DEDER GENERAL HOSPITAL

NURSING AUDIT PROTOCOL

PREPARED BY*: *HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL: NURSING AUDIT PROTOCOL

PREPARRED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Abdi Tofik (BSc, MPH)	Health Service Quality Director (HSQD)	
2	Abdella Aliyi (BSc MW)	HSQ Officer and Reform f/person	
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1	Nureddin Yigezu (BSc, MPH)	Chief Executive Officer (CEO)	
2	Dr. Derese Gosa (MD)	Medical Director	
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THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

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Purpose:

This protocol is designed to systematically audit nursing care practices, including the quality of the nursing process, patient monitoring, pain management, medication administration, and client education. The goal is to maintain high standards of patient care, identify areas for improvement, ensure adherence to evidence-based practices, and optimize patient outcomes.

Audit Structure and Overview

Audit Scope

The audit will focus on five primary areas:

1. **Quality of Nursing Process**: Assessment, diagnosis, planning, implementation, and evaluation of care.
2. **Patient Monitoring**: Regular monitoring of patients' vital signs, critical conditions, and clinical status.
3. **Pain Management**: Effectiveness and appropriateness of interventions aimed at pain relief.
4. **Medication Administration**: Adherence to safe medication administration practices, including the "5 Rights" (right patient, right drug, right dose, right route, right time).
5. **Client Education**: Provision and effectiveness of patient and family education about care, treatment, and self-management.

Audit Frequency

- **Monthly Audits**: For critical areas requiring continuous improvement (**medication administration, pain management, patient monitoring).**
- **Quarterly Audits**:

- For comprehensive reviews of the nursing process and client education practices.
- To evaluate overall performance, compliance, and the effectiveness of implemented corrective actions across all areas.

Audit Team

- Nursing leadership will establish an **audit committee** composed of:
  - Nurse managers
  - Quality improvement officers, and
  - All case team leaders

Reporting Lines

- **Primary Report**: The audit committee will submit findings to the Director of Nursing or Chief Nursing Officer.
- **Secondary Report**: A summary will be shared with the Quality Improvement and Patient Safety Committees for further action and oversight

1. NURSING AUDIT COMPONENTS

1.1. Quality of Nursing Process

Key Areas:

- **Nursing Assessment**:
  - ☞ Assess the comprehensiveness of patient assessments (e.g., physical, psychological, social).
  - ☞ Ensure assessments are completed on admission and updated regularly.
- **Nursing Diagnosis**:
  - ☞ Review the appropriateness and accuracy of nursing diagnoses based on assessment data.
- **Care Planning**:
  - ☞ Ensure individualized care plans are developed with clear, measurable objectives.
  - ☞ Verify care plans are updated in response to patient condition changes.
- **Implementation**:
  - ☞ Evaluate the timely execution of nursing interventions according to the care plan.
- **Evaluation**:
  - ☞ Ensure patient outcomes are regularly evaluated and documented.
  - ☞ Check if nursing care is adjusted based on patient progress or lack thereof.

1.2. Patient Monitoring

Key Areas for monitoring:

- **Vital Signs Monitoring**:

- ☞ Review adherence to monitoring schedules (e.g., hourly, shift-based, as needed).
- ☞ Ensure abnormal values are followed by timely interventions.

- **Critical Condition Monitoring**:
  - ☞ Evaluate protocols for monitoring patients in critical condition (e.g., post-surgery, ICU).
  - ☞ Ensure early detection and response to deteriorating conditions.

- **Use of Monitoring Tools**:
  - ☞ Assess the proper use of monitoring equipment (e.g., ECG monitors, pulse oximeters).
  - ☞ Review adherence to early warning systems (e.g., MEWS, NEWS).

1.3.Pain Management

Key Areas for Audit:

- **Pain Assessment**:
  - ☞ Ensure that pain is assessed using a standardized pain scale (e.g., Numeric Rating Scale, Visual Analogue Scale).
  - ☞ Review pain assessments during admission, routine checks, and after interventions.
- **Pain Management Plans**:
  - ☞ Evaluate the development of individualized pain management plans, including pharmacological and non-pharmacological interventions.
  - ☞ Ensure adjustments are made based on the patient's pain levels and feedback.
- **Effectiveness of Pain Interventions**:
  - ☞ Assess documentation of pain relief following interventions.

- ☞ Ensure re-assessment of pain levels after administering analgesics or other pain interventions.

1.4.Medication Administration

Key focus Areas

- **The "5 Rights"**:
  - ☞ Verify adherence to the "5 Rights" (Right Patient, Right Drug, Right Dose, Right Route, Right Time) during medication administration.
- **Documentation of Medication**:
  - ☞ Ensure that medications are documented accurately in the patient's records, including time of administration, dose, and route.
  - ☞ Review for completeness in documenting PRN (as needed) medications and any adverse reactions.
- **Medication Errors**:
  - ☞ Investigate instances of medication errors, including wrong drug, wrong dose, or missed medications.
  - ☞ Review corrective actions and reporting mechanisms for medication errors.

1.5.Client Education

Key focus Areas:

- **Patient Education Plans**:
  - ☞ Assess the development of individualized education plans based on the patient's condition, diagnosis, and treatment.
  - ☞ Ensure that education is provided at key points, such as during admission, discharge, or changes in care.

- **Content of Education**: Review the appropriateness and comprehensiveness of the information provided on medication use, lifestyle changes, pain management, and follow-up care.
- **Patient Understanding**:
  - ☞ Ensure that teaching methods are appropriate for the patient's literacy level, language, and cultural background.
  - ☞ Assess whether patients or their caregivers demonstrate understanding through teach-back methods.
- **Documentation of Education**: Ensure that patient education is documented in the patient record, including topics covered and patient comprehension.

2. Reporting and Action Plan

1. **Audit Data Collection**:
   - Data will be collected using pre-designed tools, including checklists, observation forms, and patient feedback.
2. **Data Analysis**:
   - The audit team will compile findings and analyze areas of non-compliance, best practices, and trends.
3. **Report Preparation**:
   - A comprehensive report will be submitted to the nursing leadership and quality improvement committee, including key findings, trends, and recommendations.
4. **Action Plan Development**:
   - The audit committee will collaborate with the nursing leadership to develop an action plan to address identified gaps and areas for improvement.

5. **Follow-Up Audits**:
    - Follow-up audits will be conducted within 3 months to ensure corrective actions are implemented and improvements are sustained.