ORIGINAL RESEARCH PAPER

Nursing

"A STUDY TO ASSESS THE PRACTICES OF STAFF NURSES RELATED TO NURSING DOCUMENTATION AMONG THE STAFF NURSES OF MMIMS&R, MULLANA, AMBALA, HARYANA."

KEY WORDS: Staff Nurses, Nursing Practice, Nursing documentation.

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ABSTRACT

Nursing is a profession that requires specialized skill and knowledge pertinent to the duties to be executed. There is currently considerable interest throughout the world within the health care sector to increase the quality of nursing documentation and nursing terminology. The present study was conducted to assess the practices of staff nurses regarding nursing documentation. In this study 150 sample of the nurses who are working in the ICUs and CCU at MMIMS&R Hospital was collected by purposive Sampling technique. Data was collected through Structured Observational Checklist.The result of study showed that mean percentage of patient profile is (99.16%), general consideration is (97.14%) and need based care is (76.33%). Mean±SD of patient profile is (11.9) ±(0.55). Vital sign (10.60) ±(2.06) general consideration(6.8) ±(0.7) and the mean of the practices of staff nurses regarding nursing documentation was 61.99+- 8.30 with median of 65 and mode was 70. Further In relation to area of work and work experience significant association was seen with the practice of staff nurses as p value <0.05. The study concluded that Staff Nurses had good practices (75.59) regarding nursing documentation followed by poor practices (24.41%).

INTRODUCTION

Nursing is a profession that requires specialized skill and knowledge pertinent to the duties to be executed. There is currently considerable interest throughout the world within the health care sector to increase the quality of nursing documentation and nursing terminology. This is being accomplished through creating new systems, re- evaluating old systems and analyzing reasons for poor compliance with legislation stipulating registered nurses' (Rns') obligation to document. The patient record is a principal source of information in which the nursing documentation of patient care is an essential component[1].

Documentation is a very important tool in patient safety and quality of care.

Documenting has become an important integral part of nursing activity. This leads to increase workload for nursing staffs, which leads to increased stress and resignation which inversely leads to staff storage.For Example, According to (Maximilian J Hartel, Lukas P Staub, SteffanEglli, 18 August 2011) Documentation errors occurred in 65 of 1,934 prescribed agents (3.5%). The incidence of patient charts Showing at least one error was 43%. Prescribing errors were found 39 times (37%) transcription errors 56times (53%) and administration documentation errors 10 times (10%)[2].

According to a survey done by WHO it has been shown that poor communication between health care professionals is one factor for medical errors. There are also evidence indicating that nursing documentation has relationship with patient mortality. Although keeping a patient record is part of their professional obligation, many studies identified deficiencies in practice of documentation among nurses across the globe. It has been reported that nursing records are often incomplete, lacked accuracy and had poor quality. Te challenges for documentation reported so far, include shortage of staff, inadequate knowledge concerning the importance of documentation, patient load, lack of in-service training,and lack of support from nursing leadership. As a remedy for these, many researchers recommended to use a multidisciplinary approach like to develop policies and guidelines on nursing care documentation and provide sustained continuing training opportunities for nurses on effectiveness of documentation[3].

According to Cheevakasemsook et al (2006), nursing documentation has the following important aspects which include offering a legal evidence of the medical process and outcomes of care; providing an instrument or tool to assess the quality, efficiency and effectiveness of patient care; giving evidence for several issues such as research, financial and ethical quality- assurance purposes; providing the database infrastructure supporting development of nursing knowledge; and helping in creating benchmarks to develop nursing education and standards of clinical practice. It has been argued that optimal use of nursing documentation is likely to achieve if documentation is accurate (Ellingsen and Munkvold, 2007).

MATERIAL & METHODS:

The present study was conducted in the month of June 2021 from 150 subjects from the hospital of MMIMS&R Mullana, Ambala. Formal administrative approval was obtained to conduct the study. Formal permission taken from Nursing Superintendent in MMIMS&R, Mullana, Ambala. One hundred fifty staff nurses were selected using purposive sampling technique. Data was collected through Structured Observational Checklist Data was analyzed by Descriptive Statistics using SPSS version 20.

