“Sustaining Improvements through Structured Nursing Audits; Enhancing Nursing Practice and Patient Outcomes”

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What is a Nursing Audit?

“A nursing audit is a systematic and objective review of nursing care, conducted to evaluate the quality of care provided by comparing actual nursing practices against established standards and protocols“

📘 Reference: Textbook of Fundamentals of Nursing" by Caroline Bunker Rosdahl & Mary T. Kowalski

Why Nursing Audits? Measure of Practice Vs Protocol

The NABH emphasizes nursing audits as part of PSQ requiring institutions to:

- Monitor compliance with nursing documentation and care protocols
- Identify gaps in practice and implement corrective actions
- Reassess regularly to ensure sustained improvement
- Systematic and formal evaluation of nursing care
- Measures practice compliance with established standards
- Measures safety, quality, and effectiveness of patient care

Types of Nursing Audits

Concurrent Nursing Audit

Retrospective Nursing Audit

Point Prevalence Audit

Concurrent Nursing Audit

Audit conducted while the patient is still receiving care

Allows real-time correction and immediate feedback

Example

- Audit pressure injury prevention protocols during the patient stay
- Audit Medication administration
- Audit Infection control practices

Retrospective Nursing Audit

Audit done after the patient has been discharged

Evaluates documentation compliance

Example

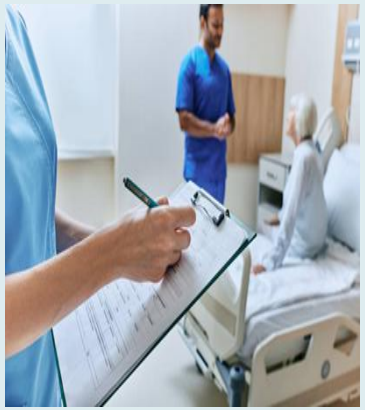
- Audit of discharged patient files
- Post-operative care documentation of past 3 months discharged surgical patients
- Pressure injury prevention care in bedridden patients of Previous 2 months of discharged ICU patients

Point Prevalence Audit

An assessment or review that is conducted at a single point in time to measure specific aspects of patient care, nursing practices, or healthcare outcomes.

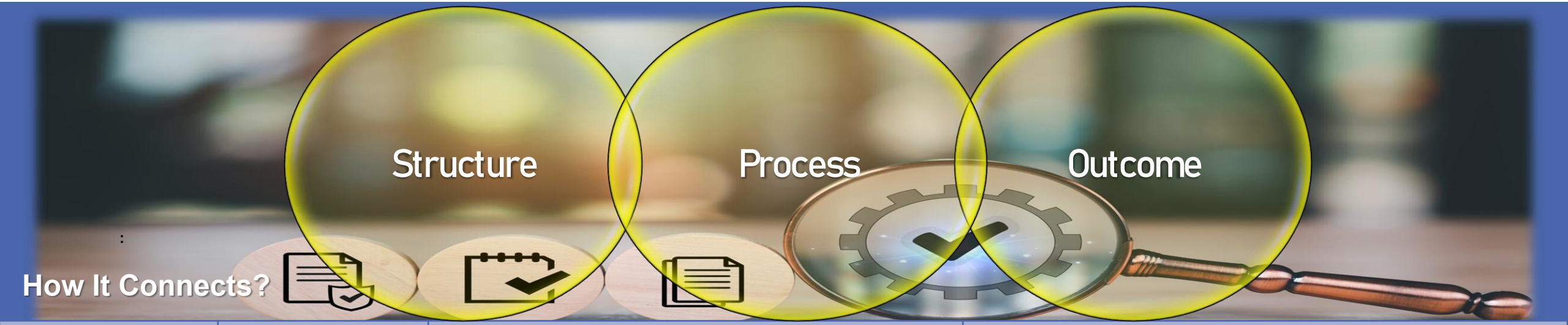
Example

Auditing all patients for skin condition for pressure ulcer prevention and management protocol



- **Point Prevalence Audit**: *How many patients have unreported pressure ulcers at this time?*
- *100% of the components*

- **Concurrent Audit**: *Is the nurse doing the specific task correctly during care delivery?*
- *Only Sampling*



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How It Connects?

