable Advanced Decision to Refuse Treatment?
YES / NO / Don't Know
If so is a copy in the notes? YES / NO / N/A
Is there a trigger for discussion of CPR? YES / NO

If so:
Has a decision (for CPR or DNACPR) been made or reviewed during this admission? YES / NO / N/A
Has this been discussed with the patient? YES / NO / N/A
Has this been discussed with anyone close to the patient? YES / NO / N/A

IF No to any of previous 3 please explain why (referring to the all Wales DNACPR policy as necessary).

If document is to be faxed or photocopied please add addressograph here.

Are there any current or ongoing risks to safety and wellbeing?
Consider:

Safeguarding concerns: Adults and Children / Domestic Abuse Issues / Risk Assessments / Risk Frameworks (where used)

Risks to self:

Risks to others:

What is the reason for you attending /contacting us today?

Advice given / Action taken:

Has the Initial Contact addressed current concerns? YES / NO
If YES, please complete outcome letter and give to the individual

If NO, continue with rest of document

Do you receive / require any care / support at home? YES / NO
If YES, complete below **If NO, proceed to previous medical history**

If document is to be faxed or photocopied please add addressograph here.

CARE & SUPPORT (THIS SECTION SHOULD BE DISCUSSED WITH NOK / CARE PROVIDER TO CONFIRM ACCURACY**)**

Person's Main Carer:	
Name:	Relationship:
Contact details:	
Does Carer have other caring responsibilities?	YES / NO
Is Carer a Child or person under 18 years of age?	YES / NO
Would the Carer like a Carer's Assessment?	YES / NO

Do you currently have help at home?	YES / NO
Do you provide care for any children or others?	YES / NO
Do you have responsibility for any pets?	YES / NO
Does your current situation affect your ability to look after them?	YES / NO

What support do you have from family, friends, Community, Health or Social Care Agencies? If you receive a Package of Care, what level of care do you receive?
Are you able to manage with you current support at home?
If not, consider what works well, what is not going so well and what needs to change?

HOME ENVIRONMENT

Accommodation type:				
House	Bungalow	Flat	Homeless	Other
If Other, identify here:				
Is this:				
Your own home	Sheltered Accommodation	Care Home		
If you currently live in a Care Home setting is this: Nursing Care or Residential Care? (Please circle) Self funded ☐ Local Authority funded ☐ Continuing NHS Health Care ☐				

Are you able to complete daily activities?
e.g. washing, ☐ dressing, ☐ shopping ☐ preparing meals ☐

Are you able to manage stairs, ☐ access bathroom facilities ☐
Do you have any equipment / aids to support independent living? e.g. walking aids ☐ chair / toilet raisers ☐

stair lift ☐ telecare ☐ home alarms ☐ lifeline systems ☐ standing aid ☐ hoist ☐
pressure relieving equipment ☐

If document is to be faxed or photocopied please add addressograph here.

	PREVIOUS MEDICAL HISTORY / OPERATIONS

Do you experience memory problems? YES / NO
IF YES CONTINUE BELOW.

Does anyone else have concerns about your memory? YES / NO

Have you been more forgetful over the past 12 months? YES / NO

Has this affected your Daily life? YES / NO

If Yes, have you spoken to anybody about this? YES / NO

Have you seen your GP? YES / NO

What advice / treatment have you had?

If document is to be faxed or photocopied please add addressograph here.

Lifestyle

Do you smoke?	YES / NO
If YES, how many per day:	
Do you use nicotine replacement therapy?	YES / NO / N/A
Would you like support to stop smoking?	YES / NO / N/A
If YES, action taken:	
Do you use recreational drugs?	YES / NO
If YES, is it impacting on your daily life / health?	YES / NO N/A
If YES, would you like support to reduce / stop?	YES / NO N/A
If YES, action taken:	
Do you regularly drink alcohol?	YES / NO
If YES, are you aware of safe drinking levels?	YES / NO N/A
Wold you like support or advice with regards to alcohol intake?	YES / NO N/A
If YES, action taken:	
Do you have concerns about your weight?	YES / NO
Are you able to undertake regular exercise?	YES / NO N/A
Would you like advice or support with regards to diet and exercise?	YES / NO N/A
If YES, action taken:	

Declaration – Personal Possessions

If document is to be faxed or photocopied please add addressograph here.

Name: ..... Ward: ..... Hospital/NHS No: .....

I confirm that it has been explained to me that facilities are provided by Abertawe Bro Morgannwg University Health Board for the safe custody of the cash and valuables in my possession.

I further confirm I have declined to take advantage of these facilities and understand that the Health Board cannot be held liable for any loss or damage to the cash or valuables remaining in my possession.

Page Number of Property Book: ..... COMPLETED PP3 YES / NO PP5 YES / NO

Signed: ..... Witnessed: ..... Date: .....
(if the patient unable to sign, Next of Kin should sign below)

Signed: ..... Witnessed: ..... Date: .....

