The Perceived Issues in Documentation among Staff Nurses

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Abstract

The present study was conducted to assess the perceived issues in documentation among staff nurses working in a selected hospital in Kozhikode district (Kerala). The main objective was to identify the issues in documentation among staff nurses. Non-experimental descriptive approach was used in this study; 150 subjects were selected using non-probability sampling technique from Baby Memorial Hospital. A semi structured questionnaire was used to assess the perceived issues in documentation among staff nurses. Content validity of the tool was ensured after consulting the experts in the nursing fields. The findings of the study were: majority of the participants faced issues in written documentation such as incomplete/ missing entries, bad handwriting, need for addition or insertion of additional data and use of incorrect abbreviations that lead to confused communication between healthcare team members. In computerised documentation, the participants perceived issues such as the software or the network provided in the hospital for computerised documentation frequently crashed or hung up and was not user-friendly. There were delay in documentation due to a greater number of assigned patients, a smaller number of computer system when compared to staff on duty and delay in accessing files. Few participants reported error in computerised documentation due to less time available for entering data and forgetting to enter data or to do intent on time.

Key words: Perceived issues, Staff nurses, Computerised documentation

Good nursing practice requires detailed record-keeping that is comprehensive, timely and accurate. Without complete recording, there is no evidence to prove that care was provided to the patient. In nursing practice there is a saying, 'What is not recorded has not been done'. Furthermore, poor record-keeping not only undermines patient care but makes the nurses more vulnerable to legal claims which arise from breakdown in communication that results from incomplete or inadequate records. According to South African Nursing Council (SANC) Rules and Regulation R387 relating to Acts and Omissions, a nurse need to keep clear and accurate records of all nursing actions always done to the patient. Failure to do so constitutes a professional misconduct and may lead to disciplinary action against such nurses (Ning Way, 2010).

Nurses providing care in all health care institutions including hospitals are expected to record all nursing actions in numerous recording forms such as the nursing process forms. The important factors affecting nursing records in hospitals were fatigue, large number of patients, high volume of nursing actions, lack of continuous monitoring and evaluation, lack of reward system to staff nurses by nursing management. Work experience of nurses and nature of nursing shifts are other factors that influence timeouts record-keeping in public hospitals. The nursing audit of patient records for quality assurance purposes peer review team meetings, mortality reviews and hospital management meetings continuously. These have led to complaints about the trend of poor record-keeping, despite all efforts to improve record-keeping challenges (Blair & Smith, 2012).

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Need for the study

Documentation plays a crucial role in any treatment setting. Without meaningful and error-free documentation, the goal for timely progress in documentation to reduce medical errors will remain dormant. Error-free documentation through consistent improvement is the long-term way to assure quality of care. Hence, it is important to document and progress in rectifying the problems or issues in documentation that are hindrances to quality services.

Objectives

The study was set out to identify the perceived issues in:

(a) Written documentation, and (b) Computerised documentation, among staff nurses among staff nurses working in selected hospital at Kozhikode district.

Review of Literature

A study was conducted to assess the perceptions of nurses' regarding the use of Health Information System (HIS) for providing patient care in terms of information and system quality. The survey response rate was 82 percent (140 out of 170 nurses responded); the resultant Cronbach's alpha statistic was 0.78. Generally, 87.9 percent of respondents utilised HIS in their daily practice. System characteristics identified by the nurses as beneficial were: timeliness, reliability, data completeness and accuracy of information which provide complete and accurate information about patients for nursing practice (Takhti et al, 2011).

Another study (Chand & Sarin 2019) on Nurses' perception and acceptability of electronic nursing documentation was conducted in Haryana, India. The study explored nurses' perception, acceptability and utility of electronic nursing documentation programme using a quasi-experimental approach with pre-test post-test design. Perception assessment scale and acceptability and utility opinionnaire was utilised to collect data from 44 nurses working in ICU, surgical ICU and emergency units in a rural teaching tertiary care hospital. Nurses' perception was assessed pre-and post-implementation of electronic nursing documentation programme, whereas nurses' acceptability and utility of electronic nursing documentation was assessed on day 100 of implementation of programme. Findings revealed a significant overall and unit-wise enhancement in the perception of nurses' post-implementation of electronic nursing documentation programme. A weak positive relationship was established between perception and acceptability of utility of nurses exposed to electronic nursing documentation programme.

Material and Methods

The study was conducted using non-experimental descriptive survey design. One hundred and fifty staff nurses from selected hospitals of Kozhikode (Kerala) were selected using non-probability convenient sampling as study participants. The tool used to collect data consisted of two tools.

Tool 1: Structured questionnaire to assess the demographic data of staff nurses.

Tool 2: Semi structured questionnaire to assess the perceived issues in documentation among staff nurses.

