REPORT ON
NURSING CARE AUDIT - PROJECT

CONDUCTED IN
GENERAL WARDS OF THE PRINCESS MARGARET HOSPITAL
6th April, 1981 - 18th September, 1981

Prepared By:

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REPORT

NURSING CARE AUDIT - PROJECT

GENERAL MEDICAL AND SURGICAL WARDS

PRINCESS MARGARET HOSPITAL

Upon transfer to the Princess Margaret Hospital 6th April, 1981, I was orientated to the management of the major areas for a period of one week.

Subsequently, meetings and discussions were held with a view to:

(a) Determining the most feasible method for initiating the proposed project and (b) Selecting those categories of patients, whose nursing care would form the initial focus for nursing audit.

The consensus of opinion was that:

(1) The Audit process should be conducted in phases.

(2) The "Bedridden Patients" comprise the most susceptible group to nursing care problems, hence consideration for audit should be given primarily to this group. This would be considered Phase One, the Pre & Post-operative Management would be Phase Two and subsequent categories would be included in other phases. The pre & post operative nursing care plans were to be implemented when staff was familiar with the planning and audit process.

(3) Nursing care plans were necessary to facilitate auditing the quality of nursing care delivered.

(4) To minimize the amount of writing envisaged, standardized nursing care plans for the Bedridden patients should be formulated.

(5) All nursing care given should be documented on the present nursing notes form.

(6) Documentation would be done immediately following the delivery of care and not summarized at the end of the shift.

(7) Objective audit criteria for the "Bedridden Patient" and other categories should also be formulated.

Due to the limited staff to assist with the audit process on an eight (8) hourly basis as was suggested, it was agreed that nursing care would be audited after twenty four (24) hours for a period of five (5) days. This would be reassessed and continued if the patient condition warrants.

After much research and discussions at supervisory and unit levels a format for the nursing care plan was made.

This involved three main areas viz, "Patients Problems", "Expected Outcome" and "Nursing Care Orders". Emphasis was placed on Maslow's approach to Man's Hierarchy of Needs. (Appendix 1)
Audit Criteria for both categories were then formulated. (Appendix 2). Both "Process" and "Outcome" criteria models were combined to produce a criterion measure more practical for the participating clinical areas.

The Male and Female Medical Wards were selected for commence­ment of the Project. Accordingly, trained staff and students were orientated to the nursing care plan as revised and the audit procedure. During these sessions emphasis was placed on the systematic planning of the patients nursing care with reference to the nursing process. The method and importance of pertinent and concise documentation of care given and patients response were discussed and supported by examples.

Planning of nursing care for the Bedridden Patients and "Concurrent" audit of the care as documented, commenced on the 4th May, 1981 in the Medical area. Subsequently, planning of nursing care and auditing were implemented in the male and female surgical wards. Both processes continued simultaneously to the end of the Project.

A total of eighty three (83) Bedridden patients nursing care were audited.

Results

Analysis of data collected, suggests that (1) Meeting the physiological needs of the patients seemed to take pre-eminece over the other basic human needs of the patient, (albeit inadequately). (2) The specific problems of the patient were seldom assessed or rarely documented. (3) Nursing notes frequently omitted the patients response to nursing intervention.

It was interesting to note that this trend was common to all of the participating areas. However, many of these deficiencies were resolved through discussions, supplementary literature and the support of the Audit Officer.

After familiarization with the first category of patients was ascertained, Phase Two, the pre & post operative nursing management, was introduced in both surgical wards. A total of thirty six (36) patients care were planned and audited using the standardized nursing care plan. (Appendix 3 & 4)

Auditing of patient's pre-operative care was conducted forty eight (48) hours prior to surgery and on the day of surgery. Post Operative care audit was done within the first eight (8) hours and continued on a twenty four (24) hour frequency for four (4) days or longer if required.

Results

With regard to the pre and post operative nursing care, data revealed that: pre-operatively, with the exception of
activities to promote post operative recovery and psychological needs, most areas of physiological preparation were considered. Post-operatively, the basic care relative to hygiene, relief of pain, and observation of vital signs were consistently documented, however, aspects of nursing care frequently omitted were family involvement, psychological support, patient teaching for self care and discharge planning. Much more consideration appears to be needed in these areas.

Staffs Reaction to Project

Response to the revised method of nursing care planning and documentation were generally favourable. Both trained staff and students participated actively and were receptive to suggestions for improving the standard of nursing care delivery.

Most students found the new format educational and very helpful.

Problems cited as possible hindrance to the consistent planning and documentation of nursing care were:-

1. Volume of ward duties and chronic staff shortages
2. Inadequate equipment and supplies
3. Irresponsible attitude of many trained staff.
4. Lack of time for extra writing.

Several staff members saw this venture as beneficial, to improving quality, and expressed their desire to see this method of planning and co-ordination of nursing care continued.

