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KNOWLEDGE AND PRACTICE OF NURSES REGARDING NURSING DOCUMENTATION: A CROSS-SECTIONAL STUDY IN TERTIARY CARE HOSPITALS OF PESHAWAR, KHYBER PAKHTUNKHWA

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ABSTRACT

Introduction: Nursing Documentation is a crucial part of the nursing process as it is the essential way of communication within the health care team regarding patient care. Nurses' knowledge about documentation is important as it is a legal requirement and main responsibility of nursing staff.

Materials & Methods: A survey of nurses was conducted in three government tertiary care hospitals of Peshawar, Khyber Pakhtunkhwa. Data were collected through a designed questionnaire from 300 staff nurses regarding demography profile, knowledge and practice about nursing documentation. Data analysis for descriptive statistics was done through SPSS 17.

Results: Overall, 180 (60%) nurses reported that nursing documentation means handling and taking over patients' charts, 66% reported that is vital signs record, 53% nurses confirmed that it is the legal safety of nurses to maintain documentation, 40% nurses reported that nursing documentation is normal and abnormal findings of patient labs and reports; only 19% nurses maintained documentation and 43% claimed the lack of check and balance as the reason why they do not maintain documentation. Only 12% of nursing staff were satisfied with their nursing documentation. Less than half (42%) of the nurses were in favour of education programs on nursing documentation.

Conclusion: There is need for strict check and balance and nurses should be trained by organizing seminars and teaching session on nursing documentation. Electronic documentation may be a way to improve the standard of nursing documentation.

Keywords: Nurses; Nursing Staff; Knowledge; Documentation.

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INTRODUCTION

Documentation is any written information about a client that describes the care or service provided to that client. Documentation is an accurate account of what occurred and when it occurred.[1] Nursing documentation is an important component of nursing practice and the inter-professional documentation that occurs within the client health record.[2] Nursing documentation is an essential way for communication within the health care team. Appropriate legible documentation provides the description of responsible nurse.[3] All entries in a record must be recorded, wherever possible, with the involvement of the patient.[4] It is very important for the nurse to keep the record as legal requirement. The Code of Professional Conduct advises that good note-taking is a vital tool of communication between nurses.[5] According to the literature, nursing documentation is a vital component of safe, ethical and effective nursing practice.[6] Documentation is a comprehensive record of care provided to a client. It demonstrates how a nurse has

applied nursing knowledge, skills and judgment according to standard protocols.[7] Knowledge of nurses regarding nursing documentation is very much necessary. Study revealed that more than half of nurses (53.97%) concerning principles, and (28.57%) of participants were got adequate level of knowledge, while the other participants got moderate level of knowledge, but none of them got high level of knowledge.[8] According to one of the research studies lack of values to the nursing documentation, shortage of time and work burden in the units are the main factors which create a barrier to a nurse for an effective documentation.[9] There are minimum data available about the knowledge of nurses about nursing documentation. Nursing documentation is one of the major responsibility of the nurse as well as it is the legal safety of the nurses. This research will enable the nursing schools and hospital management to implement courses and policies regarding nursing documentation and will help in arranging such programs which improve the quality of nursing documentation in the hospitals. The purpose of this Nursing Documentation course is to provide the knowledge and practical skills needed to ensure that accurate documentation takes place in our health care systems.[1] The documentation must not only meet professional and employer standards, but it also acceptable to our legal system.

MATERIALS & METHODS

This was a cross-sectional survey done in three major tertiary care hospitals of Peshawar, Khyber Pakhtunkhwa. The study participants were recruited during March 2016 to August 2016 from Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH) and Hayatabad Medical Complex (HMC), the major tertiary care hospitals of Peshawar. The participants were nursing staff and were selected from different nursing departments like operation room, emergency room, different wards and intensive care units. Nursing staff fulfilling inclusion criteria were included in the study. Student nurses, nurses on management side and outpatient department nursing staff were excluded.

To estimate the study variables in the population with a 95% confidence interval, a margin error of 5% and with anticipated population proportion of 27% the required sample size estimated were 303. Eventually the sample size of 300 was selected for the study. Multi-stage random sampling was used to recruit one hundred staff nurses from each hospital through lottery system hospital.

