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Some Nurse-to-Nurse communication and record keeping considerations and the Exeter Nursing Systems

Original reference Astbury, Charmian (Nursing Officer, Computer Research and Liaison, Royal Devon and Exeter Hospital) (1982) Some Nurse-to-Nurse communication and record keeping considerations and the Exeter Nursing Systems.

Presented: Seminar November 8th/9th 1982. Bazis, University Hospital of Leiden, Netherlands

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SOME

NURSE - TO - NURSE

COMMUNICATION and RECORD KEEPING

CONSIDERATIONS

AND

THE EXETER NURSING SYSTEMS

by

Charmian Astbury

Nursing Officer, Computer Research and Liaison

Royal Devon and Exeter Hospital (Wonford)

Exeter

1982

Presented:

Seminar November 8th/9th, 1982.

BAZIS

University Hospital of Leiden
The Netherlands.

SOME NURSE-TO-NURSE COMMUNICATION
AND RECORD KEEPING CONSIDERATIONS
AND
THE EXETER NURSING SYSTEMS

Charmian Astbury
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INTRODUCTION

For the purposes of this Seminar presentation, it is intended to consider, from the nursing point of view, some nurse-to-nurse communication and record keeping aspects of the Exeter Nursing Systems, against a brief background of their development and current status. The discussion will indicate the direction in which development of the Systems, particularly in relation to the philosophy of the Nursing Process, hopes to proceed.

BACKGROUND

The Royal Devon and Exeter Hospital (Wonford) is an acute general hospital of 425 beds, now 8 years old. The Nursing Systems at Exeter are part of a large computer project, 'The Exeter Community Health Services Computer Project', which, in the first instance, was government funded. The development of the Nursing Systems commenced over ten years ago in 1971, while the hospital was still on its original city site, with a survey of the nursing orders in current use on the wards. A nurse working party was formed. This was made up of a nursing team of clinical, teaching and administrative nurses, and a computer team of systems analysts, one of whom was also a nurse. The content and form of Nursing Orders in current use were classified according to an agreed format. For instance, orders concerning general hygiene, mobility, fluid intake and so forth were classified as those belonging to the Basic Care category, orders concerning such items as care of drains, dressings and similar concerns were classified as belonging to the Treatment category. (Appendix 1).

The main headings, the 'Page Numbers' in each category were expanded as to content (Appendix 2). By the end of the first years work on the analysis of the nursing orders, the working party had produced an agreed arrangement of Nursing Order information. The initial design of the Nursing Order Update sequence was developed simultaneously, and the following year saw a similar approach to the development of the facility for Reporting on Care Given.

Two wards, one medical and one surgical, piloted the Exeter Computer Nursing Systems in 1976. In 1980 all fourteen acute wards in the tower block at Exeter were introduced to the use of the Nursing System and they have been operational ever since, and have even weathered the changeover to new equipment that occurred in August of this year.

What the use of the Nursing Systems has meant to the nurses in practical terms is that they have been released from some of the burdensome paperwork of ward and hospital organisation. For instance, the Nursing Orders input to the Systems produces Ward Workload Information, a valuable communication link between ward based staff and nurse management; the Admission and Discharge information, keyed in at the Ward Visual Display Unit provides the ward and the hospital, on a daily basis, with a record of their Admissions (where from), Discharges (where to), and the numbers of patients for each Consultant.

The Information Retrieval part of the Nursing Systems can be accessed without a password, and is a much used facility. Nursing Procedures and Pharmacy Information is always available on the centrally placed, ward-based Visual Display Units.

Much interest has been, and is being shown, in the Exeter Nursing Systems. So far this year there have been twenty-two separate visits from nurses from all over the world. Papers describing the system and its use have been presented at Berlin in 1977, Dublin in March 1982, and in London and Harrogate in September, 1982, and are referenced in the Bibliography. In this paper it is intended to consider some nurse-to-nurse communication and record keeping aspects of the Exeter Nursing Systems.

