

Service Priorities and Programmes Electronic Presentations

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To promote good quality of nursing care standard by integrating nursing care document at Special Care Unit (SCU) Tung Wah Hospital (TWH) – A Pilot Study KY CHUNG (1,5); PY FAN(1,5); MM YEUNG(1,5); SM CHAN(1,5); YK CHOW(1,5); YM CHAN(1,5); NS NG (1,5); KY LEUNG (2,5), Karen CHENG (3,5) & Joseph YEUNG (4,5)

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Introduction

Exploratory audit reports on nursing documentation in clinical setting facilitate a quality standard of care in TWH. By reviewing the audit report, it demonstrated a lack of consistencies from shift to shift and day to day of nursing care delivery at SCU. There were inadequate risk assessment and nursing care plan based on standard guidelines for staff performance. It may cause a risk of nursing liability for nurses with incomplete nursing action and information.

Objectives

The goal is to enhance effective communication with caregivers that facilitates continuity and individuality of care. It is measured by using post nursing audit to nursing documentation in reflecting the actual practice at SCU.

Methodology

Using PDCA (Do- Design- Check- Action) model to develop a nursing tool – nursing care chart to enhance >85% staff compliance in nursing documentation. A pilot trial is implemented in 1Q2013 at SCU TWH.

Result

The newly developed instrument provided nurses a structural and clear process of nursing assessment, nursing observation, nursing care plan and nursing action in the daily practice. Result: The pilot study started from Jan 2013 to Mar 2013, focuses on 3 natural dimensions of nursing documentation in a structural, process and content format. The post audit demonstrated a positive effect on staff compliances towards nursing care standard in nursing documentation. As a conclusion, nursing care chart is nursing tool that pay more attention to timely, accuracy, comprehensive and completed characteristics leading to standard quality nursing practice. The overall effect demonstrated the medical liability and responsibilities of all nursing actions that is a user friendly, visual and completed document. It also showed a narrative flow in

credible and sound evidences towards standard of care in factual, precise and accurate nursing information.