

Project Title

Improving Nursing Documentation within the Nurses in Isolation Ward

Project Lead and Members

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Project members: SSN Aye Chan Moh, NC Hema Malini

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Nursing

Aims

The aim is to develop a systematic documentation while incorporating on the existing nurses' documentation templates. To ensure the content of information documented is accurate, reliable and able to be comprehend across the ISO nurses and their healthcare partners within the ward setting.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

- The unified information documented, increases the visibility of nursing interventions' among the ISO nurses.

- Positive attitude was embraced by the nurses towards the change outcome instead of taking it as a regular mundane task

Conclusion

See poster appended/ below

Project Category

Care & Process Redesign

Job Effectiveness

Keywords

Documentation Templates

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IMPROVING NURSING DOCUMENTATION WITHIN THE NURSES IN ISOLATION WARD

LEADER: SSN GIANAN ELIZABETH RAMOS
MEMBER: SSN AYE CHAN MOH
FACILITATOR: NC HEMA MALINI

- ✓ SAFETY
- ✓ QUALITY
- ☐ PATIENT EXPERIENCE
- ☐ PRODUCTIVITY
- ☐ COST

Problem & Aim

Problem

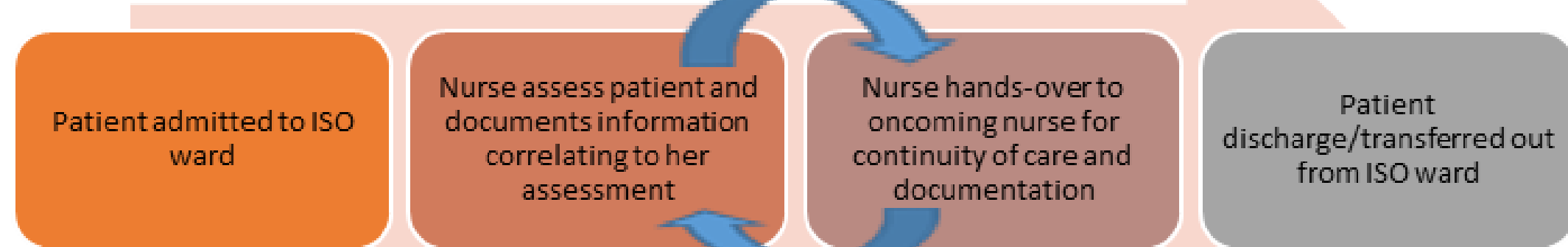
During investigation of SQ issues and other patient related enquiries in ISO Ward, crucial information on patient care were lacking. Moreover, the nurses in ISO ward had different variations in their daily nursing notes documentations on their patients' care, which can inhibit patient well being. Hence, it led to decreased clarity and poor communication on patients' continuity nursing care.

Aim

The aim is to develop a systematic documentation while incorporating on the existing nurses' documentation templates. To ensure the content of information documented is accurate, reliable and able to be comprehend across the ISO nurses and their healthcare partners within the ward setting.

