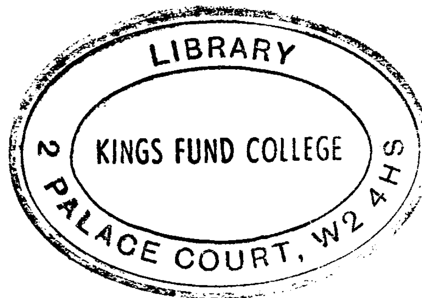
KF PROJECT PAPER

1983
REFERENCE

NUMBER 21



A handbook for nurse to nurse reporting

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The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its new permanent accommodation in Camden Town has improved facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

Published by the King's Fund Centre,
Printed in England by Trident Services, London SE1.

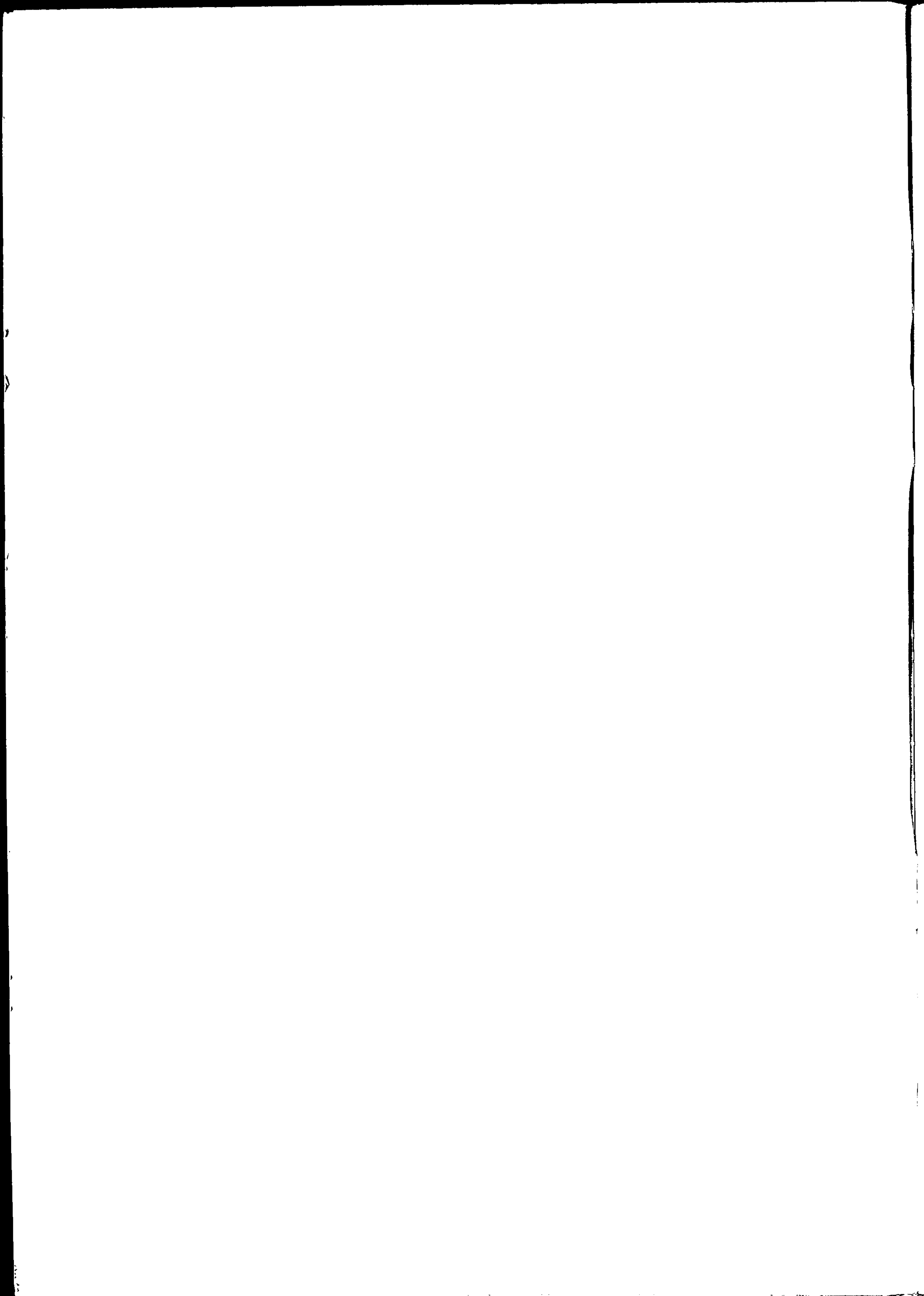
PROJECT PAPER

29 JUN

A HANDBOOK FOR NURSE TO NURSE REPORTING

March 1983
2nd Edition

King's Fund Centre
126 Albert Street
London NW1 7NF



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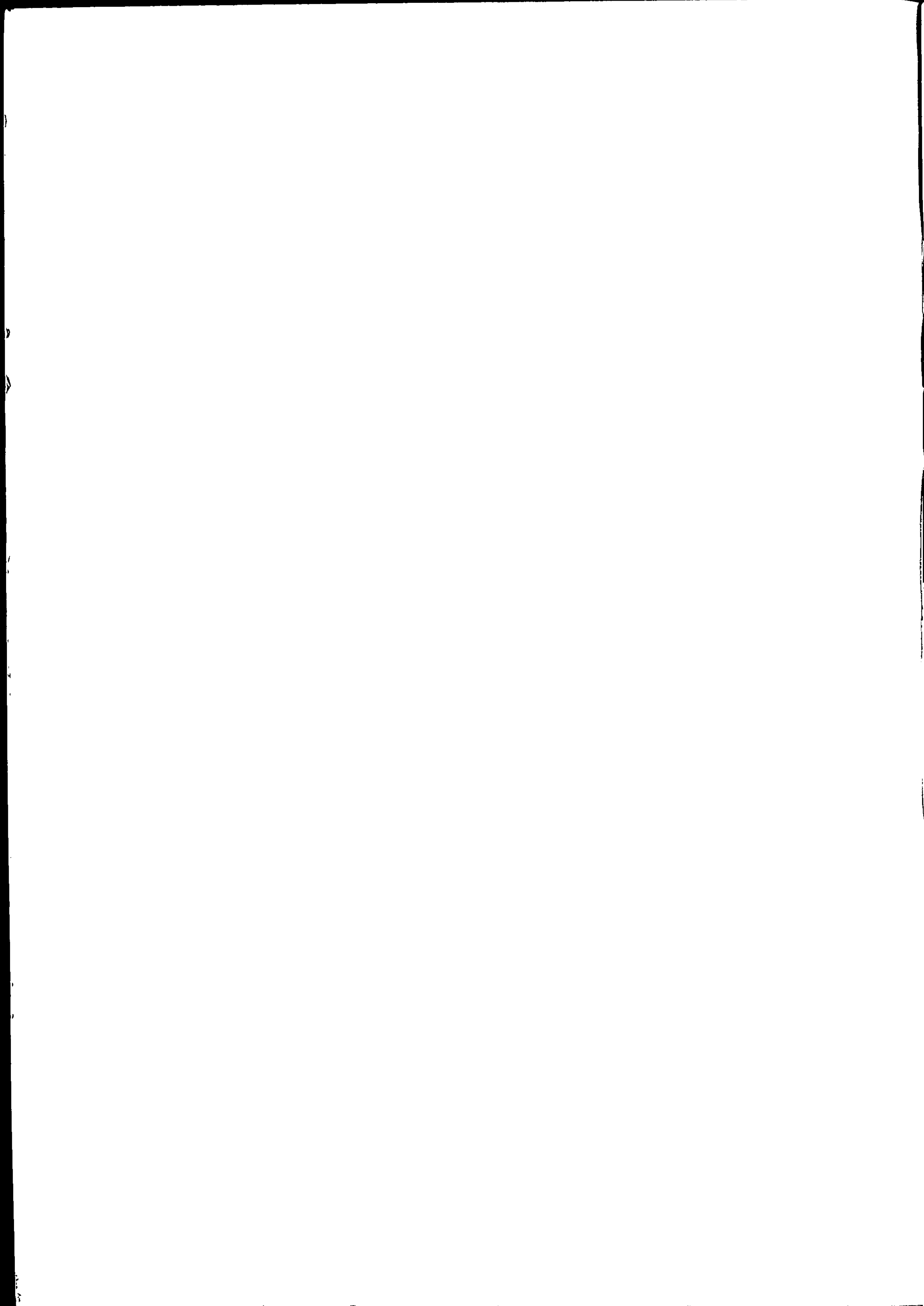


FOREWORD

The King's Fund published the first edition of this project paper in March 1979. It has been printed four times and sold over 16,000 copies.

This expresses both a need for this type of information as well as the success of the original paper.

The work originated from a series of meetings entitled "Nurses Reporting on Patients" which was held at the King's Fund Centre from 1973 to 1977. A small working party formed from among the participants met regularly in order to produce some guidelines to the subject.

The working party realised on completion of the guidelines that they were already out of date due to an increasing focus on the nursing process and subsequently, a conference "Nurse to Nurse Reporting" was held at the Centre in March 1982 to follow through some of the original ideas.

