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Assessment of Nurses' Documentation in Surgical Wards at Baghdad Governmental Hospitals

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ABSTRACT

To assess nurses' documentation in surgical wards at Baghdad Governmental Hospitals. A descriptive study was conducted, included (100) nurses from different levels of nursing who they are working in surgical words in (5) hospital related to Al-Rassafa Baghdad Health Directorate, from September 5th, 2015 to March 25th 2016, to assess the level nurses' documentation in surgical wards at Baghdad Governmental Hospitals, by using observation technique and self-reporting technique by nurses for three formal sheets related to nursing documentation in the chart of the patient, which are (vital sings sheet, nursing observation sheet, and intake and output sheet). A non-probability (purposive) sample of (100) nurses (males and females) as (20) nurses from each hospital were selected. Questionnaire format was used for data collection. The validity of questionnaire was estimated through a penal of experts related to the field of study, and its reliability was estimated through a pilot study conducted included (10) nurses (excluded from the original sample) for the period October 10th 2015 to October 24th 2015.Data were analyzed through the application of descriptive and inferential statistical analysis. The study reveals that (58%) of nurses were male, and (34%) of them their ages were between (40-49) years old, (73%) of them were married, and (64%) of them were secondary nursing school graduates. Also the study indicated that (34%) of nurses had (11–15) years of employment in nursing field. Furthermore, (36 %) of sample had sharing in one training session related to nursing documentation, while (22%) had no opportunity to be involved in training sessions related to nursing documentation . Concerning to the assessment of nurses' documentation practices who are working in surgical words, the results of this study indicate that, their practices was poor (in adequate and weak) related to the nursing documentation. The study recommends that there is a need for continuous training program in the field of nursing documentation, and this program is supervised by the Training and Development Division / Badhdad Al-Rassafa Health Directorate, established in all hospitals in collaboration with the continuing nursing education officials. The important of nursing practice supervision, quality improvement programmes, in-service training. And emphasis the hospital managers to reward and motivation the nurses who are efficient and loyal in nursing documentation, while hold accountable and punish the negligent in their duties.

Keywords: Assessment, Nurse, Documentation, Surgical ward.

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INTRODUCTION

Documentation is used extensively in the nursing profession and plays an important role in the caring of patients. Nursing documentation is an essential element of professional practice because written evidence of nursing reflects the nurses' accountability regarding patients' care (1).

Documentation as a nursing intervention is defined as "recording relevant patient data in a clinical record" It is any written or electronically generated information about a patient that describes the care or service provided to that patient.

Health records may be paper documents or electronic documents, such as electronic medical records, faxes, e -mails, audio or video tapes and images. Through documentation, nurses communicate their observations, decisions, actions and outcomes of these actions for patients. Documentation is an accurate account of what occurred and when it occurred. It allows nurses and other care providers to communicate about the care provided.
Documentation also promotes good nursing care and supports nurses in the meeting of professional and legal standards (2)..

Documentation is the written proof of the interactions between and amongst health care professionals, patients, their families and health care organizations. This entails the administration of tests, procedures, treatments, client education and the result or patients response to diagnostic tests and interventions. Additionally documentation provides written records that reflect the patient care provided on the basis of assessment data and the patient's response to the interventions. Data to be documented include the patient's condition prior to the specific intervention performed, the patients' response to the intervention and the patient's outcome. Further stresses that this documentation not only constitutes a legal record, but it also allows for valuable communication amongst other health care team members for the purpose of ensuring continuity of care and evaluating progress toward expected outcomes(3).

The nursing process serves as an organizational and conceptual framework for the practice of nursing and covers all the phases taken by the nurse in caring for the patient. These phases include assessment, nursing diagnosis, planning, implementation and evaluation.

The nursing process requires a systematic approach in documenting the performance of specific interventions and other relevant information necessary for the orderly care of the patient. The nursing process guides the nursing care of the patient in the intensive care unit and requires documentation on what was done(4).