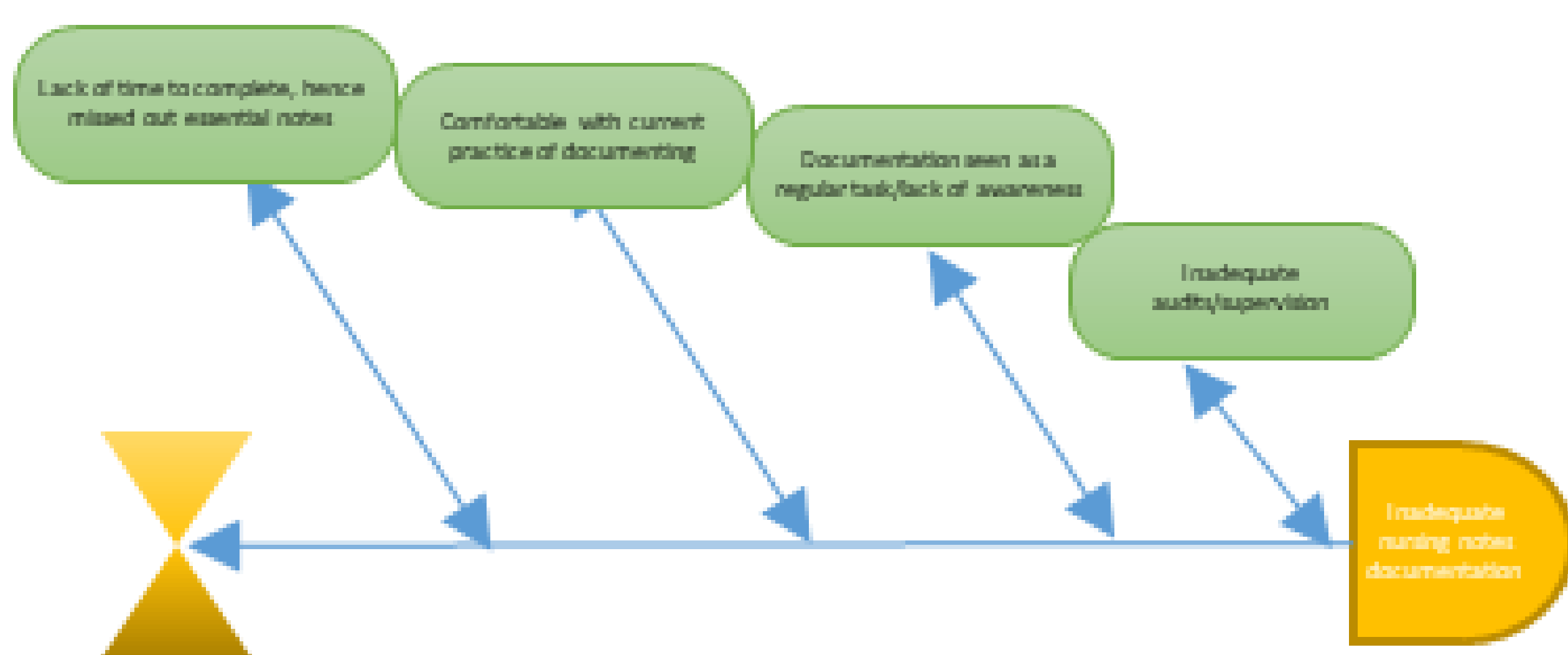
Analyzed Problem

Process Before Intervention



- Lack of clarity and visibility of nursing interventions
- Repetitive documentation in shift notes (information can be found in flowsheet)
- Incomplete/ inadequate information
- Substandard/ Un-uniformed variations in documentation
- Missing information e.g. photos on pressure ulcer, wounds

Root Cause factors



Tested and Implemented Change



- Gathered suggestions/ feedback gathered from ISO nurses to omit or add on the relevant sub-headings, appropriate for accurate and concise documentation

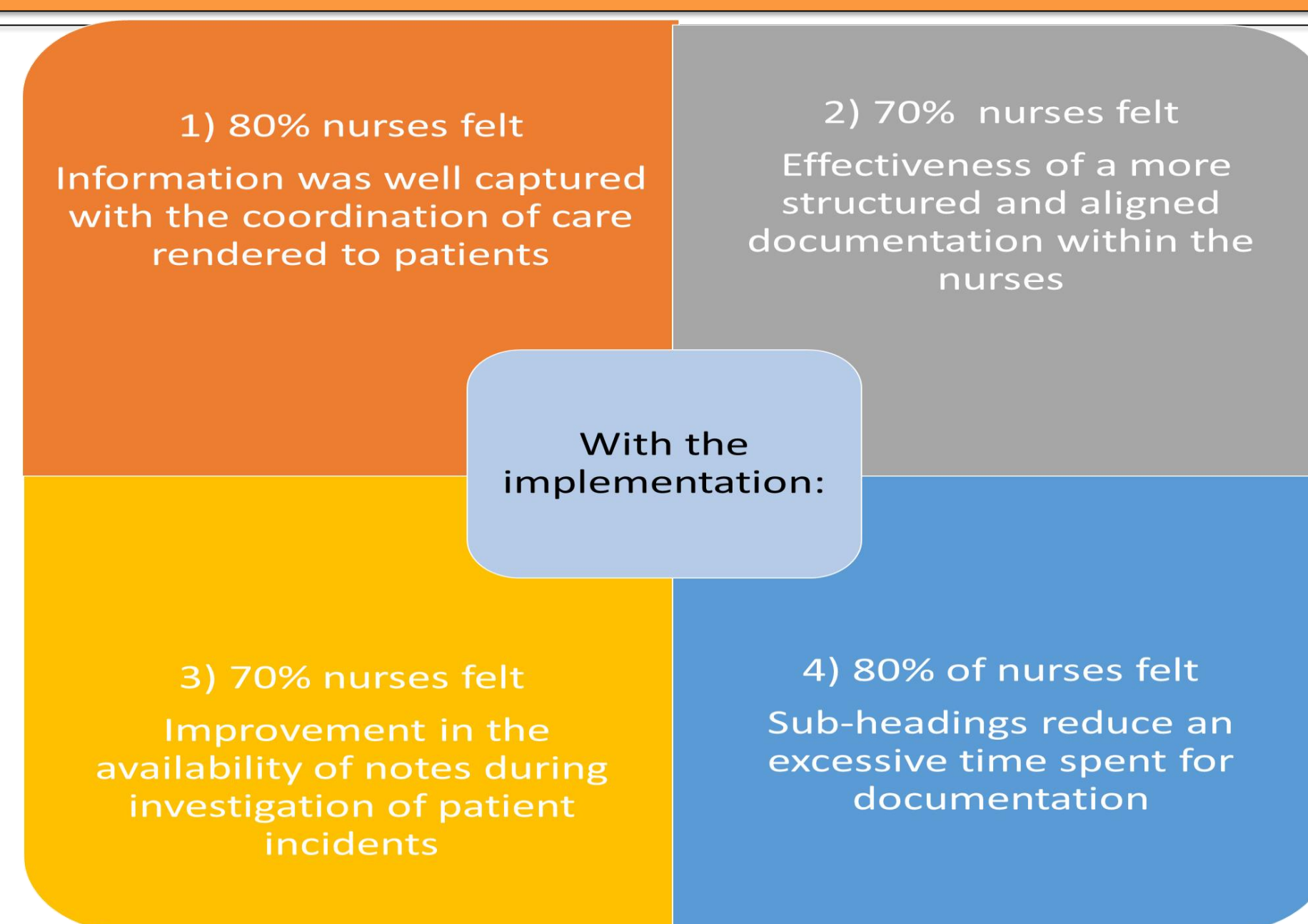


- Modified existing templates with smart phrases for nursing shift summary, admission/transfer in and discharge documentation and incorporated more specification in use for Isolation ward nurses



- Piloted for 3 days. Tweaked on certain sub-headings. Broadcasted during roll-call to the nurses within the unit on the expected changes. prior to implementation date

Results



Sustainability

- Regular audit checks for missing gaps, deviation and compliance
- Ongoing suggestions and inputs
- New hired nurses and transferred nurses were orientated on the nursing documentation

Learning Points

- The unified information documented, increases the visibility of nursing interventions' among the ISO nurses.
- Positive attitude was embraced by the nurses towards the change outcome instead of taking it as a regular mundane task