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
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

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