The participants were assessed in different duty shifts. Data were collected using a structured questionnaire in English and also translated in Urdu for better understanding. Informed consents were taken from all the participants before filling the questionnaires. Privacy of the participants was maintained during data collection. In first part of questionnaire, demographic data were collected including age, sex, experience, duty unit, etc. In the second part, data were collected about the knowledge and practice of nurses regarding nursing documentation. Information was collected about the importance of nursing documents and also about the legal aspects of documentation. Participants were inquired about the barriers due to which effective nursing documentation is not maintained. Suggestions were also asked how to improve nursing documentation in the health care settings.

Data were analyzed using SPSS version 17. The data were stratified into four main types of staff nurses. These were operation room, emergency, wards, and intensive care units nursing staff. Frequencies were calculated for all the categorical variables and mean and

standard deviation were calculated for continuous variables. This study was reviewed and given clearance by the Ethics Review Committee of the Khyber Medical University, Peshawar. Ethical approvals were also taken from all the three hospitals ethical boards.

RESULTS

A total of 300 participants were included in the study from three tertiary care government hospital of Peshawar, Khyber Pakhtunkhwa. The mean age of the nurses was 27±4 years. More than half (55%) of the participants were in age between 25-30 years. 7% of the participants were male and 93% female. 8% of the participants were BSc Nursing degree holders while the rest 92% were holding General Nursing Diploma. Nearly half (47%) of the participants were below five years while 3% of the nursing staff were above 20 years of job experience. More than half (54%) of the nursing staff were working in different Wards, 15% in Intensive Care Units, 22% Operation Room and 32% Emergency Room were working respectively (Table 1).

Table 1: Socio demographic profile of the study population (*n*= 300).

Demographic Variables	Nursing Staff by Hospitals (f = %)			Total f (%) (*n*=300)
	LRH (*n*=100)	KTH (*n*=100)	HMC (*n*=100)	
Age (Years)				
Less than 24	20	13	17	55(18%)
25-29	64	47	57	164(55%)
30-39	23	18	20	61(20%)
More than 40	09	06	05	20(7%)
Gender				
Male	12	06	05	22(7%)
Female	88	94	95	277(92.3%)
Qualification				
BSc Nursing	13	07	04	24(8%)
General Nursing	87	93	96	276(92%)
Experience				
Less than 5 years	56	48	38	142(47%)
6-10 years	32	29	37	98(32%)
11-20 years	17	19	14	50(16%)
More than 20 years	03	04	03	10(3%)
Departments				
Intensive care unit	20	13	12	45(15%)
Ward	52	61	51	164(54%)
Operation Room	13	09	16	38(22%)
Emergency	15	17	21	53(32%)

The knowledge of the nurses was assessed. 60% nurses reported that nursing documentation is maintaining, handling and taking over of patient's charts. 66% were strongly agreed that nursing documentation is main responsibility of nurse. 78% and 86% nursing staff reported that nursing documentation is patient's flow chart and patient's information respectively. 47% nurses reported that nursing documentation is communication between health care team. More than half 53% nursing staff reported that nursing documentation is permanent legal document that provides information about patients, whereas 76% participants reported that nursing documentation should include information about the status of the health situation or problem. Around 40% participants reported that normal and abnormal finding should be including in the comprehensive assessment reports of the patients (Figure 1).

