IMPLEMENTATION OF PEDIATRIC NURSING DOCUMENTATION QUALITY AUDIT: A SCOPING REVIEW

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Abstract

Background : In clinical practice, documentation of accurate nursing is essential for nurses to provide a good quality service. Inadequate documentation of nursing care can cause errors in interpretation that potentially threaten the safety of patients. Problems in nursing documentation poses more risk in pediatrics patients because of limitations in communication to convey complaints and obstacles they perceived. Special nursing documentation in child care room is required to ensure the safety and quality of care provided to the patients**.** The aim is to identify, assess, and map evidence regarding the implementation of documentation quality audits in improving the quality of pediatric nursing documentation. **Objective:** To identify, assess, and map evidence regarding the implementation of documentation quality audits in improving the quality of pediatric nursing documentation. **Methods:** A systematic search was conducted by identifying all relevant publications, in relevant bibliographic databases namely PubMed, EBSCO, and Sciencedirect. Relevant articles published in English from 2020 to 2024 were included. Six articles were included in the analysis**. Results;** Based on this review, the implementation of pediatric nursing documentation quality audit includes interventions of pediatric essential clinical data collection implementation can improve the efficiency and quality of documentation, audits can improve the utilization of pain measurement tools & identify good and suboptimal nutrition practices, management of children with gastroenteritis, transition from hospital to home, pediatric nursing clinical decision support system for hyperthermia can improve the quality of nursing records. **Conclusion**: the importance of various aspects in improving the quality of children's health care as well as the integration and automation of nursing information systems are essential to improve the accuracy and completeness of nursing records, which overall support the efficiency and quality of children's health care.

Keywords *: Audit; documentation nursing ; pediatrics*

BACKGROUND

International recognition of the importance of quality health services as a key element in improving child health still needs to be completed (Lazzerini & Tamburlini 2015), and this applies worldwide, both in developed and developing countries. More efforts are needed to improve the quality of child health services (Ferede Gebremedhin *et al.,* 2022). In clinical practice, accurate nursing documentation is essential for nurses to provide quality nursing services (D'agostino *et al.,* 2015). The implementation of inaccurate nursing documentation causes errors in interpretation, which has the potential to threaten patient safety (Paans *et al*, 2010 in Damanik and Sitorus, 2019).

The problem of nursing documentation certainly has a higher risk in pediatric patients because of their limited communication skills to convey complaints and obstacles they feel. Special nursing documentation in the pediatric ward is needed to ensure the safety and quality of care provided to pediatric patients (Hockenberry *et al.,* 2019)

Several studies have shown that the lack of implementation of nursing documentation occurs worldwide, and it is caused by incomplete, inaccurate, and poor-quality documentation (Tasew, Mariye & Teklay 2019). The implementation of documentation in Jamaica Hospital was reported to be only around 15% -25% of nurses who did nursing documentation on each shift (Lindo *et al.,* 2016). Research at Gondar Teaching Hospital, Ethiopia, shows that more than a third of respondents expressed the reasons for not doing nursing documentation because of short time 19%, many patients 22%, no time and many patients 62%, no format 2.2%, and no place 4.3% (Kebede *et al.,* 2017). Research at Felege Hiwot Referral Hospital in Northwest Ethiopia found that almost 87% of health services experienced documentation errors (Feleke *et al.,* (2015). Globally, it shows that the completeness and quality of nursing records are inadequate (Dehghan *et al*., 2013).

In Indonesia, several studies have also been conducted to evaluate the implementation of nursing documentation, such as a study conducted by Rachmania, Nursalam and Yunitasari (2016), where the results of interviews with 4 out of 13 nurses (30%) of the Teratai Inpatient Room of Amelia Pare Hospital, Kediri, namely four nurses stated that sometimes they did not have time to write in the format provided because of the many actions that had to be taken to patients. A study conducted by Kurniawandari, Siti Fatimah and Listiyanawati (2018) found that the completeness of nursing care documentation in the Inpatient Room of Wates Hospital Kulon Progo was claimed to be complete (27.9%). In addition, the results of the study (Hariati *et al*., 2022) also found that nurses had inadequate perceptions about the discharge planning process, which would affect the nursing documentation process.

