

COLLEGE OF MEDICINE AND HEALTH SCIENCE

DEPARTEMENT OF NURSING

ASSESSMENT OF KNOWLEDGE, ATTITUDE, AND PRACTICE OF NURSING DOCUMENTATION AMONG NURSES IN GURAGE ZONE,SELCTED HOSPITALS ,SNNPR, ETHIOPIA,2022

BY:

ENDALE TEKLE

KURI ABERA

SABA SOLOMON

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KURI ABERA

SABA SOLOMON

ADVISOR:

Mr. Tariku Gebre (Bsc.N, Msc.N)

Mr. Mamo Solomon (Bsc.N, Msc.N)

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ABBREVATION AND ACRONYM

- BSC……. Bachelor degree for science
- SNNPR…….South nations nationalities and people region
- SPSS…….Statistical package for social science
- WHO…….World health organization
- WKUSTH…….Wolkite university specialized teaching hospital
- CNE…….Comprehensive nursing education

ABSTRACT

Background: Documentation act as a formal legal document that gives details of client's management throughout the world. It is how nurses create and store a record of their work for the use of clients, the legal system, government agencies, accrediting bodies, researchers, and others directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nurses contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care, so complete nursing documentation is very crucial for nurses, clients and health institutions. Therefore the current study aimed to assess knowledge, attitude and practice of nursing documentation among nurses in Gurage zone, selected hospitals, SNNPR, Ethiopia, 2022.

Objective: The aim of this study to assessing knowledge, attitude, and practice of nursing documentation among nurses in Gurage zone, selected hospitals, SNNPR, Ethiopia, 2022

Method: Cross sectional study was employed to assess nursing documentation practice among nurses working in selected hospitals in GURAGE zone, selected hospitals, SNNPR Ethiopia. A total of 124 nurses was involved in the study by using simple random. Data was collected using structured self-administered questionnaires. Data was enter to epidata and export to SPSS .result was presented in text, figure, and tables, graph.

Result: A total of 124 nurses were taken to assess documentation practice. The response rate is 100% . In this study 51(41.1%) of nurses has poor knowledge, 75(60.5%) of them had unfavorable attitude and 66(53.2%) of them had poor documentation practice.

Conclusion: Studies revealed that knowledge, attitude, practice of nursing documentation. The finding from this research showed that majority of study participants 58.9% good knowledge. On the other hand good nursing documentation practice was 46.8%. On the other hand study participants were poor attitude towards nursing documentation.

Recommendation Based on the finding of this study, employing institutions need to create awareness and provide training to enhance knowledge, attitude and practice of nurses the nurses regarding documentation. Nursing leaders should motivate the employees to enhance the practice of documentation, avail the necessary documenting materials besides adequate staffing which may be related to time shortage. Researchers also need to carry out large scale studies in order to address the problem.

INTRODUCTION

1.1 Background

Documentation is any written or electronically generated information about a client that describes the care or services provided to that client.Health care systems require documentation to ensure continuity of care, serve as tool for communication, audit, education, monitoring and evaluation of patient progress and furnish as evidence in courts of law. The patient record is principal source of information, in which the nursing documentation is an essential component (1). Nursing documentation is the record of nursing care that is planned and delivered to individual patients by qualified nurses or other caregivers under the direction of qualified nursing (2).

Accurate and complete nursing documentation has been accepted as a very important aspect of professional practice to nurses the Florence Nightingale. As written in her book, "Notes on nursing: what it is and what it is note", she stated the necessity of recording of patients progress in words for communication among nurses and the importance of reporting patient related observation accurately (3).

In Africa, nurses viewed nurses documentation as an important practice towards patient care; though the act of documentation remains problematic due to lack of pre and post service training, lack of resource and supplies, lack of comprehensive nursing education(CNE),lack of time and over-crowding (4).

In Ethiopia, even though it is declared that nursing care out line; the assessment, planning and evaluation of care will be clearly documented but still know nurses knowledge, attitude and practice on nursing care documentation(5).

In past few decided the nursing profession has witnessed a change towards a more independent practice with explicit knowledge of nursing care. With this change, has come an obligation to document not only the performed interventions but also the decision process explains why a specific nursing action has been prompted and also its outcomes(6)

Nursing documentation is essential for good clinical communication. Appropriate documentation provide an accurate reflection of nursing assessments. Changes in clinical state, care provided and pertinent information to support the multi-disciplinary team to deliver great care. According to a survey done by WHO many medical errors were found to be related to poor communication between health care professionals(8)

1.2 Statement Of The Problem

Nursing documentation is an important part of health care but often neglected to document, the right way on a patient`s record that is when to document, what to document ,how to document is a vital to fill the gap (5).