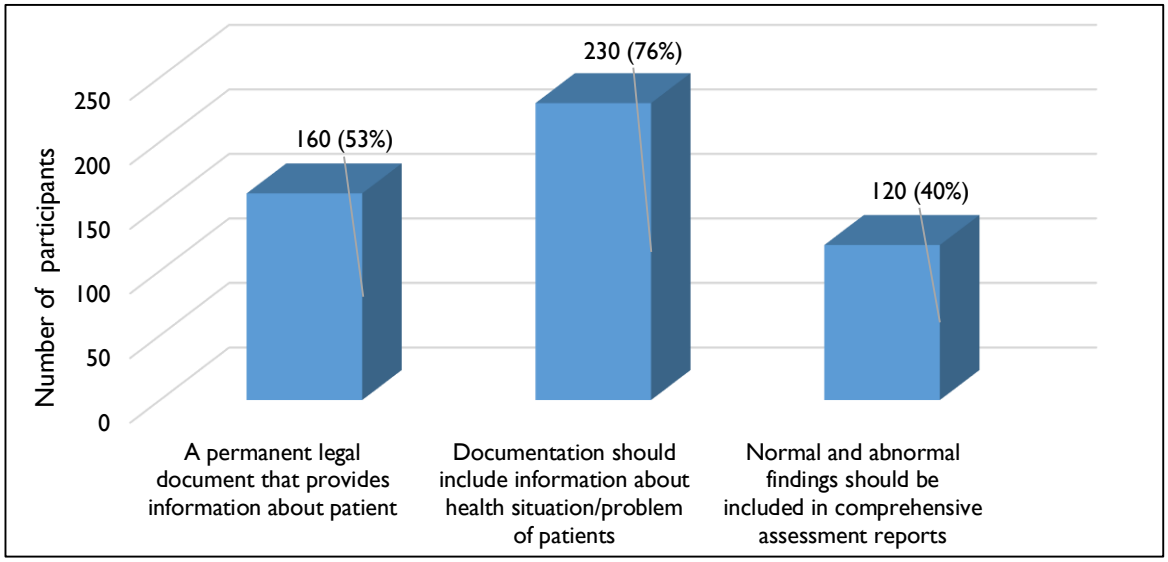

Figure 1: Knowledge of nurses regarding Nursing Documentation.

The nursing staffs were asked whether they maintain nursing documentation properly. 73% participants sometime maintain nursing documentation properly. 19% nursing staff maintain and 8% do not maintain nursing documentation (Figure 2).

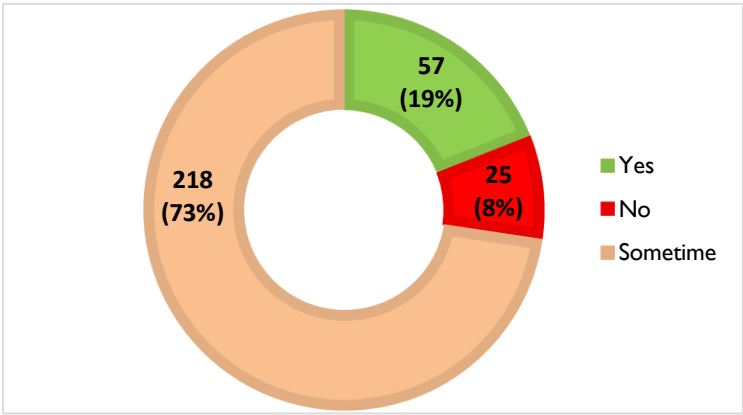

Figure 2: Percentage of nursing staff who maintain Nursing Documentation.

On enquiring 43% nursing staff report that they never maintained nursing documentation because there was no check and balance from the higher authorities. Another 17% participants did not maintain nursing documentation due to lack of knowledge about proper nursing documentation. A total of 23% reported that nursing documentation took extra time and 6% reported that it was not important to maintain nursing documentation (Figure 3).

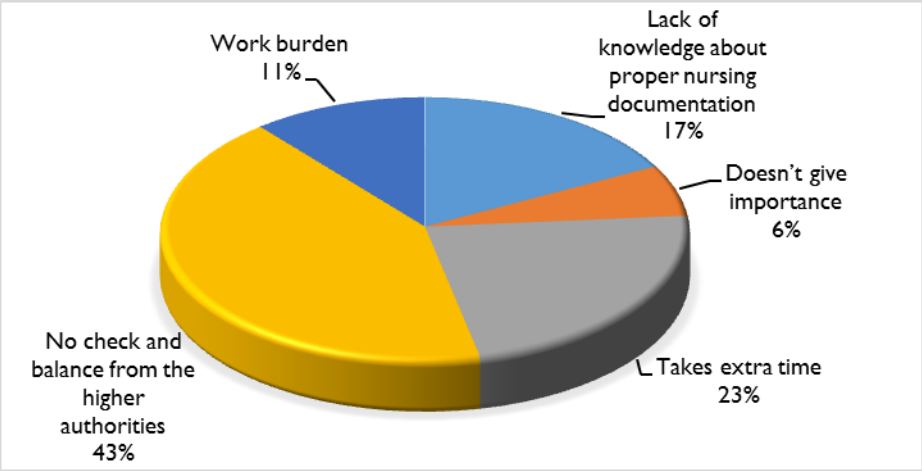

Figure 3: Reasons for not maintaining Nursing Documentation properly by the nursing staff.

