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Patient care information is often being recorded by nurses in an “inaccurate, inconsistent, repetitive and incomplete” way, leading to potential safety concerns, according to researchers.

A study at a large acute trust in England, which was led by researchers in Nottingham, found nurses sometimes completed documentation retrospectively without full knowledge that care had actually been completed.

“Nurses working with older patients find current documentation time-consuming... resulting in gaps, mishaps and overlaps of information” Study authors

One nurse in the study described a case in which a patient collapsed, but when their notes were consulted there was no information about why they had been admitted.

In other instances, documentation had been filled in before nurses had carried out procedures to ensure they did not forget ahead of any potential audits.

The researchers – Liz Charalambous, a staff nurse at Nottingham University Hospitals NHS Trust, and Sarah Goldberg, a professor in older persons’ care at

Nottingham University – also heard nurses that could not always find the information they needed, despite it being recorded in several places.

Missing information, errors and duplications were partly being caused by nurses feeling exasperated by the sheer amount of paperwork they had to complete, and the fact they believed it was often repetitive and took them away from patient care, according to the study authors.

“The findings raised a number of professional and ethical issues in that nurses were reporting suboptimal and potentially unsafe care” Study authors

The study – titled [‘Gaps, mishaps and overlaps’. Nursing documentation: How does it affect care?](#) and published in the *Journal of Research in Nursing* – looked at nurse documentation for older patients on acute wards in England. It involved in-depth interviews at the start of 2015, with eight nurses employed by Nottingham University Hospitals NHS Trust.

Accurate record keeping was particularly important for older hospital patients due to the complexity of care they require and the problems with communication they often experience, noted the study, which also highlighted that they accounted for a high proportion of acute NHS beds.

“This research reveals that nurses working with older patients living with frailty find current documentation time-consuming to complete and sometimes unnecessary to the delivery of care, resulting in gaps, mishaps and overlaps of information,” said the study authors.

“The findings raised a number of professional and ethical issues in that nurses were reporting suboptimal and potentially unsafe care,” they added, noting that the researchers had raised the issues with the trust involved in the study.

The researchers recommended that the current system of documentation for older patients in acute settings be “extensively revised”.

“In view of the increased numbers of people needing care and a forecast global shortage of nurses, new ways must be found to streamline and reduce the amount of nursing documentation to support the delivery of quality care,” they concluded.

As an example, the study authors said electronic methods for documenting care provided a “unique opportunity” to speed up and improve record keeping.

They also suggested the introduction of a manual with core care plans for common conditions in each speciality that nurses could then reference when recording care, before adding personalised notes.

In addition, a document at the patient's bedside with details of what is important to them while in hospital would help to provide person-centred care, said the researchers.

"This system would allow nurses to have more control over the planning of care, as it can be amended as required, but would not generate large amounts of paperwork," said the researchers.

"The introduction of electronic document keeping has further improved safety" Daljit Athwal

Meanwhile, the study highlighted the need for different systems within organisations to be compatible with each other.

Nottingham University Hospitals NHS Trust highlighted to *Nursing Times* that the research had been carried out two years ago and that only a small number of nurses had taken part in the study.

Its deputy director of nursing, Daljit Athwal, said: "Each of our nurses are accountable for updating documentation to ensure the safety of our patients."

She also noted that the Care Quality Commission "did not raise documentation or record keeping concerns" when they last inspected the trust's hospitals, the findings of which were published in a report last year.

"The introduction of electronic document keeping for observations, handover and bed management has further improved safety and our responsiveness to patients' needs," she added.