A Feasibility Study of Using a Modified Nursing and Midwifery Content Audit Tool (NMCAT) in a Retrospective Review of Clinical Information System (CIS) Nurse Notes Documentation for Newly Admitted Patients in Paediatric and Neonatal Intensive Care Units (PNICU).

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Background
Nursing documentation is essential for good clinical communication. Appropriate documentation provides an accurate reflection of nursing assessments, changes in conditions, care provided and evaluated the response. It provides evidence of care and is an important legal requirement of nursing practice.

Objectives
To assess the documentation in nurse notes if they were able to reflect the patient’s progress, change in conditions and respective interventions provided, and their response to treatment by using a modified NMCAT tool.

Methodology
A retrospective review of the nurse notes of the critically ill patients who were admitted to the Paediatric or Neonatal Intensive Care Unit of a local public hospital in January 2020 was performed. The nurse notes of these patients were assessed using the modified NMCAT tool for the first three consecutive shifts after admission. Therefore patients who were admitted for a short stay (less than three shifts) would be excluded from this review.

Results
Nurse notes of 38 patients (14 PICUs and 24 NICUs) with three consecutive shifts after admission were examined using the modified NMCAT tool. Nurse notes were identified as absent, present, always present or not rated according to the explanatory note of each criteria.

Discussion
The results indicated that with the use of CIS template helped all nurses write in a logical and sequential manner, and document what was observed at the beginning of each shift when writing the nursing assessment. At the end of the shift, nurses wrote duty summary and stated whether changed or unchanged at every shift. Change of condition or events were occurred in 11 cases, but entries were not written as the incidents occurred. They were written at the end of the shift and the time when events occurred were specified. Nurses were encouraged to write timely entries as incidents occurred. However, in clinical situation, prompt provision of care in PNICU setting was to stabilize patients from deterioration, thus retrospective entry was also accepted.

Patient was referred by names in 3 patient’s nurse notes. They were PICU patients and had lived in PICU for a longer period of times. Though it was not required to personalize patients’ account in nursing documentation, it helped to bring the nurses and patients closer.

Furthermore, the educational and/or psychosocial care to patient/family was not recorded in 6 patient’s notes. As parents were allowed to visit PNICU patient after admission, nurses could keep parents informed for updates and consents via phone when required.

Conclusion
In conclusion, modified NMCAT tool was feasible to examine the quality of nursing documentation. It helped to assess nurse notes if they were able to reflect the patient’s progress, change in conditions and respective interventions provided, and their response to treatment.