Over the past few years, various efforts have been made to improve the quality of healthcare documentation (Kamanzi *et al*., 2015). Evidence-based approaches to improving documentation include initiatives such as clinical audits (Brima *et al*., 2021). Law No. 29 of 2004 concerning Medical Practice and Law No. 44 of 2009 concerning Hospitals, where hospitals must carry out medical audits, which are part of clinical audits. Decree of the. Minister of Health Number HK. 01. 07/Menkes/1128/2022 concerning Hospital Accreditation Standards, Standard 7 PMKP states that improvements in clinical services can be carried out through clinical audits.

Optimals clinical audits must be supported by quality nursing audits. The importance of conducting audits is because it can be known whether there are deviations from existing standards, criteria, and norms in the work (Brima *et al*., 2021). In addition, the existence of nursing quality audits can have an impact on patient safety and increase nurse compliance (Mulyani *et al*., 2022).

Several recent studies have shown that audits can significantly improve the completeness and accuracy of nursing documentation. However, to date, no systematic review has mapped the evidence on the effectiveness of pediatric nursing documentation quality audits on patient satisfaction and safety and increasing nurse compliance. Therefore, a scoping review is needed to map the existing evidence regarding implementing documentation quality audits to improve the quality of pediatric nursing documentation

METHODS

This review provides an overview of the implementation of pediatric nursing documentation quality audits, specifically answering the question, "Are pediatric nursing documentation quality audits effective in improving the quality of nursing documentation?". This review aims to identify, assess, and map evidence regarding the implementation of documentation quality audits in improving the quality of pediatric nursing documentation. The review protocol uses the JBI checklist for various types of research. The JBI critical appraisal tool from the Joanna Briggs Institute will assist in assessing the eligibility and results of published papers. Each article will be assigned a JBI Critical Appraisal score (Peters *et al*., 2015).

Inclusion criteria Population The population of this review is pediatric nursing documentation records. 1). Draft : The review's conecpt is a quality audit, which involves assessing the accuracy, completeness, and quality of nursing documentation relating to pediatric patients. 2). Context : The context of this review is a hospital that has pediatric nursing services. 3). Source type: This review includes either qualitative or quantitative primary research studies that have been peer-reviewed. Review articles were not included, but reference lists were checked for additional sources. Search strategy, A systematic search will identify all relevant publications in relevant bibliographic databases, namely PubMed, EBSCO, and ScienceDirect. Search strategies in the database using keywords include the following: nursing audit OR nursing review OR nursing assessment OR nursing evaluation OR healthcare audit for nursing OR nursing performance audit OR nursing quality audit OR nursing care audit OR clinical nursing audit OR nursing practice audit OR nursing standards audit AND pediatric nursing documentation OR child health records OR pediatric care documentation OR pediatric healthcare records OR childcare nursing documentation OR children's nursing records OR pediatric clinical documentation OR nursing documentation for children OR nursing records for pediatric OR pediatric healthcare documentation. Selection and extraction, A total of 331 abstracts were sourced from the three databases. After the removal of duplicates, 124 articles remained, leaving 207 articles. Titles were screened for relevance, leaving 21 articles for further review.

After the application of inclusion criteria, 6 (six) articles were left for final review (Figure 1), and a further 15 articles were removed. Data were extracted to include important criteria, including country of study origin, study design and aims, sample, methods, and key findings. Inductive thematic analysis, based on the work of Braun and Cohen (2012) across the studies, was used to identify key emerging themes. This required familiarization with the findings of each study and generating initial codes. These codes were then searched for emerging themes, which were reviewed and refined to arrive at the final themes reported.