METHODOLOGY

The study is conducted at five hospitals in Baghdad City,in Al Rassafa sector (Al- kindy teaching hospital, Al- Nohman hospital, Al- Jumla al assabia for neurosurgery hospital, Al- Sader hospital, and Ebin al Nafees hospital. The study included(100) nurses from different levels of education, (20) nurses from each hospital who they are working in surgical words to determine the level of nursing documentation, from November 5th 2015to March 25th 2016, to assess the level of nursing documentation. A questionnaire format was used for data collection. The validity of questionnaire was estimated through a penal of experts related to the field of study, and its reliability was estimated through a pilot study included 10 nurses from October 10th 2015 to October 24th 2014.

A questionnaire format was used for data collection which consisted two major parts; the first part is concerned with nurses' socio- demographic characteristics of (gender, age, and level of education, years of employment, and number of training sessions in nursing documentation). The second part is concerned with nurses' documentation include (12) items related to three nursing documentation sheets (vital sings sheet, nursing observation sheet, and fluid intake and output sheet).

The content validity is estimated through a panel study of experts. Reliability of the questionnaire was estimated through the use of Alpha Cronbach for the test-retest approach [5].

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Analysis of data was performed through the application of descriptive statistics (frequency, percentage Cum. Percent, Mean of score (M.S.), and Relative Sufficiency (R.S.)) and inferential statistics (Alpha Cronbach, Reliability Coefficient, Chi Square).The items of nursing documentation were rated on three level Likert scales; always, some time, never, and scored as 3, 2 and 1, respectively [(6)]. Relative sufficiency (RS) Less than (66.66) was considered low level of practices, (66.66- 77.77) was considered pass, (77.78-88.88) was considered moderate, while (88.89- 100) was considered high level of practices.

RESULTS OF THE STUDY

Table (1): Distribution of Nurses by Their Demographic Characteristics (N= 100)

SDCv.	Group	No.	%	Cum. %
Gender	Male	58	58	58
	Female	42	42	100
	Total	**100**	**100**	
Age Groups	20 - 29	18	18	18
	30 - 39	28	28	46
	40 - 49	34	34	80
	50- and more	20	20	100
	Total	**100**	**100**	
Level of education	Nursing school graduate	14	14	14
	Secondary nursing school	64	64	78
	Nursing institute	12	12	90
	Nursing college graduate	10	10	100
	Total	**100**	**100**	
Marital status	Single	22	22	22
	Married	73	73	95
	Other	5	5	100
	Total	**100**	**100**	
Years of employment	**1 - 5**	10	10	10
	6 - 10	24	24	34
	11 - 15	34	34	68
	16 - 20	20	20	88
	≥ 21	12	12	100
	Total	**100**	**100**	
Training sessions in nursing documentation	None	22	22	22
	One	36	36	58
	Two	26	26	84
	Three and more	16	16	100
	Total	**100**	**100**	

Table (1) that the study included (100) nurses, (58%) of them were male, while nearly third of them at age group between (40-49 years old), and (73%) of them were married. Regarding to the level of education, the majority (64%) of the study sample were secondary nursing school graduated,. Furthermore, nearly third (34%) of them had from (11 - 15) years of employment in nursing field.

Concerning to the training sessions in nursing documentation (36%) of them had only one session, while (22%) 0f them had no opportunity to be involved in training sessions related to nursing documentation.

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Table (2): Assessment of Nurses' Documentation in Surgical Wards.

