Assessment Of Nurses' Knowledge About Nursing Documentation

تقييم معارف الممرضين حول التوثيق التمريضي

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الخلاصة:

الهدف: للتعرّف على معارف الممرضين/الممرضات بخصوص التوثيق التمريضي

المنهجية: دراسة استطلاعية أجريت للمدّة (حزيران الى تشرين الأول ٢٠١١) تكونت عينة الدراسة من (١٥٠) ممرض/ممرضة يعملون مستشفيين تعليميين في محافظة نينوى (السلام والجمهوري). تمَ إعداد استمارة استبانه تُملأ ذاتياً بعد مُرَاجَعَة العديد مِنْ الأدبيات ذات العلاقةِ، وتمّ التأكد من صدق الأداة من خلال استشارة سبعة خبراءِ، وتمّ التأكد من ثبات الأداة من خلال الانقسام إلى قسمين (r=0.87)، تكونت المُسوّدة النهائية للأداةِ من مجالين؛ الأُسس والأهداف، وكان لكلّ فقرة من فقرات الأداة اختياران (كلا= صفر ؛ نعم = واحد)، وتمّ جمع البيانات من خلال طريقةِ المقابلةِ.

النتائج: تبيّن من خلال نتائج الدراسة بأنّ (٥٣.٩٧%) من فقرات أسس التوثيق كذلك (٢٨.٥٧%) من أهداف التوثيق تميزت بمستوى ضعيف من المعارف، في حين تميزت باقي الفقرات بمستوى متوسط من المعارف، بينما لم تتميز أيّاً من الفقرات بمستوى عالٍ من المعارف، وكان للمستوى التعليمي للممرضين/الممرضاتِ علاقة معنوية بمجالات التوثيق (الأُسس والأهداف).

الاستنتاج: استنتجت الدراسة بأنّ المعارف بخصوص أهداف التوثيق كانتْ أفضل مِنْ المعارف بخصوص أسس التوثيق، بينما كان هناك قصور في كيفية التوثيق،

التوصيات: توصي الدراسة بتضمين التوثيق التمريضي في مناهج مدارس التمريض إضافة إلى إنجاز بعض البحوثِ التي تهدّفُ إلى تفحص أو تَقويم السجلاتِ التمريضية.

Abstract

Objective: to identify the nurses' knowledge regarding nursing documentation.

Methods: Observational study was conducted throughout the period (June – October - 2011) The sample consisted of (150) nurse working in two main teaching hospitals in Nineveh governorate. (Al-Salam and Al-Jamhori). Self-administered questionnaire was developed after reviewing many related literatures. Validity of the tool was identified through consultation of seven experts, while reliability was checked through the split-half technique to measure the internal consistency (r = 0.87). The final draft of the tool composed of two aspects; principles and purposes. Each item of the tool had two options (No = 0 ; Yes = 1). Data were collected through an interview method.

Results: More than half of items (53.97%) concerning principles, and (28.57%) of items of purposes were got level of knowledge, while the other items got moderate level of knowledge, but none of them got high level of knowledge. Educational level of nurses had significant association with aspects documentation (Principles and Purposes).

Conclusion: The study concluded that knowledge regarding purposes of documentation was better than knowledge regarding principles of documentation, while there were some deficit in what and how to document.

Recommendation: It recommended that nursing documentation might be covered widely in the nursing school curriculums, in addition to carry out such researches aiming to assess or evaluate nursing records.

Keywords; Nurse, Education, Nursing documentation

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[(1)]**.** 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 [(2)].

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. The statistics from developed countries showed that in 74% of cases the errors of health care providers reported to judicial authorities[(3)]. 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 [(4)]. 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.

METHODOLOGY

This observational study was carried out through the period "June-October/2011". Convenience sample of (150) nurse working in two main general teaching hospitals in Nineveh Governorate in Iraq "Al-Salam and Al-Jamhori" were the subjects of the study. An interview method was depended with the subjects to fulfill self-administered questionnaire in order to explain any vague or misconception of any item it can be. Each interview took (45) minutes to one hour approximately. The tool prepared after reviewing many literatures related to the topic of the study, it designed for identification of two aspects in addition to the demographic characteristics of the sample (age, gender, educational level, experience years and enrollment in an educational related sessions); principles (who=10 items; what=44 items; how=13 items and when=9 items) and purposes (communication and continuous of care=9 items; quality improvement=3 items; professional accountability=3 items; legal interest=8 items and funding=2 items). Each item had two options (No=0 ; Yes=1). Validity of the tool was identified through comments of seven experts which were depended in the final draft, while Spearman-Brawn prophecy formula as a correction equation of the split-half technique was used to measure the reliability of the tool through internal consistency (r=0.87). Frequency, mean of score and standard deviation as descriptive statistic and analysis of variance (ANOVA) as an inferential statistic were used to present and analyze the data (probability value "P.< 0.05" was depending as an accepted significance level).

