

Evaluation of Nursing Staffs' Documentation Standard Related to Nursing Procedures at Medical Wards in Al-Najaf Al-Ashraf Governorate

تقويم معايير توثيق الملاك التمريضي المتعلقة بالإجراءات التمريضية في الردهات الباطنية في محافظة النجف الأشرف

Hayder Ghaleb Jebur*

Dr. Widad Kamil Mohammed**

الخلاصة:

خلفية البحث: السجل الطبي للمريض (الطبعة) يعتبر وثيقة قانونية لذا من المهم أن يوثق بصورة واضحة ولغة مفهومة ودقيقة.

الهدف: تهدف الدراسة إلى تقويم معيار توثيق الملاكات التمريضية في الردهات الطبية وكذلك إيجاد العلاقة بين توثيق الملاكات التمريضية مع الصفات الديموغرافية للمرضى: كالعمر، الجنس، المستوى التعليمي، سنوات الخبرة، والحالة الاجتماعية.

المنهجية: أجريت دراسة وصفية لغرض تقويم معيار التوثيق التمريضي المتعلق بالخدمات والأجراءات التمريضية في الردهات الطبية. جمعت عينة غير احتمالية "غرضية" من (71) من الملاك التمريضي وتم اختيارهم من الردهات الطبية في المستشفيات (مدينة الصدر الطبية، مستشفى المناذرة العام، مستشفى الفرات العام، مستشفى الحيدرية العام، مستشفى السجاد العام، مستشفى الحكيم العام) في محافظة النجف، من خلال المقابلة المباشرة مع الممرضين. للفترة من الأول من تشرين الأول 2014 ولغاية الأول من أيلول 2015. جمعت البيانات من خلال استخدام الاستبانة المتكونة من قسمين رئيسيين وهما: الخصائص السكانية والتوثيق التمريضي والتي تم تطويرها بعد تحديد صدقها وثباتها باستخدام تقنية المحاور مع الملاك التمريضي. حددت ثبات استمارة الاستبانة من خلال اجراء الدراسة المصغرة و حددت مصداقيتها من خلال الخبراء. وتم وصف وتحليل البيانات باستخدام أساليب الاحصاء الوصفي والاستنباطي.

النتائج: أظهرت نتائج الدراسة بأن أغلبية الملاك التمريضي كانت من الذكور، وبنسبة (30-39) تخرجوا من أعدادية التمريض (50,7 %)، كان لديهم (4-1) سنة من الخبرة في الردهات الطبية (22,5 %). وأغلب عينة الدراسة كانوا مشتركين بدورات تدريبية عن التوثيق وبنسبة (80,3 %).

الاستنتاج: استنتجت الدراسة بأن التقييم للتوثيق التمريضي لدى الملاكات التمريضية العاملة في الردهات الطبية متوسط.

التوصيات: يوصي الباحث بتطبيق مايلي :-

- تطبيق برنامج التوثيق التمريضي في كل الردهات الطبية وبكافة المستشفيات العراقية.
- اجراء دورات تدريبية للملاكات التمريضية لغرض تنشيط معارف الممرضين.

مفردات البحث: التقويم، الملاكات التمريضية، التوثيق، الردهات الطبية.

Abstract

Background: A patient medical record (chart) is a legal document which may be used in court as evidence, so it is important that every chart and record must have clear, simple and an accurate language.

Objective of study: The study aims to: Evaluating of nursing staffs documentation standard in medical and, finding out the association between nursing staffs documentation and sociodemographic characteristic of (age, gender, education level , and years of experience).

Methodology: A descriptive study was carried out to evaluation of nursing staffs' documentation standard related to nursing procedures in medical wards. A purposive sample of (71) nurses was selected from medical wards of hospitals (Al-Sadder Medical City, Al-Manathra General Hospital, Al-Forat General Hospital, Al-Haydaria General Hospital, Al-Sagaad General Hospital and Al-Hakeem General Hospital) in Al Najaf governorate, direct interviewing with participant. The data collection started from first of October 2014 to first of September 2015. The constructed instrument used is compromised of two sections: section one includes the nurses demographic characteristic, section two is the documentation tool which consists of 4 parts including (vital signs form, nursing observation flow sheet, intake-output fluid flow sheet and insulin chart). Descriptive and inferential statistical methods were used to analyze the data. Reliability of the instrument was done for the tool parts and flow sheets through test and retest, also a panel of experts determined the validity of the tool. data was analysed by using descriptive and data

Result: The study showed that the majority of nurses were male, with age group (30-39), they graduated from the school of nursing (50.7%), they had (1-4) years of experience in medical wards (22.5%). Most of the study sample had sharing in training sessions related to documenting in nursing (80.3%).

