Bringing Records to Life: Why This FEN Webinar is a Must for Every Emergency Nurse

One of the most powerful webinars we've ever produced at FEN isn't about the latest tech or new medication. It's about something far more familiar—but just as critical: your documentation.

"How to Annotate a Record for a Patient with a Head Injury" continues to be one of our most viewed webinars—and with good reason.

Why? Because this session brings to life the complex clinical decisions nurses make in real time, and shows how they can be captured with clarity, confidence, and legal rigour. It's based on a real case involving an 83-year-old patient who presented following a fall with a head injury. The webinar walks through the care she received—minute by minute—with meticulous annotation and insight.

🕐 Here's what makes it stand out:

Every entry in the care record is clearly timed using a 24-hour clock and includes elapsed time since triage. This structure doesn't just meet documentation standards—it *tells a story*. It draws attention to deterioration, escalation, and the effectiveness of intervention. It also highlights just how vital regular documentation is in managing risk and communicating clinical intent.

What's more, the case illustrates how to use real-time documentation to justify decisions such as pain relief, imaging, prioritisation, and even withholding interventions like cervical collars.

The patient deteriorates significantly—GCS drops, vomiting increases, and ultimately, a subdural haemorrhage is diagnosed. The case concludes with end-of-life care and support for family members, all captured in the record with clinical and emotional clarity. It's both moving and instructive.

🖊️ What you'll learn:

- How to timestamp records using both absolute time (e.g. 13:20) and elapsed time from triage (e.g. +20 mins)
- Why regular documentation (at key events, handovers, deterioration) protects both patients and staff
- How to annotate rationale behind decisions (e.g. *why* you didn't apply a collar, or *why* a CT was needed urgently)
- How to align your notes with NICE, RCEM and best practice
- How a clear, annotated record becomes a tool for learning, revalidation and safer care

This is not a generic "how to write notes" session. It's a masterclass in emergency nursing documentation, told through the lens of a real patient journey, with every moment mapped.

🆓 Even better? This webinar is part of our open-access resources and is available free to all.
