

Knowledge and Practice of Documentation among Nurses in Ahmadu Bello University Teaching Hospital (Abuth) Zaria, Kaduna State.

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Abstract: *The study titled “Knowledge and practice of documentation among nurses in Ahmadu Bello University Teaching Hospital (ABUTH)” was carried out to determine nurses’ knowledge and practice of documentation. Relevant literatures were reviewed. A multistage and simple random sampling was used. Questionnaire (260) was the instrument of data collection with a response rate of 100% since 290 questionnaires were distributed. Frequency distribution tables, pie chart and bar chart were used to present the data. From the result of the study, most respondents (91.7%) were females and Christians (68.3%). All respondents have heard about documentation and thus practice all to the best of their abilities. About 70% of respondents practice effective documentation, 52% answered that effective documentation is done during the evening shift and 86.2% realized that there are barriers to documentation. It is recommended that there should be increased awareness about effective documentation process and implication of improper documentation.*

Key words: *knowledge, practice, documentation, nurses.*

I. Introduction

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” (Nursing and midwifery council 2002).

Documentation is the process of making an entry on a client’s record. It is an act of writing specifications or instructions (Oxford 2004). Documentation is a fundamental nursing responsibility with professional, legal and financial ramifications. Although health care organizations use different systems and forms for documentation, all client records have similar information. A number of documentation systems are in current use: the source oriented record; the problem oriented medical record; the problem, interventions evaluation (PIE) model; focus charting; charting by exception (CBE); computerized documentation; and case management (Berman, Snyder, Koziar, Erb 2008).

In the past few decades the nursing profession has witnessed a change towards a mere independent practice with explicit knowledge of nursing care. With the change, has come the obligation to document not only the performed interventions – medical and nursing but also the decision process, explaining why a specific nursing action has been prompted. During the 1980s and the early 1990s, major health related organizations and some western countries began to develop standards, laws or regulations expressing that the nursing process should be used in nursing documentation. The World Health Organization (1982), the International Council of Nursing (Clark, 1994), the American Joint Commission on Accreditation of Hospital Nursing Services Standard (1991) and the United Kingdom Central Council (1993) all prompted the use of the nursing process in nursing care. The Swedish law on this subject was passed in 1986 and was further clarified specifically for nursing by the National Board of Health and Welfare in 1993 (Swedish National Board of Health and Welfare’s regulations 1993:17).

All documentation regarding care and services given to each resident becomes part of the legal medical record. There is no way to prove care was provided without complete documentation. If a resident suffered an illness or injury and care was not completely and accurately documented; then it is doubtful quality care was completed, even though nursing staff may insist that such care was provided. The resident’s medical record is the main mechanism by which state surveyors, attorneys and the attorney’s experts will evaluate the quality of care provided by the nurses if episodes of suspected neglect or mistreatment occur (Meador 2003).

Regardless of the record system used in an agency, nurses document evidence of the nursing process on a variety of forms throughout the clinical record. Some of the documenting nursing activities include admission nursing assessment, nursing care plans, Kardexes, progress notes, flow sheets, referral summaries etc,

which ensures continuity of care, early detection of problem, better communication between members of health team, and gives accurate account of treatment, care plan and delivery of care.

Much has been said and written on the content and shortcomings of nursing documentation. Hence there is a need to study the knowledge and practice of nursing documentation, their perception as well as barrier to the process. Nurses play an important role, in the care of the patient and what they put into writing determines the standard and quality of care rendered to the patient. It also serves as a clue for the continuity of care.

II. Statement Of Problem

It is unfortunate that nursing documentation continues to draw criticism from professionals, community and regulatory organization because of incomplete, substandard charting practice (Howse & Bailey 1992; Parker & Gardner 1992). Nurses action are typically described as compassionate, committed and caring yet these attribute are often difficult to recognize in the nursing documentation. Most of nurses' actions are either not documented or not properly documented and thus crates a great problem when it comes to evaluation of client care.