Conclusion: Overall evaluation for the documentation of the nursing staffs is moderate.

Recommendations: the study recommended to:-

- Applying the modified documentation system to all Iraqi medical wards.

-Training sessions should be conducted for nurses to act as a unique challenge for showing the importance of documentation and documenting nursing activities.

Keywords: Evaluation, Nursing Staffs', Documentation, Medical Wards.

* Master student in the Department of Adult Nursing- College of Nursing/ University of Baghdad

•
** Ph.D, Assist. Prof. Department of Adult Nursing- College Of Nursing/ University of Baghdad

•
E-mail: haider.Bns@gmail.com

INTRODUCTION

Nursing documentation is a part of clinical notes which is done by nurses and it is one basic and fundamental source of information in health care, is the patient record that contains all the written information regarding a patient's conditions, his/her needs, and it is very important functions of nurses 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 and it is a source of knowledge for novice nurses and potentially for nursing theory development . Although nursing documentation provides written evidence of patient progress, it should include rationales and the underlying critical thinking behind clinical decisions, interventions, and evaluations of caregivers and must comply with established standards⁽²⁾.

Nursing documentation has a very important role regarding members of a treatment team, continuity of care, reminding nurses and their involvement in professional duties and responsibilities, evaluation of therapeutic interventions, determining health care costs, supporting and protecting legal rights of patients and nurses and providing research and training details. Despite the wide recognition of the importance of quality nursing documentation and efforts made to enhance it, there are inconsistencies in the definition of good nursing documentation because of variations in nursing documentation practice based on different local requirements, documentation systems and terminologies across countries and settings. In research settings, the quality of nursing documentation has been assessed by various auditing instruments with different criteria reflecting how quality was perceived by the researchers⁽³⁾.

OBJECTIVES:

The study aims to:

1. Evaluating of nursing staffs documentation Standard in medical wards.
2. Finding out the association between nursing staffs documentation and sociodemographic characteristic of (age, gender, education level , and years of experience).

METHODOLOGY

Descriptive study was conducted in Al Najaf Governorate, from first of October 2014 to first of September 2015, to evaluate nursing staff's documentation in medical wards. To obtain accurate data and representative sample, a purposive sample of 71 nurses from six setting was selected.

The Study Instrument:

The constructed instrument used is composed of two sections developed by investigator by reviewing related literatures, for the purpose of data collection as follows:

part I: Nurses demographic data sheet

The section includes descriptive information about the nurses, hospital name, age, gender, level of education in nursing, years of experience in hospital, years of employment in medical ward, and if the nurse has participated in turning for nursing documentation.

PartII: Documentation tool

The documentation tool consists of 4 parts according to the following:-

omit :Vital signs sheet

This part of the sheet consists of two aspects as follows:

omit: Patient admission general information

This sheet is a part of the sheet which consists of general information including (hospital No., patient name, age, sex, admission date, admission time, specialized doctor name, ward No., bed No.)

omit: Physical sheet

This sheet which assesses the patient on admission according to the systems consists of 8 items, patient's temperature every four hours, the pulse rate of the patient, the rate of breathing patient, the blood pressure of the patient, weight of the patient, bowel pattern, noticeable secretions, and tube to the patient. The nurse evaluated this assessment form by choosing yes or no in front of each item or sub item.

Part III: Nursing observation observational checklist

This part of the tool consists of two aspects as follows:

First aspect: Patient admission general information sheet

This sheet is a part of the tool which consists of general information which including (hospital No. department name, patient name, age, sex, admission date, hours of admission, specialized doctor name).

Second aspect: Management of health

Management of health aspect consists of many columns with title of information as follows: date of writing notes nursing, the time of writing the notes nursing, notes nursing every four hours, the nurse name and signature after installing all nursing note.

