

Clinical Stories shared at handover compared with formal documentation by Child and Family Health Nurses

Jane Louise Kookarkin Ba App Sc (HIM), Ass Dip MRA

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University of Technology, Sydney

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

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Abstract

The impetus for undertaking this study arises out of the author's work as a Health Information Manager (HIM), employed within an Early Parenting Centre (EPC) with a predominant nursing workforce. To a HIM, quality documentation in the clinical record is of the utmost importance in ensuring that accurate clinical coding can be achieved with positive outcomes for clients, families and the organisation.

The aim of this study is to investigate nursing documentation and handover practices within a child and family health (CFH) setting. The focus is on the differences between what nurses write in the clinical records and what they communicate verbally in 'handover'. This study builds on the development of the ICD-10-AM Early Parenting Manual to examine the accuracy and quality of information collected in the clinical record. This study was conducted in three residential units of an EPC situated in Sydney, NSW. These EPC units provide early intervention for parents with young children through support and education. Nurses provide the majority of parenting intervention, support and education during a parent and child's stay.

A qualitative interpretive research approach was used employing several forms of data including case studies, interviews, field notes and questionnaires. The data analysis involved qualitative thematic content analysis in two parts; firstly the analysis of the transcripts of handover and the clinical record documentation through the use of a coding template; and secondly examination of the nursing interview transcripts using the themes identified from the verbal and written analysis. Demographic data collected from a nursing questionnaire and field notes were used to provide context to inform the analysis process and findings.

This study identified a number of positive outcomes: comments from the nurses echoed their desire to learn and improve their documentation practices; the demographic data identified a wealth of nursing expertise and knowledge; and the changing nature of CFH nursing acknowledged that the RNs are now expected to work at a much higher level than in the past. Conversely, there were some concerns related to the barriers that impact on the nurses' ability to accurately document their practice. They included confusion regarding who is the client, inconsistency of the parenting advice given, gaps in communication transfer of both written and verbal information, the changing and increasing educational needs of staff, the environment and the workload.

It has clearly been identified that the area of CFH clinical information collection and clinical coding would benefit from more research. For the clinical coding process to be improved,

more focused education for nurses is necessary to help them understand the need for quality documentation required by clinical coders. This stresses the importance of work place education and mentoring; and the importance of education about the role of clinical coding in undergraduate and post graduate nursing programs. Continuing professional development for nurses should include topics such as the importance of clinical documentation with regard to the introduction of Activity-Based Funding and the completion of clinical documentation using the eMR. Finally, further development should be undertaken in improving formal communication processes between all clinical staff.

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Abbreviations

ABF	Activity-Based Funding
CNC	Clinical Nurse Consultant
CM	Centre Manager
CFH	Child and Family Health
DOCS	Department of Community Services (now FACS)
EDS	Edinburgh Depression Scale
EPC	Early Parenting Centre
EN	Enrolled Nurse
eMR	Electronic Medical Record
FACS	Family and Community Health Service (previously DOCS)
HREC	Human Research Ethics Committee
HIM	Health Information Manager
ICD-10-AM	International Classification of Diseases 10 th Revision. Australian Modification
MOC	Model of Care
NCCH	National Centre for Coding in Health (now NCCC)
NCCC	National Casemix and Classification Centre (previously NCCH)
NOS	Not elsewhere classified
NSW	New South Wales
NUM	Nurse Unit Manager
PND	Post Natal Depression
PNRQ	Post Natal Risk Questionnaire
RN	Registered Nurse
SW	Social Worker
UTS	University of Technology Sydney