Worried by the above facts the researcher wishes to conduct a study to assess the knowledge and practice of nurses in Ahmadu Bello University Teaching Hospital towards documentation.

III. Research Question

The research would answer the following questions during the course of the study.

1. What is the level of knowledge nurses have on documentation?
2. What percentage of nurses practice effective documentation?
3. What documenting activities do nurses carry out?
4. During what shift is proper documentation carried out?
5. What is the relationship between years of experience and documentation process by the nurses?
6. What measures can be used to improve documentation process among nurses in ABUTH?
7. What are the nurses' attitudes towards documentation?
8. What are the hinderance to nurses 'documentation'?

IV. Research Objectives

1. To determine the level of knowledge nurses have on documentation
2. To determine the percentage of nurses that practice effective documentation
3. To asses documenting nursing activities
4. To determine the shift at which proper documentation process is carried out
5. To determine the relationship between years of experience and documentation process by the nurses
6. To assess measures aimed at improving documentation process among nurses in the hospital
7. To assess nurses attitude towards documentation
8. To identify hinderance to nurses' documentation

V. Significance Of Research

1. The study would reveal the number of nurses who effectively practice documentation.
2. The study would identify barrier to effective nursing documentation in ABUTH
3. It would identify measures towards solving the problems of nursing documentation
4. The finding would be used in planning for effective documentation
5. The study would serve as a source for further studies

VI. Limitation Of The Study

Time constraint and secretive nature of some nurses in filling questionnaire are the limitation of this study.

VII. Conceptual Framework

Nursing Informatics And The Vips Model

Florence nightingale recognized the need to collect data for the care of the individual, as well as to collect data systematically about care for larger groups of patients and to analyze the data statistically (Nightingale 1860: 1863). Both type of data collection and registration are important in order to be able to communicate information about the health status of the patient with other registered nurses, physician, hospital managers and policy makers. The clinical data collected by registered nurses support the care processes of clinicians and the aggregated data support the decision of hospital mangers, researchers, educator and policy makers (Gooses 2002).

In 1991, a new documentation model was developed and tested in Sweden by Ehnfors, Thonell – Ekstrend and Ehrenberg. The model is entitled VIPs, an acronym formed from the Swedish words for well being, integrity, prevention and security, all of which are seen as major goals of nursing care (figure 1). This model is designed to be used in nursing documentation following the nursing process and therefore includes a nursing care plan. The model also includes a nursing discharge note. The purpose of the model is to guide the registered nurse in the sequence of assessment, problem identification, aim, planning, interactions, implementation and evaluations of results and thereby to make nursing documentation structured, adequate and easy to use in clinical care.

In the VIPs model, 14 keywords are used for classifying patient related information collected by the registered nurses into categories e.g. communication, nutrition and psychosocial status. 10 keywords classify nursing interventions into categories such as information, support and environment.

The use of keywords simplifies information retrieval, however, to retrieve the information asked for, a consensus regarding definitions of categories must be resolved (Globe and Hughes, 1993). The VIPs model provides such a lexicon in which each category, labeled by a keyword has a definition, a description and prototypical examples given in a manual and described with scientific base and reference keyword may be seen as a first step towards a unified nursing language in patient care.

The VIPs model has been received with great interest and appreciation by registered nurses in Sweden and is now the most commonly used model for nursing documentation in hospitals and primary health care (Ehrenberg, 1996).

The model is tested and described elsewhere (Ehnfor, 1991; Ehrenberg, 1996).

Although this model has been accepted and recognized as a standard for what to document, difficulties have been reported as to how to use it in daily practice (Ehrenberg & Ehnfors, 1999).