Special nursing observations column can be noted, changes that occur to the patient, such as abstention taking or add treatment, sensitive from drugs, sudden high temperature, skin rash, redness, shortness of breath, insert the cannulation.

The nurse evaluated this assessment form by choosing yes or no in front of each item or sub item.

Part three: Intake-output fluid flow sheet

At the top of flow sheet a spacing to write the solution type to be given intravenously gauge and site below of the flow sheet are lined vertically with 9 line which consists of information to help the nurse to inter patient data in a systematically and accurately.

The information is as follows: (time 24 hrs, I.V fluid, colloids, total in, total out, fluid entering the mouth fluid coming out of urine fluid coming out of feces fluid coming out of vomiting coming out of the suction fluid).

The nurse evaluated this assessment form by choosing yes or no in front of each item or sub item.

Part four: Insulin chart

This chart focuses on measuring the ratio of insulin and acetone in the urine, which led to the hospital's policy taken a by lifting it from the nursing staff's to the laboratory staff's. The statistical data analysis approaches was used in order to analyze the data of the study under application of the statistical package (SPSS) ver. (20), and the Microsoft excel (2010). Data were presented using descriptive the in from of frequencies and Percentages. Summary Statistics tables including: Mean, Mean of scores (M.S), standard deviation (SD). Relative sufficiency (R.S, Person's correlation coefficient: was used to estimate the scale reliability through the application. Chi- square test: was used to determine the significant relationship between different variable and their demographic characteristics at p.value less than 0.05.

RESULTS:

Table (1) Distribution of the Study Sample by their Demographic Data

-Demographic Data	Rating	F	%	Cumulative Percent	C.C.
Age/Years	20-29	22	31	31	38.507
	30-39	30	42.3	73.2	Chi-squar
	40-49	11	15.5	88.7	4
	50-59	7	9.9	98.6	.001
	60-Over	1	1.1	100	HS
Gender	Male	41	57.7	57.7	Binomial
	Female	30	42.3	100	0.235 NS
Level of Education	Turning of Nursing	1	1.4	1.4	52.873
	School of Nursing	3	4.2	5.6	4
	Nursing Secondary School graduate	32	45.1	50.7	0.001
	Institute of Nursing	25	35.2	85.9	HS
	College of Nursing	10	14.1	100	
Name of Hospital	Al-Sadder Medical City	20	28.2	28.2	
	Al Hakeem General Hospital	17	23.9	52.1	15.451
	Al Forat General Hospital	14	19.7	71.8	5
	Al Sagad General Hospital	5	7	78.9	0.009
	Al Manathra General Hospital	8	11.3	90.1	HS
Years of Experience	Al Hayderia General Hospital	7	9.9	100	
	1-4	16	22.5	22.5	1.606a
	5-8	15	21.1	43.7	4
	9-12	15	21.1	64.8	0.808
	13-16	10	14.1	78.9	NS
Training related to Documentation	17- over	15	21.1	100	
	Yes	57	80.3	80.3	Binomial
If Yes	No	14	19.7	100	0.000 HS
	Don't Participate	14	19.7	19.7	Binomial
Number of turning session	Internal	57	80.3	100	0.001 HS
	Don't Participate	14	19.7	19.7	
	1-3	24	33.8	53.5	9.493a
	4-6	11	15.5	69	4
	7-9	13	18.3	87.3	0.05
Duration of Turning	10- over	9	12.7	100	S
	Don't Participate	14	19.7	19.7	26.042c
	1-5	57	80.3	100	1 0.001 H.S

F =Frequency, % = Percentage, C.C. = Contingency Coefficients

Table 1 shows that (42.3%) of the study sample are within the second age group (30-39) years old. Also (57.7%) of the study sample are males. Regarding the study sample levels of education, the study results indicate that (45.1%) are nursing secondary. In addition, (28.2%) of the nurses are from Al-Sadder Medical City, with (1-4) years of experience (22.5%). Furthermore, (80.3%) of the nurses participate in an internal training sessions, with a 1-3 time (33.8%) have training sessions. for about (1-5) days (80.3%) as a duration of each training sessions.

