Nursing Documentation Project at Teaching Hospital in KSA

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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.

I. Introduction

Nursing documentation has both practical and legal implications in patient care therefore quality documentation and correct reporting are essential to enhance efficiency in client care (Blair & Smith, 2012). Regardless of the format used to document, the client's health-care record is a formal, legal document that details a client's care and progress. Nurses need to understand that their documentation can be examined when there has been a complaint or incident resulting in harm (sentinel event) (Collins, et al., 2013). The ability for the nurses to document in a clear concise, legible and legally careful manner can significantly reduce the risk of misunderstanding and negative patient outcomes related to poor communication (Collins et al., 2013; Blair & Smith, 2012). Nurses have to accept that documentation is not separate from nursing care and it is not optional. It is an integral part of registered nurses' practices, and an important tool that RNs use to ensure high-quality client care. Literature discussed widely the barriers encountered by nurses in documentation including time constraints, mismatches between staffing resources and work load, lack of clear guidelines for completing documentation, ambivalence towards documentation, and the bureaucratic systems and institutional policies often associated with keeping accurate documentation (Yeung, Lapinsky, Granton, Doran, & Cafazzo, 2012).

Researcher emphasized that further thought to the correctness of nursing documentation, factors leading to disparity in practice and flaws in documentation quality and the effects of these on nursing care and patient outcomes, and the assessment of quality measurement need to be conducted (Wang, Hailey & Yu, 2011).

Many scientific surveys and reviews have concord that there is no one typical or uniformed standard of documentation within one hospital that was an issue but the contents of what is written, it has been very much discussed in the literature also that different units practiced documentation differently either as narrative, nursing process, focus charting problem based etc (Asamani, Amenorpe, Babanawo & Ofei 2014).

It is based on these premises that an in dept review of the system/process of nursing documentation was undertaken with a view to providing a standard.

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The importance therefore of having standard and qualitative method of documenting nursing activities and care in a timely manner in an organization is imperative to the quality of nursing care rendered.

The term documentation as used in this project refers to: any written information about a patient by the nurse that describes patient status or the care or services provided to that patient.

II. Project Objectives

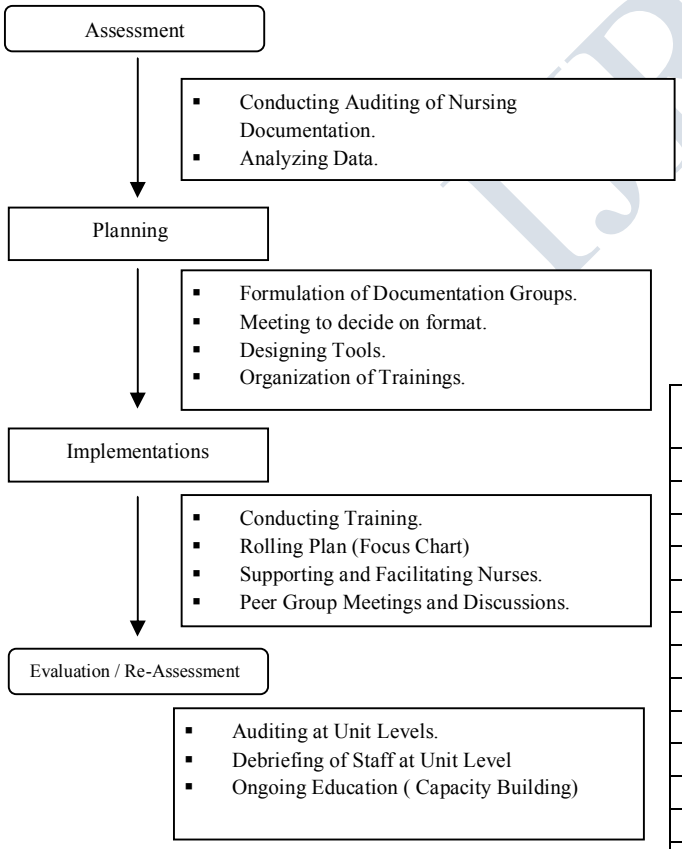
The aim of the project was to examine current nursing care documentation and to explore the reasons for the practice. The specific objectives are:

- to design the measuring tool
- to assess the nursing documentation practice
- to diagnose the common errors of nursing care documentation and
- to develop project kit

A. Project design

A prospective cross sectional method was used to evaluate nursing care documents written by the nurses. The project was carried out between January 2014 and 31 March 2014.

