Service Priorities and Programmes

Electronic Presentations

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Enhancement of nursing care documentation as evidential proof of nursing action

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Introduction
The golden rule of “Documentation is a written memory of one’s performance” is well acquainted by nursing staff in Intensive care Unit (ICU). Indeed, the tactic of transcribing sensational information (visual, audio and touch) into written format is essential.

Objectives
1.To demonstrate the skill of transforming into descriptive illustration from real life patient care actions. 2.To enhance the nursing staff in utilizing the comprehensive "NDH Patient assessment record (on admission), ICU Nursing record, Head-to-toe assessment form, Integrated Progress sheet and Nursing summary. 3.To optimize nursing care plan writing skill.

Methodology
1.Initial surveillance of the overall nursing documentation from patient’s record. 2.In Oct 2013, conducted educational program: A)Disseminated the phenomena identified from this Survey. B)Revised “Care Plan Reference" with Monitor (M), Action (A), Collaboration (C) and Education (E) format adopted in NDH; C)"Physical Assessment documentation technique” 3.Post Education Survey in Nov 2013.

Result
1.Team members identified some area for improvement from (Pre) 23 / (Post) 22 patient’s records out of 50 / 52 patient’s records. Average time spent was 10 to 20 minutes for each case. 2.Comparing the results of Pre & Post surveillance (as attached): A)NDH Patient Assessment Form (Admission from AED): (Pre: 35 missing items from 18 newly admitted cases; Post: 6 missing items from 8 newly admitted cases), B)Nursing Record: (Missing items ~ Pre: 19 / Post: 13) C)Head to Toe Assessment Documentation (Pre and Post): Care plan writing reflects patient’s need. D)IPS documentation, Nursing summary & plan: Simulated common erroneous nursing documentation for nurses to identify. It was recommended that: 1.Reinforcement of prompt nursing documentation with SBAR format ~ Situation,

Background, Action and Response. 2.The management team further fine-tuned the ICU observation chart and the Assessment form to enhance concise documentation. 3.Proposed those commonly used abbreviations in ICU to The Medical Record Management Committee for approval.