Patients Own Drugs

ABM University Health Board actively encourages patients attending hospital to bring in all the medicines they are currently taking in their original containers. This allows the Doctor, Pharmacist and/or Nurse to obtain an accurate **drug history** and to make **best use of medication resources**.

Your medicines will then be treated as follows:

1. If the medicines are suitable and relevant, they will be used during the hospital stay with any remaining medicines returned to you on discharge. Further additional supplies will be made available by the Hospital as necessary and given to you on discharge.

2. You will be informed if any medication is considered inappropriate or unsuitable for use and this will be disposed of appropriately by the Health Board.

3. Any complimentary therapy/herbal medicines, **unless falling into Category 2 above,** should be removed from the hospital for safe keeping as their safe return cannot otherwise be guaranteed.

I confirm that I wish my medication to be used in accordance with the above. I am aware that my medication may be unsuitable and unsafe and continued use is inadvisable. All drugs and medicines falling into Category 3 above will be removed from the hospital. I will NOT use any medicines without the knowledge of appropriate staff.

I understand my medication will be treated as above. I hereby confirm I have surrendered all drugs and medicines brought into this hospital with me.

Signed: ..... Witnessed: ..... Date: .....
(if the patient unable to sign, Next of Kin should sign below)

Signed: ..... Witnessed: ..... Date: .....

If document is to be faxed or photocopied please add addressograph here.

FUNDAMENTALS OF CARE NEEDS

Weight on admission

Date KG

Assessment of:	NO	YES	Action:
Physical Well being **Has the patient been admitted into a ward/clinical area?** Any significant Medical History or current chronic condition? E.g. Diabetes, Heart Disease, Epilepsy Admitted for Surgery?			**If YES - Thromboprophylaxis Reassessment Required.** If YES - Care plan for conditions in place Nutritional Risk assessment & Waterlow Risk Assessment If YES - Surgical Care Plan / Wound Care Plan Nutritional Risk assessment & Waterlow Risk Assessment.
Emotional / Mental Health & Well being Is patient confused / anxious ? Do you experience memory problems? (Verified with NOK / Carer) Evidence of, diagnosis of delirium / dementia? History of other Mental Health diagnosis – CPN involved?			If YES - Care plan & Nutritional Risk Assessment. If Yes – consider Frailty Screening If YES offer Butterfly Scheme and Care plan in place. If YES, consider contact with Mental Health team re: Care and Treatment plan.
Medication **Do you take 5 or more prescribed medications?** Is the patient receiving antibiotic treatment or a recent history of antibiotics Has patient brought medication in? Support required taking medication? Consider if patient suitable for self administration?			If yes consider complications of Poly pharmacy – Consider Frailty Screening If yes ask medical team to review and also commence stool chart. If YES - safe storage and administration All Wales Medication Chart in place. If YES – Care Plan. Refer to Self administration guidelines.
Breathing Is patient breathless / cyanosed? Does the patient require Oxygen? Smoking history and related risks			Care plan in place. If YES - care plan and consider discharge plan if O2 needed at home. All Wales Medication Chart in place and O2 prescribed. Care plan in place in hospital and provide safety advice for discharge.

If document is to be faxed or photocopied please add addressograph here.

Assessment of:	NO	YES	Action:
Infection Control Diarrhoea and vomiting present within past 48 hours? Any history of C Difficile?			If Yes commence Bristol stool chart Complete unplanned Admission diarrhoea and Vomiting checklist. Refer to Doctor to review medication and PPI. Complete Nutritional Risk Assessment.
Does the patient have a history of MRSA colonisation or MRSA infection at any time in the past?			If Yes complete the Clinical Risk Assessment (CRA) Proforma for MRSA and undertake screening as per policies and where appropriate, admit to a single room.
Is the patient currently a resident in a care home or institutional setting (eg prison, homeless hostel), or transferred from another hospital, or had multiple previous hospital admissions?			As above
Does the patient have a wound / ulcer or indwelling medical device which was present before admission to this hospital?			As above
Communication & Information Are there problems with communication? Interpreter Required? Are there any hearing difficulties?			If YES – Care Plan If YES –record action taken
Are there any Vision difficulties?			Introduce to ward area and staff, provide information on visiting hours.
Hearing Aid / spectacles with patient?			If YES, ensure safe storage and easy access
Respect & Relationships Is there anything with regard to faith or culture that we can support the individual with during their stay e.g. prayer, medication?			Ensure clearly documented. Inform Chaplaincy team of admission via switchboard.
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?			Ensure clearly documented provide support as required.
Would you like the ward staff to arrange for a Hospital Chaplain / other faith leader to visit you while in hospital?			If YES – review which faith group and support required and contact Chaplaincy team via switchboard.
Promoting Independence, Mobility & Safety Needs support with mobility, at risk of falls? Have you fallen in the past 12 months? (Verified by NOK / Carer)			If YES – Care Plan and complete risk assessments: Manual Handling / Falls / Waterlow / Bed Rails. Consider Frailty Screening
Aids used to support?			If Yes –have they been brought in, are they appropriate.