Access to accurate patient documentation is recognized as a prerequisite for delivering of safe and continuous municipal elderly care, health care professionals often fail to provide comprehensive clinical information in an accurate and timely manner(9) There is also evidence indicating that nursing documentation has relationship with patient mortality(10)

poor documentation of nursing care results in errors of treatment, inaccurate care given due to poor communication,riks to the health and safety of clients and careers, client missing pre-booked outpatients appointments or clinics, important vital sign observations not recorded so information not passed on the person in charge or the doctor. What is written in care records is the responsibility of the person who has made the record so unclear and undocumented care given can bring legal issues for everyone since it wont`s be clear whose responsibility it is to give the care. Some barriers have been identified to hinder the nursing documentation see nurses who are familiar with the availability operational standard of nursing documentation is two times more likely to document their care compared to the unfamiliar ones. Similarly, lack of time and scarcity of sheet were leading factors that negatively influence the nursing documentation practice. Respondents who had lack of time were two times more likely to document(11) The challenges for documentation reported include shortage of staff, lack of support from nursing leadership, inadequate knowledge about importance of documentation (12) Lack of in service training(13)

Poor documentation practice creates a great problem when it comes to the evaluation of client care(13) and is a key factor in misconception among nurses and physicians, delayed, repeated or omitted and fragmented care that will cause preventable medical errors which may potentially affect patient outcomes(14)

Generally, the main aim of this study is to identify knowledge, attitude and practice of nursing documentation, assess current status of nursing care documentation, compare the findings to others literature conducted in different parts of the country, and to recommend effective solutions for the identified problems.

1.3 Significance of study

Nursing record keeping is the right hand of patients and health team workers. Different literature shows that anything done for the patient should be recorded individually, accurately and honestly, but in reality nursing care documentation is absent or poor. Nurses are required to maintain reliable and complete records of patient care not only to monitor client progress but also to safeguard them because it can be used as evidence in legal cases such as litigation. When a patient makes a complaint, the only confirmation that you have met the commitment of treatment to the patient is nursing records. In certain nations, according to the rule, if care or treatment is not reported because of a patient, it may be concluded that it has not occurred. So emphasizing nursing documentation was protect the legal implication of documentation and assist nurses in the provision of safe, ethical, and effective care.

A finding of the study was important for policymakers including managers of the hospital to enable them to design evidence-based practice and important sources for further study. This study will also directly aims for nurses working in Gurage zone hospitals. In addition this study will allow the local health sector regional and federal health institution, health institution manager. In addition nursing documentation increase patient safety and enhance the quality of nursing. On the other hand, good documentation improves the credibility of the institution and makes the nursing profession visible. This means that the situation may lead to the extent that can affect the status of the health care facilities because health care facilities are evaluated by the quality of documents they keep in most cases.

CHAPTER 2

LITERATURE REVIEW

2.1.1 Nursing documentation practice

Many studies identified deficiencies in practice of documentation among nurses globally. It has been reporting that nursing records are often incomplete, lacked accuracy and poor quality.(15)

cross sectional study conducted among nurses in Ghana[54.2%] (24) Across sectional study done in Jima showed that 48.6% had accurate documentation practice. (25) ,Dire Dewa administration government hospitals, Eastern Ethiopia concluded that out of 421 reviewed medical records, good nursing documentation was found to be practiced in 38.5% (7)

A study done in Gondar university on nursing care documentation practice using institution bases cross-sectional study conducted among 220 nurses working at the university of Gondar hospital inpatient wards from March 20 to April 30,2014 found that good nursing care documentation practice among nurses was 37.4% by reviewing nursing records. Most of nursing care provided remains towards nursing care documentation were factors associated with nursing care documentation practice.(14) A study done in Tigray with little 'Nursing documentation practice and associated factors among nurses in public hospitals, Tigray, Ethiopia found 47.8%; to have good documentation practice(11)

2.2.3. Attitude towards nursing documentation practice

study done in Ghana 84.2% of respondents had positive attitude and 15.8% of respondents had negative attitude to nursing document(20)

study on Uganda shows that there are two categories of attitude (acceptable and un acceptable with scores of 70% (>45) and above categorized as acceptable attitude, while those below 70%(<44%)categorized as unacceptable attitude so in this study (54%) had un acceptable attitude (4).

Study done on Jimma 60% had good favorable attitude than unfavorable ones(40%) (21)

2.2.4. Knowledge towards nursing documentation.

A cross sectional study was conducted among nurses in Yemen shows 46.01% had good knowledge(19)

On other study done on Ghana a large majority of the respondents 84.6% had adequate knowledge on nursing documentation (20)

Study conducted on Nigeria showed that 100% of respondents said that documentation is necessary to promote continuity of care; others 89.1% said that it essential for legal backing (20). In another study on Nigeria shows that from sample size of 102 midwifes has good knowledge of documentation in labour,but their practice were poor(23)

Institutional based cross sectional study on Jimma shows that out of 396 nurses 110 had good knowledge about nursing documentation(21)

In similar study done on west Gojam 54.6% respondents had good knowledge on nursing care documentation(24)

A study conducted in Ethiopia Gondar showed that around 58.3% of participants had good knowledge (16).