No	Standard items	N =100					
		Always	Sometimes	Never	M S	R S	Severity
		F	F	F			
1	Filling up the information of vital signs sheet correctly, which includes (patient's name, sex, date of admission, ward, and the doctors' name.	46	14	40	2.06	68.7	P
2	Recorded the patients' temperature in the vital signs sheet as required time correctly.	62	11	27	2.35	78.3	M
3	Recorded the patients' pulse rate in the vital signs sheet as required time correctly	40	8	52	1.88	62.6	L
4	Recorded the patients' blood pressure rate in the vital signs sheet as required time correctly.	55	5	40	2.15	71.6	P
5	Recorded the patients' respiration rate in the vital signs sheet as required time correctly.	14	6	80	1.34	44.7	L
6	Records the patient's weight, bowel movement and urinating in the vital signs sheet, as required time correctly.	22	14	64	1.58	52.7	L
7	Filling up the information of nursing observation sheet correctly, which includes (patient's name, sex, date of admission, ward, and the doctors' name.	44	16	40	2.04	68.0	P
8	Has the ability to identify and record the patient's nursing problems (signs and symptoms) in nursing observation sheet correctly	12	24	64	1.48	49.3	L
9	Has the ability to identify and record the patient's nursing intervention according to each nursing problem in the nursing observation sheet correctly	25	7	68	1.57	52.3	L
10	Records the time and the date of the patient's nursing intervention in nursing observation sheet with writing his full name and signature	43	18	39	1.48	49.3	L
11	Documented the Fluid intake entering documented correctly.	12	13	75	1.37	45.7	L
12	Documented the Fluid output correctly.	12	13	75	1.37	45.7	L
	Total	**387**	**149**	**664**	**1.77**	**59.0**	**L**

MS= Mean of score, Low = Less than (66.66), Pass (66.66- 77.77), moderate (77.78- 88.88), and high (88.89- 100).

Table (2) demonstrate the assessment of nurses' documentation in surgical wards, which clearly depicted that there is a weak in nursing documentation in (8) items from (12) items, with respect to the total mean of scores (MS) and to the relative sufficiency (RS) which was (1.77); (59%) respectively.

Table (3): Association between nurses' documentation practices and their gender.

Gender		Always	Sometime	Never	Total
Male	F	230	88	378	696
	%				100%
Female	F	157	61	286	504
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 0.708	df=2	X^2crit= 5.991		P> 0.05	

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This table indicates that there is no significant association between nurses' documentation practices and their gender.

Table (4): Association between nurses' documentation practices and their marital status.

Marital status		Always	Sometime	Never	Total
Single	F	89	34	141	264
	%				100%
Married	F	280	108	488	876
	%				100%
Other	F	18	7	35	60
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 0.666	df= 4	X^2crit= 9.488		P> 0.05	

The findings of this table reveal that there is no significant association between nurses' documentation practices and their marital status distribution.

Table (5): Association between nurses' documentation practices and their ages

Age		Always	Sometime	Never	Total
20 - 29	F	65	23	128	216
	%				100%
30-39	F	109	42	185	336
	%				100%
40-49	F	131	52	225	408
	%				100%
50- and more	F	82	32	126	240
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 2.292	df= 6	X^2crit= 12.592		P> 0.05	

This table indicates that there is no significant association between nurses' documentation practices and their ages.

Table (6): Association between nurses' documentation practices and their level of education

level of education		Always	Sometime	Never	Total
Nursing school graduate	F	40	10	118	168
	%				100%
Secondary nursing school graduate	F	245	97	426	768
	%				100%
Nursing institute graduate	F	52	20	72	144
	%				100%
Nursing college graduate	F	50	22	48	120
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 29.608	df= 6	X^2crit= 12.592		P> 0.05	

This table indicates that there is a significant association between nurses' documentation practices and level of education.

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Table (7): Association between nurses' documentation practices and their years of employment.

years of employment.		Always	Sometime	Never	Total
1 - 5	F	36	12	72	120
	%				100%
6-10	F	92	34	162	288
	%				100%
11-15	F	130	51	227	408
	%				100%
16-20	F	80	32	128	240
	%				100%
21- and more	F	49	20	75	144
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 2.482	df= 8		X^2crit= 17.535		P> 0.05

This table indicates that there is no significant association between nurses' documentation practices and their years of employment.

Table (8): Association between nurses' documentation practices and their Training sessions in nursing documentation

Training sessions in nursing documentation		Always	Sometime	Never	Total
None	F	80	28	156	264
	%				100%
One	F	136	54	242	432
	%				100%
Two	F	106	40	166	312
	%				100%
Three and more	F	65	27	100	192
	%				100%
Total	**F**	**387**	**149**	**664**	**1200**
	%	**32.3**	**12.4**	**55.3**	**100%**
X^2obs= 3.322	df= 6		X^2crit= 12.592		P> 0.05

This table indicates that there is no significant association between nurses' documentation practices and their Training sessions in nursing documentation.