Table (2) Distribution of the Study Sample by their Overall Evaluation for the Documentation of the Vital Signs

Main domain	Rating	F	%	Cumulative Percent	Overall evaluation
Vital signs documentation	good	11	15.5	100.0	moderate
	moderate	59	83.1	84.5	
	bad	1	1.4	1.4	
	Total	71	100		

Moderate (mean of scores 1.67 – 2.33), bad (mean of scores 1– 1.66)

Table 2 shows that (83.1%) of nurses was moderate documented for vital signs in pteints sheet

Table(3) Distribution of the Study Sample by their Overall Evaluation for their Documentation of the Nurses' Notes

Main domain	Rating	F	%	Cumulative Percent	Overall evaluation
overall nurses notes documentation	moderate	35	49.3	49.3	Bad
	Weak	36	50.7	100	
	Total	71	100		

Moderate (mean of scores 1.67 – 2.33), bad (mean of scores 1– 1.66).

Table 3 shows that (50.7%) of nursr was weak documented for all their nursing practices

Table(4) Distribution of the Study Sample by their Overall Evaluation for their Documentation of the Fluids Calculation

Main Domain	Rating	F	%	Cumulative Percent	Overall evaluation
Documentation of Fluids Calculation	good	8	11.3	18.3	Bad
	moderate	14	19.7	40.8	
	weak	49	69.0	100	
	Total	71	100		

Good (mean of scores 2.34-3), Moderate (mean of scores 1.67 – 2.33), bad (mean of scores 1– 1.66)

Table 4 shows that (69.0%) of nursr was weak documented for all their nursing practices

Table(5) Distribution of the Study Sample by their Overall Evaluation for Nurses' Documentation

Main Domain	Rating	F	%	Cumulative Percent	Overall evaluation
	Good	4	5.6	5.6	Moderate

Overall Nurses Documentation	Moderate	52	73.2	78.9
	Weak	15	21.1	100
	Total	71	100	

Good (mean of scores 2.34-3), Moderate (mean of scores 1.67 – 2.33), bad (mean of scores 1– 1.66)

Table 5 shows that (73.2%) of nurses was moderate documented for overall evaluation of all their nursing practices

Table (6) Correlation Between the Overall Evaluation of the Nurses' Documentation and their Demographic Data

Demographic data	Rating	overall documentation			Sig. value (chi-square)	d.f	p-value
		good	moderate	bad			
Age / years	20-29	3	15	4	13.987	8	0.082 NS
	30-39	1	26	3			
	40-49	0	6	5			
	50-59	0	5	2			
	60-over	0	0	1			
Gender	male	3	29	9	0.603	2	0.74 NS
	female	1	23	6			
	turning of nursing school of nursing	0	1	0			
Level of education	preparatory of nursing institute	0	20	12	50.383	8	0.001 HS
	nursing institute of nursing	0	25	0			
	college of nursing	4	6	0			
Participation in training documentation	yes	4	42	11	0.955	2	0.62 NS
	no	0	10	4			
	don't participate	0	11	3			
Number of training	1-3	3	18	3	7.974	8	0.436 NS
	4-6	1	8	2			
	7-9	0	10	3			
	10-over	0	5	4			
Duration of training	don't participate	0	11	3	1.051	2	0.591 NS
	1-5	4	41	12			

NS (non-significant p-value more than 0.05), HS (high significant p-value less than 0.01) d.f. = degree of freedom, p-value = Probability value.

Table 6 shows that there is a non-significant correlation between the nurses' documentation and their demographic data at p-value more than 0.05, except with their levels of education the study results indicate that there is a high significant correlation at p-value less than 0.01.

DISCUSSION

Documentation provides a system of written records that reflect patient care provided on the basis of assessment data and patient's response to intervention. The medical record can be used by health care personnel and students as a teaching tool and is a main source of data for clinical research⁽⁴⁾.

Several significant variables (such as age, gender, level of education, name of hospital, years of experience, training session are related to documentation a number of training and duration of training sessions) have an impact on documentation related to patient information in an accurate method.

This obviously appeared in table (1) which indicates that less than half of the nurses who work in the medical wards, were between (30-39) years old, more than half of sample were male who accounted for (57.7%), most of them (45.1%) graduated from the nursing secondary school graduate, while only (35.2%) graduated from nursing institute, (14.1%) graduated from the college of nursing and most of the study sample (28.2%) were employed in Al Sadder Medical City.

