

Time to improve emergency nursing documentation: an overview of expectations

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NEW ZEALAND NURSES ORGANISATION TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Workload complexity

Lorenzetti et al – 2018
“EDs are fraught with risks for poor documentation....”




READY TO RESPOND
KIA MATAARA
CENNZ CONFERENCE 2023
19-20 October 2023 | Christchurch



Documentation



Nursing documentation is a legal record of patient/ client care. It is essential for good clinical communication and a core requirement of the Nursing Council of New Zealand (NCNZ) competencies for scopes of practice.

Good documentation helps to protect the welfare of patients by promoting:

- ☐ High standards of clinical care
- ☐ Continuity of care
- ☐ Better communication and dissemination of information between members of the multidisciplinary care team
- ☐ An accurate account of treatment, care planning and delivery
- ☐ The ability to detect problems, such as changes in the patient's condition, at an early stage.

NZNO, 2021.

Documentation audits and omissions



“A failed audit does not equal failed care”
Michl, Paterson and Bali (2023)



Omitted documented care – 8-84% fully or partly omitted care activities during the hospital stay – Saar et al (2021)

Legal Standards



Health Information Privacy Code 2020

Right 4 of the HDC Code



- Right 4 of the New Zealand Code of Health and Disability Services Consumers' Rights affirms the right to services of **an appropriate standard**.



“Appropriate standard”



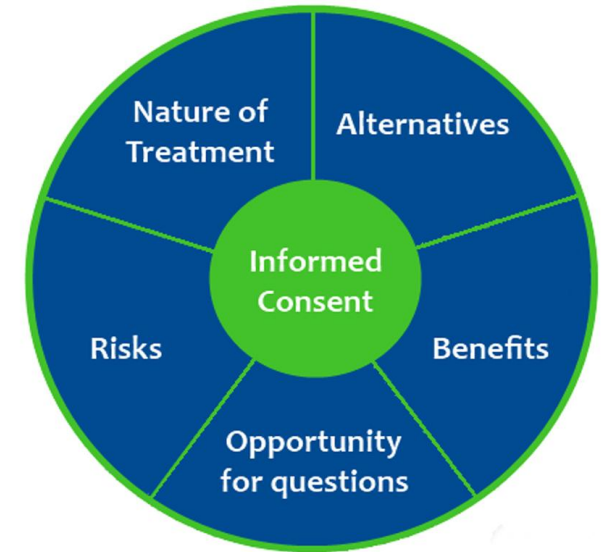
- Provided with “reasonable care and skill” (4(1))
- Comply with legal, professional, ethical standards (4(2))
- Consistent with consumers needs (4(3))
- Minimise harm to consumer and optimise quality of life (4(4))
- Provided in co-operation by providers to ensure continuity (4(5))



Gaps in documentation – red flags



- Deteriorating patients
 - Escalation pathways
- Management of pain and response to analgesia
- Delays in care and timeliness in care
- Transitions in care
- Informed consent
 - The process of gaining consent
 - Providing sufficient information to make choices and give consent



When practice is scrutinised

- Retrospective notes are not best practice
- Contemporaneous notes are gold standard
 - Timeliness
 - Escalation of issues
- Observations recording – vital signs and trends,
 - Omissions – incomplete observations
 - Limitations of digital software
- Organisational wide reporting
 - Reportable events – Riskpro, Safety First,



Documentation, 2021

Cooperation between health practitioners, referrals and advice



- Document conversations in the health record
- Emails and letters – need to have a process to access and store in the health record

Responding to adverse events



- NZNO financial members have indemnity insurance
- Notification to NZNO early is advised
 - – to enable advocacy, support, and coverage of indemnity

Future?



ARTIFICIAL INTELLIGENCE



VOICE RECOGNITION SOFTWARE



TEMPLATES NEED TO
INCORPORATE NURSING ACTIONS

Contacting NZNO:



NZNO Member Support Centre

The easy way to contact NZNO

0800 28 38 48

8 am to 6 pm Monday to Friday



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