Only 1.6% of doctors used the nursing documentation for the decision-making about patient treatment. The participants were asked about the satisfaction from their own nursing documentation. Only 12% nurses were fully satisfied from their own nursing documentation which they were doing in the hospital setting.

Regarding suggestions for improvement, 42% participants suggested that the nursing documentation could be improved if hospital management arranged educational sessions about the nursing documentation, whereas 11%, 14% and 32% nursing staff suggested that nursing documentation could be improved by verbal discussion, by arranging documentation related educational seminars and by regular checks by the hospital supervisors on nursing documentation respectively.

DISCUSSION

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 Peshawar, KPK. The knowledge of nurses regarding nursing documentation is relatively low, as documentation is the main responsibility of the nurse. Literature suggests that maintenance of patients' documentations is the main responsibility of a professional nurse.[10] It is a priority for nurses that they document each and every intervention that they do. Documentation is the confirmation of completed intervention.[11] Health records should demonstrate good patient care. There is a range of legislation, policy and guidance that should determine what nurses write about and how they share and store that information.[12]

In this study nearly half of the study participants agreed that nursing documentation is the way of communication between health care team. Nursing documentation is the best way of communication between the health care team. The standards of nursing care include the principle that any of your coworkers should

be able to pick up a chart and understand the status of that patient's condition and care. This is importance since quality care is a team effort. The team must be able to work together and ensure that each patient's individual needs are clearly communicated to each other.[13]

Nearly half of the nurses in this study were not aware whether nursing documentation is the legal safety of the nurses or not. According to a research study nursing documentation connects the nurses to the world of law. Comprehensive documentation is a legal safety for nurses as well as patients.[14] Patients will be safe as it will never provide chance of error.[15] According to a study done in Iraq, 28.57% of staff nurses had "adequate level of knowledge".[8] The differences between the nurse's knowledge is due to the good health care system in Pakistan as compared to Iraq which has been impacted by the war.[16]

The present study shows that only 19% of the nurses completed nursing documentation properly; this is a very low percentage considering the importance of documentation. According to Maryland nursing workforce commission, 54% nurses complete nursing documentation properly according to the standards. And the main cause of not proper completion is time shortage.[17]

The current study identified check and balance from the higher authorities, time wastage, and work burden as the main barriers nurses face while completing their documentation. According to one research study, time, workload constraints, attitudes towards documentation, and institutional policies associated with documentation are the main barriers to a standard and complete nursing documentation.[18]

Nearly half of nurses suggested that the nursing documentation can be improved if the management of the hospital arranged educational sessions about nursing documentation. This issue is also highlighted in another study which shows that nursing documentation is very weak in hospital settings. There is need of proper training of the nursing staff and there should be monitoring team for the nursing documentation to resolve this issue.[19] Nurses can improve the documentation by managing their time in effective way; documentation on bedside is also effective way to manage the time.[20] One other study emphasized on electronic documentation. Electronic documentation reduces the chances of error and spelling mistakes, and it can be easily followed by authorized persons for recommendations.[21] It will also help the higher authorities for check and balance.

CONCLUSION

Knowledge of nursing staff about nursing documentation was very poor, thereby showing lack of importance for such documentation. The hospital management has no check and balance on supervisors and higher authorities for nursing documentation. Majority of nurses are not satisfied with their own documentation.

RECOMMENDATIONS

It is recommended that there should be regular educational trainings on nursing documentation for the nursing staff arranged by the hospitals, and there should be regular check and balance of the nursing documentation from the nursing supervisor and higher authorities. The use of nursing documentation by the doctor for information about patient's condition will also help in the improvement of nursing documentation.

Every hospital should have nursing education system where the new/old staff should be trained about patient care, policies and nursing documentation writing technique and its importance in the health care system.