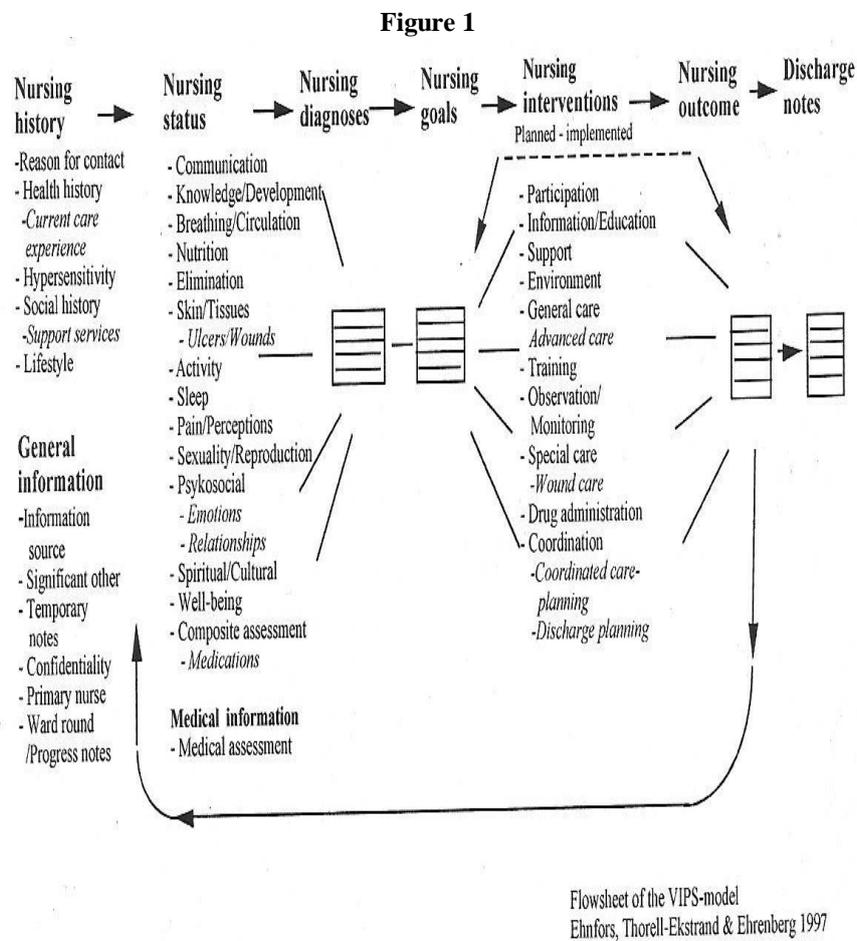


Figure 1. Flow sheet of the VIPs model (reproduced with permission).

VIII. Methodology

The approach for this study is a descriptive survey design to evaluate the knowledge and practice of nurses in Ahmadu Bello University Teaching Hospital towards documentation.

Sample And Sampling Technique.

This was determined by using 40% of the study population as suggested by NWANA(2007) who stated that if a population is a few hundred,40% is representative of the population.thus 290 respondents were used. A multi stage and simple random sampling technique was used to select the department and wards for the sample population.

Instrument And Method Of Data Collection

The study involved the use of questionnaire. The questionnaire was used to obtain the data needed for the study. The questionnaire was distributed to the nurses of the sampled ward.

Ethical Consideration

1. Consent and permission were obtained from the hospital administration to administer questionnaire to the population concerned.
2. Informed consent was obtained from each respondent, explaining the aims and objectives of the research.
3. confidentiality was ensured during the course of the research.

IX. Discussion Of Findings

A total of 290 respondents participated in the study. The ages of the respondents ranges from 15-42 with a mean age of 26.5 ± 2.0 . Most of the respondents fall within the ranges of 25-29 years age group (45%). Females are the majority of the respondents 91.7%. 56.7% of the respondents were married while 43.3% were single. Christians (88.3%) form majority of the respondents and Muslims were 31.7%. The ethnic group distribution had 31.7% of Yoruba, 20% of Igbo and Hausa had the lowest representation of 18.8%; the ethnic majority had 30%. Majority of the respondents are staff nurses i.e registered nurses (49%), 24% were staff nurses/midwives and few of the respondents are chief nursing officer (CNO), Assistant chief nursing officer (ACNO), and Nursing officer (NO). 30% of respondents were from paediatrics department, 21.7% from obstetric and gynaecology. Most of the respondents 78.3% have been in the profession for less than 10 years, 16.7% for over 30 yeas and 5 years position 10-20 years of experience, thus practice finding is consistent with data obtained from similar studies carried out in this hospital.