Study conducted in Harari showed that (46.5-56.5%) had good knowledge about nursing documentation (8).

on other study done on Dire Dewa.it shows attitude towards nursing documentation, in-service training on standards of nursing documentation (28). Out of the total study participants (45-55%) had favorable attitude (26).

A study done in Tigray with little ‘Nursing documentation practice and associated factors among nurses ,55.7% of the respondents have favorable and 44.3% of them have unfavorable attitude towards nursing documentation practice (13).

Many studies identified deficiencies in practice of documentation among nurses globally. It has been reporting that nursing records are often incomplete, lacked accuracy and poor quality (18).

Various levels of documenting by nurses have been reported in the world. Institutional cross sectional study conducted in Jamaica hospital indicated that most nurses 98% followed documentation guidelines for admission used authorized abbreviation is 97%, nursing diagnosis records had 26% and 48% had documented evidence of discharge planning study conducted in Jamaica showed that good nursing

documentation was practiced and showed high level of accurate documentation by nurses at western Jamaica (19).

On other cross sectional study done on Iran showed that all nursing records and vital sign flow sheets (81.4%) and drug interventions (85.9%) had good quality. (20) **,** Indonesia 37% (21) Canada 53.5% (22) , Yemen (36.78%) (23).

Cross sectional study conducted among nurses in Ghana [54.2%] (24) across sectional study done in Jima showed that 48.6% had accurate documentation practice. (25) A study published in 'Advances in medical education and practice journal 2021' on documentation practice and associated factors among nurses in Harari regional state and Dire Dewa administration government hospitals, Eastern Ethiopia concluded that out of 421 reviewed medical records, good nursing documentation was found to be practiced in 38.5% (8).

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CHAPTER 3

OBJECTIVES

3.1. General objective

1. To Assess knowledge, attitude, and practice of of nursing documentation among nurses in Gurage zone, selected hospitals, SNNPR, Ethiopia, 2022

3.2. Specific objective

1. Assess knowledge of nursing documentation among nurses working in selected hospitals of Gurage zone, Ethiopia, 202

2 .Assess attitude of nursing documentation among nurses working in selected hospitals of Gurage zone, Ethiopia, 2022

3 .Assess practice of nursing documentation among nurses working in selected hospitals of Gurage zone, Ethiopia, 2022

CHAPTER 4 METHODS

4.1 Study area

This study was conducted in Gurage zone, located in south west of Ethiopia . Gurage zone is bordered on southeast by Hadiya and Yam special Woreda, on West, North and East by Oromia region. Wolkite is the administration city of the zone. The zone has one general hospital, seven primary hospitals, 72 health centers, 412 health posts

WKUSTH found in Gubre town in Gurage zone SNNPR. Gubre is away from Addis Ababa 167 km this hospital established and starts to give services on 29/12/2011E.C.

Attat our lady of Lourdes catholic primary hospital established in 1969 G.C they have 25 nurses

Gunchire primary hospital is located in Gurage zone, Enamor and ener Woreda which its far away from Addis Ababa by 112km. This hospital has 34 nurses.

4.2 Study design and period

A quantitative descriptive cross sectional study design was used to assess knowledge, attitude and practice of nursing documentation of nurses. the study was conducted from may MAY15 to MAY 30

4.3 Population

4.3.1 Source population

The source population for this study was all nurses who are working in Gurage zone hospitals

4.3.2 Study population

This study was on nurses working in Wolkite University specialized teaching hospital, Attat our lady Lourdes catholic primary hospital, Gunchire primary hospital.

4.4 Eligibility criteria

4.4.1 Inclusion criteria

Nurses working in the selected hospitals with work experience of at least six month will included in this study

4.4.2 Exclusion criteria

Nurses working in office and not having direct contact with patient and not available during the study period were excluded in this study

4.5 Sample size determination

The sample size was determined by using single population proportion formula by considering 95% confidence level, 5% margin of error & prevalence of respondent who had good knowledge on nursing documentation from previous study at Harari.

P=48%=0.48

CL=95%=1.96

W=5%=0.05

$n=z^2xp(1-p)$

w^2

$=1.96^2 \times 0.48(1-0.48)$

0.05 sample size = 124

=383 since the study of population less than 10,000, a correction formula was used

$nf = \frac{ni}{1+\frac{ni}{N}} = \frac{383}{1+\frac{383}{161}}$=111.3 $where$ 383 calculated sample size:$nf = final\ sample\ size\ N = 161$

$111.3 \times \frac{10}{100} = 11.3(Non\ response\ rate) = 124$

4.6 Sampling procedure

Selection of hospitals for the study was carry out using simple random sampling after all hospitals in Gurage zone were identified. WKUSTH, Attat our lady of Lourdes catholic primary hospital, Gunchire primary hospital each comprising 102, 25 and 34 nurses respectively.

