

A Study to Assess the Knowledge about Nursing Documentation and Recording Systems of Nursing Care among Staff Nurses

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Abstract

Nursing documentation is a crucial part of the nursing process as it the essential way of communication within the health care team regarding patient care. Nurses' knowledge about documentation is important as it a legal requirement and main responsibility of nursing staff. **Objectives:** To assess the nurse's knowledge and recording system nursing documentation among staff nurses and to assess level of knowledge nursing documentation and recording systems of nursing care among staff nurses. **Methodology:** Quantitative approach with Descriptive design was used for the study. Convenience sampling technique was used to assess level of knowledge regarding system nursing documentation. **Results:** The study results show that the overall knowledge among 50 Staff nurses 12(24%) had moderately adequate knowledge, 31(62%) had adequate knowledge and only 07(14%) had inadequate knowledge regarding legal and ethical aspects among maternity staff nurses.

Keywords: Nursing Documentation, Recording Systems of Nursing Care and Staff Nurses.

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INTRODUCTION

Nursing documentation has been one of the most important functions of nurses since the time of Florence Nightingale because it serves multiple and diverse purposes. The intention of nursing documentation is to demonstrate that an organization maintains comprehensive written evidence of its planning, delivery, assessment and evaluation of patient's care [1].

Nursing documents are recorded information regarding patients' problems and interventions that conducted for obviating these problems. These documents are considered as a suitable written communication device. And despite of their basic role in improving and continuance of nursing and medical interventions provided for patients, transferring patients information to other health team members, enhance professional autonomy, critical thinking skills of nurses, development of professional knowledge and nursing education, but the most important role of it is the legal aspect, because the best witness to show health interventions provided for patients is a suitable and correct document [2].

The statistics from developed countries showed that in 74% of cases the errors of health care providers reported to judicial authorities. Documentation is one of the most important practices in nursing. It sounds that nothing can reflect the total amount of nursing care giving to the patients as documentation does. Therefore, with reliance of the facts previously mentioned and in order to identify nurse's knowledge regarding principles and purposes of nursing documentation, this study was carried out [3].

Documentation is an integral part of nursing and midwifery practice as effective communication among health professionals is vital to the quality of client care. The standard of care rendered by nurses is determined by effective documentation, without which nurses' care is not complete. "Record keeping is an integral part of nursing and midwifery. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow" [4].

The documentation of nursing assessment is the recording of the process about how a judgment was made and its related factors, in addition to the result of the judgment. It makes the process of nursing

assessment visible through what is presented in the documentation content [5].

During nursing assessment, a nurse systematically collects, verifies, analyses and communicates a health care client's information to derive a nursing diagnosis and plan individualized nursing care for the client. Complete and accurate nursing assessment determines the accuracy of the other stages of the nursing process Ehrenberg & Ehnfors, 2017. A retrospective audit of all nursing notes in patient records was made before and after the educational. Ehrenberg and Ehnfors reported improvements in the contents of the records in the study group with notes on nursing history being doubled. Also, significant increases were noted in the recording of nursing diagnoses, goals and discharges. No corresponding changes were noted in the reference group. Ehrenberg and Ehnfors reported that no record met the requirements of the national regulations on nursing documentation or followed the nursing process thoroughly [6].

Johnson, Jefferies and Langdon [16], in developing the standards for quality nursing documentation, implemented an educational program and initiated audit of a sample of health care records within a clinical setting. Johnson *et al.*, explored the use of an educational intervention to improve nursing documentation of patient care [7].

OBJECTIVES OF THE STUDY

1. To assess the nurse's knowledge and recording system nursing documentation among staff nurses.
2. To assess level of knowledge nursing documentation and recording systems of nursing care among staff nurses.

Frequency and percentage level of knowledge nursing documentation and recording systems of nursing care among staff nurses

LEVE OF KNOWLEDGE	No.	%
Inadequate	07	14.0
Moderately adequate	12	24.0
Adequate	31	62.0

The present study result shows that 12(24%) had moderately adequate knowledge, 31(62%) had adequate knowledge and only 07(14%) had inadequate knowledge regarding legal and ethical aspects among maternity staff nurses.