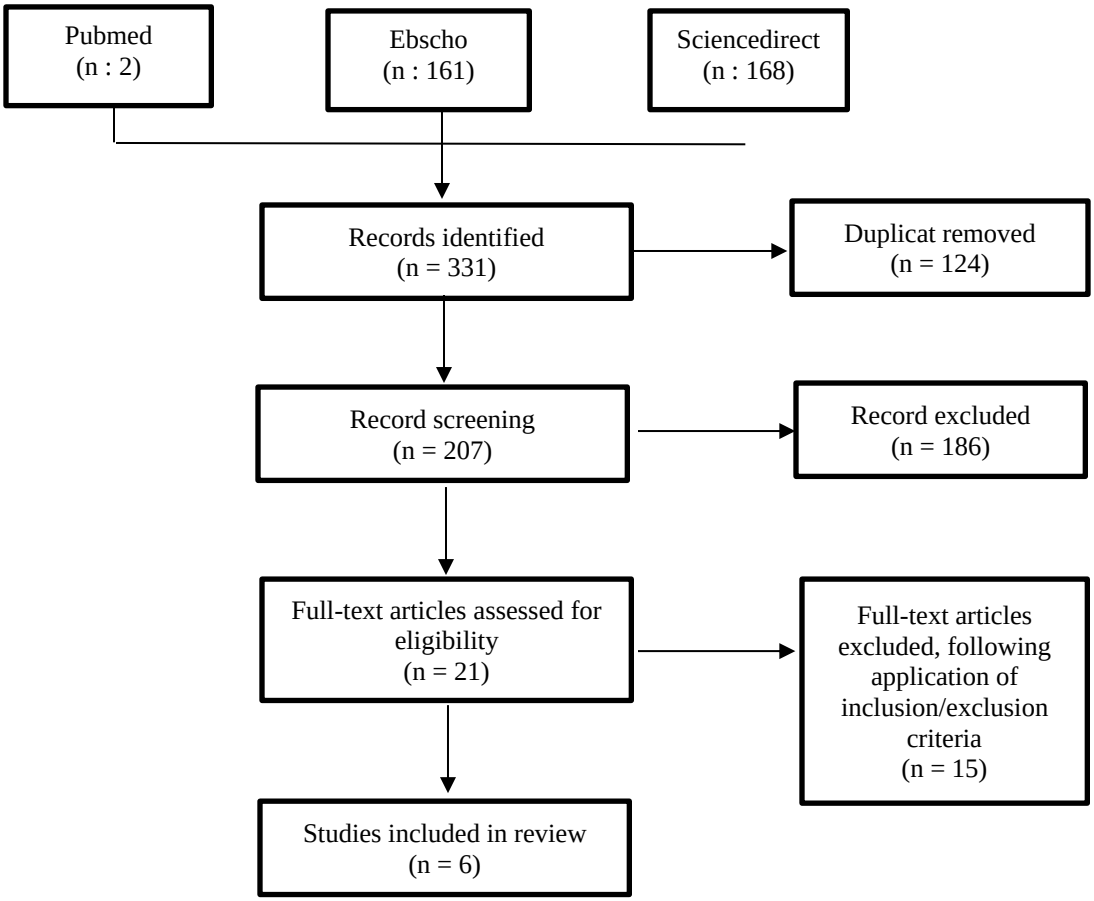

Figure 1. Explaining flow diagram details of search and selection strategies literatur

RESULT AND DISCUSSION

Of the six included studies, one was conducted in the United States with an experimental study design, one in the United Kingdom with a descriptive statistical study design, one in Kenya with a descriptive cross-sectional study design, two in Australia with a retrospective cohort and qualitative descriptive study design, and one in China with an experimental study design. Four studies addressed nurses, and two studies addressed pediatric patients. The key issues identified are summarised in Table 1.