Where N is equal to 161

WKUSTH= $(124 \times 102)/161 = 79$

Attat= $(124 \times 25)/161 = 19$

Gunchire= $(124 \times 34)/161 = 26$

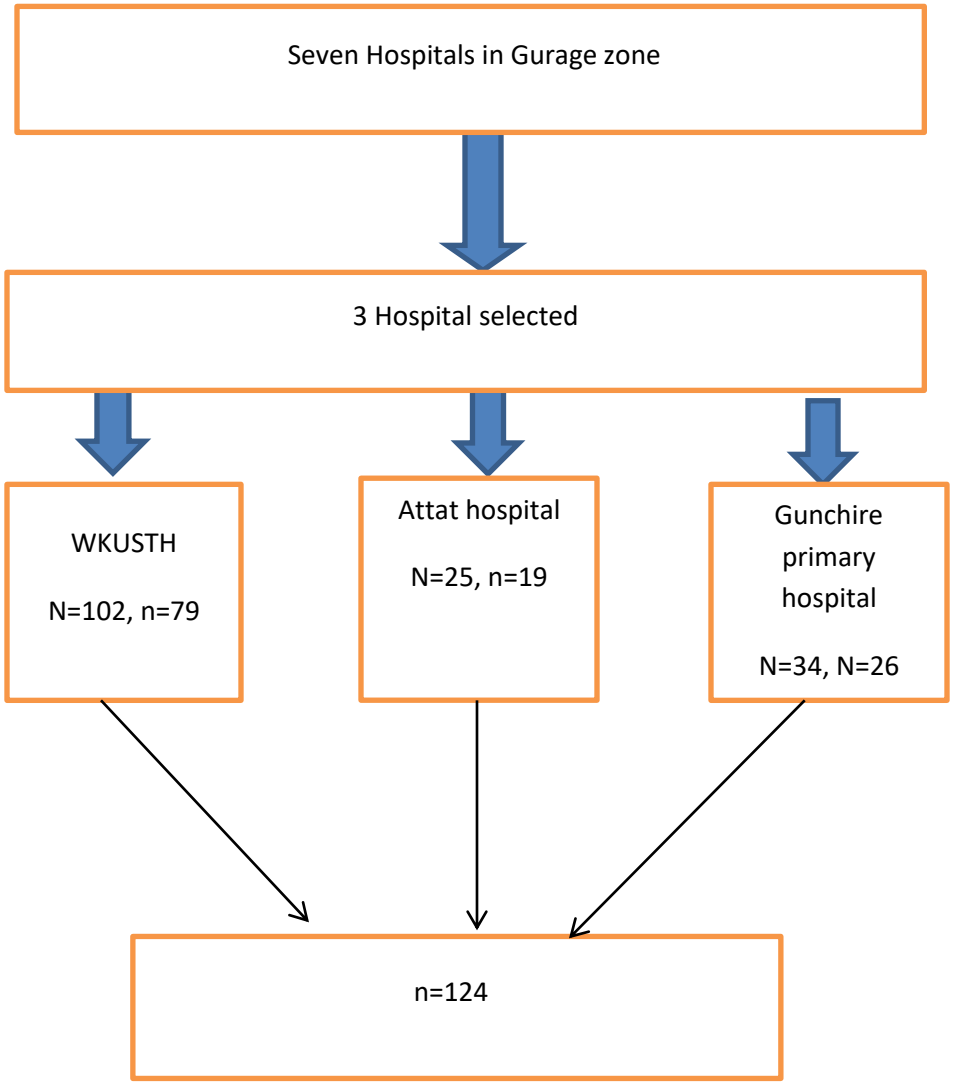


Figure 2- sampling procedure of the study on knowledge, attitude, and practice of nursing documentation among nurses in Gurage, Selected hospitals, 2022

4.7 Study variable

4.7.1 Dependent variable

- Knowledge of nursing documentation
- Attitude of nursing documentation
- Practice of nursing documentation

4.7.2 Independent variable

- Age
- Sex
- Work experience
- Educational level

4.8 Data collection tools and procedures

4.8.1 Data collection tools

The data was collected by structured questionnaire. It enables to assess socio demographic characteristics, attitude, and practice of documentation, Knowledge of documentation. The questionnaire was prepared in English language.

4.8.2 Data Quality Assurance

Data was collected by three graduating class students of nursing. Before data collection there was one day training for data collector in order to have common understanding of the objectives of the study.

4.9 Operational definitions

Good knowledge: - Refers to respondents with individual knowledge scores of mean and above.

Poor knowledge: - Refers to respondents with individual knowledge scores below the mean score.

Good Practice: Refers to those study participants who scored to practice questions above or equal to the mean value.

Poor Practice: Refers to those study participants who scored to practice question below mean value.

Favorable Attitude: Refers to those study participants who scored greater than or equal to the mean of attitude questions.

Unfavorable Attitude: Refers to those study participants who scored less than the mean of attitude questions.

