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Knowledge and Practice of Documentation Techniques among Staff Nurses

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ABSTRACT

Introduction

Nurses are the backbone of health care systems. They are have to deal with documentation process regularly.There may be good knowledge and poor practice about documentation.The objective of the study is to find out knowledge and practice of documentation among staff nurses.

Methods

A descriptive cross-sectional study was conducted on staff nurses of a college of medical sciences hospital between, after taking ethical approval from the Institutional Review Committee. A purposive sampling method was used and sample size was calculated to be 200. A structured questionnaire was used to collect the demographic details and knowledge and practice of documentation. Data was analyzed using statistical package for the social sciences version 20. Point estimate at 95% Confidence Interval was calculated along with frequency and percentage for binary data.

Results

The knowledge of documentation was seen adequate among 150(75%) staff nurses. The practice of documentation was seen poor 188(94%) among staff nurses.

Conclusions

The prevalence of adequate knowledge and poor practice is more in our study which is similar to other studies done in similar settings. Therefore, there is need of inservice education among staff nurses, thereby reaching a better patient care and safeguarding them from legal issues.

Keywords: knowledge; practice; documentation; staff nurses.

INTRODUCTION

The word document is derived from a Latin word – 'documentum'. Documentation is a very important tool in patient safety and quality of care. Documentation and record keeping systems are to facilitate information flow that supports the continuity of care of the patient. Documentation serves multiple purposes.[1]

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One reason for the emphasis on nursing documentation may be the increasing need for secure and accurate transfer of patient-related information between different caregivers. The patient record is a principal source of information in which the nursing documentation of patient care is an essential component.[2]

There are several genres of nursing documentation, those that examine record keeping practices as a whole, those that examine issues relating the documentation ie, time, content, competence and comparative evaluation of different types of changes in the documentation regime including automation versus paper. Whether paper or electronic documentation is used, it highlights the challenge the nurses' encounter in ensuring continuity of care during patients' trajectory through the health system.[3]

Tapp (1990) interviewed 14 RNs with the aim of identifying RNs' perception of inhibitors and facilitators to their documentation. The participants in the study indicated that the lack of a distinct professional identity and language in nursing and a redundancy of forms result in inaccurate and devalued documentation of nursing care. Tapp also reported other inhibitors, such as lack of time, space and place. Facilitating issues described were the use of a theoretical framework, positive reinforcement by supervisors and change in the condition of the patient.[4]

Much effort has been made in the development of nursing documentation. Electronic patient record system has been introduced, bringing new challenge. Electronic patient record documentation is an integral part of the patient-focused care. The patient's voice is an effective tool in nursing and its documentation that saves time and helps to get clear information for improving the patients' care.[3]

A complete, accurate and up-to date document is a defense tool to prevent liability if nurses are involved in a lawsuit. Strategies have been implemented to improve nursing documentation. Researchers, practitioners and hospital administrators view documentation as an important element leading to continuity of care, safety, quality care and compliance.[5]

Proper documentation techniques are used to implement and evaluate a standardized nursing record. The standardized nursing record led to more informative, comprehensive and knowledge – intensive documentation. Regular in – service training together with use of evidence based standardized nursing record could be ways effecting change.[6]

Nurses are essential for the keeping the documentation which is largely affected by their knowledge and practice towards documentatios. Thus, the study aimed to find out knowledge and practice of documentation towards staff nurses.

METHODS

A cross-Sectional analytical study was conducted among staff nurses (Proficiency Certificate Level, Bachelor of Science in Nursing, Bachelor of Nursing Science) of College of Medical Sciences (CMS), Nepal, in September 2021. The purposive sampling (200) was used to collect data. The participants voluntarily participated in study. The study was approved by the Institutional Review Committee of CMS,Chitwan (Ref. No: COMSTH-IRC/2021-46) Nepal.

Sample size calculation,

$N = Z^2 \times p \times q / e^2$

$= (1.96)^2 \times 0.5 \times 0.5 / (0.07)^2$

$= 196$

Where,

N = Sample size

Z = 1.96 at 95% Confidence Interval

p = prevalence of adequate knowledge and practice of documentation for maximum sample size,50%

q = 1 - p = 0.5

e = margin of error, 7%

However, the total sample size taken was 200.

Structured knowledge questionnaires and observation checklist to assess the practice, which contains items on the following aspects.

