An audit of Nursing Documentation at three Jamaican public hospitals

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Acknowledgment

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Learner Objectives

At the end of this session the learner will be able to:

- discuss nursing documentation and its role in monitoring the quality of nursing care rendered
- make inferences about nurses' use of the nursing process in caring for clients in Jamaican public hospitals
- concede gaps in nurses' conduct of discharge planning and patient education and discuss its implication for the management of the emerging chronic disease epidemic facing the region.

Introduction

- Nursing documentation provides critical information about the patient and assists in the clinical decision making process.
- The quality of nursing documentation is an important construct in the health care setting.
- Information gathered or mined from patient records maybe used as a proxy of the quality of care given to clients.

Defining Nursing Documentation

Nursing documentation is a written or electronic communication tool, which generates information about a patient.

Typically, it is used to describe the care and response to treatment for individual clients.

Other purposes of documentation include quality assurance, legal issues, health planning, nursing development, and research.

(Urquhart et al., 2009; Wang et al. 2011)

Criteria for Quality of Nursing Documentation

Nursing documentation must include appropriate structure and specific formatting.

Should bear evidence of the use of the nursing process (assessment, diagnosis or identification of problem, goal, interventions and evaluation).

This documentation must reflect valid and reliable information and comply with established standards.

Nursing Documentation the Jamaican Context

The Jamaican health care system:

- employs a **paper-based health record system**; and
- nursing documentation is primarily completed by **registered nurses and fewer enrolled assistant nurses (similar to the LPN).**

This **no user fee system** is burdened by the high prevalence of chronic diseases which often requires prolonged and or repeated hospital admissions.

(Boyne, 2009)

Nursing Documentation the Jamaican Context

A 2013 review of 90 patient-records at one Western Jamaican public hospital raised concerns about nursing documentation. These included:

- inadequate patient education and discharge planning
- insufficiencies in the use of the nursing process.

Researchers highlighted the singleness of the institution studied as a limitation of the study.

(Blake-Mowatt et al. 2013)

Nursing Documentation as a Proxy for Quality of Care in Jamaica

- The failure of nurses to adequately reflect the use of the nursing process in their documentation is notable, since the nursing process provides a framework for solving patient care problems and ensures the provision of high quality care.

  (Yildirim, & Ozkahraman, 2011)

- However, the limitations of the 2013 documentation study prohibit one's ability to make inferences about nursing documentation at the national level.
- Interventions and national policy decisions should be driven by credible generalizable evidence.

Purpose of the Study

- This follow up study sought to assess the quality of nursing documentation on medical wards at three public hospitals in Jamaica.

- In order to present a more comprehensive assessment of nursing documentation in the country.

- This type of activity is recommended by World Health Organization as a means of monitoring quality of care and ensuring the achievement Universal Health Coverage.

(Dye, Reeder & Terry, 2013)