All the respondents in this study have sufficient knowledge in documentation. This is in contrast to studies in Sweden which shows that registered nurses lack sufficient knowledge in documentation procedures (Ehinfors, 1993; Jelock and Segerter, 1994; Lorsen et al, 1995; Tornknot et al., 1997; Etirenberg, 2001). The major source of information about documentation was school of nursing (77.3%), some (7.6%) obtained their information from tertiary institution, 13.6% from medical personnel and 1.5% from friends. Majority of respondents 45% had knowledge on computerized documentation, 36.7% on source-oriented record, 18.3% problem-oriented records. 23.9% of respondents carryout admission nursing activities, 10.9% progress note, kardex 23.2% and most of the respondents 29% carryout the nursing care plan which is similar to Icelandic study (Thoroddsen and Thorsteinsson, 2002) in which 60% gave a high rating to planned interventions.

All respondents (100%) think it is important to document nurses' care and they like documenting their activities. Majority of respondents 98.8% say documentation ensures continuity of care, 96.7% said it allows for early detection of problem, 87.5% said it ensures high standard of clinical care, 85.4% said it makes the nurses to be respected and all (100%) said it allows better communication between members of health team. Most of the respondents 45.8% liked documenting because it ensures continuity of care, 21.7% because it serves as a legal backup and 1.5% because it helps to detect problem. Most (80%) of respondents gave the response that their level of experience affect their documentation positively, 135 said it affects its negatively while 7% do not know.

All respondents practice effective documentation. Majority of respondents 96.7% document anytime a case is rendered, 3.3% documents 3-4 times in a shift. 52.2% of respondents gave the opinion that effective documentation is done during the morning shift, 18.9% said during the evening shift and 28.9% went for the night shift. Majority of respondents (88%) document by going to the patient's bed, 84.8% by sitting at nurses' station and reading what they've written to make corrections respectively and 7.4% check the previous information and formulate theirs.

Most of the respondents 88.7% admitted that there are barriers to documentation, 13.3% said there are no barriers. Majority of respondents 41.7% answered that time constraint were the barriers to nursing documentation. This is similar to the study in Sweden where most of the registered nurses ranked lack of time as

the primary barrier to nursing documentation, 23.3% of respondents recognized lack of knowledge about documentation process as a barrier, 28.3% said lack of proper documentation facilities, 15.5% recognized shortage of staff and 17.5% recognized the fact that nurses are immature of the implication of not documenting as a barrier.

Most of the respondents, 32% suggested that proper training about documenting system and employment of more nurses respectively will help solve the issues of barriers to documentation. 21.4% suggested proper allocation of duty, 11.0% suggested sanctioning of poorly written documents and 3.6% suggested provision of documenting facilities. Most of the respondents 41.3% blame the government for the barrier to documentation, 41.7% blame the nurses and 7.5% blame the doctors and all hospital workers respectively.

X. Recommendations

1. There should be continued enlightenment programme in form of public seminars, awareness to nurses about the importance of documenting patient's care.
2. Government should provide adequate documenting facilities and also employ more nurses in the hospital.
3. Leaders are the nursing profession should emphasize the importance of documentation and proper searching should be made for proper documentation.
4. Nurses should be encouraged and set to further higher in order to improve their care.
5. Dissemination of information and research finding should be done online to improve its utilization.
6. Similar study should be carried out in hospitals in order to compare findings and make generalization.
7. The health care workers should work hand in hand in order to achieve the desired goal.
8. a social interaction group should be created for the nurses of a particular hospital or geographical location so as to help tackle the problem of nurses.

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