A project 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 project kit which consists of audit tool, documentation based policy/guidelines, initiation of education strategy and finally the evaluation audit guide to assess the outcome of the project.

B. Project setting

The project took place in an 800 bed capacity teaching facility care that provides all categories of services to patients in the secondary and tertiary levels which includes general Medical-Surgical wards, Critical Care units includes Neonatal and Pediatric Intensive Care units; Labor & Delivery, Obstetric & Gynae, Day Care, Emergency Department, Operating Room, Endoscopy, Out Patient Department, Specialist Clinics and Home Health Care and general clinics.

The hospital has a pool of 1140 nursing staff of which over 800 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.

C. Project implementation

Phase 1: Assessment & Diagnoses

In 2013 during an educational needs assessment in the clinical areas, nursing education department discovered that the nursing documentation lacked clarity in utilizing focus charting and also with no standard system of documentation. In 2005 focus charting was introduced as the mode of nursing documentation in the hospital. However, half of the units from the thorough assessment conducted revealed that there is still no one standard system of nursing documentation existing amongst all the 32 units till date.

At the end of the assessment the diagnoses made were:

1. There are areas or units with established focus charting system of documentation and is ongoing, yet some are ineffective and lack compliance to the hospital policy.
2. There are sixteen areas or units that have various types of documentation existed in some and none in other units, all with no standard system of documentation nevertheless some king of recordings are done based on the staff's discretion.

List of units in the Hospital:

Units with established focus charting.	Units without focus charting.
Male Medical	Medical Intensive
Female Medical	Surgical Intensive
Male Surgical	Out Patient
Female Surgical	Endoscopy
Emergency Department	ESWL
Private One	Out Patient Dialysis
Private Two	In Patient Dialysis
Gynecology	Labor and Delivery
Pediatrics Medical	Obstetrics
Pediatric Step Down	Nursery
Pediatrics Surgical	Cardiac Critical
Pediatrics Intensive Critical	Operating Room
Neonatal Intensive Critical	Specialist Clinic
Day Care	Cardiac Catheterization Lab.
Home Health Care	Sleep laboratory
Isolation	Respiratory Care
16 units	16 units

The assessment also uncovered that the records of nursing activities are performed based on individual Nurse's judgment; with no standardized form of documentation that is relative to the hospital documentation policy.

The reviewed hospital documentation related policies which dictate that "It is the policy of the organization that nursing documentation will be the focus charting that integrated nursing care plans". Focus charting was chosen because it encourages the clear identification of a focus for the nursing note and provides a clear framework 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.

This necessitates the need for reshaping and redesigning the nursing care documentation system for effective and efficient usage of focus charting in all units in this hospital. This situation requires the formation of documentation project team, with the aim of improving the standard of clinical documentation and adherence to the hospital's documentation policy.

Phase 2: Planning Strategy and Process

In order to achieve the goal of effective and total implementation of focus charting nursing documentation as per the standard of the policy, it was decided that first strategy was to identify those units that have in place the focus charting system, and to revitalize and refresh their knowledge and second the units without focus charting will be given a time window weight to introduce focus charting in their documentation. Therefore the team to focus on documentation project was created.

The course in the project was first training the champions; second designs tools for assessment, educating the staff and finally conduct continuous monitoring with auditing and periodical visits.

Phase 3: Implementation

Training the champions

Champions were selected from the clinical instructors, nurse educators and nursing staffs that have shown good and sustained documentation skills based on edited samples of patients' focus charting in their units. This team was given refresher training on focus charting documentation as mode of nursing care plans. The emphasis on the program was the use of nursing assessment tools as a base for nursing care planning and documentation. The workshop also dealt with the construction of integrated nursing care plan as part of the incorporation to the focus charting.

The Clinical Instructors (CIs) were grouped according to clinical unit similarities such as those in the critical areas as one entity, Obstetric, Nursery, Labor and Delivery in another team while the ambulatory Care the third; and medical surgical as the fourth. Those specialized care settings such as Emergency Department, Operating Room, and Specialty Clinics that can not fit to the grouping worked as unique entities.

The training was conducted as a workshop and attended by 32 participants includes the clinical instructors, nurse educators and nursing staffs as representatives of those units without designated CI's. Their function was to work with staff nurses on the ground at unit level by coaching and guiding them, to make sure that nursing documentation namely focus charting is done accordingly and fully in conformity to the hospital's policy requirement.

