Service Priorities and Programmes

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Submitting author: Mr Tak Ki CHUNG
Post title: Advanced Practice Nurse, Prince of Wales Hospital, NTEC

Service improvement through evaluation

Chung TK (1), Ho PYB (1) & Chan YMA (2)
(1) Central Nursing Division, (2) Department of Pediatrics, Prince of Wales Hospital

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Introduction

Documentation in nursing records is essential for patient safety and high quality care. Accurate and complete documentation of patient's data is also critical to proper treatment and any potential subsequent litigation. To better improve the service, a cycle for improvement was adopted to enhance nurses' compliance in documentation.

Objectives

To enhance nurses' compliance in documentation in the areas of (1) All assessment items in Patient Assessment Form, (2) Checklist for ILI symptoms & TOCC, (3) Double checking of first time scheduling in MAR form, (4) Physical restraint observation, (5) Patient suicide observation, and (6) Vital signs documentation for patient having blood transfusion.

Methodology

A retrospective audit of 400 nursing records was performed by a reviewing team. The team members consisted of CND staff and nursing staff in various departments. Audit skills training was provided to help each auditor effectively gather information and create consistency in data collection. Patients admitted to the hospital from December 2012 to February 2013 were randomly recruited for record review. Sample size in each caring setting was maintained at least 10 cases. After understanding the inadequacies, a series of interventions including staff education, clarification of misunderstanding, staff engagement involvement and re-evaluation were performed.

Result

Results: Patient assessment form is the compulsory part of nursing record. Comparing 2012 and 2013 data, significant improvement of documentation in the areas of (i) vital signs, conscious level & general condition (compliance rate rose from 47% to 93%), (ii) swallowing & chewing (from 56% to 81%), and (iii) infection risk (from 74% to 86%). However, the audit showed that several parts needed to be improved, for instance in the area of patient's nutritional status (compliance rate 47% for body weight charting). After having the result, an improvement work on Body Weight Measurement was piloted in a clinical area. For other areas of audit, 93% of TOCC checklist records; 91% of double checking of first time scheduling records;

60-100% of physical restraint observation records; 100% of suicidal observation records; and 78-100% of vital sign records for patient having blood transfusion were identified. Outcome: The study showed that nurses needed to improve certain areas of documentation. Continuous feedback on documentation performance to all nursing units is the key factor for care improvement and its sustainability.