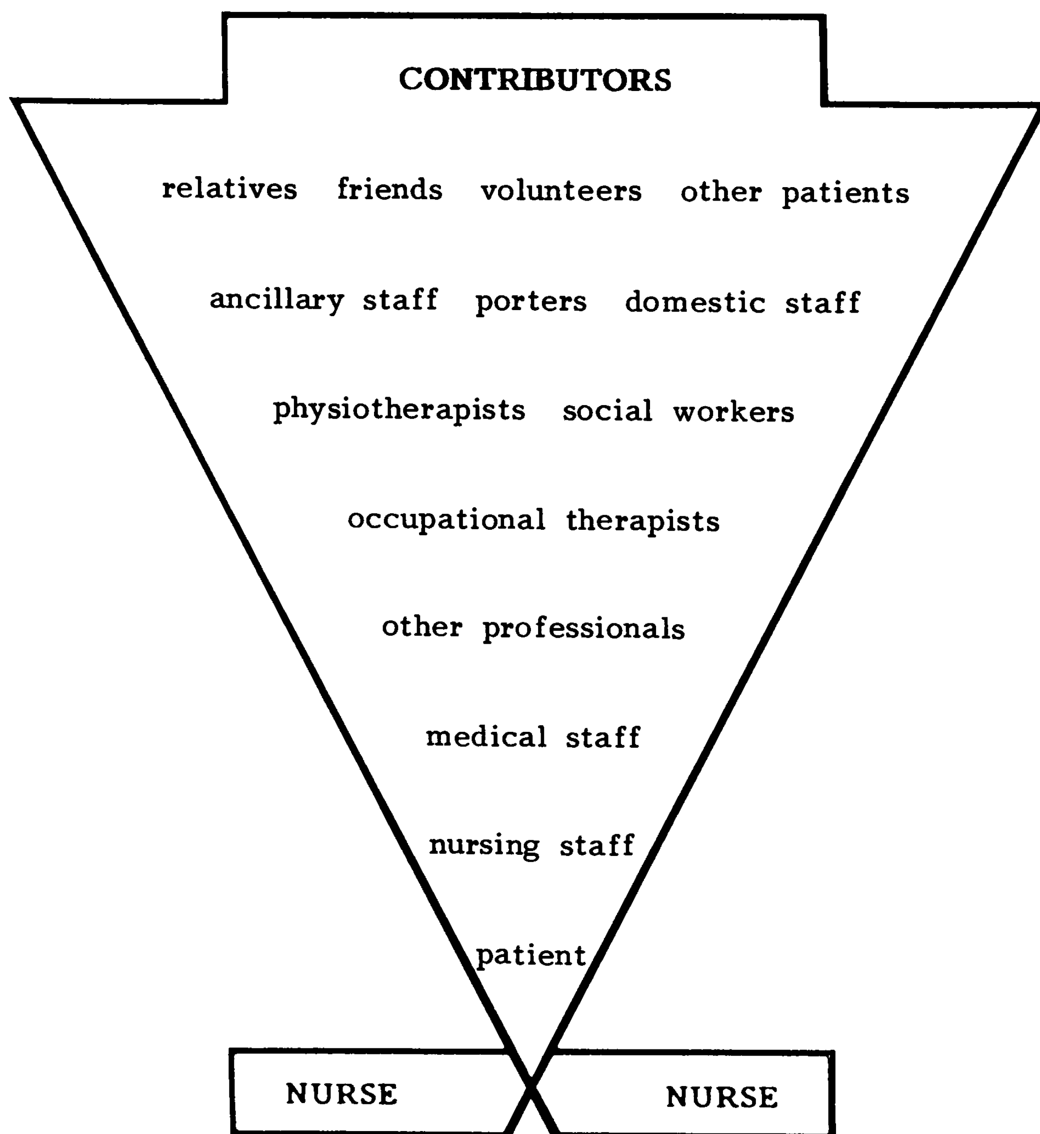
Participants requested that there should be a revision of the work in order to keep up with developments. This edition is the result and builds upon knowledge of the prior work.

Although the guidelines have been written for nurses working in acute specialties, the principles for good nurse to nurse reporting also apply to other specialties and in primary health care.

For convenience and by custom the feminine pronoun is used throughout to refer to nurses and the male pronoun to patients.

All statements can refer equally to men or women.

CONTRIBUTORS TO COMMUNICATION



INTRODUCTION

Communication

Communication is about much more than the passing of instructions from senior to junior staff. The skills needed by nurses to communicate effectively with patients, patients' families, colleagues and other members of the health care team are many and varied. They include speaking and listening, reading and writing as well as the non-verbal methods people use to convey meanings to each other.

We communicate by:

* what we say
* the tone of voice we use
* our use of pauses or silence
* the way we stand or where we sit
* the way we walk
* the hand movements we use
* facial expressions - smiles, frowns, grimaces
* the way we look at each other - eye contact
* touch
* the sounds we make - sighing or laughing.

We are often not aware of the nature and intensity of the non-verbal messages that we are transmitting to others. Considerable anxiety is evoked in the person we

are trying to communicate with when verbal and non-verbal messages do not match. This is because the receiver of the communication has to decide which of two or more messages to respond to.

An example of this kind of situation is where a nurse says to a patient "How do you feel?" (inviting him to talk about himself) and at the same time edges away from him (showing that she is too busy to listen to a long and complicated reply). Often a patient will respond to the non-verbal message, mutters "fine" and fails to reveal some important change in the nature or severity of his symptoms.

Remember that when made to choose between the verbal and non-verbal message people will tend to act on the non-verbal one. This is particularly true of children and the very ill patient.

Nurses communicate all the time. They exchange ideas, information and feelings with patients, patients' families and with colleagues. Effective communication is a skill and is as important as the technical skills which nurses need to develop. Nurses constantly need to reinforce these skills in order to report accurately and concisely. One way of helping this is through the reporting system.

Job satisfaction for nurses and patient satisfaction with nursing care are both increased by good communication.

A nurse who is able to communicate with a patient and is sensitive to what a patient is trying to say will be better able to identify his nursing problems, plan his nursing care and involve him and his family in that care.