The Methodology

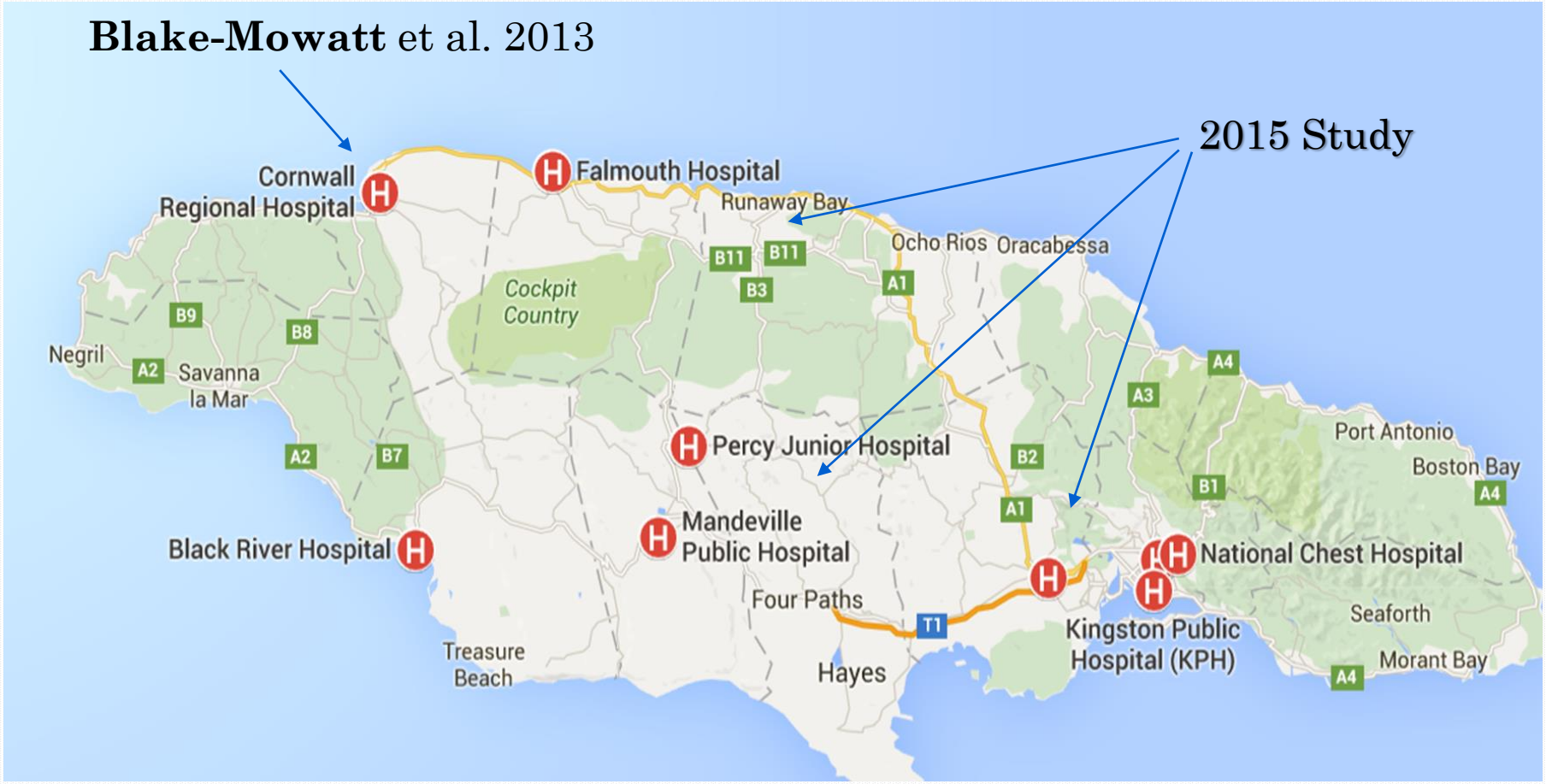
- **Research Design**: A descriptive cross-sectional quantitative design was employed; using an audit tool.

Audits permit a systematic, independent and documented process of evaluation through which one can objectively determine whether the audit criteria are fulfilled.

(Domingues, Sampaio, & Arezes, 2011)

Population & Setting:

Eight medical wards at three public hospitals across Jamaica were studied; complementing the 2013 documentation study done in Western Jamaica



Sample Size and Sample Selection

- Using a margin of error of 5%, confidence level of 95%, along with a response distribution of 50% which recommended a minimum sample size of 187.

- The multi-level sampling strategy employed included stratification at the level of hospital for comparativeness

Inclusion Criteria

- Records selected reflected admission dates between Jan – March 2015 and clients admitted to the medical wards for a period of 4 or more days.

Data Collection Procedures

Instrumentation

- The records were reviewed using Blake-Mowatt et al. (2013) audit instrument which was developed by the Ministry of Health Jamaica guidelines (2008).

- With permission, the instrument was strengthened based on a review of the literature.

(Björvell, et al., 2003; Jeffries et al., 2011; Wang et al, 2011)

Data Collection Procedures

Instrumentation

The Audit tool consisted of 4 sections:

- **Section A:** completeness of nursing history and assessment
- **Section B**: ascertained the organizing framework used
- **Section C**: assessed standard requirements for data entry
- **Section D**: presence of patient teaching and discharge planning

Training of Data collectors

- This study facilitated the learning experiences in a research methods course delivered at three schools of nursing in Jamaica.

- Final year undergraduate students were trained as data collectors.

- Students attended a one day training workshop which included:
  - lecture on nursing documentation,
  - a review of the nursing process,
  - role play, demonstration and
  - mock records were used to facilitate data collection practice.

Ethical Consideration

Ethical approval was obtained from the universities' IRB and the Ministry of Health Jamaica.

Permission was obtained from the proposed Institutions.

Confidentiality and privacy of patient records were maintained (no client identifying data collected).

Records were not removed from the site and the actual wards were not identified publicly.

Data Analysis Methods

Quantitative data were analyzed using the SPSS version 19® for Windows® .

Descriptive and inferential statistics were used to summarize data and compare the audited information among hospitals.

RESULTS

A total of 245 medical records from eight adult medical wards at 3 public hospitals were audited.

Hospital	Frequency	Percent	Number of Wards
Hospital # 1	119	48.6	2
Hospital # 2	56	22.9	4
Hospital # 3	70	28.6	2
All Hospitals (Total)	245	100.0	8

Documentation of Client History (all hospitals)

Specific elements of the clients history documented by the nurses based on the 245 records audited revealed:

- Client's chief complaint 82% of records
- History of present illness 79%
- Past health history 79%

In contrast

- Psychosocial history was documented in 10% of records.
- Family health history 11%.

