Gap Analysis of Nurse's Documentation at Moolchand Hospital: A Nurse audit complying to NABH and JCI standards

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Summary

- Nurses are the backbone of the hospital. Starting from the entry of the patient in the ward till the discharge of the patient, nurses play a major role in the recovery of patient's condition. During the stay of the patient in the hospital, it is nurse's responsibility to document the care provided, e.g. medicines administered, vitals monitoring, Assessment of the patient etc. Nursing documentation in the patient records helps in continuity of care of the patient and helps to understand the course of treatment in the hospital.

- However, with increase in workload, the importance of timely and accurate documentation in the patient records is sidelined and is often overlooked. This might lead to discrepancies in the hospital charges leading to revenue loss, indicate errors in the care processes and infringe on ethical and legal aspects of the category.

- This study was conducted in Moolchand Hospital to understand the gaps in the nursing documentation according to NABH and JCI standards in the IPD areas. The study was conducted over a period of three months (6 February 2017 to 6 May 2017). 254 inpatient records were audited with the help of a nursing audit toolkit.

- Auditing of records was done on all the four inpatient floors of the hospital (First Floor, Ground Floor, Third Floor, International wing). Results indicated a lack of compliance in all the floors.

Introduction

- Nursing documentation constitutes an integral part of the nurse's daily work. Meticulous nursing documentation is an important part of multiprofessional patient care . The delivery of good care and the ability to communicate effectively about patient care depends on the quality of information available to all health care professionals. One important part of this information is nursing documentation in nursing care plans.
- Nursing Audit is defined as a review of the patient record designed to identify, examine, or verify the performance of certain specified aspects of nursing care by using established criteria.

- **Purpose of nursing audit:**
- **Evaluation:** Evaluating the nursing care given. Achieve deserved and feasible quality of nursing care.
- **Verification:** Stimulant to better records. Focuses on care provided and not on care provider.
- **Contributes to research.** Review of professional work or in other words the quality of nursing care i.e. we try to see how far the nurses have confirmed to the norms and standards of nursing practice while taking care of patients.
- It encourages followers to be actively involved in the quality control process and better records.
- It clearly communicates standards of care to subordinates.
- Facilitates more efficient use of health resources.
- Helps in designing response orientation and in-service education programme.

Incomplete documentation by nurse's in the patients' record can lead to:

- Unnecessary delays in diagnosis, treatment and care
- Repeated tests
- Missed or delayed communication of test results
- Incorrect treatment or medication errors.

Accreditation boards also recommend complete and legible documentation in the patient's record to facilitate quality patient care.

JCI Recommendations:

- **Standard IPSG.1** Identify patient correctly

  Use two identifiers other than room number.

- **Standard IPSG.2** Improve effective communication

IPSG.2.1 Verbal medication, non-medication orders and communication of test findings should be documented in the patient's record file.

Standard IPSG.2.2

The hospital develops and implements a process for handover communication

- **Standard IPSG.3**

The hospital develops and implements a process to improve the safety of high-alert medications.

- **Patient Centered Standard:**

Patient and family education:

Patient and family should be educated about their disease process, proposed plan of care and effects, nutrition, medication.This must be documented in the case records

NABH Recommendations:

Standard AAC 5: Patient cared for by the organization undergo an established initial assessment.

Objective elements:

- The organization defines the content of the assessment for the out-patients, inpatients and emergency patients.
- The organization defines, who can perform the assessment.
- The organization defines the time frame within which the initial assessment is completed.
- The initial assessment includes screening for nutritional needs.
- The initial assessment results in documented plan of care which is monitored

Objectives of the study:

- To design a nurse toolkit for auditing the nursing documentation in IPD area of the hospital.
- To identify the gaps in nursing documentation in IPD area of the hospital
- To suggest measures to improve timely and accurate documentation by nurses.

Material and methods:

- **Study Design:** Descriptive study.
- **Setting:** Moolchand Hospital, New Delhi.
- **Duration of study:** 6 February 2017 to 6 May 2017.
- **Sample Size: Total 254 case records**

  Ground floor- 58

  First floor- 76

  Third floor- 71

  International wing- 49

- **Sampling Technique:** Convenient sampling technique

Sample Selection

- Inclusion criteria: Inpatient active files (files of currently admitted patients) on all the four floors of IPD including ground floor, first floor, third floor and international wing.

- Exclusion criteria: Inactive files (files already sent to medical records department post discharge).

Data collection procedure:

Primary data collection:

- Direct observation of the nursing assessment and vitals monitoring post new IPD admission on the floors.

Secondary data collection:

- Daily audit of the inpatient records on the floors in IPD with the help of nursing audit toolkit.

Table 1: List of documents audited during the study

Nurse assessment form	This form is filled when the patient is admitted in any of the wards. it contains vital signs, fall risk assessment, functional screening, nutritional screening, pain assessment etc. The assessment should be ideally done and documented within 30 minutes of admission according to hospital policy.
Daily patient care record	This form is filled by the nurses to document the daily patient care activities, investigations ordered, procedures ordered, Vital monitoring chart, safety measures taken. During shift change, nurses are supposed to sign for handing over and taking over of the patients.
Billing activity record	This record contains the details of items billed for the patient. During each shift, name and signature of nurse updating the BAR should be there.