RESULTS

Table -1: Demographic Characteristics of the Sample.

Variable	No.	%
Age:		
20-24 years.	21	14
25-29 years.	19	12.7
30-34 years.	65	43.3
35-39 years.	17	11.3
40-44 years.	10	6.7
45-49 years.	8	5.3
≤ 50 years.	10	6.7
Total	150	100
Gender:		
Male	103	68.66
Female	47	31.34
Total	150	100
Tenure:		
≤ 5 years	43	28.7
More than 5 years – 10 years	56	37.3
More than 10 years – 15 years	9	6
More than 15 years – 20 years	10	6.7
More than 20 years – 25 years	11	7.3
More than 25 years – 30 years	12	8
More than 30 years	9	6
Total	150	100
Ward:		
Surgery	34	22.7
Internal Medicine	32	21.3
Pediatric	21	14
Emergency	19	12.7
Maternity	23	15.3
ICU	21	14
Total	150	100

Table (1) presents the highest percentages of distribution of the sample as; 43.3% of the sample were from the age group (30-34) years, 68.66% were males, 37.3% of the sample had a tenure more than five years till ten years, eventually, 22.7% of the sample were working in surgery wards.

Table(2):Descriptive Statistic of Principles and Purposes of Nursing Documentation.

Aspect	Number of Items	Mean	SD	Percentage of Moderate level of Knowledge
Principles;				
Who	5	7.813	0.943	60%
What	39	57.827	3.181	58.62%
How	13	19.14	1.316	38.46%
When	6	9.487	0.968	66.67%
Purposes;				
Communication and Continuity of Care	7	11.573	1.623	71.43%
Quality Improvement	3	5.34	0.842	100%
Professional Accountability	3	4.553	0.894	66.67%
Legal Interest	6	9.173	1.268	50%
Funding	2	3.24	0.692	100%

Table (2) demonstrates that the aspects of **How to document** scored the lowest percentage of moderate level among all aspects as (38.46%), while, two aspects of purposes of documentation scored the highest percentages of moderate level of knowledge among all aspects as 100% which were **Quality Improvement** and **Funding**, whereas, none of items had got high level of knowledge.

Table -3: Association between Nurse's Knowledge in regard to Nursing Documentation (Principles and Purposes) with Educational Level of Nurses by using ANOVA

		Mean Square	Sum of Squares	df	F	Sig.
Principles	Between Groups	74.686	149.372	2	5.791	0.004
	Within Groups	12.898	1895.961	147		
	Total		2045.333	149		
Purposes	Between Groups	102.384	204.768	2	8.366	0.000
	Within Groups	12.239	1799.072	147		
	Total		2003.84	149		

Table (3) shows that there were significant statistical differences in nursing documentation with regard to educational level of nurses at (P.<0.05).

DISCUSSION;

Who- In case the nurse works alone, documentation must be by him/herself, but when working as a team, one member of the team must be authorized to document all the work and the others should ascertain from what was documented referring to him/herself before signing and putting on their names and titles, else, documentation will be interrupted and uncomplimentary, this was the weak points in our study referred ,to despite the moderate level of knowledge constituted 60% as in (Table-2).

What- Documentation must be alive scene or picture of what had been happened all over 24 hours and it must describe thoroughly and continuously any piece of information if it is from/or against the patient, nurse, physician, other health team member, family, companion and so on, also, refer to any plan, procedure, care provided and any interruption took place and related to/or affected the patient, else, any negligence of what had been happened all over the day will make the documentation ambiguous and unclear, eventually, the health status of the patient can't be estimated precisely and any deterioration can took place at any time without knowing the causes. Our study indicated four weak main aspects of nursing tasks, jobs or responsibilities; Contact via telephone- from whom, with whom, the time, date and the consequences, any recommendations with referring to that as via telephone, if not, who was responsible for what had been happened, Using ambiguous or probabilistic words or expressions- in describing the actual health status of the patient, Absence of individualistic care plan, and Drug administration-description and related notes. So, if any deterioration in the health status of the patient occurs; why, how, the responsibility and emergency interventions will be obscure, individualistic and extemporaneous, and can't carry out any goal of care, despite that, the moderate level of knowledge regarding what must be documented constituted 58.62% as in (Table- 2). Contradictory to that, many nurses documented symptoms and complaints as reported by the patient in her own words [(5)].