4.10 Data analysis and management

After the completion of data collection process, all the questionnaire's was checked for completeness, clarity and consistency and the data was analysed by using epi data method and export to SPSS and result was presented by table, graph.

4.11 Ethical consideration

Ethical clearance was obtained from Wolkite University, to ask permission and helpful cooperation of the responsible person in the area will be the study under taken. Moreover, informed verbal consent was obtained from each study participant. In order to ensure confidentiality, the study participants name was be not written on the questionnaire. The privacy of participants was maintained. As well, the objective of the study is communicated to each individual participant.

4.12 Dissemination of the result

The final report will presented and discussed at Wolkite University College of medicine and health science department of nursing disseminated to Gurage zone hospitals as partial fulfillment of the Bachelor of Science degree of nursing copies of this study was sent to Wolkite health center. It also being disseminated through publication on local or international journals and presentation on scientific conference.

CHAPTER 5-

RESULT

5.1 Socio demographic characteristics of respondents

Out of 124 sampled nurses, all returned the questionnaire and to complete information making the response rate 100%.among a total of nurses who participated in this study,66(53.2%) were male. Of the total respondents, most of them 74(59.9%) fall within the range of 20-30 years age group. The rest 38(30.5%), were aged 31-40, Most of them were married 68(54.8%). Majority of nurses 87(70.2%) had a degree. about 73(66.8%) respondents had work experience less than five year. Almost half 82(66.2%) of respondents were working in the inpatient department.

5.2 practice of nursing documentation

Table 1 -practice of respondents among nurses working in selected hospitals of Gurage zone, Ethiopia, 2022

variable	Category	frequency	percentage
Nursing documentation for every patient	Never	11	8.9%
	Some times	59	47.6%
	Always	54	43.5%
Time preference to document a care	I don`t know	15	12.1%
	At the end of shift hour	31	25.0%
	Any time when convenient	27	21.8%
	Immediately or soon after care rendered	51	41.1%
Ways to keep confidentiality of record	I don't know	26	21.0%
	Protect computer password	22	17.7%
	Obtain informed consent	37	29.8%
	Confidentiality after death	15	12.1%
	Access for authorized ones only	24	19.4%
Read colleagues notes	No	40	32.7%
	Yes	84	67.7%
Colleagues note full fill standards	No	53	42.7%
	Yes	71	57.3%
Documents education or advice	Never	19	15.3%
	Some times	61	49.2%
	Always	44	35.5%
Report any medical error voluntarily	No	40	32.3%
	Yes	84	67.7%
Use computerized system	No	67	54.0%

	Yes	57	46.0%
Ways of error recording	No words like "error" or "mistakes	59	47.6%
	I don't know	17	13.7%
	Facts only	48	38.7%
Documents patient response to care	No	39	31.5%
	Yes	85	68.5%
In what way you chose nursing profession	Family orientation	43	34.7%
	Accidentally	49	39.5%
	Others	5	4.0%
	willingly	27	21.8%
You satisfaction with studying in the nursing department	Not satisfied	39	31.5%
	Partially satisfied	33	26.6%
	Satisfied	52	41.9%
Feeling competent in understanding the individuals receiving services	Rarely	25	20.2%
	Some times	50	40.3%
	Always	49	39.5%

Table 2 -level of nursing documentation practice among nurses working in selected hospitals of Gurage zone, Ethiopia, 2022

Variable	Frequency	percentage
Poor practice	66	53.2%
Good practice	58	46.8%

5.4 knowledge of nursing documentation

Table 3- knowledge characteristics of study participants at selected hospital found at Gurage zone, 2022

Variables	category	frequency	Percentage
Do you know documentation of patients care is part of professional responsibilities?	No yes	27 97	21.8% 78.2%
Does complete documentation is a principle needed to be followed while documenting?	No yes	44 80	35.5% 64.5%
Does easily readable nursing documentation is principle needed to be followed while documenting?	No yes	40 84	32.3% 67.7%
Do you know error-free nursing documentation is a principle needed to be followed while documenting?	No yes	44 80	35.5% 67.7%
Does improve the quality of care is an advantage of patient care documentation?	No yes	32 97	25.8% 74.2%
Do you know patient care documentation is important for better communication with health care staff?	No yes	37 87	29.8% 70.2%
Does legal protection is an advantage of patient care documentation?	No yes	40 84	32.3% 67.7%
Do you know the progress of patients condition is the main nursing activity?	No yes	53 87	42.7% 57.3%
Does discharge of patients are the main nursing activity?	No Yes	70 54	56.5% 43.5%
Does inadequate documentation have a potential consequence for the poor development of nursing profession?	No Yes	37 87	29.8% 70.2%
Does recording only what you saw is important to protect you from legal suit?	No Yes	65 59	52.4% 47.6%
Do you know that frequent documentation can protect you from legal suit?	No Yes	38 86	30.6% 69.4%