New information relating to a patient's condition and his response to care is being obtained all the time. Such information must be available to all members of the team. It should therefore be written down as well as communicated orally. In this way it is incorporated into the formal system used for nurse to nurse reporting. This system, when used flexibly and creatively, is the key to nursing action.

Formal nurse to nurse reporting is made up of the following elements:

1 oral* and verbal* reports e.g. in handover period between shifts, messages between the nurse in charge and other nurses during a shift, telephone calls.

* see page 5 for definition

Such reports include:

a general information about a patient on arrival
b care plan for nursing action required
c daily record of a patient's progress
d observations required and/or carried out by the nurse

This information may be recorded in the nursing history, care plans, nursing assessments, progress reports, nursing sheets, charts, ward record books.

2 the written nursing records.

3 written reports or letters used for communicating with nurses outside the immediate work area, for example, senior night staff, or with community staff, when a patient is being transferred or discharged.

This handbook is concerned with verbal reports and the written record.

Remember that neither you nor others can act without the necessary information. Others in the team are often dependent on what you said or wrote yesterday in deciding what they will do for a patient today.

ORAL AND VERBAL COMMUNICATION

Definitions

Oral Communication - refers to the spoken word only.

Verbal Communication - refers to the spoken word that will eventually be written down as part of the formal record.

Oral Communication

All nurses need to receive a report on their patients before they start a period of duty. This may be given by the nurse in charge or by each nurse who has been caring for a group of patients on the previous shift. If there are detailed written care plans available, the oral report needs only to be a brief updating of a patient's progress and any significant changes in his condition.

In order to be effective, efficient and safe oral communications need:

* to be a two-way process
* to be supervised for accuracy and detail when given by a learner
* to be conducted in an undisturbed, quiet area of the ward, or if appropriate, privately by the patient's bedside with the patient participating

* to be audible and delivered in a simple, concise manner explaining unfamiliar terms to the learners
* to involve teaching and discussion e.g. in case conferences, in patient-centred problem solving tutorials.

Verbal Communication

Accurate verbal reporting in the form of nurse to nurse reporting is essential in order to ensure good communication not only between nurses but with the patient and other members of the health care team.

Verbal communications need:

* to be accurate and concise relating at all times to previous reports or problems identified
* consistently to use familiar terminology that is understood by all

Verbal communications involve:

* discussion with patients about their care and progress quoting the patients' actual comments
* consultation with the patient and his family when relating to the written care plan: this may involve documenting that the care is to be given by them
* checking that support and services are actually available and ordered when discharging patients into the community.

Dealing with the telephone calls from relatives and friends about patients is another aspect of verbal reporting. The nurse needs to give accurate and individual information about a patient, having verified the identity of the caller if she does not recognise the voice. Specific details about diagnosis, findings at operation and biopsy reports should not usually be given over the telephone. However, if a patient's condition is serious, the nurse should indicate to the family how quickly they need to come and visit the patient.

Messages for a patient should always be conveyed as soon as possible. The substance of the telephone conversation should also be reported to the nurse in charge and relevant information written in the appropriate nursing record. Junior nurses should not be expected to deal with enquiries without adequate supervision from the nurse in charge.

Safe telephone usage requires:

* permission from the nurse in charge when giving information by telephone
* confirmation by the nurse in charge that information obtained from a telephone call should be given to the patient
* accuracy of detail when dealing with telephone information which involves

  - listening to the message
  - writing the message down
  - repeating it back to confirm accuracy
  - reporting to the nurse in charge as soon as possible
  - recording it if need be.

Transfer of patients

When patients are transferred between wards, hospitals, or to the community ensure good preparation by checking:

* when the transfer is to take place
* where the patient is to go
* that relatives have been informed
* that any property is transferred with the patient
* that notes, nursing records, drugs, observation charts, x-rays, care plans, drug charts, aids are all transferred with the patient.

Oral communication

* consider the patient's feelings, tell him why he has to be moved
* if possible, tell relatives why and where their relative is to be moved.

Verbal communication

The nurse caring for the patient should preferably conduct the transfer:

* to the nurse who will be caring for the patient and/or to the nurse in charge

* referring to the care plan and nursing records as a guide when reporting; this will help with accuracy
* concisely covering all aspects of care; physical, psychological and social
* without rushing her report as this will be the only means of providing good continuity of care.

THE NURSING RECORD

The nursing record is the only continuous account of a patient's nursing care in hospital/community and may provide information which is not available elsewhere. It is a confidential document and consists of:

information about a patient including background, lifestyle and problems

a written plan of nursing care

a record of the care which has been given

a record of the care given and an assessment of its effectiveness.

Sources of information about the patient

There are various sources from which information concerning a patient may be obtained. These include:

* the patient himself
* his family or close friends
* the nurse's own observations
* other nurses who have cared for him
* medical staff and case notes
* other members of the health care team e.g. social workers.

In some hospitals the nurse who admits a patient makes a brief summary about the patient, his social circumstances, medical diagnosis and proposed treatment and writes this information at the start of the nursing record.

Other hospitals and community nurses now have a printed nursing assessment or nursing history form where detailed information about the patient can be written down. The nursing assessment helps to identify current 'problems' or 'needs' that the patient has and to set realistic goals for his care. The written record allows information to be shared with all nurses involved in the care of the patient on day and night duty.