Medical Administration record	**It contains the details of the medicines administered to the patient along with nurse's signature and time. In case of high risk medication administration, there should be a counter sign also. The verbal orders are documented with seal and verification signature of doctor is very important. Stat/verbal orders are also documented in MAR.**
Patient and family education	This form contains the details of patient condition, treatment plan, nutritional requirements and is signed by the nurse and patient's attendant.

Note: The above forms are attached daily in the patient record and are arranged date wise.

Patient identifiers i.e Name and HUID are recorded in every document of the patient's file. The ID band is provided to patient in order to avoid any patient identification error.

Data Analysis:

The analysis is based on the scoring for documentation of 11 different parameters in patient record of Ground, First, Third floor and International Wing.

The scoring criteria is as follows:

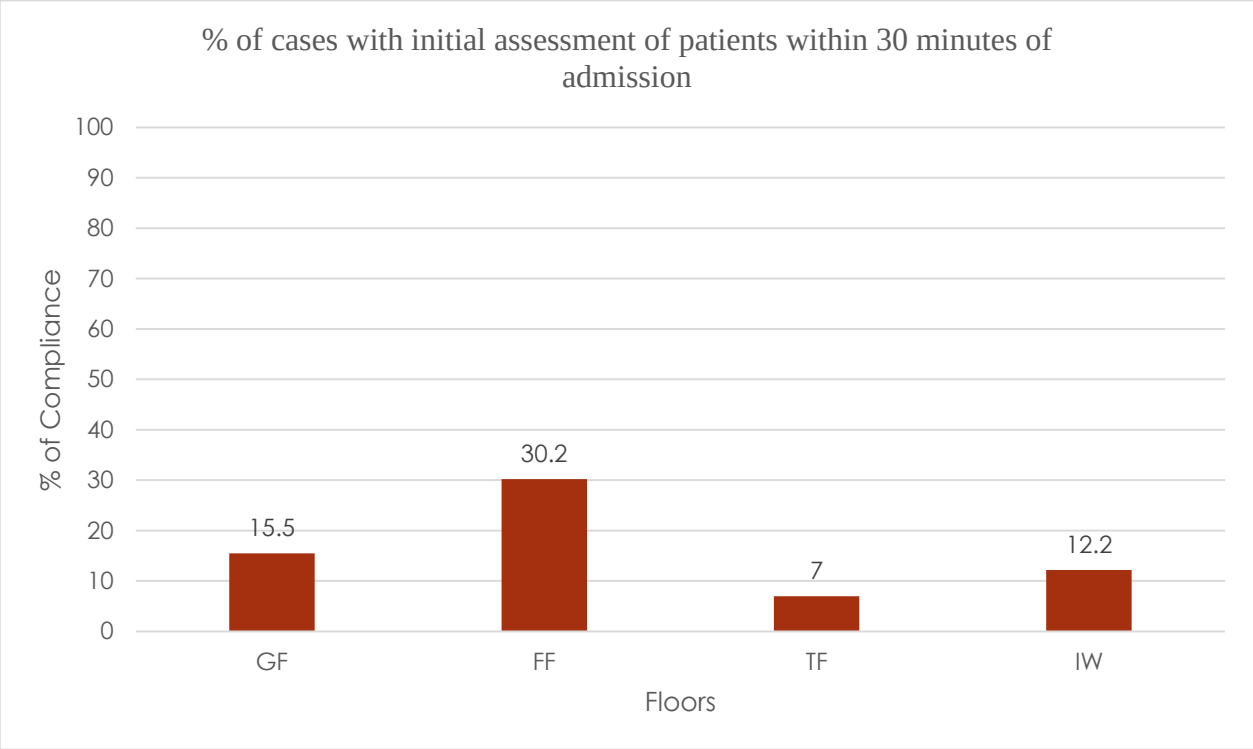
- Total compliance: Score 10 (When documentation is complete and is present in all the forms arranged date wise in the file)
- Partial compliance: Score 5 (When documentation is present in two or more forms arranged date wise in the file)
- No compliance: Score 0 (When documentation is present in only one or less than one forms, arranged date wise in the record)

Parameters:

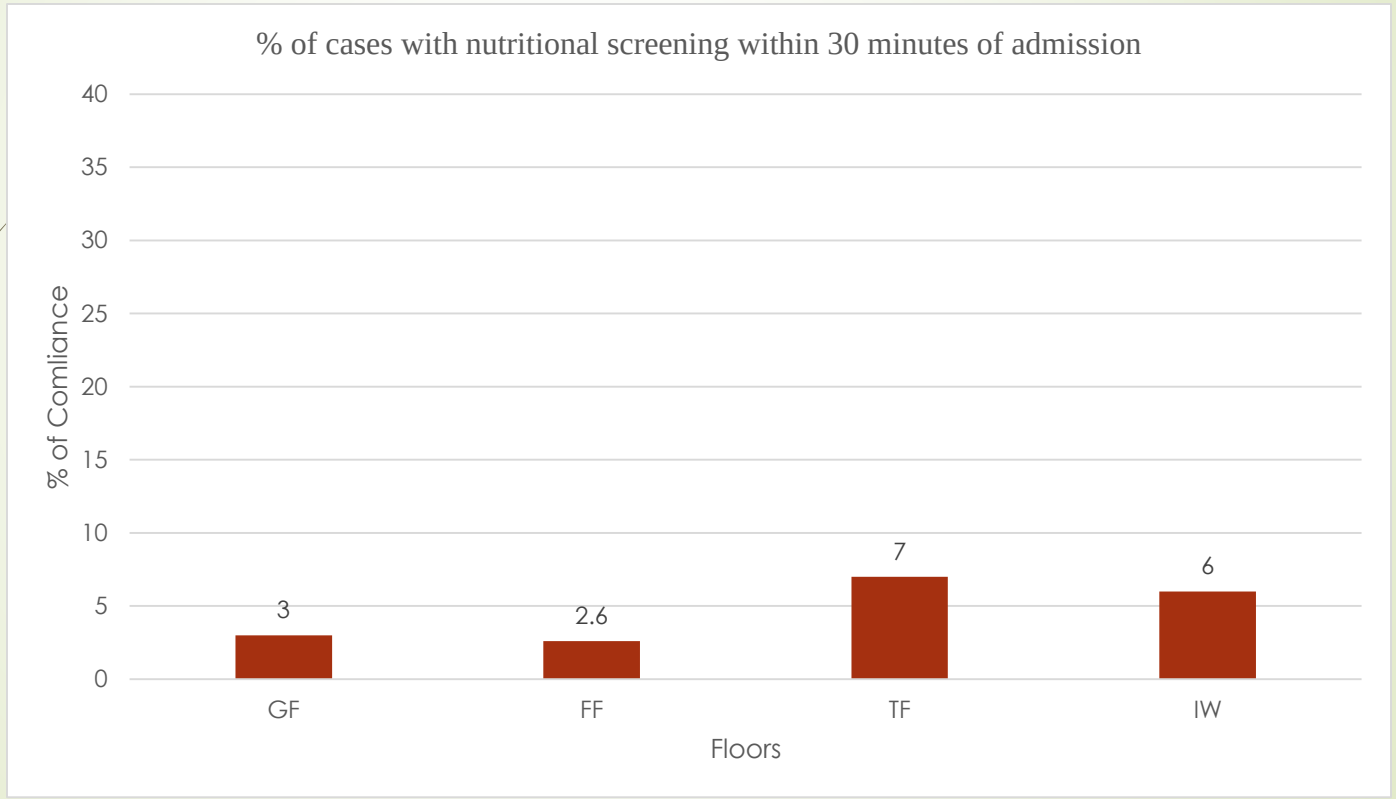
- Initial assessment of patients within 30 minutes of admission
- Nutritional screening within 30 minutes of admission
- Vital Monitoring and documentation in daily patient record
- Nurse sign and counter sign in case any high alert medication administered
- Signatures in BAR sheet
- Nursing Handover Signature
- Documentation of Patients Name
- HUID documentation
- Patient Identification by ID band
- Documentation of Verbal/Stat order
- Patient and family education documentation

Findings:

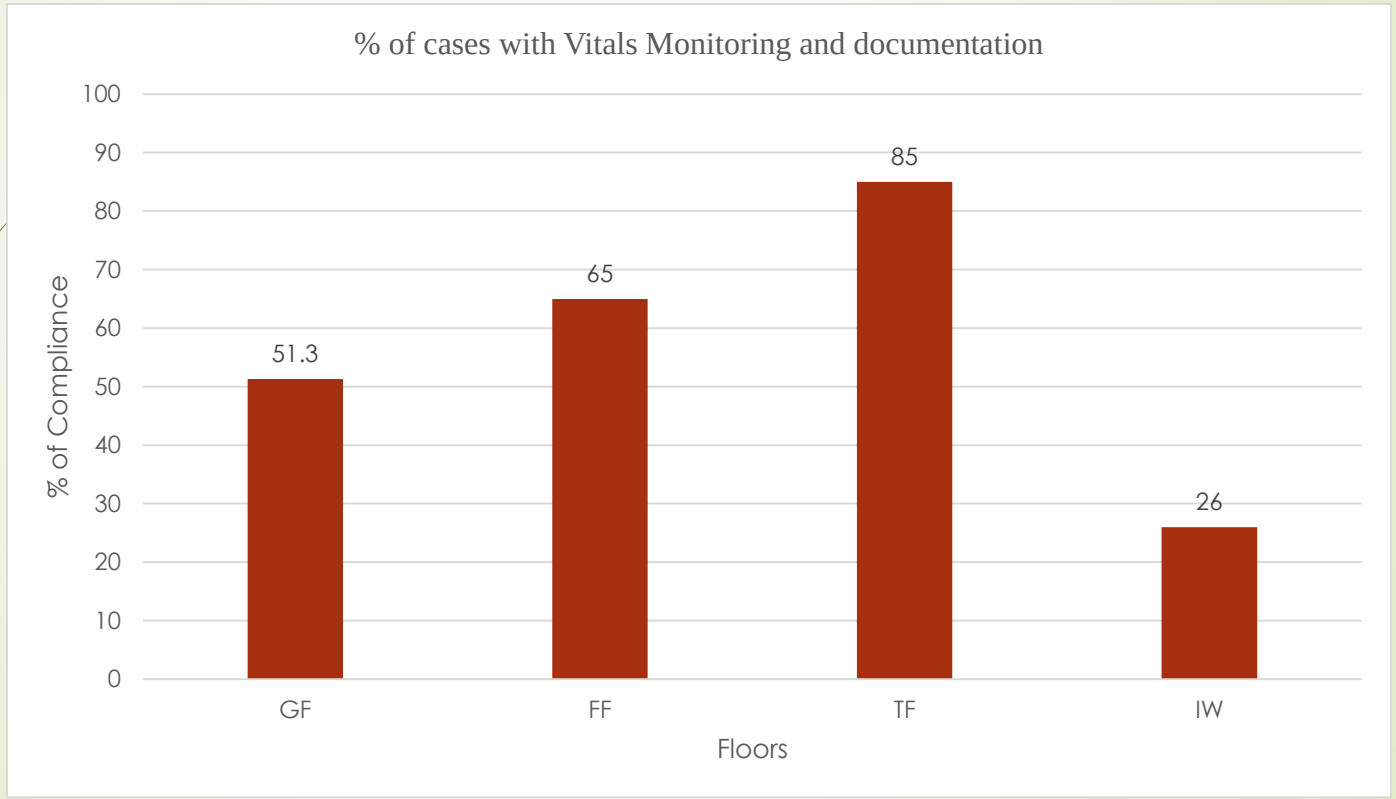
Initial assessment of patients



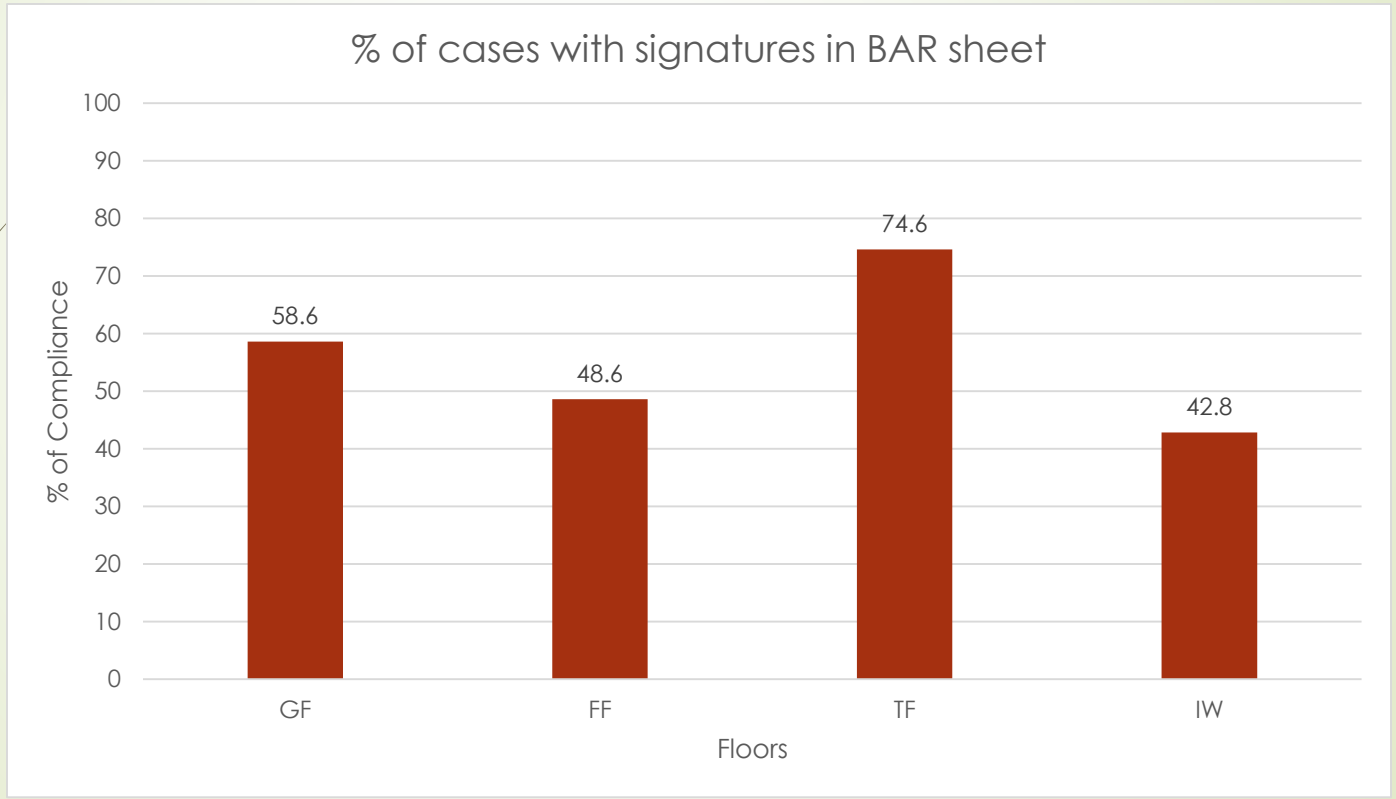
Nutritional Screening within 30 minutes of admission