Documentation Of Clients Biographical Data Across Hospitals (%)

Characteristics	H #1	H #2	H #3	Total	p value
Age	91	98	93	93	NS
Sex	87	98	81	88	0.014
Marital status	36	4	43	31	0.0001
# of children	3	2	4.3	3	NS
Occupation	22	2	24	18	0.001
Education	2	0	1	1	NS
Religious Affiliation	19	4	22	16	0.012
Living Accommodations	11	2	36	16	0.0001

DOCUMENTATION OF PHYSICAL ASSESSMENT ACROSS HOSPITALS (FIRST 7-3 SHIFT FOLLOWING ADMISSION)

Nine in ten records (91%) had evidence of the conduct of a physical assessment of the client.

Various types of physical assessments were noted within the institutions:

- Focus Assessment -- 44.7%
- Head to toe Assessment -- 35.4%
- Systemic Assessment -- 34.2%

Organizing Framework – SOAPIE/ ADPIE

- The organizing framework which governed the nurse's documentation was unclear in 61% of dockets audited.

- Records reflected only some elements of the nursing process, for example:
  a) Nursing interventions were noted 67% of records
  b) Subjective and objective statements <10%
  c) Nursing diagnosis 29%
  d) Evaluation 22%

Nursing Documentation Standards

- Almost all of the entries assessed had been timed (99%), dated (98%) and signed (100%) by a licensed nurse.
- Nurses' hand writing was legible in 88% of records
- Errors were properly correctly in 52% of the records

Documentation entries related to discharge planning & patient teaching

Nursing documentation	Within 24hrs	Within 72 hrs
Patient Teaching	1.7% (4/ 245)	4.2 % (10/245)
Discharge Planning	0/245	13.5% (33/245)

Among the 10 records with documented patient teaching the topics taught included medication, patient safety, disease process and plan of care.

Summary and Discussion

Nursing documentation of the client care continues to show both strengths and weaknesses.

Nurses are to be commended for the:

- high rates of documentation of the clients' physical assessment completed within 24 hours of admission

- adherence to the majority of the standards of documentation which the audit evaluated.

This is in sharp contrast to studies in other developing countries (Asamani, et al. 2014)

Summary and Discussion

Areas for Improvement

(1) Use of an organizing Framework

- The organizing framework which governed nursing documentation was unclear across institutions.
  - This has implications for quality of care.

(2) Quality of client assessment-

- These were primarily focused assessments.
- Recording of family health and psychosocial history as well as biographic data (including marital status, occupation) was inconsistent.

Summary and Discussion

Areas for Improvement

(3) Nursing documentation Standard

- Errors made in the documentation process were improperly corrected in almost a half of the records
  - This has obvious legal implications

(4) Organizing Framework

- Frequent absence of documented nursing diagnosis and evaluations in nursing notes
  - Has implication for quality of care

Nurses in Australia have also shown a preference for documenting patient assessments and interventions (Kirrane, 2001).

Summary and Discussion

Areas for Improvement

(5) Significant gaps in discharge planning and client/family teaching

- Less than 15% of records reflected patient teaching or discharge planning

This lack of patient centeredness in nurses' documentation has been described in handover records of Swedish patients diagnosed with chronic diseases.

As flagrant absence of information regarding patients achieving a shared understanding or agreement about their treatment was reported (Flink et al., 2015).

Limitations

- The quality of nursing documentation entries was not assessed; based on the basic descriptive nature of this study
- Nurses were not studied (it is possible that care was given but not documented)

Implications for Nursing Practice

- Continuing in-service education is necessary to ensure that all staff are knowledgeable about documentation guidelines of the Ministry of Health Jamaica, as well as …
- Continuous monitoring of nursing documentation for quality assurance purposes.
- These hospitals are teaching hospitals which facilitate nursing student's transition of theory to practice and therefore appropriate standards must be maintained to ensure a competent grandaunt.

Conclusion

- Nursing documentation met the Ministry of Health guidelines in many of areas audited.
- Notwithstanding, there is a need for reeducation and reorientation on the appropriate legal correction of errors, improved history taking and use of the nursing process.
- The finding of inadequate patient teaching and discharge planning could negatively impact the success of Jamaica's National Development Plan (PIOJ, 2009).

Conclusion

- Improved quality of care can reduce the financial burden associated with chronic diseases such as diabetes and hypertension (PIOJ, 2009).

- Continuous monitoring of nursing documentation is recommended as a component of the strategic plan geared at achieving Universal Health Coverage.

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Thank you