

Improving the quality of nursing documentation: An action research project

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Background: Documentation is an important function of professional nursing practise. In spite of numerous improvement efforts globally, inadequate documentation continues to be reported as nurse authors investigate barriers and challenges.

Objectives: The project aimed to improve nurses' documentation of their patient assessments at the CURE Children's Hospital of Uganda in order to enhance the quality of nursing practise.

Method: An action research methodology, using repeated cycles of planning, intervention, reflection and modification, was used to establish best practise approaches in this context for improving nurses' efficacy in documenting assessments in the patient record. The researchers gathered data from chart audits, literature reviews and key informant interviews. Thorough analysis and critical reflection, these data informed three cycles of systems and practise modifications to improve the quality of documentation.

Results: The initial cycle revealed that staff training alone was insufficient to achieve the project goal. To achieve improved documentation, broader changes were necessary, including building a critical mass of competent staff, redesigned orientation and continuing education, documentation form redesign, changes in nurse skill mix, and continuous leadership support.

Conclusion: Improving nursing documentation involved complex challenges in this setting and demanded multiple approaches. Evidence-based practise was the foundation of changes in systems required to produce visible improvement in practise. The involved role of leadership in these efforts was very important.

Introduction

Assessment is the first standard of nursing practise (American Nurses Association 2010). Adequate assessment is essential in guiding interventions and evaluating the effect of care. Assessment includes gathering, validating and analysing subjective (symptoms) and objective (signs) information about a patient's health status. Assessment directly influences the nurses' plan of care, (Taylor *et al.* 2011:559) and is necessary for continuous provision of quality care. It is therefore important that nursing assessment is communicated accurately and stored effectively in the patient record.

In a British study, Rothman *et al.* (2012) found that substandard documentation of nursing assessments was associated with increased in-hospital and post-discharge mortality. Initial chart audits of documentation at the CURE Children's Hospital of Uganda (CCHU) revealed that the quality of the documentation of nurses' assessments was poor. Nursing leadership therefore undertook to work with nurses to improve the standard of documentation.

Problem statement

CCHU uses paper-based documentation, with the scientific nursing process as the documentation guiding framework. However, audits of patient records for quality assurance purposes and morbidity and mortality reviews revealed poor documentation of nursing assessments and other pertinent patient care information. Since the majority of nurses employed at the hospital were enrolled nurses with limited experience and little formal training in nursing assessment.

Aim

This project aimed to improve the documentation of nursing assessments in the patient record as a step toward improving nursing practise at the hospital.

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