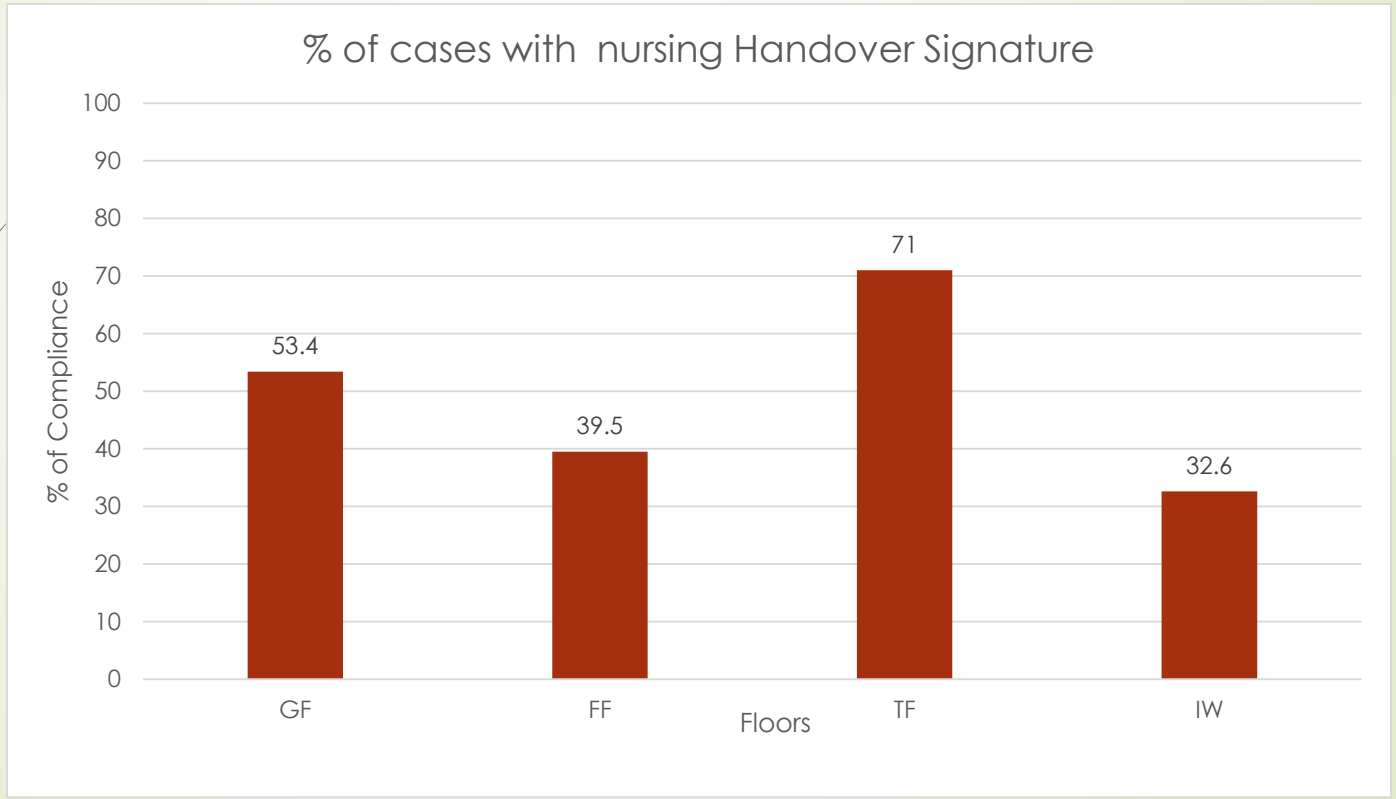
Vitals monitoring and documentation:



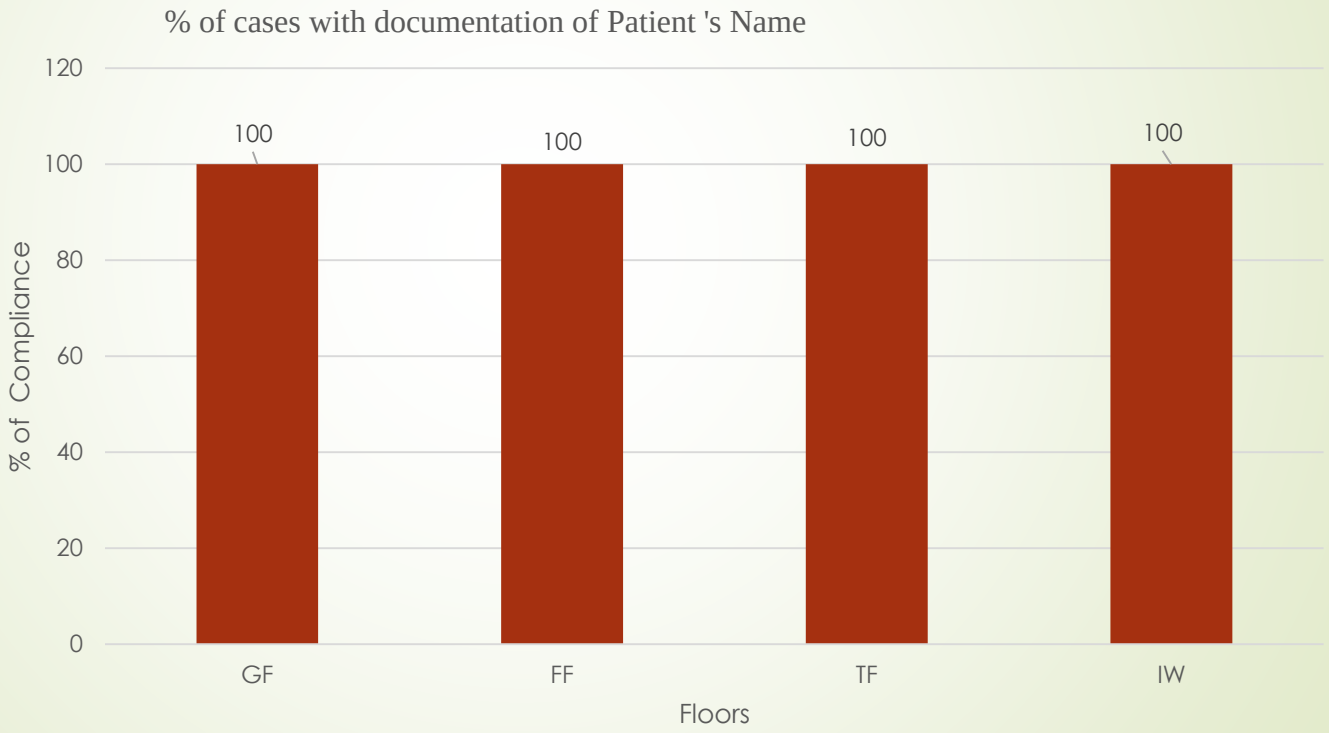
Signatures in BAR sheet



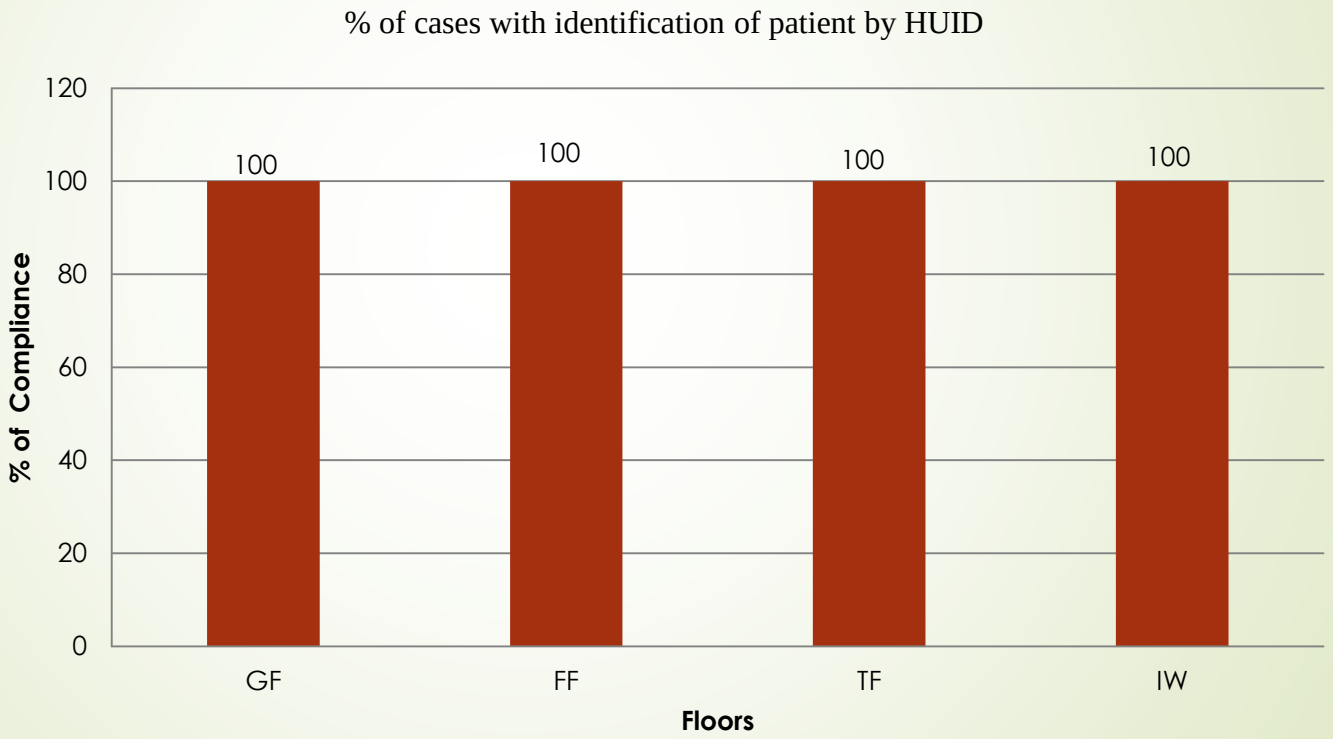
Nursing handover signatures



Documentation of Patient's Name

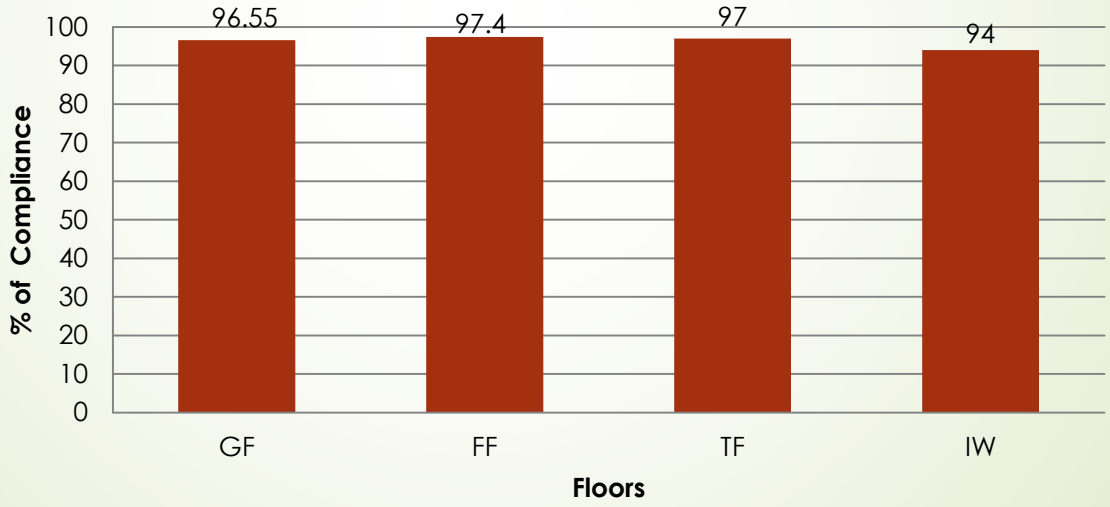


HUID documentation as patient identifier

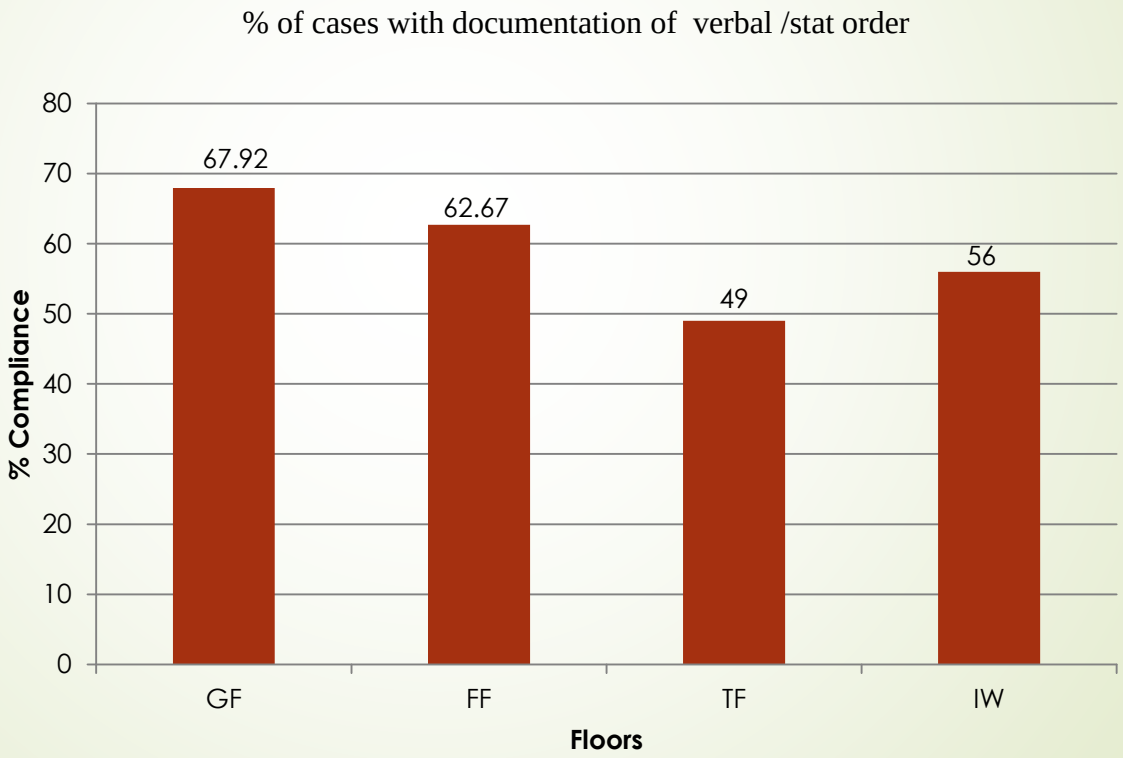


Patient Identification by ID band

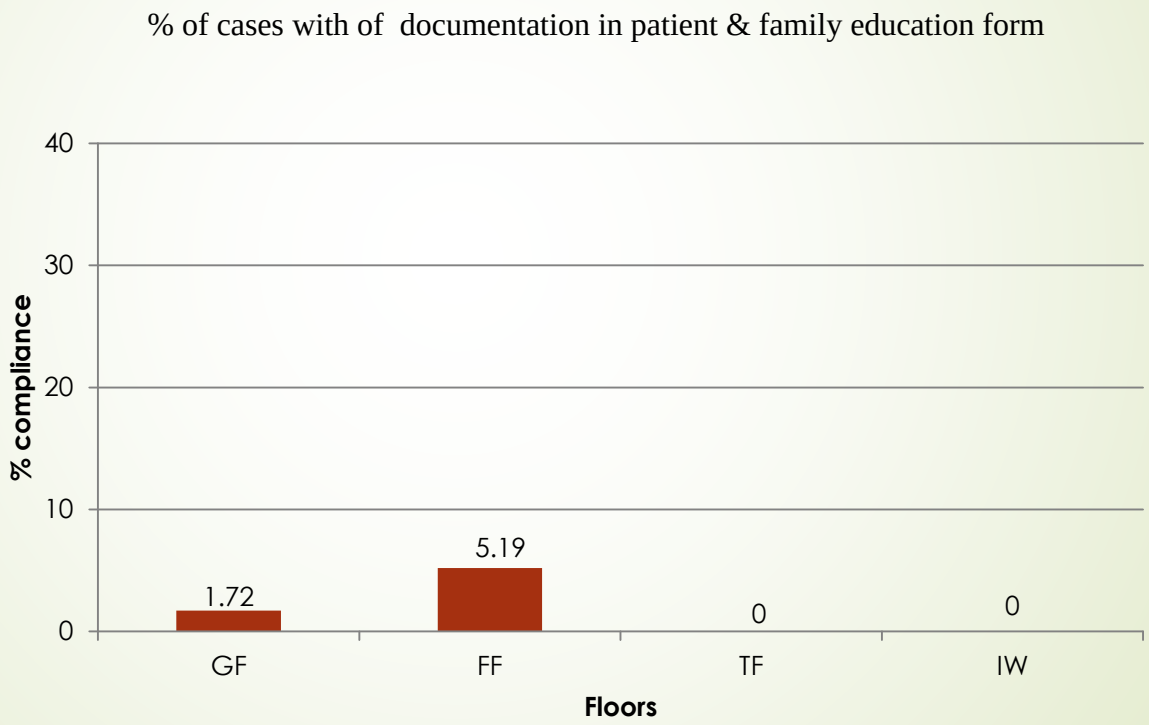
% of cases with identification of patient by ID band



Documentation of Verbal/Stat order



Patient and family education documentation



Interpretation:

- Compliance in documentation of vitals, Handover signatures, BAR sheet is maximum on Third floor (85%,71%, 74.6 % respectively) as compared to other floors.
- Initial assessment and nutritional screening are not done within 30 minutes in majority of the cases. Maximum compliance of initial assessment is seen in First floor (30%) and minimum is seen on Third floor (7%).
- Nutritional screening has lower compliance as compared to other parameters audited on GF, FF, TF, IW (3%, 2.6%, 7%, 6%) respectively.