Component	Focus	Example	Audit Example
Structure	Components to deliver care	• Nurse–patient ratio • Availability of necessary equipment • Infection control measures	• Are enough trained nurses available? • Whether the PPE are available?
Process	SOPs	• Medication administration • Hand hygiene • Pain assessment & Management	• Whether the nurses followed all rights of medication administration? • Did the nurse follow the 5 moments and steps of hand hygiene during care delivery? • Is pain assessment done every shift?
Outcome	Results of care	• Patient satisfaction Scores • Pressure ulcers /Fall prevention	• Are the patients satisfied with the nursing care provided? • What is the Fall incidence

Steps in the Structured Audit Cycle

- Set Standards of Procedures -SOP
- Audit Tool
- Define Audit Plan
- Data Collection
- Analyse Gaps
- Develop & Implement Action Plan
- Re-Audit

1.Standard Operating Procedure (SOP)

Policy on Nursing Handover

1. Nurse Handover happens at the time of shift change / transfer from one department to another
2. Handover conducted at the patient's bedside ensuring safety and patient involvement
3. Perform safety checks before handover
4. Nurse handoff shall be documented
5. Outgoing nurse should: Review notes, orders, and care plans

2. Audit Tool- Nursing Handover

Audit on Nursing Handover

josnamariya1012@gmail.com Switc

Not shared

Area

Your answer

MR No of the patient

Your answer

Name of the assigned staff

Your answer

Bedside Check

Hand over done at the patient's bed side

- Yes
- No

Verification of ID band done

- Yes
- No

Staff practiced AIDET while communicati with patient

- Yes
- No

Staff checked the patient's room / bed sid (working condition of O2 ,suction,monitor other patient care equipments)

- Yes

Diagnosis is documented accurately

- Yes
- No

basic nursing care including the skin assessment

- Yes
- No

Staff assessed the patency of tubes and lines of the patient

- Yes
- No
- NA

Fall risk is documented

- Yes
- No

Past history is endorsed and documented

- Yes
- No
- NA

Status of Pressure Injury is endorsed and documented (if any)

- Yes
- No
- NA

Allergy status is endorsed and documented (if any)

- Yes
- No
- NA

Due medicines for the patient is properly endorsed and documented

- Yes
- No

Intake and Output is documented

- Yes
- No

Status of the IV canula including the due for change documented

- Yes
- No
- NA

Pending investigations are endorsed and documented (if any)

- Yes
- No
- NA

Neurological status of the patient is documented (AVPU)

- Yes
- No

3. Define the Audit Plan

Audit Criteria	Standard/Benchmark	Frequency	Audit Method
Initial Nursing assessment documented within 30min of admission	≥ 95% compliance	Daily	Random sample of 5 charts- Initial Nursing Assessment
Pain assessment recorded hourly in ICU	100% compliance	Daily	ICU chart review
Medication administration documented in EMR on time	100% compliance	Daily	Medication Chart /EMR
Nursing care plan updated in each shift and modified as and when necessary	≥ 90% compliance	Daily	Nursing Care plan
Patient identification band applied and cross-checked daily	100% compliance	Daily	Observation & Patient interview
IV site inspection & documentation in every shift	≥ 90% compliance	Daily	IV Site checking & IV Cannula Tracker

Trained and Objective Auditors

- Applies scoring criteria uniformly across cases
- Gives constructive, evidence-based feedback
- Findings in comparison with protocols
- Accurately identifies missed entries vs. acceptable delays
- Maintains neutrality, avoids favouritism/ bias

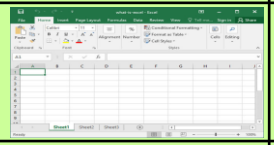
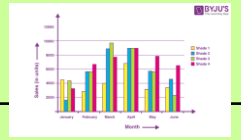
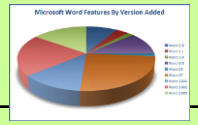
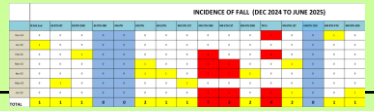
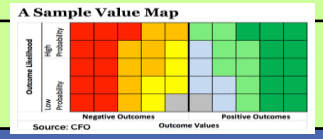
4.Data Collection

