Better Communication with Quality Nursing Documentation
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Introduction
Nursing Documentation encompasses observation, assessment, planning of nursing action, care provided, patients’ response and effectiveness of nursing actions with professional account of critical thinking and judgment. However, there are various documentation format in TWEH which lead to undesirable impacts on documentation. A nursing documentation audit was conducted in 2014/15 and the overall compliance was 88.32% with 100% compliance on all critical items. It was relatively lower than the previous audit in 2011 (96.08%). Planning of nursing action and care provided were dropped particularly. Aiming at effective supervision and monitoring of nursing documentation, a series of improvements have been initiated.

Objectives
☐ To improve nurses’ compliance to HAHO Nursing Standard for Patient Care (M2.1) on documenting patient’s condition and care provided. ☐ To provide an accurate account of assessment, care planning, treatment and care evaluation ☐ To improve communication and dissemination of information between and across service providers

Methodology
Standardization of Nursing Practice Working group members standardized Nursing Prescriptions with pre-print items, revised Nursing Care Plan format and developed the TWEH References on Nursing Documentation Practice to unify practices of different documentation. An integrated Patient Discharge Checklist was also developed to strengthen communication across healthcare providers for ensuring the continuity of care. Nursing Staff Training on Documentation 3 identical Nursing
Documentation Workshops was organized for all TWEH nurses. Good documentation samples, practices not recommended and other professional perspectives of documentation were illustrated. Staffs had to complete a Nursing Documentation Quiz in the workshop for cross-checking their understanding. Training video and materials were also uploaded onto web for staff easy reference. Nursing Care Management Round Periodic Nursing Care Management Care Round is done by nurse supervisors with frontline staff to strengthen the management of different patients. It emphasizes on review of nursing assessment, nursing care plan, nursing prescription and discharge planning so that proper, clear, concise and comprehensive nursing documentation is further enhanced.

**Result**
Over 95% of TWEH nursing staff obtained full marks in the Nursing Documentation Quiz. 100% of nursing staff would receive training on nursing documentation by 2Q15. Nursing care management rounds findings were shared among staff to reinforce proper practice continuously. The Way Forward: Since nurses have to be accountable and responsible for all aspects of care delivered, quality nursing documentation is certainly very essential in the care process. It actually reflects the application of nursing knowledge, skills, expertise and professional judgment. Thus, regular evaluation audits with suggested improvement strategies would be continued to ensure the quality of nursing documentation.