COMMUNICATION

Communication may be described as the interchange of meaning between individuals (Kings Fund, 1979). For communication to occur there must be one who sends, one who receives, a route between them, a message and a response. (Figure 1)

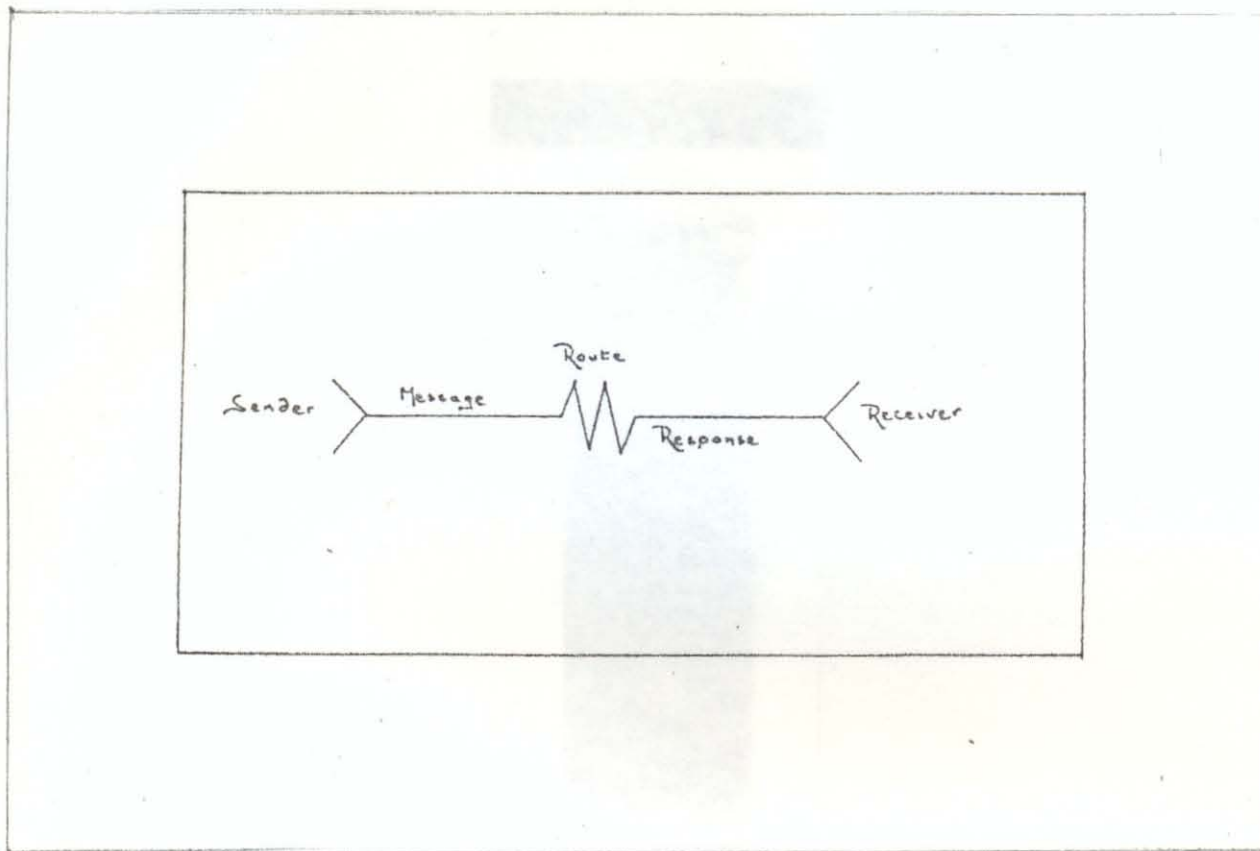


Figure 1. Communication Pathway

Nurse-to Nurse communication is vulnerable to the complexities within this apparently simple pathway. Communication between individuals may be verbal or non-verbal. It depends upon the skills of writing, reading, comprehension and composition, as well as an understanding of human behaviour. It further depends on language and vocabulary used. In English, the Oxford English Dictionary describes some 14,000 different meanings for 500 words in common use. Providing information in a nurse-to-nurse communication pathway that is easily read and easily understood, as well as quickly composed and written, can be difficult. Communication pathways can, and do, breakdown, and the detrimental effect on both staff morale and patient recovery rates is recognised (Revans, 1964).

Effective management, in whatever organisation, can only exist where there are good, workable communication systems, whether or not these rely on the spoken word, pencil and paper or a computer. The management theorist Drucker (1967) identified communication as a significant component of effective management. Revans (1972) discussed the understanding of an organisation by its members as a crucial communication element, and Pembrey (1980), in her analysis of the work of the ward sister, stressed the requirement for communication in the hospital environment to be information based.

The communication pathway of the Exeter Nursing Systems provides the nurse, at the point of delivery of care, with a clearly printed, readily understood and unambiguous statement of nursing information for each patient.

The password system identifies the nurse using the Nursing Systems, and this allows the fact that care has been given to be 'reported' or 'signed for'. This communicates to other nurses what care a particular patient has received and who has given it.

