Nursing Documentation Project at Teaching Hospital in KSA

Sabo Y. Machudo RNT, PG Dip Admin
Nursing Education & Development Unit,
King Abdulaziz University Hospital
Jeddah K S A
Smaccido56@gmail.com

Sharifah Mohidin RN (Mal), MN (Can)
Nursing Clinical Practice & Research Unit,
King Abdulaziz University Hospital
Jeddah K S A
shadeila@yahoo.com

Abstract - The aim of the project was to examine the current practice of nursing care documentation and to identify the common errors of nursing care documentation. A prospective cross sectional method was used to evaluate nursing care documents done by the nurses. The project was carried out between January 2014 and 31 March 2014.

The project phase was based on the fundamental concepts divided to three phases. Phase 1 was assessment and diagnostic, phase 2: Planning Strategy and Process, and in phase 3: Implementation, Designing tool, Continuous monitoring.

First phase started with assessment to diagnose the current practice; therefore baseline auditing was conducted by development of audit tool in documentation based on policy/guidelines, development and initiation of education strategy and finally the evaluation audit conducted to assess the outcome of the project.

This project gave depth attention to the standardization of nursing documentation practice and the factors that leading to variation in practice which may cause the flaws in documentation quality. The project identified the barriers and opportunities to improve the efficiency of nursing documentation have been placed. The next stage of this project is to review the effectiveness of the method of documentation through the development and implementation of an audit tool.

Alongside this, the plan is to continue regular education related to focus charting in order to fully imbibe this change into daily nursing practice.

Nurses in organizations that are struggling with documentation issues can conquer it by using focus note method as it can easily be adapted to different clinical situations. This project also supported the nurses to provide legally prudent information related to patient care and nursing activities performed. There are hopes for the nursing documentation and record audit processes to be developed into electronic and systematic process and used as an aspect of a regular credentialing process in the near future.

It is recommended that nursing administration should use a multidisciplinary approach to develop policies and guidelines on nursing care documentation and provide sustained continuing training opportunities for nurses on effectiveness of documentation and also aimed at putting the policy to improve daily use of standardized nursing languages.