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SK108 Medical and Surgical Nursing in a Norwegian Context

Sogn and Fjordane University College, Faculty of Health Studies

Title: DO NURSING DOCUMENTATION SYSTEMS ENSURE CONTINUE OF CARE FOR STROKE PATIENTS?

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INTRODUCTION:

Nursing documentation is the record of nursing care that is planned and given to individual patients and clients by qualified nurses or by other caregivers under the direction of a qualified Nurse (Urquhart et al. 2009). Documentation of the nursing care for patients with stroke is very cardinal as this forms a basis for information which will assist in the planning and continuity of care in the acute phase of illness. According to Urquhart et al 2009 'the benefits expected from the consistent and directed recording of patient care information are clear, and include, for example, patient safety and continuity of care'. When done well, nursing documentation is a valuable tool to support effective communication between care providers for continuity of care (College and Association of Registered Nurses of Alberta, 2006).

Having worked in a neurological ward at a Central Hospital in Norway and seen how documented information is used for patient's continued care; I want to compare the system of documentation in Norway and Zambia, and find out which system yields more information with regard to identifying specific care needs and continuity of care in stroke patients during the acute phase of illness. I intend to describe the documentation systems in Norway and Zambia specifically for stroke patients in the acute phase of illness. Which system is able to provide necessary information to ensure continuity of care for stroke patients? How does the documented information ensure continuity of care? Is the documentation system in Norway possible in Zambia?

DESCRIPTION:

Stroke is a term used to describe neurological changes caused by an interruption in the blood supply to a part of the brain (Bowman, 2009). During my clinical practice at the neurological ward in Norway the majority of patients I nursed were diagnosed with stroke and I had an opportunity of seeing how documentation of nursing care was done.

Documentation of care for stroke patients in the acute phase of illness is very important to provide relevant information for continuous care; this phase of illness is life threatening

and might last 1 to 3 days (Smeltzer et al, 2008) and requires proper documentation of nursing care. In order for all information to be documented, assessment of all systems is required, the neurological assessment tools such as the Glasgow coma scale and National Institute of Health stroke scale are used (Bowman, 2009).

In the acute phase of stroke, measures are put to prevent complications. The patient is observed for complications such as cerebral oedema by noting for signs of increased intracranial pressure such as loss of consciousness, reflex hypertension and worsening of neurological status (Bowman, 2009). The blood pressure is closely monitored in order to prevent another stroke. Stroke reoccurrence should be prevented by administration of anticoagulants for patients who are at risk for cardiogenic emboli. The patient is monitored for any signs of intracranial haemorrhage and systemic bleeding which may be due to the therapy.

It is also important to control blood glucose levels as hyperglycaemia can lead to poor outcome, as it lowers perfusion of the brain during thrombolysis, therefore patients should not be given glucose through intravenous fluids (Bowman, 2009).

Stroke patients should be monitored for loss of pharyngeal sensation, oral pharyngeal motor control and decreased levels of consciousness. Oral fluids may be withheld in the first 24-48 hours as there is impaired swallowing, gag reflux and depressed cough. If patient is given fluids orally there is risk of aspirating hence alternative feeding through the nasal gastric tube is required.

Hyperthermia is prevented as it may lead to increased metabolic needs which in turn cause celebral oedema and increase the risk for celebral ischaemia. Therefore there is need to monitor the temperature (Bowman, 2009).

It is also important to note for fluctuations in blood pressure, altered respiratory patterns and complications of immobility (Bowman, 2009).

Due to these complications a patient with stroke requires adequate care to prevent progression of the condition and avoid permanent neurological disabilities; therefore nursing care should be continuous to give a positive outcome. In order for nursing care to

be continuous relevant information should be communicated to the next care giver, as such all the data should be well documented using a good system.

Documentation system in Norway

After working at the neurological ward for six weeks I observed that the documentation of nursing care was done using the electronic system. The electronic health record system is used for storing, processing and transmitting client data over a computer network. This network is a series of terminals attached to a computer and consists of a monitor and key board which are allocated in every nursing care unit. Information is entered using a keyboard and a mouse (Rosdahl and Kowalski, 2008).