A WRITTEN PLAN OF NURSING CARE

Instructions indicating the nursing care needed by a patient can be given at any time orally or in writing. If an instruction is given orally it should subsequently be documented in an appropriate part of the nursing record.

There are several different formats for written plans of nursing care. Regardless of these differences, all should enhance continuity of care.

Written instructions must be:

Legible

Up-to-date - An instruction given at the beginning of a shift should be reviewed and altered as necessary.

Unambiguous - 'Push fluids' is an example of an instruction that is frequently given. It may have a single meaning for the nurse who gives the instruction but is open to many interpretations. The nurse looking after a patient must know how much her patient should be encouraged to drink, how often he should drink and whether there are restrictions on what he may drink e.g. 100ml fluid each hour, Marmite not to be given.

Related to an individual - The nurse giving an instruction and the nurse carrying out the care must be sure that they know about which patient they are talking. Care should be tailored to the needs of each particular patient.

Accessible - To the nurses caring for the patient.

NURSING CARE PLANS

These are written statements of the needs and/or problems of a particular patient, specific goals of care to meet each need or problem and the nursing action required. Plans usually include individual goals related to self care, for example "to manage own colostomy" or "to dress without assistance" which help to define what it is that the nurse and patient are trying to achieve together.

Nursing care plans are based on all the facts gathered during the nursing assessment of a patient and on the nurse's clinical knowledge. They therefore encompass the physical, psychological, social and spiritual aspects of the patient's care.

The patient and appropriate relatives should be involved in the drawing up of the care plan unless circumstances dictate otherwise. The care plan is written by the nurse allocated to the care of a particular patient but it is there for everyone working with the patient to see and use. It is updated whenever necessary.

NURSING ORDER SHEETS

Occasionally a patient may have a sheet which details the nursing care he needs in chronological order. It usually concentrates on the physical aspects of care. This is updated as the patient's condition changes and he, therefore, requires different nursing care.

COMPUTER PRINTOUT NURSING INSTRUCTIONS

Some nurses have access to a computer and are able to produce printed care plans for each patient. They can be updated easily by feeding in any change in care and continuing nursing care which has not been changed.

Whatever type of written plan of nursing care is used, it must be easily accessible to all nurses who are caring for the patient. Some hospitals keep them at the end of each patient's bed. Other hospitals store care plans in ring-binders or individual folders at a central point such as sister's desk where they may be consulted easily.

District nurses may leave individual records in each patient's home. Care should be taken that no embarrassing or otherwise confidential information is included.

Giving the care which has been planned

The nurse in charge needs to know that the nurses understand the care that they are to give to the patient and that they have the necessary skills and knowledge to carry it out. The nurse in charge is responsible for ensuring that the correct care has been given to the patient. Priorities will have to be set according to the availability of staff and resources.

Reporting on the care given and assessing its effectiveness

The format of some written instructions about nursing care allows space for a signed confirmation that the care has been given and for comments and observations or for an explanation why certain aspects of the care have not been carried out. Other types of nursing record have a separate sheet where regular reports are written about the care which has been given and a patient's progress or deterioration.

Written reports such as "usual day" or "satisfactory" are only meaningful to someone who knows the patient well. For example, for a patient receiving terminal care, sitting out of bed for half an hour and drinking a little soup for lunch may well be a "satisfactory day", but for someone who is recovering from an operation this term might indicate that he has eaten well, enjoyed a walk to the shop and helped to make his bed. It is more helpful to write a brief factual statement of events.

Assessment of the effectiveness of nursing care for a particular patient is made easier when his needs and problems have been clearly identified and goals of care written. It is then possible to evaluate whether nursing action is achieving those goals and, if not, consider changing some aspects of nursing care. It is often helpful to record the patient's comments on his progress using his own words as well as the nurse's assessment.

While a summary of the patient's condition may be recorded at the end of each shift any information concerning him should be recorded as soon as it is possible. Situations giving cause for concern should be reported to the medical staff, the fact recorded immediately and a note made of the action taken.

Writing the nursing record may be undertaken by a learner. It will provide experience in writing concisely, reviewing the nursing care given and anticipating the patient's future needs. However, the learner should be supervised until proficient and all written nursing records should be checked by the trained nurse in charge.

Remember that:

* information about the patient is written down so that it is shared with all nurses involved in his care
* written instructions about nursing care must be legible, up-to-date, unambiguous, relate to an individual and be easily accessible to the nurses caring for the patient
* written records do help to ensure that a systematic picture of a patient's progress is available at all times and is not just held in the mind of the person in charge.

CLASSIFICATION OF THE RECORD

In order to standardise record management, the Standing Medical Advisory Committee (Tunbridge 1965) suggested a classification for records. The nursing record is classified as a **primary document** that is a record that will be of importance to a patient's care throughout his stay and during later spells of treatment. It will form a permanent part of the patient's case folder together with other documents, like the general practitioner's original referral letter, the hospital medical record and social records.

Diagnostic reports such as microbiology, haemotology and electrocardiograph reports, are classified as **secondary documents.**

Temperature, pulse and respiration and blood pressure charts are all **transitory documents** and may be destroyed when the patient is discharged as it is expected that observations considered significant at the time of recording should have been noted in the primary document.