A further element in this consideration of nurse-to-nurse communication is that Exeter, since February 1981, has been part of the World Health Organisation Medium Term Nursing Process Development Project. Therefore, the organisation of nursing information to be communicated to the nurse, has to be within the Nursing Process philosophy of assessment of needs, planning of care, giving of care and evaluation of care given. At present the documentation of patient care in use at Exeter consists of a care plan (manual) in which the patients history is recorded, and a care plan print (computer) on which the nursing information/orders are printed. (Appendix 3). The computer printout, on which non-sensitive information only is printed, is kept, either at the end of the patients bed, or at the entrance to the six bed bay. It is not considered a document to be kept out of the patients way, or that of his relatives.

The Exeter Nursing System allows for nurse-to-nurse communication beyond the immediate care situation of the ward. The Recording of Care Given facility, which requires the nurse to 'sign off' not only informs nurses on the ward about care given, but may be used by the School of Nursing as a record of learner experience. Furthermore, each nursing order attracts a certain weighting which allows the daily workload for each ward to be calculated. The weighting figure is based on the patient dependency studies of Barr (1967) who identified five major patient dependency groups. The use of such information can be a valuable management tool (Jarvis, 1982).

The nursing care information input to the Computer Nursing Systems at Exeter provide for a nurse-to-nurse communication medium in four areas :-

- (i) at delivery of patient care
- (ii) whether care has been given and by whom
- (iii) learner practical experience
- (iv) workload information

THE NURSING RECORD

Paperwork has never been popular with nurses, for it is always seen as interfering with their primary function of patient care, an attitude that may result in inadequate nursing reports leading to misunderstandings, with the additional possibility of disastrous legal consequences (Young, 1982). The maintaining of the nursing record is a patient related skill that has to be learnt and practiced like any other (RCN 1981). The nursing record itself forms one of the three significant parts of nurse-to-nurse reporting, the other two being the verbal communication at the end of shift handover as well as the 'out of ward' communication, in the form of letters or reports to community staff or senior night staff (Kings Fund, 1979).

The nursing record provides the only continuous account of the patients' hospital stay, and should be considered a primary document (Kings Fund, 1979). It is an aid to both teaching and research, it is confidential, and as a professional document it may be required for legal purposes. But, first and foremost, the nursing record is the patient care plan, and the nursing information relating to that care plan, and as such is a guide to the assessment, planning, implementation and evaluation of nursing care.

There are many formats for recording care within the overall philosophy of the Nursing Process (Heath & Law, 1982) most of which use some form of card system, such as Kardex, to hold the nursing history and care plan, as well as some form of nursing information or order sheets. The requirements for the actual documenting of patient care are that the entries should be legible and clearly stated, that neither abbreviations nor colour-coding should be used, and that the nurse inputting the entry should be guided by the policy of the hospital (Gwynne 1978; Kings Fund, 1979; Young, 1982).

In producing a nursing care plan print for each patient everyday, the Exeter Nursing System provides automatically for the nurse a format that conforms to these criteria (Head, 1977). The print is clear, using upper and lower case type on good quality paper. The statements are clear, unambiguous and arranged within the categories of care, and the care already carried out will carry the appropriate signature, (Appendix 3). Abbreviations are avoided, and it is interesting to note here that the introduction of the computer nursing systems at Exeter caused the abbreviation use rate of 17.4% apparent in the manual record to fall to 0% (Kumpel & Davis, 1982).

Following the patient care policies of the hospital when using the Exeter nursing systems is straightforward, even for recently appointed staff, for by merely depressing the appropriate key the nursing procedures as practiced will appear on the Ward Visual Display Unit.

The two parts of the Nursing Record are stored separately. The care plan print part of the nursing record is, at present, stored on micro-fiche. This means that the nursing care for every patient everyday, and the identity of those who prescribed and gave the care, may be accessed by nursing staff if required. The Kardex care plan is filed with the medical notes, as is the Discharge Print, a document containing the current orders for the day, the deleted orders, and the identity of the nurse creating or cancelling these nursing orders. The Discharge Print is produced automatically when the patient is discharged from the Nursing Systems.

The care plan print produced by the Nursing Systems at Exeter records -

- i) the care ordered
- ii) the care given and by whom
- iii) the learners practical experience
- iv) workload information

THE FUTURE

Indications of the direction in which the development of the use of the Exeter Nursing Systems are proceeding have been discussed recently. Its potential for use as a tool for nurse management (Jarvis, 1982), and its potential for use in the organisation of care information (Head, 1982) have aroused interest nationally and internationally.