- Patient Medical Records/EMR
- Direct Observation
- Nurse Interviews
- Patient Feedback
- Incident Reports

Representation of Audit data

- Compare findings against benchmarks
- Identify gaps, trends, and non-compliance areas

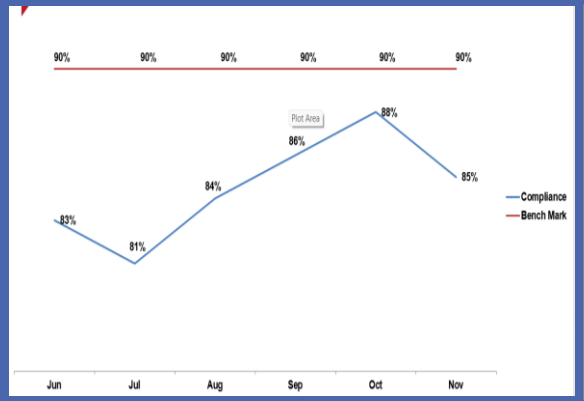
📊 Tools Used in Audit Data presentation

Tool	Purpose
❑ Microsoft Excel 	Data entry, tabulation, and auto-calculations
❑ Bar/Line Graphs 	Visualize trends, gaps, and comparisons
❑ Pie Charts 	Show proportion of compliant vs. non-compliant
❑ Dashboards 	Interactive, real-time displays for leadership
❑ Pareto Chart 	Focus on vital few problems
❑ Heat Maps 	Highlight high-risk areas or units

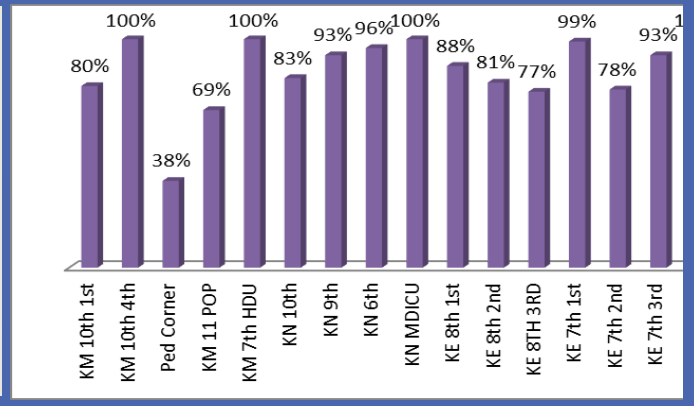
5. Analyse the Gap- Nursing Handover Compliance

Date &Time of Audit	Area	MR No of the patient	Hand over done at the patient's bed side	Verification of ID band done	Staff practiced AIDET while communicating with patient	Staff checked the patient's room / bed side	Staff assessed whether the patient met the basic nursing care	Staff assessed the patency of tubes and lines of the patient	Specified the Length of stay (Days after admission)	Diagnosis is documented correctly	Past history is endorsed and documented	Status of Pressure Injury is endorsed and documented (if any)	Allergy status is endorsed and documented (if any)	Intake and Output is documented	Status of the IV canula documented	Neurological status of the patient is documented (AVPU)	Fall risk is documented	Pressure injury prevention aspects were documented	Frequency of glucose monitoring is endorsed and documented (if any)	Due medicines/Pending lab tests/Pending consultations are endorsed	Name of the auditor
07-09-2025 14:10	SICU Main	44225	No	Yes	No	No	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	Roby
07-09-2025 14:17	Stroke unit	1487220	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Sheeja M S
07-09-2025 14:18	9th 1st	9478023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Ajitha Kumari S
07-09-2025 14:23	NSICU 2	4503625	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	NA	NA	Yes	No	Yes	Yes	Yes	Yes	Yes	Jojo Vs
07-09-2025 14:28	KM5th 1st	4811025	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mercy thomas
07-09-2025 14:28	SICU	4306225	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Roby
07-09-2025 14:32	Km5th 1st	2757220	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Mercy Thomas
07-09-2025 14:35	KE 8th 2nd	447615	Yes	Yes	Yes	Yes	No	NA	No	Yes	Yes	NA	Yes	Yes	Yes	No	Yes	NA	NA	Yes	Sujitha R B
07-09-2025 14:36	9th 1st	5051225	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Ajitha Kumari S
07-09-2025 14:38	Ke Burn's ICU	Muthu Kumari	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Surya S
07-09-2025 14:40	Stroke unit	5108825	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Sheeja M S
07-09-2025 14:48	KE 7 th 1 st	3464505	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Mercy V Mannooran
07-09-2025 14:49	7th acute onco care	1379124	No	Yes	Yes	Yes	No	Yes	Yes	No	No	NA	NA	No	No	Yes	No	No	No	No	Jansammma joseph
07-09-2025 14:57	LTICU	4641125	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Sarithamol SS
07-09-2025 15:01	KE 8th 2nd	10785824	Yes	Yes	Yes	No	Yes	NA	No	Yes	Yes	NA	Yes	No	NA	Yes	Yes	NA	NA	Yes	Sujitha