The national sample survey of the registered nurses in the United States estimated that the male nurses accounted for (5.4%) of (2.69) million nurses, they represented a (226%) increase in their number in the last years. revealed in his study that the majority of Erbil nurses in cardiac care unit are young male nurses at a degree of institute education level, and had experience which ranged between (1-5) years⁽⁵⁾.

Related to the years of experience, most of the nurse had (1-4) years in documentation standard for medical wards.

Concerning to the training sessions the result indicated that the majority of them had training session related to documentation (80.3%), with (1-3) a time No. of training session who were accounted (33.8%), while the duration of each training sessions for about (1-5) days (Table 1).

The result of the study disagree with who stated that the documentation in the study, that spite of the complexity and expanding of nurses' responsibilities, with the importance of documentation for their professional work, the results indicated that no nurse of the sample had training session in documentation⁽⁶⁾.

The result of present study indicated that (83.1%) of the nurses overall evaluation toward documentation of the vital signs is moderate (Table 2).

The problem-oriented medical record of vital signs is a format for documentation that places emphasis on the patient's problems data are organized by problem or diagnosis and narrative notes include assessment, planning, intervention, and evaluative information specific to the patients health status⁽⁷⁾.

A problem oriented in vital signs medical record is organized around a patient's problems rather than around sources of information. The advantage of this type of record are that the entire health care team works together in identifying a master list of patient problem and care plan⁽⁸⁾.

Documentation of vital sign can be improved the quality and safety of patient care, therefore we should developed a system for recording vital signs observations at the beside to give for us early warning score and saving data (the researcher).

The standard of care in developed countries is routine monitoring of the basic vital signs (HR, RR, BP and Temperature), at least every 12 hours with the values of the vital signs being input in to an early warning scoring. The score is used to determine how regularly the future vital signs observation should be recorded. Documentation is carried out using paper - beside vital sign charts with manual calculation of the early warning scoring (the researcher).

The result of the present study in table (3) showed the effected evaluating of nursing note documentation in chart form by (15) items under 3 level scale its (never, sometime and always). table shows that the majority of the study sample never be document the name of ward, patient age, patient gender, the time of writing the nursing notes, nursing notes every four hours, changes in the patient's condition, such as refuse from taking treatment, the nurse name and signature after documentation all nursing note. Furthermore, this items affected at mild level .

The result of present study indicated that (50.7%) of the nurses overall evaluation toward documentation of their notes is bad.

Nursing intervention are any direct care or treatment that a nurse performs on the behalf of a patient⁽⁹⁾.

Besides that, documenting the nursing note contributes to evaluating patient's goals attainment as a result of nursing care, determining care which is provided by the current progress toward the expected outcome, communication among caregiver opportunity, for reimbursement purposes, legal protection and enhancing nursing knowledge⁽¹⁰⁾.

Tables (4) showed the result of present study indicated that (69.0%) of nursr was weak documented for all their nursing practices.

Intake and output fluid flow sheet, with vertical or horizontal columns for recording data, time and assessment data and intervention information, make it easy to track the client's change in condition. Special equipment used in client teaching and I.V therapy are other parts of flow sheet. These forms usually contain legends identifying approved abbreviations for charting data because they have small space for recording, and must completely filled out any blank space which means thatsomething was not recognized⁽¹¹⁾.

Moreover⁽¹²⁾, mentioned that flow sheet was designed to document routine nursing procedures and to free nurses from writing out continuing procedures repeatedly. Intake and output sheet, assessment is also documented in this manner.

The findings of present study in table (5) showed That (73.2%) of nursing documents, based on standard principles of nursing documentation, are at a moderate level.

This result agrees with the study which is done⁽¹³⁾ who indicated that the quality of nurses' documents in medical-surgical wards of teaching hospitals related to Tabriz University of Medical Sciences was assessed, and showed that 70.6% are at a moderate level.

A patient record was introduced to facilitate the documentation and evaluation of care. Documentation by nurses is assumed to contribute to the view of the patient so that safe can be carried out in medical wards (the researcher).

