THE RELATIONSHIP BETWEEN QUALITY OF NURSING DOCUMENTATION SYSTEM AND CONTINUITY OF PATIENT CARE IN MEDICINE HOSPITAL AT CAIRO UNIVERISITY HOSPITALS

By

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(B.Sc. Nursing)

Submitted in partial fulfillment of master degree in

Nursing Administration

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APPROVAL PAGE

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Bashair Mohamed Elsayed Abdu

Dedication

Words are completely deficit

To describe my aspect of thanks to my parents for their encouragement, support, and hope to me a great future.

Special thanks to my lovely husband who gave me love, encouragement, tolerance, endless support and pushing me forward.

The Relationship between Quality of Nursing Documentation System and Continuity of Patient Care in Medicine Hospital at Cairo University Hospitals

By

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Abstract

Nursing documentation is a fundamental nursing responsibility. Good documentation ensures continuity of care furnishes legal evidence of the process of care and supports evaluation of patient care. The current study seeks to assess the relationship between quality of nursing documentation system and the continuity of patient care in medicine hospital. A descriptive correlational design was utilized to achieve the aim of the present study. The study was conducted at Medicine hospital affiliated to Cairo university Hospitals. The study had two samples. First sample was a convenient sample of (44) unit managers and staff nurses working at six floors for inpatients services in medicine hospital and the second sample was patient's files of thirty percent of new admitted patients of total records (540). All over three months period. Three tools were used, first tool about quality of nursing documentation system questionnaire, second tool was a concurrent auditing checklist about quality of nursing documentation and the third tool about continuity of patient care developed observational checklist. The current study showed that all nurses (100%) agreed about the importance of documentation and continuity of patient care also all nurses (100%) agreed that documentation consume long time and there was high work load and the majority (88.6%) of nurses agreed that they perform non-nursing activities. The current study indicated that the majority (99.40% & 86.10%) of reviewed patient's files had unacceptable levels of both quality of nursing documentation and continuity of patient care respectively. Moreover, there was a statistical significant relationship between nurses educational level and both total observed continuity of patient care and total observed quality of nursing documentation i.e. technical nurses had the highest mean scores (81.96 and 37.27) in relation to total observed continuity of patient care and total observed quality of nursing documentation respectively. Also, a statistical significant relationship between nurses years of experience and both total observed continuity of patient care and total observed quality of nursing documentation i.e. less than one year experience nurses had the highest mean scores (88 and50.50) in relation to total observed continuity of patient care and total observed quality of nursing documentation respectively. Finally, the current study showed that there was highly significant positive correlation between total observed quality of nursing documentation and total observed continuity of patient care ($P<.000$)and($r=0.712^{**}$).The study recommended that unit managers should increase their monitoring of nursing documentation to be sure of using quality documentation standard . Documentation formats should design to be simple in use.

Key words: Nursing documentation, continuity of patient care, standard of nursing documentation.

Chairperson of thesis
Signed…

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No		
1	ANA	American nurses association
2	AIR	Assessment, Intervention, Response
3	POMR	Problem Oriented Medical Record
4	PIE	Problem, Intervention and Evaluation
5	CBE	Charting By Exception
6	FACT	Flow sheets assessment-concise-timely
7	JCAHO	Joint Commission on Accreditation of Healthcare Organization
8	ISMP	Institute for Safe Medication Practices
9	DAR	Data, Action ,Response
10	MAR	Medication administration record
11	LPN	Licensed Practicing Nurse
12	EMR	Electronic Medical Record
13	COC	Continuity of care

Appendices

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Quality of nursing documentation questionnaire

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CHAPTER I

Introduction

Standardized documentation in patient records is one of the critical aspects of quality healthcare and hospital accreditation. The records of clinical data are the major guides for clinical decision making and the provision of timely interventions for patients. In addition, the progress of medicines an evidence-based science is dependent on the availability of accurate patient records for use in research. These facts represent standard medical documentation as an extremely important requirement for providing safe and quality care to patients and in a broader perspective, developing clinical process. Despite their importance, medical records are often incomplete. Some of the deficiencies include incomplete coverage of patient care data and inappropriate reporting of errors and their corrections. The most important factor in the low quality documentation of clinical records is the lack of commitment to the standard measures (Hoseinpourfard, Dezfouli, Ayoubian**,** Izadi & Mahjob**,** 2012).

Quality nursing documentation had specific characteristics such as accessible, accurate, relevant, consistent and auditable. Also, it should be clear, concise, complete, legible/readable, timely, sequential and reflective of the nursing process and document fact. An extension of this principle is that nurses should write health care records objectively. (Berman, Erb, Kozier & Snyder 2010). Also (Mitchell & Haroun 2011) added that poorly written documentation can be easily misinterpreted and give the appearance of carelessness when record is reviewed by others, so, important details should correctly be noteed as temperature, fluid, drainage and medications.

Documentation has several purposes: Quality nursing documentation promotes effective communication between caregivers which facilitates continuity and individuality of care; nurses communicate with other nurses and care providers their assessments about the status of clients, nursing interventions that are carried out and the results of these interventions. Thorough, accurate documentation decreases the potential for miscommunication and errors. Documentation promote good nursing care and encourages nurses to assess client progress and determine which interventions are effective and which are ineffective and document changes to the plan of care as needed. Also meet professional and legal standards; documentation is a valuable method for demonstrating the nurse-client relationship, the nurse has applied nursing knowledge, skills and judgment according to professional standards also, the nurse's documentation may be used as evidence in legal proceedings such as lawsuits (Wang, Hailey & Yuphd, 2011; College of Registered Nurses of British Columbia [CRNBC], 2013)

Furthermore, nursing documents has a basic role in improving nursing and medical interventions provided for patients; transferring patients' information to other health team members, serves as the vehicle by which different health professionals who interact with a client communicate with each other. This prevents fragmentation, repetition, and delays in client care, enhance professional autonomy, critical thinking skills of nurses, development of professional knowledge and nursing education. The information contained in nursing documents can be a valuable source of data for research (Aghdam, Jasemi, Zadeh, Rahmani & Zadeh, 2009; Berman et al., 2010)