Results & Data Analysis:

TABLE 1: Frequency and percentage distribution of the selected socio- demographic variables N=150

S.N O	SOCIO-DEMOGRAPHIC VARIABLES	f %
1 1.1	Age (in Years) 18-25	86(57%)
1.2	26-35	62(41%)
1.3	36-45	2(1.3%)
2	Gender	
2.1	Male	22(4.6%)
2.2	Female	128(85.3%)

3	Educational status	
3.1	G.N.M	72(48%)
3.2	PB BSc. Nursing	26(17.3%)
3.3	BSc. Nursing	52(34.6%)
4	Work experience	
4.1	>1 year	58(38.6%)
4.2	1-3 years	56(37.33%)
4.3	3-5 years	19(12.66%)
4.4	<5 years	17(11.33%)
5	Area of work	
5.1	CCU	17(11.33 %)
5.2	SICU	16(10.66%)
5.3	MICU	94(62.66%)
5.4	PICU	13(8.66%)
5.6	OTHERS	10(6.66%)
6	Attended workshop r/t nursing documentation	
6.1	Yes	56(37.35%)
6.2	No	94(62.6%)

Data presented in Table 1 describes the socio-demographic variables like age, gender, educational status work experience, area of work, attending work shop related to nursing documentation .These data further presented by graphs:

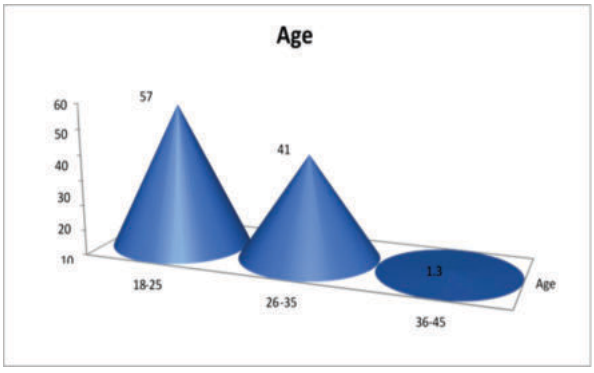

Fig 1 Percentage Distribution of Age of Staff Nurses

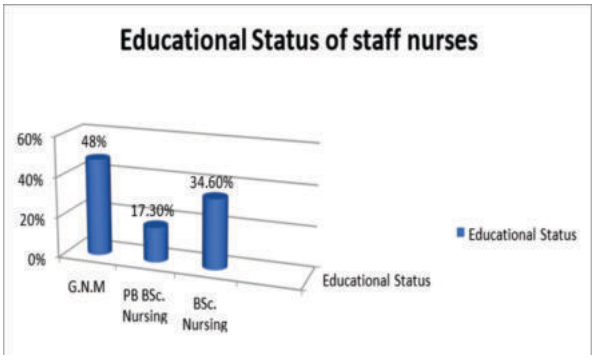

Fig 2: Percentage Distribution of Educational Status of Staff Nurses

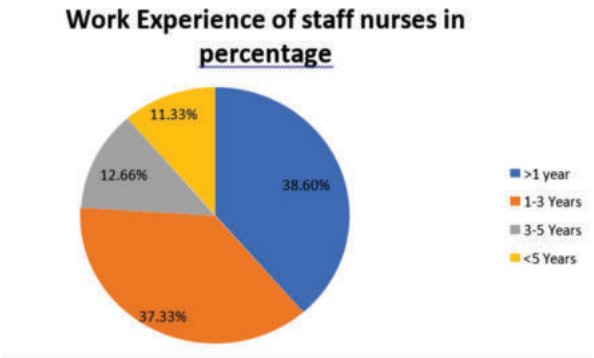

Fig.3 :Pie Chart Showing Work Experience of Staff Nurses.

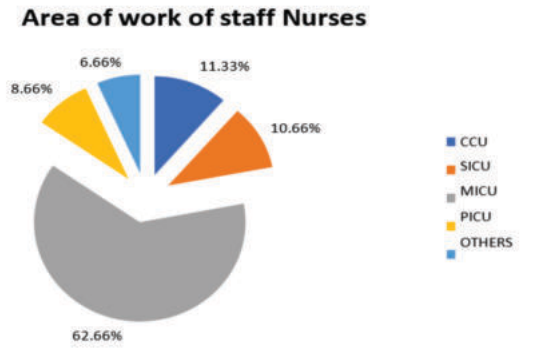

Fig.4 : Pie Chart Showing Area of Work of Staff Nurses

TABLE 2 Area Wise Range, Mean±SD, Median, Mode and Mean Percentage of Practices of Staff Nurses Regarding Nursing Documentation.

AREA	Range	Mean+- S.D	Median	Mode	Mean %
Patient Profile	8-12	11.9±0.55	12	12	99.16
Admission	2-11	10.5±1.61	11	11	95.45
Vital Signs	4-12	10.60±2.06	12	12	88.33
Intake And Output	13-22	19.2±2.57	19	22	87.27
Medication And Administration	3-6	5.75±0.85	6	6	95.83
Need Based Care	2-12	9.16±4.08	12	12	76.33
General Consideration	3-7	6.8±0.7	7	7	97.14

Maximum range = 81 Minimum range = 0

TABLE 2: shows mean percentage of patient profile is (99.16%), general consideration is (97.14%) and need based care is (76.33%). Mean±SD of patient profile is (11.9) ±(0.55). Vital sign (10.60) ±(2.06) general consideration(6.8) ±(0.7).