The result of this study shows that practice nursing care documentation was inadequate (47.8%) among nurses similar to Nigeria where both the documentation practice and knowledge were found to be insufficient. This finding is higher from Indonesia 33.3% and University of Gondar hospital (37.4%) This discrepancy might be due to difference in the study period since there might be information difference with time gap because the studies were done before 2 years

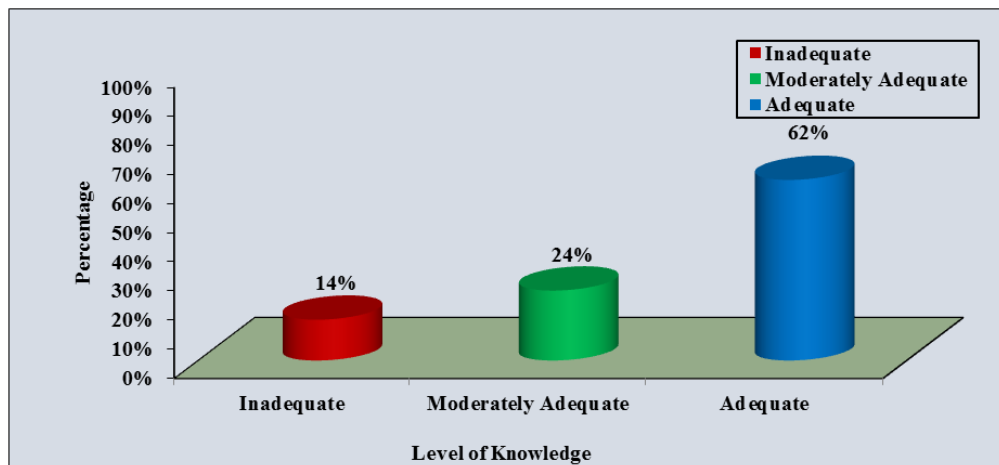
METHODS AND MATERIALS

Descriptive design was adopted by the investigator to assess the nurse's knowledge and recording system nursing documentation among staff nurses. The study was conducted at Saveetha Medical College Hospital. The samples who met the inclusion criteria were selected by using convenience sampling technique. Nurses working in inpatient wards and outpatient departments; nurses having work status as a professional nurse at least for 6 months and those who were voluntary to participate were included in the study. Fifty samples were selected for the study. Data was collected using a structured self-administered questionnaire to collect data regarding demographic variables and to assess the knowledge regarding nursing documentation. The project has been approved by the ethics committee of the institution. Informed consent was obtained from the participants before initiating the study

RESULTS AND DISCUSSION

The present study characteristics show that 50 respondents participated in this study. From 50 nurses who participated in this study, 33 (65%) were females and 17 (35%) were males. Two hundred eight (65%) fall within the ranges of 25–34 years age group. Most of the respondents were holding diploma degree 44 (88%). 24 (48%) of them were senior nurse professionals while 23 (46%) were junior nurse professionals and 3 (6%) were junior clinical nurses. One third of the participants were worked as a nurse for 2–5 years when 16 (33%) and 15 (31%) of them worked for more than 5 years and less than 2 years respectively.

and after technology had faster growth like smart care introduced in most hospitals of Ethiopia. The other reason could be nurses educational development variation across the countries. Most (52.2%) of the study participants in this study revealed poor nursing documentation practice which coincides with a study done in Felege Hiwot referral hospital (87.5%) where medication administration errors were due to nursing documentation error. This finding is lower than a finding from South Africa 68.3% and Nigeria 70%. This might be due to insufficient knowledge as indicated in those studies favourability of the working environment and organizational structure [8-15].



Percentage distribution of level of knowledge nursing documentation and recording systems of nursing care among staff nurses

CONCLUSION

Nursing care documentation practice was poor among nurses. Inadequacy of documenting sheets, lack of time and familiarity with operational standard of nursing documentation were factors associated with nursing care documentation practice. The following recommendation should forward to the healthcare facilities to Provide a training program to enhance the knowledge of nurses and to familiarize them with institutional policy regarding documentation and provide adequate documentation materials.

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