Retention of personal health records

The retention of all personal health records is the responsibility of the Health Authority and Departmental guidance is contained in DHSS Health Circular HC(80)7.

THE WRITTEN NURSING RECORD AS A PROFESSIONAL DOCUMENT

The main purposes of the nursing record are to:

* demonstrate that each patient receives the appropriate nursing care at a professionally acceptable standard
* maintain continuity and to provide a means of communication between the various disciplines concerned
* record any changes in the condition or circumstances of the patient
* provide a permanent record for future reference for research, teaching and/or investigation for legal purposes.

The nursing record should demonstrate that nursing care is planned and not simply an haphazard series of events. It should record the fact that planned care has been given, its effect and the general state of the patient.

It is a professional document and what is recorded by whom and the frequency of recordings is a matter for professional judgement in the light of local circumstances. Responsibility for the maintenance, content and standard of the nursing record rests with the nurse in charge of the clinical area concerned - taking into account any specific guidelines which may be laid down by the Health Authority.

As with other areas of professional practice the nurse will be expected to maintain records to professionally acceptable standards. Likewise, details of patient care recorded will be expected to meet professionally acceptable standards. The record should be complete and in any matters involving litigation would be expected to demonstrate:

* a professionally acceptable standard of record keeping and
* a professionally acceptable standard of care.

Separate temperature and bathing books are traditional records outmoded by modern practice and should not be kept.

When formulating local guidelines on nursing records it is important that they concentrate on what is professionally acceptable and required in order to meet the primary purpose, that is to provide a complete record of the patient's nursing care needs, progress and the care and treatment given (or not given where this is significant). The guidelines should give a clear indication of which nurse has responsibility for the quality and completion of the record. This will usually be the nurse actually giving the care to the patient.

The record and the nurse's duty of care

A nurse will be liable in negligence if her acts or omissions fall short of the standard of her profession and damage results to a patient. The nursing record will be important evidence if such allegations are made.

The nurse in charge need not countersign another nurse's entry; but it should be remembered that she is responsible for the supervision of unqualified staff in the management of the nursing records. The nurse in charge should be traceable through

1. the ward record of staffing levels
2. the nursing administrators
3. the hospital personnel department.

Safe recording practices

* records should be completed as near to the event or observation as possible
* entries in the written nursing record should be in indelible ink - replay ballpoints or pencil should not be used
* each entry should be dated and signed with the initials and full surname of the nurse writing it - recording the time may also be important
* errors should be lined through and signed or initialled by the nurse correcting the error (as if it were a cheque book mistake)
* the use of correcting fluid or sticky-backed paper should be discouraged
* abbreviations can lead to misunderstandings
* colour coding should not usually be used - certain colours are difficult to read and can confuse where staff and records are mobile

* the administration of Controlled Drugs need not additionally be noted in the nursing record unless this is significant to the nursing care, because there is Controlled Drug recording elsewhere.

Nursing auxiliaries should not usually write in the nursing record as it is a professional document. If however the hospital policy is such that it gives authority to auxiliaries so to do and the hospital is satisfied that this should continue for reasons such as trained and student staff shortages, then such practice may continue.

CONFIDENTIALITY AND RESPONSIBILITY FOR STORAGE OF PATIENTS' NURSING RECORDS

The nursing record is a confidential document. Access to it may be restricted but it should be available for doctors, nurses and approved paramedical staff.

Patients' records must always be kept in a safe container or trolley in the sister's office or similar accommodation and the **nurse in charge is responsible for safe storage.**

Storage of records in the community requires special consideration. They should be stored in locked, fixed containers at Health Centres or offices. Great care must be taken over the holding of the keys.

Additionally, if electronic storage and/or computers are in use in the hospital, ward, department, community, the nurse using the machine must further satisfy herself that she knows how to operate the system, and that there is no breach of confidentiality by any unauthorised person, interfering with the system in any way.

Nurses need to be clear about the extent of their responsibility and this should be discussed with their nurse managers and/or professional body. A nurse should consult those to whom she is accountable if she foresees any difficulty.

The nursing record and other components of a patient's record may be released by court order to legal, medical or other professional advisers of a patient either prior to or during legal action.

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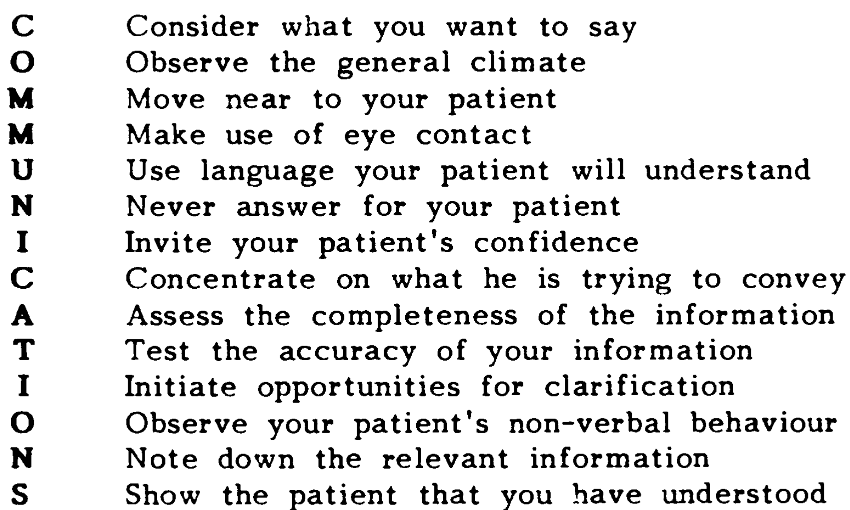
C Consider what you want to say
O Observe the general climate
M Move near to your patient
M Make use of eye contact
U Use language your patient will understand
N Never answer for your patient
I Invite your patient's confidence
C Concentrate on what he is trying to convey
A Assess the completeness of the information
T Test the accuracy of your information
I Initiate opportunities for clarification
O Observe your patient's non-verbal behaviour
N Note down the relevant information
S Show the patient that you have understood