Data collection procedure

Data was collected after getting the approval from the concerned authority. Participants were selected according to the inclusion criteria. The research group conducted pilot study from 25-27 September, 2021 and main study was conducted from 4 to 9 October 2021. After introduction and explaining the purpose of the study, informed consent from the participants was obtained. Structured questionnaire data collection tool was distributed among 150 staff nurses and it was ensured that they followed the instructions.

Analysis of the study was done using descriptive statistics by calculating frequency and percentage distribution of socio-demographic data of participants and perceived issues in written and computerised documentation.

Results

Major results of the study are discussed under the following headings:

Frequency and percentage distribution of participants based on socio demographic data; perceived issues in written documentation among staff nurses; and perceived issues in computerised documentation among staff nurses.

Frequency and percentage distribution of participants based on sociodemographic data

Perceived Issues in Written Documentation among Staff Nurses

Major issues in written documentation perceived by staff nurses were incomplete or missing data that caused errors in delivery of care and legal issues, bad handwriting, use of incorrect abbreviations, time consumption in completing documentation, need for addition or insertion for completion of data to already documented information.

Sixty-one percent of participants reported that incomplete/missing documentation is usually done by senior doctors; 19 percent of participants reported that incomplete/missing documentation is done by all health care workers involved in documentation. Nine percent of participants opined that incomplete/missing documentation was done by junior doctors and six percentage opined that it was done by staff nurses. Five percentage of participants reported that incomplete/missing documentation was done by physiotherapist.

Twenty-four percent participants reported that incomplete/ missing documentation was done by one self or by colleague that led to errors in delivery of care. Few participants (14.7%) reported that

Table 1: Frequency and percentage distribution based on socio demographic data (n=150)

Socio-demographic data	Frequency	Percentage (%)
Age in years		
≤24 years	35	23
25-35 years	108	72
36-45 years	7	5
Gender		
Male	0	0
Female	150	100
Educational qualification		
General nursing	26	17.3
Post BSc nursing	10	6.7
BSc nursing	114	76
Marital status		
Married	76	50.6
Unmarried	74	49.4
Working area		
Wards	118	78.6
ICU	25	16.6
Emergency unit	5	3.3
Infection control unit	2	1.5
Clinical experience		
0-3 years	51	34
4-7 years	70	46.6
8-11 years	25	16.6
>12 years	4	2.8
Computer-related courses		
Not completed	134	89.3
Completed	16	10.7

it led to fight between care givers. Other participants (5.3%) reported that they had to face legal issues due to incomplete/ missing documentation. Fifty-six percentage participants reported that they had not faced any of the above-mentioned issues due to incomplete/ missing documentation by self or by colleagues.

Among 150 participants, majority of the participants (91%) reported that bad hand writing is mostly exhibited by doctors which led to documentation issues and seven percent participants opined that bad handwriting is exhibited by nurses.

Out of 150 participants, 44 percent of participants reported that false and inaccurate information in documentation by self or by colleague had occurred in vital signs chart, inventory checklist, infection control-related routine checks; 23 percent participants reported that false/ inaccurate documentation occurs in none of them, 15 percent participants reported that it occurs in inventory checklist only, 13 percent reported that it occurs in vital signs chart only, and five percent of participants mentioned that it occurs in infection control-related routines alone.

Fifty-two percent of participants communicated that use of incorrect abbreviations had led to confused communication in between health care team members; 25 percent participants reported that use of incorrect abbreviations leads to error in patient care delivery services like medication, fluids, transfusions, etc.; 19 percent participants opined that it does not cause any issues, seven percent participants reported that it leads to being ridiculed or teased or shouted at for lack of proper education and teaching, six percent participants reported that it led to error in patient care delivery system.

Majority of participants reported that written documentation is considered as time consuming as there is not enough staff to delegate patient care activities (60.2%). Few participants (31.8%) reported that too much patients were assigned to a single person, which requires extensive and repetitive data entry. Eight percent participants opined that it required more time to write whole sentences and paragraphs in English which is time consuming.

Fifty-six percentage participants revealed that addition or insertion of data to already documented information entered by all health professionals is needed for completion of documented data. Forty-four percent participants stated that addition or insertion of data to already documented data entered by doctors is needed for it to be complete.

Perceived Issues in Computerised Documentation among Staff Nurses

Major issues in computerised documentation perceived by staff nurses were software/ network issues, delay in documentation and accessing files, a smaller number of systems available for documentation, errors occur while entering data and incompetency/ inadequate use of computerised documentation due to hidden information, lack of trust and difficulty in decision making with available data entered.

Thirty-six percent of participants are of the opinion that the software or the network provided in the hospital for computerised documentation frequently crashes or hangs up. Some participants (35.6%) reported that the software or the network is always slow to load data. Few participants (28.4%) reported that the software or the network provided have the issues such as always slow to load data, frequent crashes or hangs up and difficulty to access when there is huge online traffic.