In Norway the health personnel act recommends that 'patient's records maybe kept electronically' (The Health Personnel Act, 1999). The electronic patient record system in Norway is provided by different software companies. At the hospital where I did my clinical practice, DIPS ASA provides a wide range of products for health documentation and among these there is a nursing documentation component (DIPS website).

In the neurological ward a special care plan is used for stroke patients in the acute phase. The care plan helps the nurses to assess for specific patient problems under the following headings;

1. Communication /Senses – this component guide the nurse to assess for any talking, hearing, and sight problems. Enquiries are made to the speech therapist and social worker

3. Circulation – Monitor Blood pressure and manual pulse 4 times daily, assess current measures for pressure lowering. Monitor Temperature. If there is any fever possibly give antipyretics, oxygen saturation; if low give oxygen as prescribed by a doctor

4. Nutrition – guides the nurse to assess on the type of diet whether normal or diabetic diet, fluid intake, pharyngeal function and need for nasal tube

5. Elimination - assesses if any problems with urine output: observe residual urine, need for bladder scan daily and regular toilet times

7.   Activities/ function status measures - place the bed and night table for outcome intention, observe for palsy, paralysis, dizziness, and fall hazard. Prepare daily schedule – physiotherapy, occupational therapy

8.   Pain, sleep, rest - Decrease visits and monitor if patient has adapted to the peace and rest

10.   Social / planning for discharge measures – assess need for rehabilitation, prepare individual plan, plan for interdisciplinary meeting.

After the problems have been identified and interventions implemented the nurse then documents the outcomes of care. Documentation of this information is done by the primary nurse as each nurse is allocated 1 to 3 patients depending on their condition. The nurse taking over then accesses information by logging on the electronic system using a user name and password, and is able to check what was done and continue with the care.

Documentation system in Zambia

On the other hand in Zambia nursing care is documented using the manual system, were information is written on paper and entered by hand using ink. Nursing care is documented on nursing care plan and the Glasgow coma scale is used for the neurological assessment of a stroke patient.

Assessment data is obtained through interview, observation and physical examination (White, 2003). The collected data is assessed and actual problems identified and a plan of care written with proposed interventions to resolve the problem, and patient's response is then evaluated (Rich and Brady, 2002).

The nursing care plan is kept at the patient's bed side for easy access and later in the patients file that is kept in the duty room. The nurses who continue with the care are able to check at the bedside as bed to bed handover is being given. The nursing care is also recorded in the Doctors round book which has a provision for each shift to document nursing care done on all the patients.

ANALYSIS:

Which system is able to provide necessary information to ensure continuity of care for patients?

Continuity of care is needed in order to have a good patient outcome. Nursing care has to be documented by using the best system possible in which all the care given can be easily accessed by authorized personnel. Documentation is a communication method that confirms the care provided to the patient and clearly outlines all important information regarding the patient. Thorough documentation provides accurate data to plan and ensure continuity of care (White, 2005). Furthermore, thorough documentation should be aimed at facilitating on going patient care (Simon, 2011)

According to the College of Nurses of Ontario, 2009 revised article on documentation for individual clients, documentation should provide a clear picture of the needs or goals of the client and the nurse's actions based on the needs assessment and the outcomes and evaluation of those actions. This according to the author clearly out lines what should be contained in any documented care so that the nurse who will continue with the patient care is able to have adequate information regarding the patient.

The electronic system of documentation as I observed during my clinical practice had a structured format which aids the nurse on what to document (Milstead and Furlong, 2006) This Format guided the nurse on what needed to be written, ensuring that all the information regarding the patient was documented. In a study done by Menke (2001) it was noted that the electronic system 'forced the clinician to document in a certain way, was guided on what to document and it was easy to use the system. The computerized documentation system provided a more legible, complete patient record without increasing the time needed to document care and this system was more accessible and it improved shift to shift reporting'.

In the electronic nursing documentation of a stroke patient in Norway, all the relevant information is able to be documented because of the nursing care plan component which

has a specific format, the nurse is able to use this to communicate information to the nurse in the next shift.