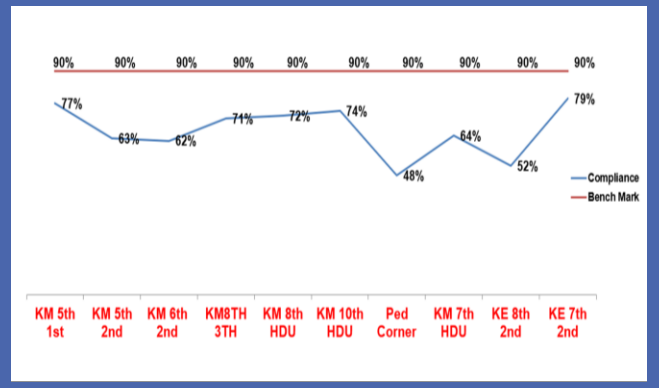
Overall compliance

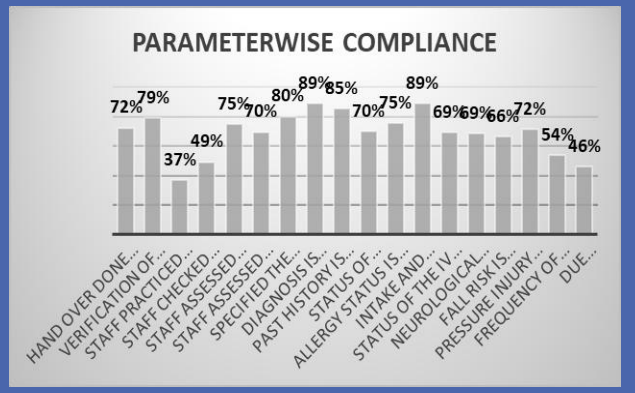


Departmentwise compliance



Identification of High priority Areas





6. Develop and Implement Action Plan

Audit Finding	Intervention /Action	Responsibility	Key Audit Checkpoints
AIDET communication – 37 %	Micro-training (10-min huddle demo on every shift for 1 week)	Unit Educator & In-charge	Spot observation checklist (≥90 % goal)
Glucose monitoring frequency documented – 54 %	Standardize physician order	In-charge & Endocrinologist	Sample Chart review
Room / bedside safety check – 49 %	Two-person handover so one nurse verifies environment	Shift Incharge	Random evening rounds (goal ≥85 %)
IV cannula status – 69 %	Daily site checking Flushing of line during	IV Champion Nurse	IV Cannula Tracker
Fall-risk scored – 66 %	Training on Fall Risk Scoring Validation of scoring	Unit Educator /Incharge	Fall risk Scoring in EMR Chart review
Pressure-injury prevention actions – 72 %	Turning-clock above bed Turn-alert every 2 hrly	Incharge/ Quality Nurse Wound Care Team	Weekly prevalence spot survey