Out of 150 participants, 33.3 percent participants communicated that the computer system provided in the hospital for documentation are less in number when compared to number of staff who use it; 32.3 percent participants say that computer system provided needs frequent maintenance calls, 22 percent participants reported that computers are outdated or old and slow; 12.4 percent participants stated that computer system used for documentation are efficient machines.

Out of 150 participants, 48 percent participants stated that computerised documentation bring problem in documentation among health care professionals for delay in accessing files; 24 percentage participants reported that computerised documentation brings problems in documentation as no correction is possible after saving the data. Few participants (20.3%) think that computerised documentation brings problem in documentation due to lack of direct communication between health professionals and some participants (7.7%) reported that it leads to vulnerability of system failure in hospital.

Among the 150 participants, 32 percent participants reported that computerised documentation is hard for them or colleagues because of time limits in entering data; 19.4 percent participants say that computerised documentation is hard due to lack of adequate basic computer skills; 19.3 percent participants opined that computerised documentation is hard because of the difficulty to understand software guidelines or procedures; 18 percent participants stated that computerised documentation is hard because of the issues such as time little availabe for entering data, lack of adequate basic computer skills, difficulty to understand software guidelines or procedures, difficulty to correlate data in written documentation with software options or inputs and computerised documentation is simple; 11.3 percent participants reported that computerised documentation is hard due to difficulty to correlate data in written documentation with software options or inputs.

A third of the study participants (39.3%) reported that error in computerised documentation were mostly exhibited by self or colleagues due to forgetting to enter data or to intent or to order at correct/ scheduled time; 22.6 percent participants, perceived that error in computerised documentation results in intending wrong medications by confusing medication name; 14.2 percent participants perceived that error in computerised documentation leads to ordering wrong investigations; 14.6 percent participants perceived that error in computerised documentation is mostly exhibited due to multiple reasons such as forgetting to enter data or intent or order at the proper time, intending wrong medications due to confusing medication/ drug names, ordering wrong investigation, entering data related to patients with similar name; 9.3 percent subjects attributed the error in computerised documentation to difficulty in entering data for patients with similar name.

Among 150 subjects, 34 percent participants reported that the major issues associated with use of computerised documentation is hidden information; 27.3 percent participants perceived that major issues associated with use of computerised documentation is information overload; 21.2 percent participants opined that it leads to difficulty in decision making with available data entered; 17.5 percent participants reported that major issues associated with the use of computerised documentation are hidden information, difficulty in decision making with available data and lack in trust of entered data.

Discussion

Nursing documentation is an important indicator of the quality of the care provided for hospitalised patients. The findings of the present study show that inefficient documentation system reduces the effectiveness of care giving and increases the stress among the staff nurses. In the present study, the majority of participants faced issues in both written and computerised documentation. The results are consistent with a systematic review of Nurses' experiences with unintended consequences when using the Electronic Health Record (EHR) conducted by Sheila Gephart and Jane Carrington. The findings of the study demonstrate that nurses experience changes to workflow, must continually adapt to meet patient's needs in the context of imperfect EHR systems, and have difficulty accessing the information they need to make patient care decisions (Sheila et al, 2015).

Nursing documentation on medical wards of three public hospitals in Jamaica, a cross-sectional study audited a multilevel stratified sample of 245 patient records from three public hospitals. The audit noted 90 percent of records had a physical assessment completed within 24 hours of admission and entries timed, dated, and signed by a nurse. Less than 5 percent of dockets had evidence of patient teaching, and 13.5 percent had documented evidence of discharge planning conducted within 72 hour of admission (Lindo et al, 2016).

The present study results are contradictory to the results of study conducted at Georgia by Lorenzi et al (2009) to examine the effectiveness of documentation which is conducted around 845 staff nurses. The finding implies that efficient documentation system reduces the workload among staff nurses.

Recommendations

- A comparative study can be conducted to compare the perceived issues among nurses in written documentation and electronic documentation.
- A descriptive study can be conducted to assess the knowledge on electronic documentation among nurses.

Nursing Implications

Nursing administration: The nurse administrators can organise in-service education program to improve the electronic documentation and make it error-free. Nurse administrators can also encourage and depute nurses to participate in such programmes conducted by any other voluntary organisations.

Nursing education: The nursing education curriculum can include electronic documentation process to educate student nurses in enhancing electronic documentation process. The acquisition of knowledge about electronic documentation at student level would better equip novice nurses to provide error-free nursing services.

Conclusion

This stuy demonstrated that out of 150 participants, the major issues found in the written documentation are incomplete or missing documentation, false or inaccurate information in documentation, time consuming nature of written documentation and use of incorrect abbreviations.

The major issues found in the computerised documentation are less number of computer system, frequent crashes or hangs up, delay in accessing files among health care professionals and forgetting to enter data or intent or order at the proper time. There are also certain other issues in written as well as in the computerised documentation.

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