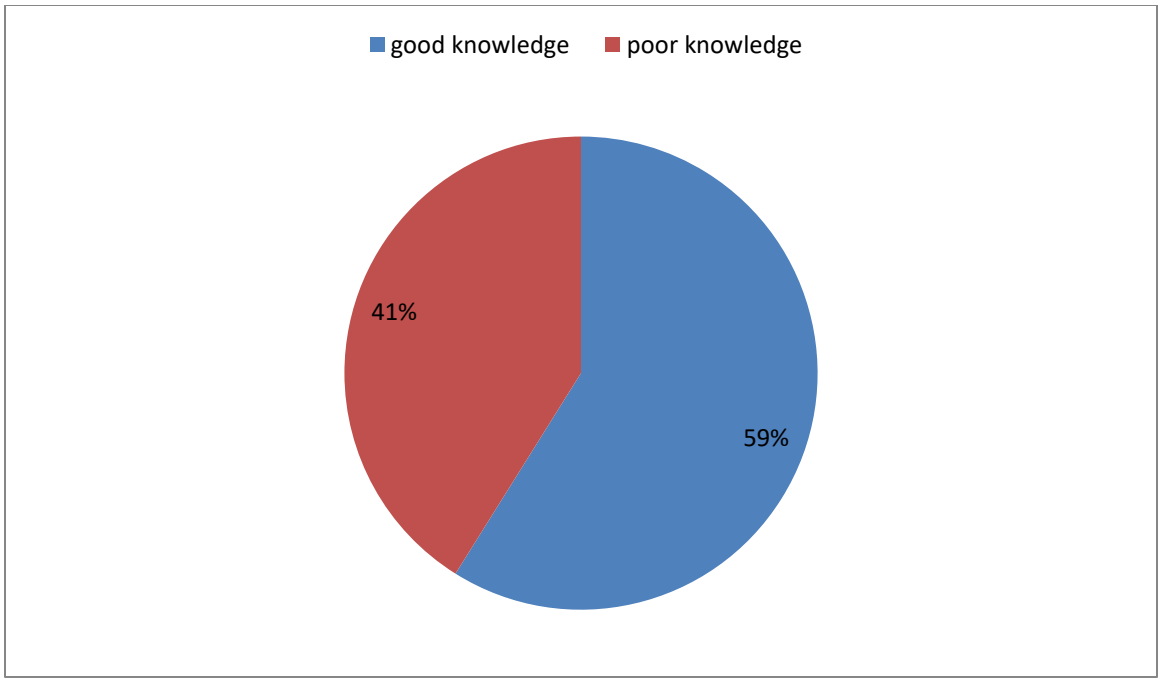


Figure 2 -Level of knowledge among nurses working at selected hospitals found in Gurage zone, 2022

5.5 Attitude of respondents about nursing documentation practice

Table 4- Attitude characteristics among selected nurses working in Gurage zone, Ethiopia, 2022

Variables	Strongly agree	agree	Neutral	Disagree	Strongly disagree
Nursing documentation has an advantage in daily work?	50 (40.3%)	51 (41.1%)	2 (1.6%)	6 (4.8%)	15 (12.1%)
Proper documentation has a positive impact on patient safety?	61 (49.2%)	34 (27.4%)	5 (4.0)	10 (8.1%)	14 (11.3%)
Although challenges are known to exist ,I am expected to do complete and accurate documentation?	37 (29.8%)	42 (33.9%)	19 (15.3%)	14 (11.3%)	12 (9.7%)
A well written report can replace an oral shift report?	37 (29.8%)	41 (33.1%)	19 (15.3%)	10 (8.1%)	17 (13.7%)
Nursing notes are meaningful and give you legal protection?	37 (29.8%)	43 (34.7%)	19 (15.3%)	8 (6.5%)	17 (13.7%)
Quality documentation of nursing care can add value to my hospital?	43 (34.7%)	47 (36.3%)	15 (12.1%)	8 (6.5%)	13 (10.5%)
Nurses have sufficient knowledge of the documentation procedure?	25 (20.2%)	48 (38.7%)	21 (16.9%)	18 (14.5%)	12 (9.7%)
Nursing admission assessment should be completed within 1 hour?	31 (25.0%)	46 (37.1%)	14 (11.3%)	17 (13.7%)	16 (12.9%)
Patient's participants in care planning to improve the quality of care?	63 (50.8%)	42 (33.9%)	4 (3.2%)	4 (3.2%)	11 (8.9%)

