THE COMPARISON OF THE QUALITY OF NURSING DOCUMENTATION BETWEEN WRITTEN AND ELECTRONIC HEALTH RECORDS: A PILOT STUDY

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Statement of the Problem: The quality nursing documentation, which follows the steps of the nursing process, ensures systematic nursing care of patients and provides support to nurses in clinical decision-making. The literature review, however, shows that data gaps and inaccurate data are often listed in the documentation and that documentation is often lacking in important information. The electronic records and standardized nursing language influence the improvement of the quality of nursing documentation, yet the area is still not well researched. The purpose of this pilot study is to validate the Slovenian version of Quality of Diagnoses, Interventions, and Outcomes (Q-DIO) Instrument and to compare the quality of paper-based records versus electronic records.

Methodology: A cross-sectional observational study will be carried out using a standard Q-DIO instrument. The sample for the pilot study will include 30 health records (10 electronic and 20 paper-based records) of children aged 1 to 9 years diagnosed with lower respiratory infection. Children included in the study were hospitalized in 2017 in three different tertiary clinics in Slovenia.

Findings & Conclusion: We expect that the quality of electronic records will be significantly higher in comparison with paper-based records.