Action-Oriented Feedback Mechanism- Nursing Handover

- ***Who Gives Feedback*** **?** Nurse Auditor
- ***To Whom*** **?** Nurse Manager and RN (Registered Nurses)
- ***How*** **?** Unit-based meeting
- ***Content*** **?** Identified gaps, Specific non-compliances, Unit-specific observations, Re-orientation on Nursing Handover Process
- ***Timeline for Action*** **?** Within 2 weeks
- ***Re-Audit Date*** **?** 1 month after intervention
- ***Responsibility Assigned?*** Nurse Manager and Nurse Educator

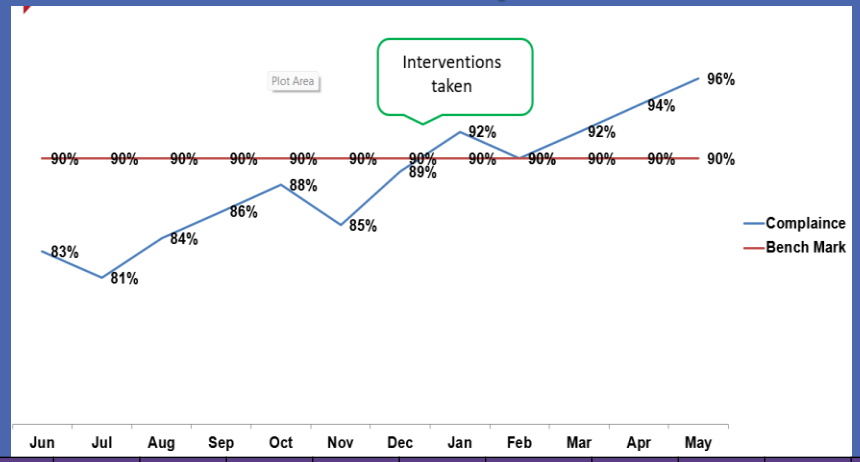
7.Re-Audit

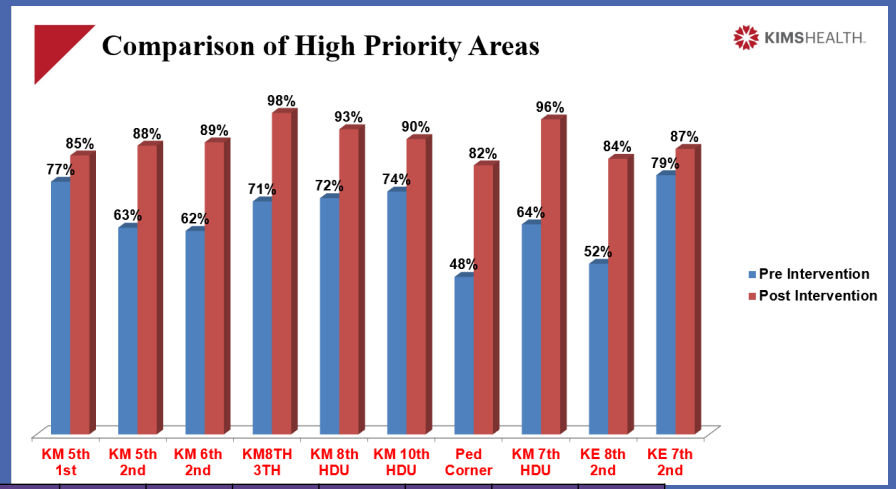
Monitoring Aspect	Action Taken
Timeline for Re-Audit	Conducted 4 weeks after intervention
Sample Size	5 random patient files from the same unit daily
Re-Audit Results	Compliance improved to 88% in timely risk assessment
Ongoing Monitoring Tool	Monthly compliance tracker + Spot audits by Nurse Auditor
Reporting Mechanism	Monthly reports shared with Nursing Managers and Quality Department
Sustainability Strategy	Quarterly refresher sessions