1. Interventions for implementing pediatric essential clinical datasets can improve documentation efficiency and quality

A key theme emerging from this review was nursing documentation time and patient satisfaction. The studies demonstrated that implementing a pediatric essential clinical dataset (ECD) as a research intervention reduced the time required to complete documentation of pediatric admission histories. The intervention helped define critical data elements that facilitated the documentation process for nurses, although the difference in dataset completion rates was minimal and not statistically significant. In addition, nurses' perceptions of time spent on documentation did not change significantly, with many nurses reporting spending 10–20 minutes per patient before and after the intervention (Horn, Doucette & Sweeney 2021)

2. Audits can improve pain assessment tool utilization and identify good and suboptimal nutrition practices

Health system factors influencing pain assessment scale utilization were explored. Most study participants (99.4%) reported that their hospital had a role in pain assessment scale utilization among health professionals. However, 0.6% of study participants felt otherwise (Limungi *et al*. 2021).

Staff training on pain assessment, having a pain management protocol and frequent utilization audits were identified as the top three factors influencing pain assessment scale utilization in a children hospital. While these factors are similar to those found by other researchers (Ehwarieme, Amiegheme, & Chinenye, 2018), regular monthly audits of pain assessment scale utilization may be a unique health system factor identified in this study (Ehwarieme *et al.,* 2018), noted that seminars/workshops and staff training were associated with pain assessment scale utilization/non-utilization. (Zahra 2015) noted postgraduate training as a factor influencing the utilization of pain rating scales, while (Richardson and Gregory (2014) observed that nurses who had been trained in pain provided better pain management to patients.

Currently, there are no pediatric oncology-specific nutrition guidelines or standardized nutrition practices (Sala, Pencharz & Barr 2004) in (Glatt *et al*., 2020). Although the scientific literature is relatively consistent with recommendations for nutritional care, these have yet to be translated into clinical practice. The audit successfully established current nutrition practices in Oncology and Haematology departments; identifying areas of good and suboptimal practice and establishing a baseline for the next stage of the audit. Good practices included PYMS screening in IP, documentation of height and weight in OP, and reassessing potassium, magnesium, phosphate, calcium and albumin. Areas for improvement included anthropometric assessment in DC, malnutrition screening in DC and OP, and incorporation of arm anthropometry and blood nutrients Vitamins E, A, B12, D and PTH as part of routine practice. These results are unsurprising given the lack of nationally or globally agreed nutrition standards and the variable nutrition practices in pediatric oncology (Ladas *et al*., 2006 in Glatt *et al*., 2020).

Areas of audit requiring improvement were appropriate height and weight assessment and documentation in Day Care (DC); head circumference measurement in Inpatient (IP); incorporating arm anthropometric assessment into routine clinical dietetic practice; introduction of malnutrition screening in Day Care (DC) and Out Patient (OP); and comprehensive routine nutritional biochemical assessment.

3. Management of Children Suffering from Gastroenteritis

ED management of children with gastroenteritis is mostly consistent with evidence-based recommendations. However, areas for improvement identified in this study were assessment of dehydration, blood pressure measurement, fluid balance charting, initiation of rehydration and discharge advice (Sunderland *et al*., 2019). The low frequency of skin color documentation may be influenced by the number of Aboriginal Australian children in this study (66.5%).Clinicians may be unsure how to document skin color indicating good circulating blood volume in children with dark skin color or may be unable to detect when there is decreased circulating blood volume as pallor may be more challenging to detect, and there is little published literature there was little difference in the severity of dehydration and complications of gastroenteritis between Aboriginal Australian children compared with non-Aboriginal children. However, there were differences in management strategies, with Aboriginal Australian children receiving more pathology tests, fewer antiemetics, and more hospital admissions.

4. Transition from Hospital to Home

Education regarding transition information and discharge planning/process is essential for junior staff to ensure consistency in information delivery. Nursing staff needs to undertake a readiness-to-discharge assessment. Future research is needed to determine the reliability and suitability of validated instruments, namely the 'Readiness for Hospital Discharge Scale', 'Quality of Discharge Teaching Scale' and 'Post Discharge Coping Difficulties Scale' in Western Australia (Zhou, Roberts & Della 2021). Interpreter services should be arranged throughout the hospital stay, particularly when transition information occurs. It is important to assess nurses' understanding of the information using teach-back before discharging the patient.