The finding of the present study indicated (Table 6).that evaluation of the nurses documentation and their demographic data, is influenced significantly by the education level at (P less than 0.001), while the other results show that there was no influenced significant relationship between sociodemographic characteristics (age, gender, participation in training documentation, number of training session, and during of training session) and documentation

This result disagrees with the study done ⁽¹⁴⁾ who showed that the nurses who have the Baccalaureate degree in nursing perform better than others.

In addition⁽¹⁵⁾, mentioned that there is a highly significant relationship between nursing care provided and their level of education.

Moreover, the finding is congruent with that of ⁽¹⁶⁾ who reported that the highly educated nurses may work more accurately and scientifically than the nurses with a low education level because these nurses can increase their knowledge and practices with frequent evaluation by themselves.

CONCLUSION

The study concluded that the majority of nurses were male, with age group (30-39) years. The majority of the sample graduated from the school of nursing. The majority of the study sample had (1-4) years of experience medical wards. Most of the study sample had sharing in training sessions related to documenting in the nursing. Overall evaluation for the documentation of the nursing staffs is moderate.

RECOMMENDATIONS:

The study recommends the following:

1. Direct supervision by officials on the application of the nursing documentation according to international standards, put sanctions on the nurses staffs that non-application of nursing documentation tools.
2. Planed training session need to be delivered at a time most convenient to staffs. Indeed, some companies pay nursing staff for attend training in their own time.
3. Applying the modified documentation system to all Iraqi medical wards.

REFERENCES:

1. White, L. Foundation of nursing, Thomson Comp., Australia, 2005, 2nd ed., pp: 128-416.
2. Dehghan, M. Dehghan, D. and Sadeghi, M.: Quality Improvement in Clinical Documentation Dose Clinical Governance Work, *Journal of Multidisciplinary Healthcare*, 2013.PP:13-32.
3. Hameed, R. and Allo, R.: Assessment of Nursing Knowledge about Nursing Documentation, *Journal of Kufa for Nursing Science*, 2014, Vol 4, No 1. PP:36-72.
4. Daniel, W.: Biostatistics: A foundation for analysis in the health sciences, 4th edition, New York, John Wiley and Soudluc, 2004. PP:31-22.
5. Francis K, Davies C. The study of nursing documentation complexities. *International Journal of Nursing Practice*, 2006; 12(6): 366-74.
6. Al Botany, and Gorges, S.: Construction of a Documentation Tool for Nursing Recording System in CCU, Baghdad, Iraq. Vol. 20, No. 1-2, 2007. pp: 75-78.
7. Potter, P and Perry, A. Basic Nursing Essential for practice, 5th edition Mosby company, U.S.A. 2003, pp:100-113.
8. Taylor, C. ; Lillis, C.; LeMone, P.; and Lynn, P.: Fundamental Nursing, the Art and Science of Nursing Care, Lippincott and Wilkins company, Philadelphia, 6th ed., 2008, pp: 353-385.
9. Carpinto, L.: Nursing Dagnosis Application to Clinical Practice, 9th. edition, Lippincott, 2002.
10. Kozier, B. Erb, G. and Berman, A.: Fundamental of nursing, concepts, process and practice, 7th. Edition, person edition, U.S.A. 2004, pp: 245-350.
11. Eriksson K. Structuring the documentation of nursing care on the basis of theoretical process model. *Scand J Caring* 2004; 18(2): 229-36.
12. Francis K, Davies C. The study of nursing documentation complexities. *International Journal of Nursing Practice*, 2006; 12(6): 366-74.
13. Aghdam, A., Jasemi, M. and Zadeh, F.: Quality of Nursing Documentation in Medical-Surgical Wards of Teaching Hospitals Related to Tabriz University of Medical Science, 2009, Vol 14, No2.
14. Breseem, R.: Evaluation of Nurse's Performance toward Patients with Cardiogenic shock in cardiac care, Master thesis, university of Baghdad, college of nursing, 2004.

15. Gardi, Y. Evaluation of nursing practices for patients with angina pectoris, Master thesis, University of Salahddin, college of nursing, 2005 , pp: 40-76..
16. Al – sanria, j: Clinical nursing skill, 6th edition person education, New Jersey, 2004, pp: 70-89.