The present position at Exeter is that screens or pages are being developed that reflect a Nursing Process approach for patient care assessment. The nursing information is organised by using, as a guide to assessment, the activities of daily living, (Roper, Logan & Tierney 1980; Henderson 1966). The nursing organisation is divided into two main areas of non-sensitive (appearing on printout) and sensitive (not appearing on printout) information, and further divided into sections relating to mobility, sleep patterns, communications and so forth. It is intended that this type of information should be collected during the patients admission and the first day or so of his stay in hospital.

At the same time as the developments just mentioned, one of the surgical wards at Exeter is exploring a possible problem orientated record approach (Phaneuf, 1976) to the documenting of care using the Nursing Systems. The identifying of nursing actions, and the problems or potential problems that caused the nursing actions, for a particular fit surgical admission, has provided a valued ward teaching aid as well as a possible format for the communication and recording of care required and given. (Head, 1982).

Discussions concerning the development of approaches to the organisation of nursing care using the communication and recording medium offered by the Exeter Nursing Systems are both formal and informal, involving Sisters, Teaching Staff, the Support Staff for Computer Liaison and the Facilitation of the Nursing Process, Senior Nurse Management and the Senior Systems Analyst. The Nursing Systems are continually proving their adaptability, for the initial development occurred some years before the general acceptance within the nurse profession of the now established nursing care philosophies.

SUMMARY

This paper has discussed briefly some nurse-to-nurse communication and record keeping aspects of the Exeter Computer Nursing Systems, systems that are part of a large, originally government funded, health services computer development project now entering its second decade. Nursing developments covering the organisation and documentation of care have been indicated in relation to the philosophies of patient care, in particular the Nursing Process, the Activities of Daily Living and the Problem Orientated Record.

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Page Nos. for Nursing Orders

Basic Care.

- 1 General Hygiene - excluding Facial Hygiene.
- 2 Facial Hygiene.
- 3 Pressure Area & Sore Care.
- 4 Aids for Relief of Pressure.
- 5 Position.
- 6 Mobility.
- 7 Intake - Diet.
- 8 Intake - Fluids.
- 9 Observation Charts.
- 10 Observations.
- 13 Recordings.

Tests.

- 20 Urine Tests (Ward).
- 21 Urine Tests (Laboratory).
- 22 Tests - Excretory (except urine) & Blood.
- 26 Swabs & Aspirates.
- 28 Biopsies.
- 30 X-Ray Investigations.
- 35 Investigations - excluding X-Rays.
- 39 Bovey Day Cases.

Treatments.

- 40 Alimentary Canal - Upper.
- 41 Cardiac Therapy.
- 42 Dialysis.
- 43 Genito - Urinary Tract - Catheters.
- 44 Urology.
- 45 Genito - Urinary Tract - excluding Catheters.
- 47 Infusion Therapy.
- 48 Intestinal Tract.
- 50 Orthopaedic - Traction.
- 51 Orthopaedic - Plaster.
- 53 Orthopaedic - Exercise & Appliances.
- 53 Ear, Nose & Throat.
- 55 Radiotherapy - Oncology.
- 56 Respiratory Tract - Inhalations.
- 57 Respiratory Tract - excluding Inhalations.
- 58 Skin - Topical Applications.
- 59 Skin - Non Topical
- 60 Bandages.
- 61 Clips, Sutures, Clamp & Rod.
- 63 Drains.
- 64 Dressings.
- 66 Packs.
- 67 Operation or Investigation.
- 69 Treatments & Applications - Hot & Cold.

Miscellaneous

- 70 Patient/Relative Tuition.
- 71 Patient/Relative Appointments, etc.
- 72 Therapy, Clinics, Visits & Domiciliary Services.
- 73 Transfer & Transport.
- 74 Handicaps etc.
- 75 Special Precautions.
- 76 Reminders to Nurse in Charge.
- 77 } Nursing Problems (Printed on Care Plans).
- 78 }
- 79 Sensitive Problems (Not printed on Care Plans).