5. Nursing Clinical Decision Support System for Pediatric Hyperthermia Can Improve the Quality of Nursing Records.

Nurses spend 15%-50% of their time and energy on nursing, which also reflects the hospital management level. A total of 26 nursing records that initially met the inclusion criteria in the control group were excluded due to the unavailability of nursing diagnoses, which reflects that each step in the control group of the nursing process is not integrated. There is no proper control before using PedN-CDSS-Hyperthermia. Any errors or omissions in nursing assessment may affect the process or accuracy of subsequent steps (Zhao *et al*., 2022). (Zega 2015) also found that although nursing assessments were accurate and complete in most nursing information systems, nursing diagnoses and subsequent steps were incomplete and inaccurate. The reason is that nurses are easily distracted by other work or other staff when caring for children with hyperthermia, and the original system lacks a reminder function. Therefore, it cannot prevent delays in assessment, diagnosis, management, and evaluation. PedN-CDSS-Hyperthermia can automatically extract each step of the nursing process and fill it into a standardized, structured, and formatted nursing record sheet; it can effectively prevent the loss of content in the record and improve the quality of nursing records.

Table 1. Details of studies in this review

Author (Year)	Country	search purposes	Design and Methods	Samples and Settings	Key Findings
Horn, Doucette and Sweeney (2021)	United States of America	improve nursing documentation efficiency and pediatric admission history workflow satisfaction	Survey method that is in nature quasi-experimental	Nurse	• Nursing documentation time • Data set completion rate • Satisfaction
Glatt et al., (2020)	English	Audit current nutritional practices in the areas of anthropometry, nutritional biochemistry, and malnutrition screening for pediatric cancer patients against nutritional standards to identify areas of concern	• Clinical audit • Analyze documentation and observing clinical practice	• Patients aged 0-18 years • undergoing treatment for cancer diagnosis child malignant (ICCC-3 or Langerhans Cell (Histiocytosis).	• 82% of 50 audit criteria did not meet 100% standards. • Audit areas requiring improvement were appropriate height and weight assessment and documentation in DC; head circumference measurement in IP; incorporating arm anthropometry assessment into routine clinical dietetic practice; introduction of malnutrition screening in DC and op; and routine comprehensive nutritional biochemistry assessment
Limungi et al., (2021)	Kenya	Assessing the use of pain assessment scales in children's hospitals as a basis for making	• Descriptive cross-sectional uses quantitative and qualitative approaches. • Semi-structured questionnaire • Interview • Observation checklist	• Health workers working in the hospital and patient records. • 158 health workers,	• The health system plays a significant role in the use of good pain assessment scales in children's hospitals. • Staff training, pain management protocols

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				re-interviewed 2-4 weeks after hospital discharge.	casual staff to ensure consistency of information delivery. • Interpreter services should be provided for nurses with limited language skills during the hospital stay, especially when transition information is provided. • Nurses should implement teach-back method to enhance their understanding of information
Zhao et al., (2022)	China	Describes the process of developing and implementing a pediatric nursing clinical decision support system for hyperthermia	• Experiment • Development of PedN-CDSS-hyperthermia • Using PedN-CDSS-hyperthermia	Multidisciplinary team: • Nursing • Information and technology • Quality control • Ewell technology company • Head and senior nurses as users	Based on the nursing process framework, PedN-CDSS-Hyperthermia combines evidence-based nursing and clinical decision support technology, which includes four modules, namely, nursing assessment, nursing plan, nursing orders, and nursing task list.

The study results showed that implementing an ECD reduced the time required to complete documentation of a pediatric admission history. With structured data elements, nurses did not have to record the same information repeatedly, making the documentation

process more efficient. Despite the reduction in documentation time noted in the study, nurses' perceptions of the time they spent on documentation did not change significantly. Many nurses reported spending 10-20 minutes per patient before and after implementing the ECD, which indicates that despite changes in the documentation system, nurses' perceptions of their workload in terms of documentation remained consistent (Horn *et al*., 2021).

