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## **Abstract**

**Introduction:** The purpose of this study was to assess and compare nursing documentation of the patient assessment and subsequent care plan in semi-electronic and paper records. In semi-electronic care plans, a new professional practice model incorporating a standardised Nursing Language was used. In paper records the care plan was based on a traditional professional practice model and mostly written in free text. Assessment booklet and risk assessments were similar in both formats.

**Methods:** Data was collected by way of audit. Records consisted of patients cared for in medical wards. Two of which use semi-electronic documentation and two wards that use paper based format. Data for the audits were collected using elements from the QC-M nursing documentation audit tool. Microsoft Excel 2016 was used for data collection, storage and analysis. Content, timeliness, completeness and accuracy were applied while assessing the standard of data in the nursing record.

**Results:** The nursing care plan in semi-electronic format achieved higher compliance rating with regard to professional and legal requirements. Nurses using semi-electronic care plans demonstrated appropriate use of SNL in measuring patient's problems and determining nursing diagnoses. Discharge planning, initiation of prevention care plans for patients at risk of falls and pressure ulcers along with co-signing of student entries revealed poor compliance rates on both formats. Overall results for quality care metrics were compliant, however when combined with paper based results the compliance rates slipped to that of partial compliant.

**Conclusion:** Areas of non-compliance were evident on both formats of documentation. These need to be addressed in a timely manner as this is an indication of the quality of care delivered. Discharge planning needs to be addressed if a focus on early discharge to primary care can support acute services is addressed, appropriate prevention care-planning is necessary to ensure the delivery of safe effective care. Student nurses are the future generation staff nurses and need to learn early in their career the importance of legal and professional accountability in documentation of their work. A suggestion of real-time data collection and an interactive metrics dashboard to be displayed in ward areas present an opportunity for Clinical Nurse Managers to acknowledge areas of good compliance and observe areas underperforming; this measure will afford time to improve prior to receiving the month end report and reduce the risk of a patient suffering an adverse event. Metrics highlighted as non-compliant could be considered when designing electronic records. Mandatory field functionality in electronic records for identified metric indicators would ensure 100% compliance.