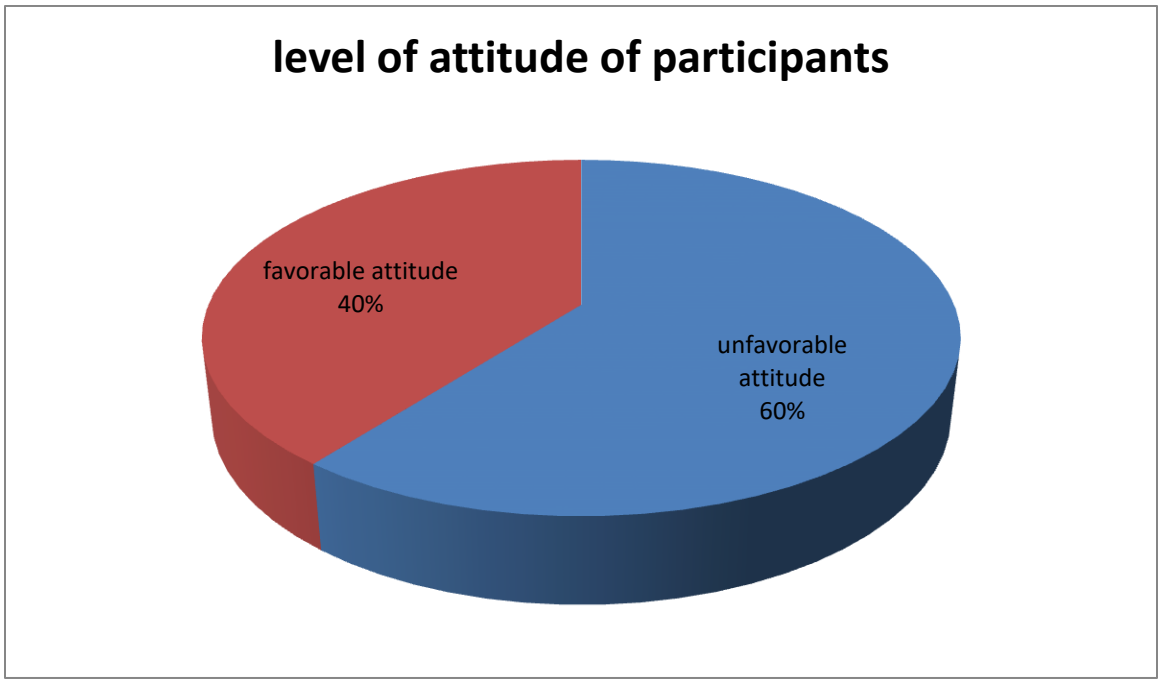


Figure 3 Attitude level of respondents working in selected hospitals among nurses at Gurage zone, 2022

Chapter 6

DISCUSSIONS

Poor documentation in nurses has been shown to have negative impact on the health of patients various studies have shown that documentation problem is still a critical issues in both developed and under developed countries, especially in sub Saharan Africa including Ethiopia.

The present study knowledge of nursing documentation practice in this study most of the study participants know about nursing documentation (58.9%). [CI 95% : (57.6-60.1)which is in line with study conducted in Zambia(60%),0000 Our study greater than study conducted in Addis Ababa public hospital 50%.the difference might be due to sample size. On the other hand lower than study finding from (82.7%). These discrepancies might be related to the difference in the countries socio demographic factors for nurses and organizational facilities that facilities that facilitate nursing documentation.

The result of this study showed that good nursing care documentation was practiced by 58(46.8%).[CI 95%:44.4-47.8)] This finding almost similar to Addis Ababa(47.8%)(33) Debre Behan(47.7%)(27), On the other hand it is higher than findings in Tigray(37.4%(26). The difference might be due to sample size. on the other hand it is less than findings from Nigeria(70%)(29) Jamaica(98%), Jimma(51.4%(25).(19)the difference might be educational difference

The finding of this study indicated that 39.5% [CI:37.6-41.3)] of nurses had favorable attitude towards nursing documentation. These finding were in line with study conducted on tigray.(37.6%) On the other hand less than other studies conducted in Ghana (84.2%) (24) and Addis Ababa 55.7% (33). The possible reason for having different attitude level might be due to carelessness.

Chapter 7

CONCLUSION AND RECOMENDATION

7.1 Conclusion

Studies revealed that knowledge, attitude, practice of nursing documentation. The finding from this research showed that majority of study participants 58.9% good knowledge. On the other hand good nursing documentation practice was 46.8%. On the other hand study participants were poor attitude towards nursing documentation 59.5%

7.2 Recommendation

Based on the finding of this study, employing institutions need to create awareness and provide training to enhance knowledge, attitude and practice of the nurses regarding documentation. Nursing leaders should motivate the employees to enhance the practice of documentation, avail the necessary documenting materials besides adequate staffing which may be related to time shortage. Researchers also need to carry out large scale studies in order to address the problem.

7.3 Limitation

Since this study is based on self-reported data, most of the variables might have been exposed for social desirability bias.

No adequate literatures were found on similar topic especially in Gurage zone, making it difficult for comparison.

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Annex

Annex: Questioner

Wolkite University College of medicine and health sciences

Department of Nursing

Informed consent

Hello. My name is_____ . I am the representative data collector student of Wolkite University who is conducting a survey on knowledge attitude and practice of nursing documentation among nurses working in Gurage zone selected hospitals. The main objective of the survey is to asses knowledge attitude and practice of nursing documentation at Gurage zone 2022.

