Developing Approaches to Measure the Quality of Electronic versus Paper-based Nursing Documentation in Australian Aged Care Homes

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Introduction

- An ARC Linkage project
- Evaluation of electronic nursing documentation systems in Australian aged care homes
- Development of a nursing documentation audit instrument to measure the quality of electronic versus paper-based nursing documentation

Background

- The quality of care depends on access to quality nursing documentation
- Traditional paper-based nursing documentation has been recognized of poor quality
- Electronic systems have been implemented across a number of Australian aged care organizations
- Electronic nursing documentation systems are anticipated to increase caregivers' access to high quality of information

Developing A Nursing Documentation Audit Instrument

Three sources of information were reviewed

- Current literature
- The relevant legal, governmental and professional requirements
- Partner aged care organizations' nursing documentation practice

Literature Review

- Databases: PubMed, CINAHL and Cochrane
- Topic: how to measure the quality of nursing documentation
- Keywords : nursing, documentation, records, charting, audit, quality, care plan
- Papers published in the past ten years

Review of Legal, Governmental and Professional Requirements

- Aged Care Act 1997
- Accreditation Standards and requirements
- Residential Care Manual
- Documentation and Accountability Manual
- Several Nursing Board Guidelines on nursing documentation

Review of Partner Aged Care Organisational Nursing Documentation Practice

- Partner aged care organizations' policies on nursing documentation
- Nursing documentation protocols
- Nursing documentation audit tools

Results

Approaches in measuring the quality of nursing documentation has mainly focused on:

- Description of nursing process
- Completeness and comprehensiveness of information
- Quality of recording

Nursing Process

- A structured problem solving approach to nursing practice and its evaluation
- With five phases, which constitute a systematic process of nursing care
  - Assessment
  - Problem
  - Goal
  - Intervention
  - Evaluation

Quality Criteria of Nursing Process

Phases	Quality criteria
Nursing assessment	Use of framework, use of assessment tool, comprehensive assessment
Nursing problem	Identification of current and potential needs, description of signs, symptoms and etiological factors
Nursing goal	Relevance to the nursing problem and etiologies, being realistic, measurable and involving patient and family
Nursing intervention	Relevance to goals and etiologies, concrete instruction, patient and family involvement, and the implementation of intervention
Nursing evaluation	Relevance to goals, patient involvement, regularity, up-to-datedness of care plan

Completeness and Comprehensiveness

- Completeness referred to the extent to which nursing documents and items in a nursing document were filled in
- Comprehensiveness refers to the scope of care evidenced in the nursing records against established coverage of care needs

Quality of Recording

- Focused on the mechanical process of recording
- Quality criteria may include:

Patient's identity, legibility, standard abbreviations, proper correction of error, factuality and briefness of language, timelessness, signature, date and designation.

Instrument Construction

- A preliminary nursing documentation audit instrument has been developed
- Consists of a list of questions against the quality criteria established from above
- A initial consultation with nursing managers was carried out
- Further consultations with experts and validation of the instrument will be conducted

Example Questions of Audit Instrument

- Is/are there nursing documents recording nursing history has been completed?
- Is the resident's assessment competed on admission?
- Is/are nursing problem(s) identified which address the resident's current and potential conditions?
- Does the problem statement indicate contributing factor?
- Is/are nursing goal(s) set up in relation to the nursing problem/care need identified?
- Is/are the nursing goals resident centred?
- Is/are nursing intervention(s) planned to address the nursing problems identified?
- Is/are the intervention(s) specific and detailed?

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