DISCUSSION

Discussion of demographic characteristics and reproductive health information of study sample.

Throughout the course of the present study, and as it has been shown in table (1) that the study included (100) nurses working at (5) hospitals in surgical wards, (58%) of them were male. To find a logical explanation for the increase the proportion of male nurses over women, one can say that the nursing male's percentage in Iraq is more than women. This fact supported by the National sample survey of registered nurses in the United States, they estimated that male nurses accounted 54% of 2.69 million nurses, they represent a 226% increase in their number in the last years[7]).

Regarding age group, nearly third of them at age group between (40-49 years old), and (73%) of them were married. Regarding to the level of education, the majority (64%) of the study sample were secondary nursing school graduated.

This result is agree with McClosky and Grace who says that the mix of educational levels among the staff greatly influence the assignment systems used to cover the patient needs[8]).

Furthermore, nearly third (34%) of them had from (11 - 15) years of employment in nursing field. Concerning to the training sessions in nursing documentation (36%) of them had only one session, while (22%) 0f them had no opportunity to be involved in training sessions related to nursing documentation.

Discussion of Nurses' Documentation in Surgical Wards.

Concerning to the nurses' documentation in surgical wards, table (2) shows that nurses' documentation in surgical wards, which clearly depicted that there is a weak in nursing documentation (inadequate and poor documentation) in (8) items from (12) items, with respect to the total mean of scores (MS) and to the relative sufficiency (RS) which was (1.77); (59%) respectively.

The findings of this study is agree with the study done to assess nursing documentation in the intensive care units of an academic hospital in Western Cape, which show that the nursing documentation in the intensive unit is inadequate during the first 48 hours of admission. Poor documentation threatens the safety of patients and demands urgent improvement. with the following total mean scores:

- Assessment 62.6%
- Nursing diagnosis 53.1%
- Nursing care plans 37.1%
- Implementation 72.6%
- Evaluation 40.5%.

Also this result recommended to improve the documentation include nursing practice supervision, quality improvement programmes, in-service training, evidence based practice and further research [(9)].

This result in (table 2) with respect to the items (1,7) indicated that nurses not give attention to record in the sheets the socio-economic status of patient which it is very important in nursing documentation.

This result is agree with a study found that units are less likely to record the socio-economic status of the patient. The information obtained about the socio-economic status guides the professional nurse in setting long - term goals for patient rehabilitation to achieve an acceptable quality of life [(10)].

Discussion the association between nurses' Documentation practices with their demographic characteristics:

Results of data analysis illustrated that there was no significant relationship between nurses' documentation practices and their gender, age, marital status, years of employment, and training session table (3,4,5,7,8). Unfortunately, there was no evidence to support these findings. Based on the researcher’s point of view, the nurses (regardless of their gender and marital status) who were working in the hospital had the same level of knowledge concerning nursing documentation.

This result is disagree with the scientific literatures which indicated that whenever there is increase in the number of training sessions there is an increase in nurses' knowledge and practices.

To found interpretation for this result, the reason may be due to the lack of supervision and surveillance as well as a lack of knowledge for those nurses and lack of accountability to them, and lack of in-service training.

Furthermore, the result of this study found that there is a significant relationship between nurses' documentation practices and their educational level (table 6). It has been considered that the higher level of educational preparation is the better of knowledge acquired.

RECOMMENDATIONS

The study recommends that the following:

1. There is a need for continuous training program in the field of nursing documentation, and this program is supervised by the Training and Development Division / Badhdad Al-Rasafa Health Directorate, established in all hospitals in collaboration with the continuing nursing education officials.
2. The important of nursing practice supervision, quality improvement programmes, in-service training.
3. Emphasis the hospital managers to reward and motivation the nurses who are efficient and loyal in nursing documentation, while hold accountable and punish the negligent in their duties.

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