Once information is available it is used to continue with the caring process, by using the electronic system the nurses have a specific source were they obtain the information regarding the care that was given. Electronic system of documenting is able to provide necessary information for continuation of nursing care because it is easy to document in. It is easy to access all the patient information which is clear and easy to read (Complete guide to documentation, 2008), therefore it improves communication between nurses.

The manual system of documentation is also able to provide information for continuity of care but it is sometimes difficult to read this information due to poor handwriting. This may result in communication of wrong information. Information should be legible for it to be used for patient care. If not legible it may result in confusion and misunderstanding of important information which may cause harm to the patient (Complete guide to documentation, 2008). Spelling errors are also common when using the manual method and this also communicates wrong information.

The other problem with the manual system is that information regarding patient care may be misplaced, resulting in loss of patient data, therefore proper storage is required to easily access the information. According to my experience the chances of information being misplaced is high compared to electronic system in which information is stored safely in a specific component. However if well utilized it can provide necessary information if it is legible has no spelling errors and is properly stored in order for nursing records to be easily retrieved.

How does the documented information ensure continuity of care?

Documented information ensures continuity of care because it provides information that is communicated to the next care giver. In a research done by Pereira, 2005, it was noted that information is relevant in the continuity of care and that for it to be beneficial depended on how nurses valued the information. Documented information once valued maybe used,

therefore,' the continuity of care is associated with the quality of information presented about patients; to the availability and the possibility of it being re-used and, moreover, being used to provide a better assistance' (Brunt et al, 1999). Nursing documentation influences continuity of care, and should facilitate on going patient care.

Information may be available but how it is utilised for caring for a patient is what is important. Documentation alone however does not guarantee the quality of care to be given but it promotes the flow of information from one care provider to another. Documentation enables the nurse to monitor the progress of the patient and prevents repetition of care. For example if a patient was changed position at the change of shift and this action was not documented then the nurse in the next shift would perform the same task risking the comfort of the patient. Information ensures that the clients care is consistent and effective.

Is it possible for Zambia to adopt the documentation system in Norway?

Manual documentation which is commonly used in Zambia requires a lot of time to document and adequate human resource for effective documentation of patient care. The poor staffing levels has resulted in information not being recorded, therefore necessary information is not communicated compromising patient care. The other problem as noted by the author is the nurse's attitude towards documentation, sometimes nursing care is not recorded and this results in care not being consistent. The inability to document is attributed to lack of time as most of the focus is on accomplishing tasks. Task allocation is used because in the wards a nurse is expected to nurse about 15 to 20 patients. This is so because of lack of human resource as compared to Norway.

Since electronic documentation is easy to use and has a standardised system it may be beneficial in the Zambian set up so that the nurses can easily document and access information. The electronic system has already been introduced by Ministry of Health, through the smart care program; however it does not contain any nursing care component. Its services are mainly focused on care for Maternal Child health, Voluntary counseling and testing, HIV Antiretroviral Therapy and Prevention of mother to child transmission of HIV. The intention of the Smart Care system is to improve patient care, and also, data

accuracy & reliability (Smart care, 2010). It is my hope that the Ministry of Health shall also focus on the care of patients in the ward set up and provide a nursing care component so that documentation of care is effectively done for all illnesses in particular Stroke.

Conclusion:

Documentation of nursing care is very important to communicate relevant information for continuity of care of stroke patients in the acute phase of illness. Regardless of the system of documentation, information may be transferred from one care giver to the other, provided the nurse effectively records all the care given. However a systematic way of documenting nursing care is needed in order for the nurse to easily document and retrieve information that will guide in the continuity of care for stroke patients.

Challenges:

The author had problems in accessing information on the documentation system in Zambia, it appears not much has been written or researched on documentation and continuity of care in Zambia.

Recommendations for Zambia

- The Ministry of Health should consider introducing a nursing care component in the Smart care package. This component will enable the nurses to have a documentation system which makes it easy to record and retrieve information.

- Nurses should be involved in the formulation of a standardized nursing component in the health electronic system for it to be user friendly, and enable relevant nursing documents for patient care to be formulated.

- There is need to formulate a care plan that is specific for stroke patients so that all the relevant information required is documented for continuity of care.

- There should be legislature regarding documentation of patient care in order to ensure effective documentation of nursing care.

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