If document is to be faxed or photocopied please add addressograph here.

Assessment of:	NO	YES	Action:
Rest & Sleep Difficulties? Aids used to support? Medication?			If YES – Care Plan in place. All Wales Medication Chart.
Pain / Comfort Experiencing pain? Patient has difficulty communicating levels of pain?			If YES – Ensure Pain Score within the NEWS Assessment is completed and acted upon. Care Plan in place. Consider analgesia and alternative pain control methods. If YES – complete the revised Abbey Pain Score
Hygiene, Appearance & Foot Care Is assistance required with Personal Hygiene? Needs help with grooming? Needs help with foot and nail care?			If YES – Care Plan in place. If YES – Care Plan to include hair care and shaving. If YES – Inspect condition of feet and nails.
Eating & Drinking Assistance required eating and drinking / Aids required? Recent unexpected weight loss/ weigh management issues? Poor appetite problems with nutritional intake? Current pressures ulcers or surgical wounds? Swallowing difficulties? Special Diets? Assistance with Hygiene pre meals? Intravenous / subcutaneous fluids required? Poor fluid intake			If YES - complete all Wales Nutritional Risk Assessment and Waterlow. Care Plan in place. Discuss family support. Swallowing Screening / Assessment. Link with Catering. Ensure hand washing / cleansing wipes in place. Fluid Balance Chart needed. Care Plan in place. Peripheral Cannular Bundle completed.
Oral Care Patient is not alert and unable to eat and drink unaided? Patient is unable to clean their teeth and mouth unaided? Patient reports painful mouth / dry mouth / soreness? Does the patient wear dentures? Are they with the patient?			If YES – All Wales Oral Care Tool Mouth Care Plan in place. Mouth care - Brushing teeth/gums Denture Care - Cleaning dentures If YES - ensure they are kept safe in a named lidded container.

If document is to be faxed or photocopied please add addressograph here.

Assessment of:	NO	YES	Action:
Toilet Needs **Are there difficulties with being fully continent of urine at present?** **(Verified by NOK / Carer)** **Are there difficulties with being fully continent of faeces at present?** **(Verified by NOK / Carer)** Does the patient have an indwelling Catheter in situ? Does the patient perform intermittent catheterisation? Assistance required? Continence issues? Moisture Leision? Problems with Constipation / Loose stool?			Consider Frailty Screening If YES Care Plan in place If YES Care Plan in place If Yes, Complete All Wales Bowel and Bladder Assessments refer to All Wales Continence Bundle Complete Waterlow Score. Care Plan in place. Complete Bristol Stool Chart
Preventing Pressure Ulcers & Skin Care Concerns in relation to skin condition			If YES – complete Waterlow and Body map. Waterlow Score 10+ Care Plan in place. Waterlow Score 15+ Care Plan & Skin Bundle Consider need for Datix reporting. DATIX INC number if reported:
Signature:			**Date:**

If document is to be faxed or photocopied please add addressograph here.

Discharge Planning Check List

Action needed:	YES	NO	N/A		**Comments/Signature**
Relative / NOK informed of discharge date & time				Informed by	Date & time
Care Providers Informed, name of agency/ provider:				arranged by:	Detail of agreed care:
Patient has supply of Heating / Lighting / Food and Fluids on discharge				Action taken if not available.	
Follow up appointment				arranged by:	with who and date:
Take home medication				arranged by:	Detail of explanation to patient/carer and by whom:
Take home medication Needing to be administered in the community				Medication chart arranged by:	
Plaster of Paris check				arranged by and date:	Advice given:
Venflon removed				Removed by:	
Discharge advice given				Advice given by:	detail advice given:
Wound care/ removal of sutures/ clips/ staples (delete as necessary)				Dressings supplied for 3 dressing changes by:	Advice for wound care:
Drain/s				Removed by:	If not removed advice for care of and removal:
PICC/ HICK line				Advice given by:	detail advice given:
Catheter care				Catheter discharge pack supplied:	Details:
Continence Aids				Continence Supply Referral made	Details:
Practice nurse (non housebound patients)				Dressings supplied for 3 dressing changes by:	Reason for referral/ professional nursing care required:
District Nurse (if the patient is housebound) please consider if patient/carer/ family are able to perform the care				arranged by:	Reason for referral/ professional nursing care required:
Community Resource Team / Specialist Team				arranged by:	Reason for referral
Equipment				arranged by:	
Transport				arranged by:	