- In all the cases with high risk medication administration, nurse's counter sign was missing. Hence there is 100% partial compliance with only one nurse signature on administration record
- Documentation of Patients name and HUID has 100% compliance in records of the floors audited.

- Patient identification check by ID band is maximum followed by first floor (97.4%) followed by third floor (97%) and least compliance percentage is of International wing (94%).
- Patient and family education parameter has least percentage compliance as compared to other parameters. Maximum compliance was found to be only 5%.

Conclusion

- From the study, it can be concluded that the nursing care was not fully expressed in the records, so written communication between different caregivers about patients was inadequate.
- The accuracy of documentation content in relation to patients' actual conditions and the care given is an important process feature of documentation quality.
- Quality nursing documentation promotes structured, consistent and effective communication between caregivers and facilitates continuity and individuality of care and safety of patients.
- Measures should be taken to improve the same in hospitals

Suggestions:

1.Education and training programs to be organized for nurses for timely and accurate documentation in the patient records. During the trainings,

- The nurses should be explained about the importance of documentation of the vitals and regular monitoring which may otherwise lead to unexpected outcome and compromised patient care leading to their dissatisfaction.
- They should be educated that if the BAR sheet is filled properly, it will help in reducing billing errors which in turn will reduce the revenue loss.
- Accountability of patient care during a particular shift depends on the assigned nurse, hence importance of documentation of handing over and taking over should be communicated to the nurses.
- Nurses should be explained that if initial assessment and nutritional screening is not done within 30 minutes, there will be delay in the further treatment plan and it can have adverse outcomes.

2.To design a system of Peer Audit and regular monitoring among peers so that documentation becomes the culture of the system.

3.To conduct regular on the job training for the nurses.

Thank you