SUGGESTED FURTHER READING

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ACKNOWLEDGEMENTS

We wish to thank all the hospitals and organisations as well as the many ward sisters, nurse tutors and student nurses who have influenced our thinking.

We appreciate, also, the advice and assistance extended to us by the Department of Health and Social Security, the General Nursing Council and the Royal College of Nursing.

We have drawn heavily upon the successful work of those who produced the first edition - without whom our task would have been more difficult and less inspired. We hope that in developing their previous thinking we have done justice to the work they so ably began.

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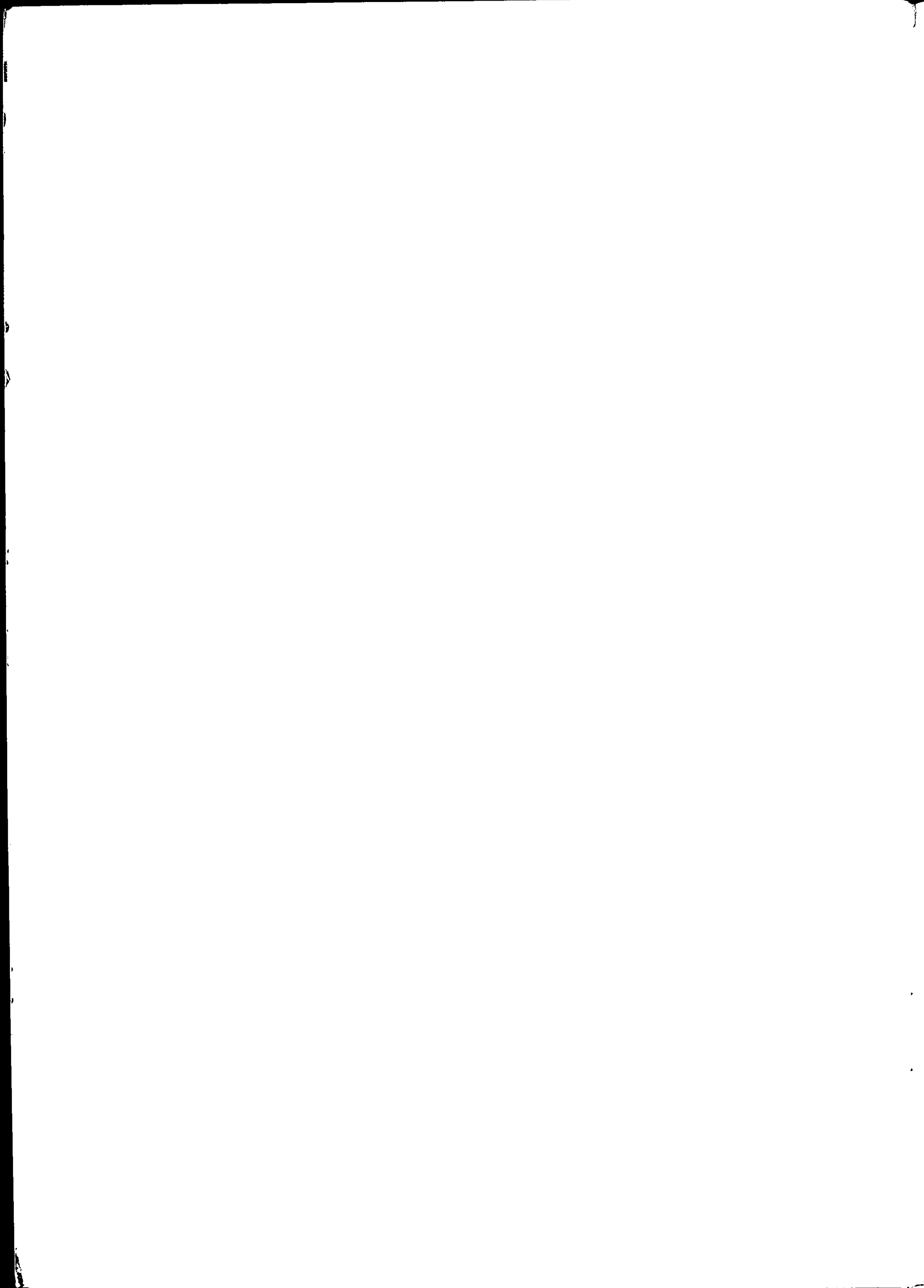
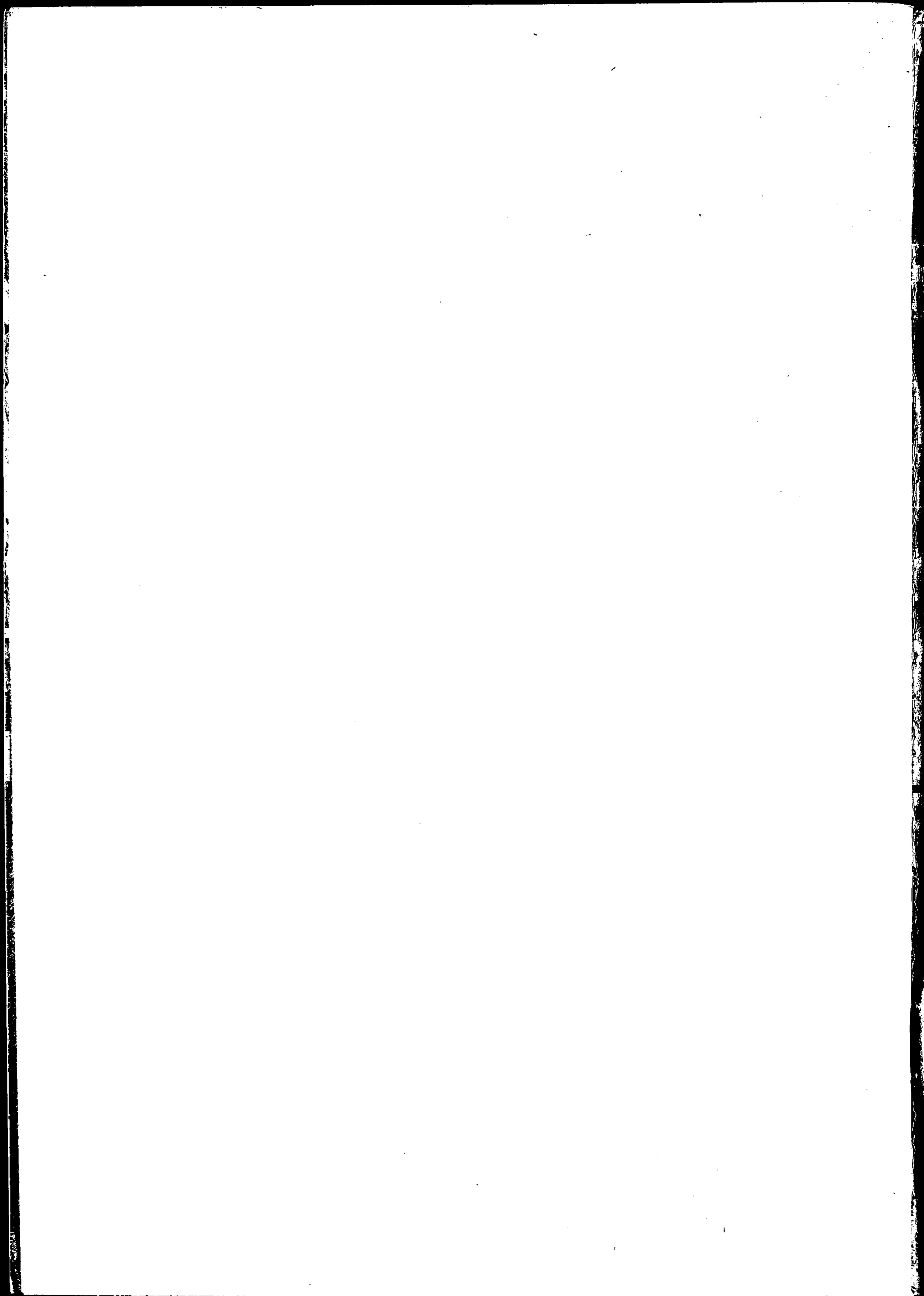
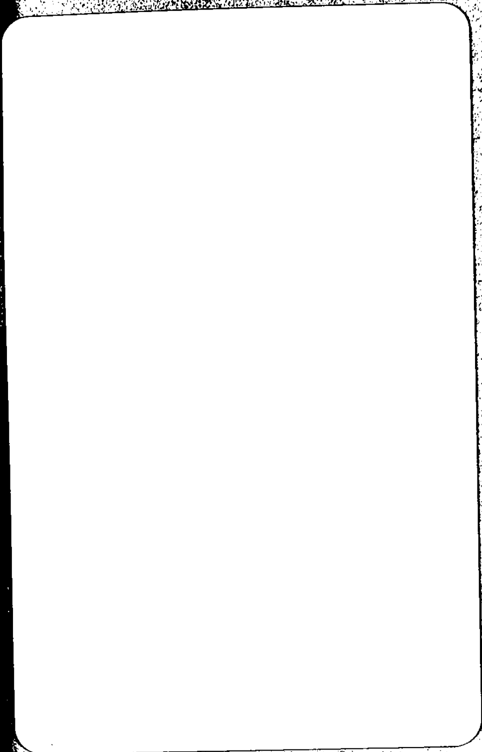
The Working Party are indebted to Miss P Hannay for her work in placing the draft on the word processor.







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