The questionnaire were consist of three part : Part - I: Demographic Data (This section consisted of 7 items seeking personal information such as age, gender, religion, marital status, educational qualification, experience and attendance of in-service education program.), Part - II: Knowledge questionnaires (The knowledge questionnaires consisted of 20 items on four knowledge aspects such as General aspect of documentation, Tools and methods of documentation, Directives of documentation and Use of technology in documentation.) Each question had 4 responses with which one correct response and 3 distracters. Score '1' was given for correct response in a single question and score '0' was given for wrong response. The total numbers of items were 20 giving rise to maximum score of 20. The resulting score were ranged as follows (Adequate knowledge: more than 75 % (≥ 16), Inadequate: less than 25 % (<16), Part III: Observation checklist to assess the practice. Two point observation checklist to assess the practice of documentation techniques. It consist totally 15 items were placed against yes or no. Score '1' was given for the response 'yes' and score '0' was given for the response 'no'. The total numbers of items were 15 giving rise to maximum score of 15. The resulting score were ranged as follows:

Good practice : more than 75 % (≥ 12), Poor practice: less than 25 % (<12).

Participants were explained about the data collection method and Data were collected from who fulfilled the inclusion and exclusion criteria. The techniques followed during the interview was staff nurses were made to feel comfortable and relaxed, a rapport was established, consent was taken, questions regarding demographic data were asked first and then knowledge questions regarding the documentation techniques and then practice items were asked in the interview schedule, responses were recorded as per the schedule.

All the data were checked for completeness. The data were analyzed using SPSS version 16. Descriptive statistics (frequency, percentage, and mean) were used to describe the demographic data and find out the knowledge and practice level. Inferential statistics (Chi-square test and Pearson correlation analysis) was used to determine the association between knowledge and practice; and between demographic variables and knowledge and practice. A p-Value was set at 0.05 to be statistically significant.

RESULTS

The knowledge of documentation was seen adequate in 50(25%)

Table 1. Knowledge of documentation among staff nurses.

Knowledge	n(%)
Adequate	150(75%)
Inadequate	50(25%)
Total	200(100%)

Table 2. Practice of documentation among staff nurses.	
Practice	n(%)
Good practice	12(6%)
Poor practice	188(94%)
Total	200(100%)

Documentation is a effective way in safeguarding the staff nurses from legal aspects

Table 3. shows the demographic characteristics of staff nurses who participated in the study.	
Age	n(%)
< 30 years	102(51%)
31 - 40 years	70(35%)
>40 years	28(14%)
Gender	
Female	200(100%)
Religion	
Hindu	60(30%)
Muslim	26(13%)
Christian	34(17%)
Other	80(40%)
Marital status	
Married	68(34%)
Unmarried	92(46%)
Other	40(20%)
Education qualification	
PCL Nursing	108(54%)
Bachelor Nursing	92(46%)
Experience in years	
<1years	57(28.5%)
1 – 3years	103(51.5%)
>3years	40(20%)
In-service education program attended on documentation techniques	
Yes	31(15.5%)
No	169(84.5%)

DISCUSSIONS

Nurses are considered the back bone of health care system. Their assessments and records attribute main role in the treatment plan of the patients. Our study is the first to provide valuable data on knowledge and practice of nurses regarding nursing documentation in college of medical sciences.

Knowledge of nurses towards nursing care documentation In this study 150 (75%) of the respondents had good knowledge on nursing care documentation which along with a studies conducted in Iraq 56%, [7] Zambia 60% [8], Gondar58.3%[9]and Addis Ababa public hospitals 50% .[10] This study finding was lower than result from study in Iran 86% .[11] This difference might be due to tool difference and accessibility of reading materials about nursing documentation. It was also low compared with study in Uganda 91.2% . This discrepancy might be due to working environment and work load difference that was in the present study nurses had unfavorable working environment and high patient load as compared to previous study. In contrast this study result was higher than findings from study in Iran 14.1%. [12]This might be due to instrument difference that this study used only self-administered questionnaires but the previous study included checklists and also the present study included all wards and outpatient departments but the previous study was conducted only on medical-surgical ward. Similarly the current study finding was higher than finding of Addis Ababa study 43%.[13] This discrepancy might be due to work load difference by which most of included hospitals of the present study were district that had a little bit low workload as compared to Addis Ababa study areas.

The result of this study shows that practice nursing care documentation was inadequate

(12%) among nurses similar to Nigeria where both the documentation practice and knowledge were found to be insufficient. This finding is less from Indonesia 33.3% and University of Gondar hospital (37.4%).[14,15,16] 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 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.[17] 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%). This finding is lower than a finding from South Africa 68.3% and Nigeria 70%. [18,19,20]

CONCLUSIONS

The adequate knowledge is more and good practice is less of documentation among staff nurses is…which is similar to the findings of other studies done in similar settings.The findings of this study may be helpful for the nursing managers to provide a inservice education for the nurses.Since nursing profession includes legal aspects,so upgrading the knowledge and practice represent a significant legal safety in the nursing profession.

Conflict of interest: None

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