

# 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.

# Example Of Nursing Documentation Assessment

**B Lingard**



### **Example Of Nursing Documentation Assessment:**

**Complete Guide to Documentation** Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

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MSN is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport North Carolina *Nursing Documentation* Patricia W. Iyer, Nancy Hand Camp, 1995 Clearly and concisely provides guidelines for appropriate and careful documentation of care Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources In addition it plays a large role in how third party payors make payment or denial decisions This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment Special attention focuses on the latest documentation issues specific to specialty settings such as acute care home care and long term care and a variety of clinical specialties such as obstetrics pediatrics and critical care Amazon com **Documentation Skills for Quality Patient Care** Fay Yocum, 1993 DOCUMENTATION SKILLS FOR QUALITY PATIENT CARE is written for students professional nurses who want to develop or strengthen existing documentation skills Documentation meets many needs requirements This book reviews those needs outlines the regulations that nurses must adhere to JCAHO ANA standards of nursing practice that relate to documentation are featured Nursing process writing NANDA nursing diagnoses are reviewed The book describes what needs to be documented as well as techniques pitfalls of documentation Numerous examples of nursing notes based on the author's long varied clinical experiences are included to guide the reader Written in a clear accessible style the book is intended for use as a primer refresher guide A busy teacher or hospital educator could use the book as a guideline for instruction Order from Awareness Productions P O Box 85 Tipp City OH 45371 0085 513 845 3617 **Legal and Ethical Issues** Susan Westrick Killion, Susan J. Westrick, 2006 **Medical Records for Attorneys** Laurence M. Deutsch, 2001 **Nursing Documentation** Ellen Thomas Egglund, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation **Legal Issues in School Health Services** Nadine Schwab, 2005-07 Legal Issues in School Health Services offers a legal resource never before available for education and health professionals and their legal advisors All professionals involved in the development implementation and evaluation of school health services will find this an exceptional tool This book addresses the spirit and letter of the laws the related standards the conflict between them and how they affect the delivery of school health services in regular and special education Special attention is given to pertinent issues for school administrators school attorneys and school nurses in order to foster school practices that are safe and effective Designed as a guide and reference work this book is written by 15 highly credentialed nurses attorneys and educators and offers detailed discussions of the legal challenges that exist in the 21st century KEY FEATURES School nursing practice standards and performance issues Risk management strategies for school administrators school boards and attorneys Multi disciplinary approaches in ethico legal problem solving Collaborative approaches in promoting student learning and success Financial special education record confidentiality and future genetic challenges In depth legal references citations and research plus a comprehensive glossary and table of federal statutes and regulations

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