How- Information related to the patient's health status must be well planned, organized and documented in case to reflect the actuality, else, any one can't understand and estimate what had happened and can't expect what will happen. This study indicated many errors or mistakes of how to document; leaving a blank spaces between information documented and the signature- this spaces can be used erroneously intentional or unintentional later which can lead to false documentation, Using another pen or color in recording the information- this can lead any one to misunderstand which information was the correct and behave accordingly, Using symbols and/or abbreviations in recording any information, Linguistic mistake in using drugs and/or some terms while describing the patient's health status. Also, the absence of any sign refer to mistake in documentation, this can lead, if occurred, to misconception of what had been happened. In addition to all that, moderate level of knowledge in regard to what must be documented constituted 38.46% as in (Table-2).

When- Nurses may consider documentation their foe, because it steals time from direct patient care, or their friend, giving direction and ensuring quality in patient care. The time and effort the nurse devotes to the patient's record allows the documentation to be pertinent, up-to-date, correct and complete [(6)]. Any information, care, procedure, accident and/or anything related to the patient must be chronological in sequence, otherwise, the actuality will be scattered and obscured and didn't lead to correct perception about the patient's health status. From another side, documentation must be carried out after implementation of the planned action. These points were the weak points the present study identified, whereas, moderate level of knowledge constituted 66.67% as in (Table- 2).

Communication and Continuity of Care- Problems associated with nursing documentation are related to the purpose and worth of nurses' notes. Nurses used the clinical record to express their activities and concerns, achieve patient outcomes, or fulfill hospital requirements. In a previous study, six out of seven nurses stated that they wrote nurses' notes primarily for other nurses to help them generally know what's happened to that patient during the day. The emphasis on a physical or systems assessment was prevalent throughout the interview documentation even when patients were described as "stable". Staff nurses may be motivated to improve charting performance if criteria to determine the content of nursing documentation were under professional control. When nurses believe their notes are ineffective, not read, a waste of time, or don't say anything, they lose interest in documenting their clinical knowledge, and thereby minimize their contributions to health care [(1)]. Two points were weak in nurse's knowledge in regard to documentation despite the moderate level as 71.43% (Table- 2). Our sample considered that documentation wasn't reliant as a communication mean among the health team members, also, they indicated that there was no need to document any planned or implemented care, therefore, how can fellows or colleagues share in carrying out the care with their ignorance or unawareness of the changes of the patient's condition or what were implemented.

Quality Improvement- Documentation is not separate from care and it is not optional. It is an integral part of nursing practice, and an important tool to ensure high-quality client care. The quality of documentation is a reflection of the standard of professional practice and an indicator of the skilled and safe practitioner [(7)]. Practice was generally charted in terms of scientific, technical, or organizational strategies, with little reference to the connection and concern so often associated with nursing care. This could imply that nurses' notes were not capturing nurses' holistic

concerns, while documentation in the clinical record was not perceived as the place to share and integrate new knowledge but rather as a defense and justification of nursing actions[1]. Quality nursing documentation promotes effective communication between caregivers, which facilitates continuity and individuality of care [8]. Quality documentation and reporting are necessary to enhance efficient, individualized client care [9]. Documentation considers truly the criteria or the standard for weighing the professionalism of care provided to the patient, also, any modification needed for the care provided must be emerged from what was documented. Nurse's knowledge among the study sample in respect to this aspect is cheerful as in (Table- 2).