REFERENCES

1. Keenan GM, Yakel E, Tschannen D, Mandeville M. Documentation and the Nurse Care Planning Process. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 49. Advances in Patient Safety.
2. Halifax NS. Documentation guidelines for registered nurses, College of Registered Nurses of Nova Scotia: Available from; https://crnns.ca/wpcontent/uploads/2015/02/DocumentationGuidelines.pdf.
3. Stevens S, Pickering D. Keeping good nursing records: a guide. Community Eye Health. 2010;23(74):44-5.
4. Bravo A. Literature review: on the importance, problems and solution of health record keeping in hospital. Available from: http://projectkeeper.blogspot.com/2015/08/literature-review-on-importance.html.
5. Wood C. The importance of good record-keeping for nurses | Practice | Nursing Times [Internet]. Available from: http://www.nursingtimes.net/nursing-practice/specialisms/practice-nursing/the-importance-of-good-record-keeping-for-nurses/205784.article.
6. Regina Sk. Documentation: Guidelines for registered nurses. Saskatchewan Registered Nurses' Association (SRNA) (2011). Available from: https://srna.org/wp-content/uploads/2017/09/documentation_guidelines_for_registered_nurses_22_11_2011.pdf
7. Blake-Mowatt C, Lindo JLM, Bennett J. Evaluation of registered nurses' knowledge and practice of documentation at a Jamaican hospital. Int Nurs Rev. [Internet]. 2013 Sep 15;60(3):328–334. Available from: http://onlinelibrary.wiley.com/doi/10.1111/inr.12040/epdf.
8. Hameed RY, Allo R. Assessment of nurses' knowledge about nursing documentation. Journal of Kufa for Nursing Science. 2014;4(1):1-9.
9. Björvell C. Nursing documentation in clinical practice: Instrument development and evaluation of a comprehensive intervention programme Doctoral Theses; [Internet]. 2002. 1-65. Available from: http://publications.ki.se/jspui/handle/10616/3803.
10. Mak JM. Oncology nursing: professional development as a clinical specialty in Hong Kong. J Adv Nurs. 1997;26(6):1086-90.
11. Stevens S, Pickering D. Keeping good nursing records: a guide. Community Eye Health. 2011;23(74):44-5.
12. Beach J, Oates J. Maintaining best practice in record-keeping and documentation. Nurs Stand. 2014;28(36):45-50.
13. Hendrich A, Chow M. Maximizing the Impact of Nursing Care Quality: a closer look at the hospital work environment and the nurse's impact on patient-care quality | The Center for Health Design [Internet]. Healthdesign.org. 2008 Available from: https://www.healthdesign.org/chd/knowledge-repository/maximizing_impact_nursing_care_quality_closer_look_hospital_work_environmen
14. Clarke SP, Donaldson NE. Nurse staffing and patient care quality and safety. In: Ronda G. Hughes. Patient Safety and Quality; an Evidence-Based Handbook for Nurses, Agency for Healthcare Research and Quality U.S. Gaither Road Rockville, MD 20850, 2011.
15. Quigley, E. Contributions of the professional, public, and private sectors in promoting patient safety. Online Journal of Issues in Nursing; 2003 8(3); 11p.
16. IRIN. Iraq 10 years on: War leaves lasting impact on healthcare [Internet]. IRIN. 2013. Available from: http://www.irinnews.org/feature/2013/05/02/iraq-10-years-war-leaves-lasting-impact-healthcare
17. Nakate G, Dahl D, Petrucka P, Drake K, Dunlap R. The nursing documentation dilemma in Uganda: neglected but necessary. A case study at Mulago National Referral Hospital. Open Journal of Nursing. 2015;05(12):1063-71.
18. Blair W, Smith B. Nursing documentation: frameworks and barriers. Contemporary Nurse.

2012 Jun;41(2):160-8.

19. Nicole H, Johanna C, Kaycee S. Safety auditing as a nursing accountability measure for hospital fall prevention (ppt). [Internet]. Nursinglibrary.org. 2016. Available from: http://www.nursinglibrary.org/vhl/handle/10755/603311.
20. Duclos-Miller PA. Improving nursing documentation and reducing risk. HCPro 2016; Available from: https://hcmarketplace.com/aitdownloadablefiles/download/aitfile/aitfile_id/1806.pdf.
21. Nielsen G, Peschel L, Burgess A. Essential documentation elements: quality tool for the emergency department nurse. Adv Emerg Nurs J. 2014;36(2):199-205.