



Service Priorities and Programmes
Electronic Presentations

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Regular Compliance Checking on Nursing Documentation in Acute Geriatrics Unit.

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Introduction

Purpose of nursing documentation provides an important indicator of the quality of care provided for hospitalized patients. It provides the most objective evidence on quality patient care and litigation defense. As reported in the "Periodic Review 2016" at United Christian Hospital, regular medical records audits, including Nursing professional, were recommended.

Objectives

1. To enhance the quality of nursing documentation in compliance with Nursing Standards.
2. To reflect the quality of care through appropriate nursing documentation.
3. To identify areas for improvement.

Methodology

1. Monthly compliance checking on the nursing documentation by one APN (as Coordinator) and two RN (rotating by all unit colleagues monthly) was conducted against the Acute Geriatrics Unit.
2. Audit instruments were used which assessed nursing documentation of Patient Assessment Form; Fragility Fracture Risk Management; Intravenous (IV) & Subcutaneous (SC) Site Assessment Record; Fall & Pressure Ulcer Risk Assessment and Nursing Care Plan (Adult); Generic Nursing Care Plan and Admission time record.
3. Sharing on good practice, lesson learnt and common mistakes on nursing documentation were conducted for frontline colleagues.

Result

There was a significant improvement in the standard of documentation on the unit after the project. At the initial audit there was only 58.3% compliance rate; this rose to 95.49% after the project was launched 12 months, indicating that standards had increased considerably. Overall this project has delivered an improvement in practice at no extra cost and resulted in improved levels of documentation for all patient notes

concerned. In addition, all the outcomes have been met. Regular re-auditing should also be performed to ensure continuous quality improvement.