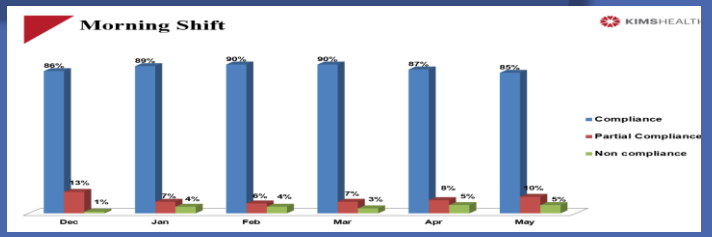
- Compare results with baseline audit
- Use bar graphs/ pie charts to visualize improvement
- Identify areas of continued non-compliance for further action

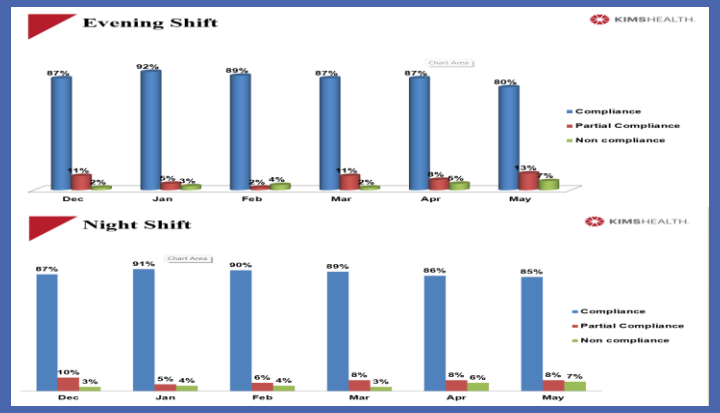
Nursing Handover compliance

Pre and Post Comparison









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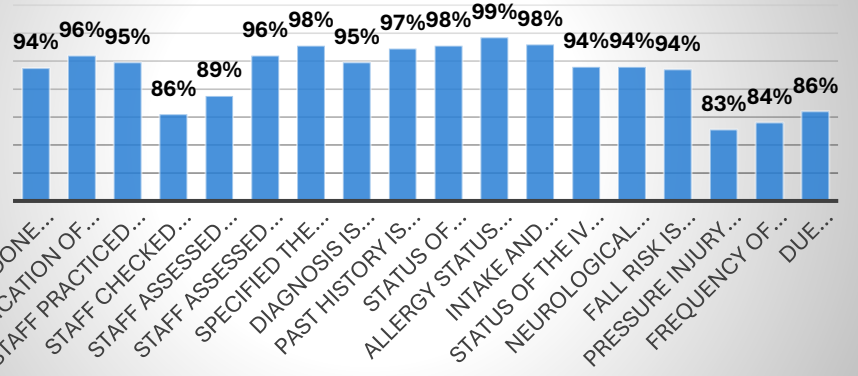
375	384	379	342	355	384	391	379	389	391	397	392	376	376	374	331	336	344
400	400	400	400	400	400	400	400	400	400	400	400	400	400	400	400	400	400
94%	96%	95%	86%	89%	96%	98%	95%	97%	98%	99%	98%	94%	94%	94%	83%	84%	86%

Parameter-wise comparison



What can be audited,,,,?

Nursing Documentation

- Initial Nursing assessments
- Nursing care plans

Patient Safety &Risk Management

- Fall risk assessments
- Pressure injury prevention
- Hand hygiene, PPE use

Medication Management

- Rights of medication administration
- Documentation of drug allergies
- High-alert medication handling

Communication & Handover

- Quality of shift handovers

Infection Prevention & Control

- Care Bundles
- Isolation precautions
- Proper Bio medical waste segregation

Timeliness & Responsiveness

- Timely response to call bells
- Response to critical lab values

Staff Competency & Professionalism

- Nurse skill levels and training records
- Professional behavior
- Grooming

Outcome Indicators

- Adverse events (falls, medication errors)
- Patient satisfaction feedback

Digital Tools & Dashboards in Nursing Audits

- Electronic Audit Checklists
- Integration with EMR/EHR
- Mobile Accessibility
- Auto-generated Reports
- Real-Time Dashboards
- Automated Alerts
- Secure Cloud Storage

"SUSTAINING CHANGE IS NOT ABOUT DOING MORE. IT'S ABOUT DOING THE RIGHT THINGS CONSISTENTLY."