DRESSINGS

- | | | |
|---------------------------|---|----------------------|
| APPLY 1 ALUMINIUM PASTE | :30 TO DRAIN SITE | : |
| 2 DEODORISING DRESSING | :31 TO INFLAMED AREA | :50 2-HOURLY |
| 3 DRY DRESSING | :32 TO PRESSURE SORE | :51 [?]-HOURLY |
| 4 EUSOL DRESSING | :33 TO SINUS | :52 DAILY |
| 5 ARACHIS OIL | :34 TO TRACHEOSTOMY | :53 2xDAILY |
| 6 MALATEX CREAM | :35 TO ULCER | :54 3xDAILY |
| 7 MALATEX LOTION | :36 TO [named site] | :55 4xDAILY |
| 8 MELOLIN DRESSING | : | :56 AT [?]-HOURS |
| 9 PARAFFIN GAUZE | :40 (MANY-TAIL BANDAGE) | :57 BEFORE [?]-HOL |
| 10 PLASTIC SPRAY DRESSING | :41 (T-BANDAGE) | :58 BEFORE BATH |
| 11 STERILE SANITARY TOWEL | :42 (TUBULAR BANDAGE) | :59 AFTER BATH |
| 12 STERISTRIPS | :43 TO STUMP | :60 BEFORE ROUND |
| 13 ZINC PASTE BANDAGE | :44 TO DRY SKIN | :61 WHEN NECESSARY |
| 14 [named dressings] | :45 TO ISCHAEMIC AREAS | :62 TEACH PATIENT |
| | | :63 TEACH RELATIVE |
| 15 REMOVE DRESSING | :23 WITH MALATEX LOTION | :64 CONSULT NURSE |
| 16 CLEAN WOUND | :20 WITH EUSOL | : |
| 17 IRRIGATE WOUND | :21 WITH STERILE NORMAL SALINE | :65 POST-OP |
| 18 CHECK DRESSING | :22 WITH HYDROGEN PEROXIDE | :66 HALF STRENGTH |
| 19 CHECK WOUND | : | (QUARTER STRENGTH) : |
| 70 KEEP WOUND OPEN | 71 APPLY DRESSING AS PRESCRIPTION SHEET | |

List additions

GENERAL HYGIENE

- | | | |
|---|----------------------|------------------|
| 1 BED BATH | : | |
| 2 WASH IN BED WITH HELP | : | |
| 3 BABY BATH | : | |
| 4 WASH AT WASH BASIN WITH HELP | :20 MAY SHAVE | |
| 5 WASH AT WASH BASIN | :21 DAILY | |
| 6 USE BIDET WITH HELP | :22 2xDAILY | |
| 7 BATH WITH AMBULIFT | :23 3xDAILY | |
| 8 ARJO-BATH | :24 4xDAILY | |
| 9 SHOWER | :25 BEFORE [?]-HOURS | |
| 10 BATH WITH HELP | : | |
| 11 BATH | :29 OR | |
| 12 SALINE BATH WITH HELP | : | |
| 13 SALINE BATH | : | |
| 16 PREP. BATH [named type] | : | |
| 17 WASH FACE & HANDS POST-OP | : | |
| 30 BARBER | | 35 CARE OF NAILS |
| 31 HAIRDRESSER AT [?]-HOURS ON [dd.mm.yy] | | 36 CUT TOE NAILS |
| 32 INSPECT HAIR & TREAT IF NECESSARY | | |
| 33 WASH HAIR | | |
| 34 CHIROPODIST AT [?]-HOURS ON [dd.mm.yy] | | |

List additions

-1149-HOURS- SINGLE ROOMS WARD OKEMENT

-----1149-HOURS-02.11.82-----Tuesday

Special Needs & Precautions

PROTECTIVE ISOLATION (BLUE CARD).

WEARS GLASSES.

WEARS DENTURES, UPPER.

SOAK DENTURES IN NYSTATIN FOUR TIMES DAILY.

* More Information on VDU *

Basic Care

WASH AT WASH BASIN, OR SHOWER, WITH HELP.

(---)

MOUTHCARE, 2-HOURLY.

(chart)

TREAT PRESSURE AREA 4-HOURLY WITH SOAP AND WATER.

(R1,R2,R3,R4,R5,R6)

PATIENT LIKES 3 PILLOWS AT NIGHT.

(---)

Mobility

UP AS ABLE.

(---)

Diet & Fluids

DIET: NORMAL.

FREE FLUIDS.

(chart)

Observations & Recordings

RECORD TEMPERATURE, PULSE 4xDAILY.

(SF' 10, 14, 21)

RECORD BLOOD PRESSURE 2xDAILY.

(10, 16)

RECORD WEIGHT WEEKLY ON SUNDAY.

(---)

Tests & Investigations

ROUTINE URINE TEST, 2xWEEKLY ON THURSDAY AND SUNDAY.

(---)

TEST URINE FOR BLOOD, DAILY.

(SF)

Technical Care

INTRAVENOUS MEDICATION AS PRESCRIPTION SHEET.

(chart)

CARE OF VENFLON.