Table 3 Mean, Median and Mode percentage, standard deviation and range of nurses practices regarding nursing documentation N=150

Range	Mean+- S.D	Median	Mode	Mean %age
42-81	61.99+- 8.30	65.00	70	75.59%

Maximum range = 81 Minimum range = 0

In Table 3 illustrates the mean, median, mode, standard deviations and range .It was found that mean of the practices of staff nurses regarding nursing documentation was 61.99+- 8.30 with median of 65 and mode was 70.

Conflict of Interest

There is no conflict of interest.

Funding

Self Funding

Ethical Consideration

Formal administrative approval was obtained from the Institutional Ethical Committee of MMIMS&R, Hospital, Mullana, Ambala to conduct the study. Permission for study was taken from Medical Superintendent MMIMS&R, Hospital, Mullana, Ambala, and Haryana.

DISCUSSION

The study conducted by **Tamir T et al.**[23] showed the age of participant were from 26-30(35.3) year of age. The majority of nurses were male (54.4%), (79.3%) had B.Sc. Degree and above in nursing more than half (52.1%) of respondent had work 4-5 year (52.1%) and less as a nursing professional. This is in contrast with the present study where (57%) of the nurse

are of age 18-25, 85.3 % of the nurses are female. Majority of the nurses were holding GNM diploma (48%).maximum no. of nurses have less than 1 year of experience (38.6%).

The findings of present study included that more than 97% documented vital signs which is in contrast to the study conducted by **Daskein R et al.**[7] where only 66% nurses documented vital signs.

The findings of the study revealed that there is no significance association between age and practices of nursing documentation ((p=0.88) which is consistent with the study conducted by **Wong et al.**[11] where no significant association between age and practices of staff nurses regarding nursing documentation.(p=0.477).

The findings of this study also presented that85% of nurses were female which is consistent with the study conducted by **A Cheevakasemsook et al.**[15] where 85% of the nurses were female.

The findings of the present study is not consistent with the study conducted by **Majd H et al.**[13] where 47.8% of nurses have inadequate practices regarding nursing documentation. In present study more than 90% of staff nurses follow good practices regarding nursing documenation

Recommendation

- Staff development is urgently needed to improve nurses'' knowledge and skills concerning nursing documentation. This is of particular importance for diploma nurses.
- Continuous supervision of nursing documentation through regular and periodic auditing is suggested, with constructive feedback, as well as disciplinary actions for defaulters and rewards for good achievers.
- The hospital administration should address the barriers to adequate nursing documentation identified by the nurses, and provide all needed resources.
- The nursing schools'' curricula should give more emphasis to nursing documentation, with more focus on its importance and principles.

CONCLUSION

- The study concluded that Staff Nurses had good practice (75.59%) regarding nursing documentation followed by poor practices(24.41%).

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REFERENCES

1. Shihundla, RC lebere, RT and Maputlet,(2018). Workload on quality of documentation of patient information, 3rd edition Primary Health Care Facilities in chamber District , J ClinNurs. 18:2018–98.
2. Daskein R, Moyle W, Creedy D (2019). Aged-care nurses' knowledge of nursing documentation: an Australian perspective. J ClinNurs. ;18:2087–95.
3. Gugerty, B., Maranda, M.J., Beachley, et al. (2007). Challenges and Opportunities in Documentation of the Nursing Care of Patients: A Report of the Maryland Nursing Workforce Commis-sion, Documentation Work Group. Maryland Nursing Workforce Commission, Baltimore.
4. Majd H and KahooeiMurvey (2013). The Effect of the Quality of Nursing Practice on Documentation to determine their Training Needs and Providing Them with a Program of Quality Promotion, Journal of Sabzevar University of Medical Sciences 2013; 10(4): 61.
5. Asamani, J.A. Asamani, (2014). Nursing documentation of inpatient care in eastern Ghana British Journal of Nursing, 23: (1).
6. A Cheevakasemsook, Y Chapman,(2016). Effects of increased nurses' workload on quality documentation of patient information at selected Primary Health Care facilities,6th ed., Journal of nursing.
7. Thoroddsen A, Ehnfors M, (2015).Nursing documentation of inpatient care in eastern Ghana. 5th ed., Journal of Advanced Nursing.
8. Tamir T,(2021). Documentation Practice and Associated Factors Among Nurses in Harari Regional State and Dire Dawa Administration Governmental Hospitals, Eastern Ethiopia, 12th ed., Advances in medical education and practice.