Professional Accountability- Nursing documentation can create the premises for the development of new knowledge in nursing and the improvement of nursing performance and can provide data and information necessary for nursing researchers to evaluate the quality of interventions and participate in the formulation of healthcare policy [10]. Since nursing documentation did not adequately reflect actual work done in such shift, nurses should evaluate methods for communicating clinical practice and knowledge in relation to care outcomes. So problems associated with written communication may be a consequence of the lack of correlation between nursing practice and expectations for documentation. For nurses to remain viable health care providers, they will need to clearly and succinctly present their unique approach to patient care in the clinical record [1]. Sophisticated nursing knowledge and intuitive judgments are positively affecting patient outcomes and influencing the actions of other health care providers. Therefore, nurses should confidently document their professional knowledge and clinical insights. Solutions to improve the content of nurses' notes will depend on a clearer understanding of problems associated with documentation so that strategies to better articulate nursing care and practice can be achieved. It was found through previous study carried out at (2007) that three-quarters (76%) of the respondents reported that the documentation they do is related to the nursing care they provide [11]. Depending on professional accountability, testimony and credibility must be from the momentous characters of the nurse in order to demonstrate or reflect the actual scene of the daily life of the patient, whereas, moderate level of knowledge in regard to this topic was 66.67% as in (Table- 2).

Legal Interest- Documentation provides a chronological record of the many events involving a client from admission to discharge and may be used to refresh the nurse’s memory if they are required to give evidence in court. It is very common for the courts to use clinical documents to reconstruct events, establish times and dates, and resolve conflict in testimony [7,12,13]. Nurses have always faced the challenge of reconciling documentation with quality patient care. However, with proper documentation on the patient's chart, the nurse should have the information he/she need to ensure quality care and to defend that care in court [6]. Five of seven subjects in a previous study emphasized the legal ramifications of their notes [1]. Unfortunately, in spite of the importance of nursing documentation, research reports from many countries showed that the nurses' performance regarding documentation of cares were weak [12]. For example, 41% of nursing documents have a low quality and in 50% of documents legal aspects didn't considered [13]. Another researches approved the unsuitable quality of nursing documents [12,14]. Majd and colleagues (2003) showed that the quality of nursing documents in hospitals of Tehran and Golestan states was unsuitable [15]. In another study, medical records of Ardebil teaching hospitals were incomplete and didn't contain necessary information[16]. The

weak matters from the sample's point of view in respect to this topic represented in; the satisfaction that any care provided considered carried out legally despite it was carried out or non, documentation didn't witness on the appropriateness of the care provided, and in case of false documentation, a crime isn't materialized. False documentation misleads the all to follow or carry out inappropriate care or decisions that can be of adverse consequences on the health status of the patient. Despite that moderate of knowledge in respect to this topic constituted 50% as in (Table- 2).

Funding- Precise and in-depth documentation considers the most important key role in administration, management, organization and supervision of nursing work, also it can be depended in staffing nursing personnel, for, any negligence or carelessness in documentation of what was happened all over the day absolutely will tinge the actuality of the daily nursing work and the patient's health status with foggy nature, from the other side, false or imprecise documentation definitely reflect on disturbances or problems in allocating budget, disbursement and other management and administration resources and services.

The level of education may affect the performance of nurses [17,18]. Education helps to define what a nurse is able to do and what he or she can be expected to do[19,20]. Also, nursing qualification have more knowledge than the general nursing staff, it was found to be statistically significant [32]. In the present study, educational level had statistical significant associations in relation with principles and purposes of documentation as in (Table- 3).

More than one limitations emerged since we desired and interested to study nursing documentation; **Firstly-** we didn't find any study regarding this topic as the aspects we depended, else, some comments in different studies, **Secondly-** the detailed items in respect to the aspects selected for documentation which took long time for completion especially the method of data collection was interview, **Thirdly-** the less cooperation and unwillingness from nurses to participate in such studies, these all imposed us to restrict the study on small sample and to take into consideration one character of the nurse (Educational level) believing that this variable considers the cornerstone in exploring the nurse's knowledge regarding documentation, therefore, we can't generalize our study results on all nursing staff.

CONCLUSIONS:

The study concluded that; masculine feature of nursing is dominant, experience in nursing is somewhat little, nursing staff in contact with almost patients are of initial nursing certificates, knowledge regarding purposes of documentation is better than that of principles, and there are some defects in how to document.

RECOMMENDATIONS:

The study recommended that;

1. Joining to nursing profession must enhance by altering the societal attitude toward it
2. Involvement of advanced nursing certificates with nursing staff close to patients in the general wards,
3. Nursing documentation must be covered widely and in-depth in nursing curriculum of nursing schools,
4. Continuous teaching programs or sessions must emphasize on all aspects of nursing documentation, and
5. Such researches and studies must aim to assess or evaluate nursing records.

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