

A Study to Assess the Importance of Nursing Documentation in a Tertiary Care Hospital

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Abstract: Background: Nursing documentation is a legal record and a communication for continuity of care. This audit is aimed to examine the current practice of nursing care documentation and develop project for improvement. It is based on the fundamental concepts of assessment; planning; implementation and evaluation. A concurrent review method has been used to evaluate nursing documents. One nurse's documentation per unit per day for two weeks is being assessed and analyzed from all units using the nursing clinical audit tool. Material and Methods: This Audit Took place in an 50 beds' capacity Tertiary care centre which has facility like Day Care, Emergency Department, Operating Room, Out Patient Department, Cath Lab. The hospital has a pool of 76 nursing staff of which over 70 staffs are providing direct care for patients. Result: Results from the assessment carried out showed that 51.79% Patients File are not having proper documentation as per patient Diagnosis. 48.21% Patients File are having proper documentation as per patient Diagnosis. Conclusion: Our study highlights that Findings show that development of documentation improvement package and processes put in place together to redress the documentation concern. The nursing care plan, patient assessment and activity flow sheets have been reviewed and recommendation are made for nursing administration, in order to impart multidisciplinary approach to improve nursing documentation.

1. Introduction

Nursing documentation refers to written or electronically generated client information obtained through the nursing process. Documentation is an integral part of nursing practice and professional patient care rather than something that takes away from patient care. Information in the chart helps other medical workers understand what is going on with the patient. A medical chart also provides information in the event of legal action or concerns, which is another reason accurate documentation is so critical.

2. Purpose

- Evaluating nursing care given
- Achieves deserved and feasible quality of nursing care
- Verification: stimulant to better records
- Focus on care provided and on care provider
- Review of professional work or in other words the quality of nursing care, we try to see how far the nurses have confirmed to the norms and standards of nursing practice while taking care of patients.
- The program is reviewed for record nursing plan, nurses' notes, patient condition, nursing care.

3. Objectives

The objectives of the study was to:

- a) The aim of the Audit is to examine current nursing care documentation and to explore the reasons for the practice.
- b) The specific objectives are:
 - To design the measuring tool
 - To assess the nursing documentation practice to diagnose the common errors of nursing care documentation

4. Materials and Methods

- A concurrent review method is used to evaluate nursing care documents written by the nurses in Medical records .
- The study was carried out from 16th June 2016
- The study phase was based on the fundamental concepts of assessment, planning, implementation and evaluation .
- The first phase started with assessment to diagnose the current practice, therefore baseline auditing was conducted and development of the study kit which consists of audit tool, initiation of education strategy and finally the evaluation audit guide to assess the outcome of the study
- This Audit Took place in an 50 beds' capacity Tertiary care centre which has facility like Day Care, Emergency Department, Operating Room, Out Patient Department, Cath Lab.
- The hospital has a pool of 76 nursing staff of which over 70 staffs are providing direct care for patients.
- The facility has a functional nursing education unit
- Operating a two tier roles, educating and clinical teaching to enhance and support nurses on the provision of high quality care.

5. Results

The key issues were identified as:

a) Nursing documentation in medical notes:

- Too much unclear information;
- Information omitted;
- The poor Quality of Progress Notes, I/O Chart, Vitals sign chart & Nursing Care plan

b) Nursing documentation and standards of record keeping:

- Lack of systematic process for assessment and admission documentation;

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- Separation of risk assessment and care planning;
 - Lack of continuity evaluation of care planned.
- c) The issues fell broadly into four categories:**
- The patient assessment and documentation process;
 - The poor quality of fall risk assessments, Medication safety ;
 - Inadequate care planning and evaluation.
 - Poor Diet, Elimination habit assessment
 - Results from the assessment carried out showed that 51.79% Patients File are not having proper documentation as per patient Diagnosis.
 - 48.21% Patients File are having proper documentation as per patient Diagnosis.
 - Focus charting & SBAR are selected to give the clear identification of a focus for the nursing Documentation and provides an understandable structure that fits well with the nursing process which nurses are already using.
 - It also provides information within the nursing notes that is easy to locate as the reader can go to the appropriate focus and see the patients' progress.

6. Discussion

- 1) The quality of the documentation is a Mirror of Patient care .
- 2) This project has given in depth understanding of nursing documentation practice.
- 3) It helped us to find out the error in Nursing Documentation.
- 4) Good Quality Nursing documentation ensure the continuity of care & patient Safety.
- 5) Barriers have been identified in this project and the opportunities to improve the efficiency of nursing documentation have been placed.
- 6) The next stage of this project is to review the effectiveness of the method of documentation through the utilization of a Nursing clinical audit tool

7. Limitations

As our institution is small sample size is very low.

8. Conclusion and Recommendations

For Nursing administrator

- 1) Provide constant regular training opportunities for nurses on effectiveness of documentation.
- 2) Improve daily use of standardized nursing languages.
- 3) Quality documentation and reporting are necessary to enhance efficient individualized patient care .
- 4) Quarterly review of Nursing Documentation By Nursing In charges

For Nurses:

- 1) Check that you have the correct file before you begin writing.
- 2) Make sure your documentation reflects the nursing process.
- 3) Educate The patient and relatives for diet & exercise.
- 4) Skin Assessment & Pain Assessment should be done as per patient Diagnosis .

- 5) Risk assessment to be followed such as Medication safety, Fall Assessment.
- 6) Record each phone call to a physician, including the exact time, message, and response.
- 7) Chart patient care at the time you provide it.
- 8) HIC Bundle checklist to be followed & document in proper manner
- 9) Document often enough to tell the whole story.

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