Another study found that nearly all participants (99.4%) agreed that the hospital played a significant role in using pain rating scales among healthcare professionals, while only 0.6% disagreed. Key factors influencing the utilization of pain rating scales in children's hospitals included staff training, pain management protocols, and regular audits. Ongoing education and training for health care professionals is essential to ensure they have the skills and knowledge to use pain rating scales effectively. Pain management protocols help provide consistent guidance for healthcare professionals in assessing and managing patient pain. The audit helped ensure that the pain rating scale was used consistently and according to established standards (Limungi *et al.*, 2021).

Another study also identified that the audit successfully established current nutrition practices and identified areas for improvement, namely PYMS screening in Inpatients (IP), which helps in identifying patients at risk of malnutrition so that appropriate interventions can be made, documentation of height and weight in Outpatient (OP) which accurately monitors patient growth and development, reassessment of electrolytes and proteins is vital to ensure patient nutritional balance. The audit also identified several areas for improvement, such as anthropometric assessment in Day Care (DC) to monitor patient nutritional status, malnutrition screening in DC and OP can help in early detection and management of malnutrition, integration of arm anthropometry and blood nutritional assessment will provide a more comprehensive picture of patient nutritional status (Glatt *et al*., 2020).

Other findings suggest that the low documentation of skin color may be due to the large number of Aboriginal Australian children in the study (66.5%). Clinicians may face challenges documenting skin color in dark-skinned children, particularly in detecting signs of decreased circulating blood volume, such as pallor. The study also found that there was little difference in the severity of dehydration and gastroenteritis complications between Aboriginal Australian and non-Aboriginal children. However, there were differences in management strategies, with Aboriginal Australian children receiving more pathology tests, fewer antiemetics, and more hospital admissions (Robson *et al*., 2024).

The study identified the importance of education regarding transition information and discharge planning/processes for junior staff to ensure consistency in delivering information to patients. It aims to ensure they can provide consistent and accurate information to patients and their families, reducing the risk of confusion or ambiguity regarding discharge steps. Nurses need to assess patient readiness for discharge before granting discharge to ensure that patients are physically and mentally ready to continue care at home. Arranging interpreter services during the hospital stay, especially when transition information is being delivered, is essential to ensure that non-English speaking patients and their families can understand the information clearly and accurately. It is important to assess nurses' understanding of the information delivered using a teach-back method before discharge to ensure that the information provided is understood correctly and that nurses are prepared to answer questions from patients or families (Zhou *et al*., 2021).

The study found that nurses spent 15%-50% of their time and energy on nursing activities. This result also reflects the level of hospital management that affects the efficiency and quality of nursing care. A total of 26 nursing records in the control group were excluded due to the absence of a nursing diagnosis. This suggests that the nursing process in the control group was poorly integrated and there was no proper control before using the PedN-CDSS-Hyperthermia. Errors or omissions in nursing assessment can affect the accuracy and sustainability of subsequent steps in the nursing process (Zhao *et al*., 2022).

Zega (2015) found that although nursing assessments were accurate and complete in most nursing information systems, nursing diagnoses and subsequent steps often needed to

be completed and accurate. This result was because nurses were easily distracted by other tasks or by other staff when caring for children with hyperthermia. In addition, existing nursing information systems lacked a reminder function, resulting in delays in patient assessment, diagnosis, management, and evaluation.

CONCLUSION

The findings discussed in this paper highlight the importance of multiple aspects of improving the quality of pediatric healthcare. Implementation of the Pediatric Essential Clinical Data Set (ECD) showed potential for reducing documentation time. However, it did not significantly improve dataset completion or nurses' perceptions of documentation time, suggesting the need for further research for long-term evaluation.

Training, clear protocols, and regular audits are important in clinical practice, particularly in pain assessment and nutrition management in pediatric oncology. Additionally, comprehensive assessment and appropriate documentation are essential in the management of gastroenteritis, including special attention to children of color and differences in management strategies based on ethnicity.

The discharge process requires consistent information delivery, readiness assessment, and interpreter services to ensure a smooth transition. Finally, integration and automation of nursing information systems are essential to improve the accuracy and completeness of nursing records that support the efficiency and quality of pediatric healthcare.

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