Therefore, your honest and genuine participation and responses to the questions will help in guiding the framing of intervention strategies towards improving nursing care documentation practice.

Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you provide. However, your honest responses to these questions will help us better understand the level of knowledge, attitude and practice nursing care documentation at Gurage zone and the factors that affect it. We would greatly appreciate your help in responding to this survey.

Are you be willing to participate?

Yes _____

No _____

Make a "✓ "mark in your choice box.

Please fill the blank space accordingly for open ended questions

Part i socio- demographic related questions

No	Statements	Alternative response	

			Remark
1	Sex	1. Male 2. Female	
2.	Age	…….in years	
3.	Marital status	1. Single 2. Married 3. Divorced 4. Widowed	
4.	Education level	1. Diploma 2. Degree 3. MSC	
5.	Work experience	……. In years	
6.	Work setting	1.medical ward 2.Surgical ward 3. pediatric ward 4. intensive care unit 5. regular OPD 6.Emergency OPD 7.pediatric OPD 8. OR	
7.	Monthly income	…… ETB	

Part ii organizational related variable questions

1	Availability of operational standard for nursing care documentation	1.Yes 2.No	
2.	In –service training	1.Yes 2.No	

3	Availability of nursing care plan sheet	1.Yes 2.No	
4	Average number of patient seen by one nurse	……per a day	
5	Reason for not documenting all nursing care provided to patient	1.inadequate documenting sheets 2.un familiarity with standard of nursing documentation 3.lack of skill 4.inadequate staff 5. lack of time 6.no obligation from the hospital 7. no motivation from supervisor 8.un satisfied monthly salary	

Part iii practice of nursing documentation questions

1.	Nursing documentation for every patient	1.Never 2.Some times 3.Always	
2	Time preference to document a care	1.I don't know 2.at the end of shift hour 3.Immediately or soon after care rendered 4.Any time when convenient	
3	Ways to keep confidentiality of record	1.Access for authorized ones only 2.protect computer pass words 3.Obtain informed consent 4.Confidentiality after death 5.I don't know	
4	Read colleague's notes	1.Yes 2.No	
5	Colleagues note full fill standards	1.Yes 2.No	
6	Documents education or advice	1.Never 2.Some times 3.Always	
7	Report any medical error voluntarily	1.Yes 2.No	
8	Uses computerized documentation system	1.Yes 2.No	
9	Way of error recording	1.No words like'' error'' or "mistake'' 2.Facts only 3.I don't know	
10	Documents patient response to care	1.Yes 2.No	

11	In what way you choose nursing profession	1.willingly 2.family orientation 3.Accedentialy 4.Others	
12	You satisfaction with studying in the nursing department	1.Not satisfied 2.Satisfied 3.Partially satisfied	
13.	Feeling competent in understanding the individuals receiving services	1.Rarely 2.Some times 3.Always	

Part iv knowledge related questions

	Statements	Alternative response	Remark
1.	Do you know documentation of patients care is a part of professional responsibilities?	1.No 2.Yes	
2.	Does complete documentation is a principle needed to be followed while documenting?	1.No 2.Yes	
3.	Does easily readable nursing documentation is a principle needed to be followed while documenting?	1.No 2. Yes	
4.	Do you know error –free nursing documentation is a principle needed to be followed while documenting?	1.No 2.Yes	

5.	Does improve the quality of care is an advantage of patient care documentation?	1.No 2. Yes	
6.	Do you know patient care documentation is important for batter communication with health care staff?	1.No 2Yes	
7.	Does legal protection is an advantage of patient care documentation?	1.No 2.Yes	
8..	Do you know the progress of patients condition is the main nursing activity?	1.No 2.Yes	
9	Does discharge of patients are the main nursing activity?	1.No 2.Yes	
10.	Does inadequate documentation have a potential consequence for the poor development of the nursing profession?	1.No 2.Yes	
11.	Does recording only what you saw is important to protect you from legal suit?	1.No 2.Yes	
12.	Do you know that frequent documentation can protect you from legal suit?	1.No 2. Yes	

Part v Attitude related questions

S.NO	Statement	Strongly Dis agree	Disagree	neutral	agree	Strongly agree
1.	Nursing documentation has an advantage in daily work?					
2.	Proper documentation has a positive impact on patient safety?					

3.	Although challenges are known to exist, I am expected to do complete and accurate documentation?					
4.	A well-written report can replace an oral shift report?					
5.	Nursing notes are meaningful and give you legal protection?					
6.	Quality documentation of nursing care can add value to my hospital?					
7.	Nurses have sufficient knowledge of the documentation procedure?					
8.	Nursing admission assessment should be completed within 1 hour?					
9.	Patients participants in care planning to improve the quality the quality of care?					