Problems Identified

Based on observation, discussions and interaction within the areas, some problems identified as possible causes of the deficiencies in the delivery of quality nursing care were:

1. Insufficient supplies to maintain the required standard of nursing care.
2. The apparent lack of adequate and consistent supervision of subordinate staff providing direct nursing care.
3. The apparent lack of commitment among trained staff towards the planning of nursing care and documentation.
4. The apparent lack of innovation and continuity in nursing practice directed towards improving clinical performance.
5. The need for more emphasis on current trends in clinical practice through inservice or continuing education.
6. The lack of recognition of the value of planned education in patient care delivery.
(7) Neglect on the part of the other health professionals to expect and collaborate with nursing personnel on patient management.

(8) Apparent lack of the application of a holistic approach and the nursing process in delivery of nursing care.

(9) Lack of established standards from which criterion measures can be formulated to facilitate evaluation of the quality of nursing care.

(10) Inadequate procedure for collecting an appropriate nursing history to enhance assessment of patients needs.

(11) Inadequate system or established procedure for discharge planning and utilization of resources.

**Suggested Activities**

(1) Efforts should be made to obtain the collective opinions of trained staff towards the setting of standards and upgrading the quality of nursing care. This might be achieved through a workshop, planned and conducted for junior and senior staff members to facilitate total involvement in decisions and formulating methods to improve nursing practice. During this, consideration should be given to:

1.1 A complete survey of current nursing practices and policies etc., in Princess Margaret Hospital, with a view to rejuvenating, modifying, or discarding those practices now inadequate or obsolete. An up to date nursing manual of procedures and policies can then be formulated.

1.2 Ascertaining present knowledge and feeling of staff towards planned nursing care and documentation with a view to formulating standards for nursing practice and nursing care plans, thus fostering quality performance.

1.3 Reviewing the present nursing structure with a view to establishing a "Clinical" area and/or Co-Ordinator within the nursing hierarchy. This office or area will be solely responsible for the co-ordination of nursing care and quality assurance, i.e., setting standards, maintaining and reviewing standards, consistent upgrading of nursing procedures, evaluating the quality of care delivered, planning and implementing programmes, e.g. discharge planning, patient education, etc.

(2) A review of the present method of supplying stores to the Units. A more adequate method of co-ordination and control by non nursing personnel appears to be needed to improve the quantity and consistency of ward supplies.

(3) Continuing or inservice education sessions for senior staff where current concepts and issues in nursing and health practice can be discussed and explored.
(4) An organized system of education for patients with common or chronic disorders, e.g., diabetes or hypertension.

(5) Reviewing the present procedure for reception and discharge with a view to implementing the format submitted for nursing reception/interview and formulating a new procedure for discharge.

(6) Recognition and improvement of the collaborative role of the Nurse in planning and decision making in patient care. This should serve to motivate staff and foster the systematic nursing assessment of patients.

(7) Newly qualified staff should be given a period of organized internship during which basic applied management principles, and leadership skills are emphasized.

(8) Supplying sufficient personnel (nursing and others) to meet the complex needs of the system.

(9) Improving collaboration between clinical teacher and Unit Supervisor to foster better learning, control, and supervision of students in the clinical area.

In order to monitor other areas and categories of nursing care, additional nursing care plans were formulated. These include Nursing Care Plans for the: (Appendix 5-12)

1. Management of the Patient with Hypertension

2. Management of the Patient with Diabetes

3. Nursing Care of the Patients after reception and assessment.

Other submissions include a Nursing Reception/Interview format, differential definitions of Bedridden and Critically Ill Patients and discharge status check list. However, none of the above were implemented. (attached)

Conclusion

It has long been recognized by contemporary nursing leaders that nurses are accountable for the quality of nursing care they deliver. Accordingly many sought to monitor the levels of this care through the establishment of standards and protocols for ongoing evaluation. This has been referred to as the Nursing Audit. It also stipulates that this process and the results that are accrued should not be used as punitive measure, instead should be considered a means whereby changes and improvements can be made to those standards and criteria which measures quality within the health system.

Auditing of any aspect of an activity or role of a group is made more difficult or impossible if a criterion measure is non existent, and goals not clearly defined. This has been the experience of this Officer during the present project.

Nurses in our health system must of necessity come to grips with the change within this system and initiate similar changes in their
attitude towards accountability for the service they give.

They must become aware of the fact that it is their right and responsibility to appraise the quality of nursing care patients receive, and to collaborate with other professionals to foster a multi-disciplinary approach to quality assurance.

It ought to be recognized too, that proposed change in any situation produces anxiety. Therefore, adequate time must be allowed for acceptance and adaptation of the change before a detailed evaluation of accomplishments can be made.

At the end of this project, a short questionnaire was distributed among trained staff and students. Those responding, felt that nursing care has shown some noticeable improvement in the short duration of the project. It is felt that such a programme, if continued, could only lead to more improvement in nursing practice hence patient care delivery.