

Introducing a dashboard approach to improve documentation and monitoring of Haemodialysis (HD) patients.

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Problem

Nursing documentation is a written or electronic record that describes the health condition of a patient or the care provided to that patient. The Nursing Midwifery Council (NMC) code asserts that registered healthcare professionals' records need to be clear, concise and accurate. However, it remains the nurse's responsibility, to give high-quality patient care that is safe, effective and evidence-based, to ensure their records are legal, ethical and professional.

Following a review within our HD unit, nursing documentation was found to be variable in quality, some exceptional, some poor. This ultimately affects efficacy of communication, continuity of care and monitoring of patients. It was found that with differing levels of record-keeping, there were lapses in vital care and continued monitoring of our renal patients.

Purpose

We wanted to improve our documentation to meet standards expected by the Trust and the NMC, ensuring high-quality care and on-going surveillance of our patients to maximise the patient experience, reduce patient harm and provide an evidential governance tool. We also wanted consistency and conformity with documentation, ensuring all staff were using a standardised, holistic care pathway, with on-going re-evaluation standards.

Design

We introduced a dashboard approach, basing it on retrospective empirical evidence. A dashboard is a tool used to analyse data, which is then displayed. Carrying out a monthly audit of key areas of the documentation and surveillance tools we use. We ensured up to the moment continued monitoring. Locally derived target were set following discussions with the renal management team. Using a colour coded Red, Amber, Green (RAG) system to highlight specific areas and themes the data was presented monthly, in a fun, easy to read display

Findings

A plethora of data has been simply analysed following monthly audits and findings interpreted into percentages and displayed for staff to see on a dedicated Continuing Improvement Dashboard. The data shows major improvements in target weight assessments, Waterlow assessments, the frequency of handling plans, virology screening and care planning re-evaluation. There were several areas in the documentation that have been deemed not fit for purpose and areas for improved staff training were also identified.

Conclusions

By using a RAG dashboard approach, we have been able to convert data into actionable processes. These have been instrumental in improving the complex needs of renal patients in our unit. We have also provided the Trust with a governance tool that is more relevant and individualised to the needs of the out-patient HD Renal population. We can now see at a glance where we excel and where we need to make changes to improve. Initially, it appears that we have inspired staff to improve the quality of their documentation, surveillance and on-going monitoring of our renal patients endeavouring to ultimately enhance the patient experience.

Relevance

The dashboard is an ever-changing audit tool, which has facilitated identification of problems, which we have tackled. It has provided us with confidence that we can work as a team to improve the lives of our patients and improve the quality of our activity.