Those identified areas in hospital that have not introduced the focus charting documentation were placed in a special group. The series of meeting were held with their head nurses, and clinical instructors to map out the strategy to build their capacities in the implementation of the focus charting system of documentation.

D. Designing tool

The first challenge was to design the standard tool to conduct the continuous assessment to assess the compliance to focus charting documentation, like unique specific assessment tools - As part of objective assessment guideline, a simple checklist was extracted from the hospital existing review toll and documentation policy to help produce standard audit guide to the entire units and improve reliable. The review tool concentrated on nursing notes in the areas of admission assessment in Emergency Department, Inpatient units and nursing Focus notes.

The ward/units representatives were required to develop the unit specific tools individually. They were supplied with related documents such as:

Patient assessment checklists for critical Care, Intermediate Care that includes Day Care, Out Patient Department, Specialist Clinics, ESWL, Radiology, Endoscopy and Out Patient Dialysis); Labor and Delivery/Obstetric and Nursery Care.

Activity flow sheets for the recording of routine care rendered by nurses that are too numerous to be documented on the focus chart instrument. The education developed materials (assessment checklists and the patients' activity flow sheets) were presented to the hospital main documentation committee attention for vetting, approval and adaptation prior to use in the units.

Educating the clinical staff - Development of a new patient focused assessment checklist and activity flow sheets which were created for the routine records of nursing activities to overcome the cumbersome routine to recording on the focus chart. Scheduled training on how to write effective focus charting documentation and utilization of the activity flow sheet for documenting routine care was conducted at unit level by the champions for all the nursing staff. Subsequently, Focus Charting was introduced to the rest of the sixteen units.

Continuous monitoring - Periodical visits and internal auditing by CI's was routinely made in the units as a form of motivation for staff to imbibe the culture of effective documentation as soon as an activity is carried out, and to provide opportunity for the staff to ask questions in areas of thought. To this, the Clinical Instructors (CIs) were directed to review daily two focus charting documentation notes in their areas and to guide the nurses accordingly.

This approach created confidence building within the staff as was noticed in the flow of inquiries received during these visits. On completion of training, a pilot program was conducted in the adult surgical critical care unit for two weeks; during this time, daily visit was

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carried out to support and review the documentation and adjust/guide the staff were necessary.

In order to sustain the gains, and improve compliance, a champion forum was agreed upon to meet ones weekly to review any challenges encountered during the past week with a view to addressing them collectively. Also to learn from one another issues that arose and how they were resolved by the champions from different units.

III. Discussion & recommendation

This project gave depth attention to the standardization of nursing documentation practice and the factors that lead to variation in practice which may cause the flaws in documentation quality (Asamani, Amenorpe, Babanawo, & Ofei, 2014; Vaz & Whitby, 2006). Maintaining quality and standard practice in nursing documentation is important (Johnson, Jefferies, & Langdon, 2010). to promote a structured, consistent and effective communication (Wang, Hailey & Yu, 2011) to ensure the continuity of care and patients safety (Wang, Hailey & Yu, 2011; Prideaux 2011; Stewart & Robben, 2010).

The quality of the documentation is a reflection of the standard of the nurses' practice (Prideaux 2011; Johnson, Jefferies & Langdon, 2010), it could be an indicator of the skilled and safe care practiced by the nurses. Documentation should be timely, meticulous, appropriate, and accurate to meet the obligations of registered nursing requirement while minimizing legal involvement due to inaccurate or deficient documentation (Blair & Smith 2012; Paans, Nieweg, Van der Schans & Sermeus, 2011; Wang, Hailey & Yu, 2011; Daskein, Moyle & Creedy, 2009).

In this project barriers have been identified 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 a specific audit tool. Alongside this the plan is to continue regular education of the nursing staff on issues related to focus charting in order to fully imbibe this change into daily nursing practice. The nursing organizations that are struggling with documentation issue can conquer it by using focus note method as it is easily adapted to different clinical situations and supports nurses to provide legally prudent information related to their patient care. 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 use a multidisciplinary approach to develop policies (Tranter, 2009; Thoroddsen & Ehnfors 2007) 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.

As quality documentation and reporting are necessary to enhance efficient, individualized client care (Daskein, Moyle & Creedy, 2009).

Finally, recommendation for further research is imperative, that will pay more attention to the accuracy of nursing documentation, factors leading to variation in practice, flaws in documentation quality and the effects of these on nursing practice and patient outcomes.

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