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COLLEGE OF MEDICINE AND HEALTH SCIENCE

DEPARTMENT OF PUBLIC HEALTH

NURSING DOCUMENTATION KNOWLEDGE, ATTITUDE AND PRACTICE, AMONG NURSES WORKING IN WOLKITE UNIVERSITY SEPCIALIZED HOSPITAL, CENTRAL ETHIOPIA, ETHIOPIA.

A THESIS REPORT SUBMITTED TO DEPARTMENT OF PUBLIC HEALTH, COLLEGE OF MEDICINE AND HEALTH SCIENCE, WOLKITE UNIVERSITY FOR PARTIAL FULFILLEMENT OF REQUIREMENT FOR THE DEGREE DOCTOR OF MEDICINE.

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APPROVAL

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LIST OF ABBREVIATION

BSC: Bachelor of Science

EHSTG: Ethiopian Hospital Services Transformation Guidelines.

FMOH: Federal Ministry of Health.

CCD: Centralized Clearance Department

WUSH: Wolkite University Specialized Hospital

HMIS: Health Management Information System.

MPH: Master of public health.

MSC: Master of Science.

OPD: Out-Patient Department.

HSM: Health Service Management

SPSS: Statistical Package for Social Sciences.

WHO: World Health Organization

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ABSTRACT

Background: Nursing documentation is an essential component of nursing practice that has a Potential to improve patient care outcomes. Poor documentation of nursing care activities among Nurses have been shown to have negative impacts on the health care quality. Interestingly, despite the immense clinical relevance, to date, no studies were evaluated nursing documentation practice in WUSH, Central Ethiopia. Therefore, the current study aimed to determine nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia.

Objective: The study conducted to assess nursing documentation knowledge, attitude and practice among nurses who are working at WUSH, Central Ethiopia, Ethiopia**.**

Method: Institutional based cross-sectional study was conducted at WUSH. The estimated sample size was 111. The number of samples in each ward was selected according to proportional allocation formula. A simple random sampling technique was used to select nurses, who have been working at WUSH were participated. Data was collected by using structured pre-tested self-administered questionnaires and patient cards were reviewed during the study period. Data was entered Epi Data 4.6 and analysis was conducted by using SPSS version 27.0. The results presented in the form of figures, tables, and texts.

Result: In current study the proportion of good documentation practice is 47%, knowledge toward nursing documentation is 30% and proportion of favorable attitude is 66%.

Conclusion and Recommendation: Nursing documentation practice was poor among nurses under the study. Knowledge towards nursing documentation was also poor among nurses under study. Nurses under study had favorable attitude (66%) towards nursing documentation practice. Updating nurse's knowledge and creating awareness regarding documentation guidelines can contribute to improving documentation practice,

Key words: Knowledge, Attitude, Documentation practice,

1. Introduction

1.1 Background

Documentation is a formal way of recording the account of what happened and when it happened [1]. Medical Documentation is any paper or electronically produced medical or health related information about patients that clarifies the care or service provided to that particular patient [1]. Nursing documentation is the record of nursing care prepared and provided to individual patients by registered nurses or other caregivers under the supervision of professional nurses [2]. It is a crucial part of the nursing process as it the essential way of communication within the health care team regarding patient care [3, 4]. It is a vital component of safe, ethics, and effective whether done manually or electronically. It is essential for early recognition of patients' deteriorating condition followed by effective communication and response by members of the multidisciplinary care team leads to decreased hospital mortality [5]. Nurses should document what they see, not what they think [5, 6].

Nursing documentation that is accurate and complete has been accepted as a very important feature of professional practice to nurses since the Florence Nightingale era. As written in her book, "Notes on nursing: What it is and what it is not", she stated the importance of recording patients' progress in words for communication among nurses and the importance of reporting patient-related observation accurately [6].

In developed countries, technology is rapidly gaining prominence as the model for health information services and electronic health record (EHR) is becoming the standard. A Health Canada Info way study conducted by the Canadian Nurses Protective Society (CNPS) approximated that 75% of nurses use information technology in practice and 50% use a combination of paper-based and electronic documentation [6].

In a study conducted in Ghana, showed that 46% of care given to patients was not recorded in the nursing care records; that nurses' progress notes were not written for 63% of patients after the first day of admission, and that 57% of documentation was not signed by nurses [7].

The study conducted in Jimma Ethiopia, showed that 48.6% of nurses have good nursing documentation practice [8].

Another study conducted in Ghana on nursing documentation of inpatient care found that time constraints, discrepancies between staffing resources and workload, lack of clear guidelines for completing documentation, uncertainty towards documentation, and institutional policies and bureaucracies were often associated with keeping accurate documentation [7].

A study conducted in Ethiopia showed that more than half of the participants (58.3%) had a good knowledge of nursing care documentation and nurses who had a good knowledge of nursing care documentation were 2.16 times more likely to have good nursing care documentation practice as compared to those with poor nursing care documentation knowledge [1].

According to a study conducted in Gondar (Ethiopia), majority of the respondents (60.7%) had a positive attitude towards nursing care documentation. Compared to nurses who had poor attitude towards nursing care documentation, those who had good attitude were 2.22 times more likely to have good documentation practice [1].

In Ethiopia, nursing communication is mostly limited to handwritten in most health settings even though an electronic method called health management information system (HMIS) has been rolled out across different hospitals [6]. Based on observation, there are limited critical reflections on the nature and outcomes of nursing care for the patients. Even though the quality and effectiveness of nursing practice are mostly demonstrated by documenting the application of the nursing process [6]. Therefore, the purpose of this research is to assess nursing documentation practice, knowledge and attitude among nurses working in WUSH, Central Ethiopia, and Ethiopia.

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, and how to document is vital to fill the gaps [1]. The quality of patient care depends on the caregiver's ability

to have an accurate, effective, and timely exchange of oral or written information and feeling with patients and colleagues. Even though there is no way to prove care was provided without completed documentation [9].

According to a survey done by WHO, it has been shown that poor communication between health care professionals is one factor for medical errors [2]. As many studies indicated globally most of the nurse's actions are either not documented or not properly documented [2, 10-12].

Poor documentation in nurses has been shown to have negative impacts on the healthcare of patients, the health care providers, on the profession, associated with the problem of omitting medications, and the risk of legal harm become high [1, 6, 14]. Inadequate documentation is one of the most serious situations that could involve severe injury or death of a client [15].The impact may lead to harmful consequences like exposing the care provider for medication administration error [6]. A study done in Felge Hiwot referral hospital revealed that about 87.5% of medication administration errors were due to nursing documentation errors [16].

Ineffective documentation causes clinical mishaps and crucial issues in many malpractice cases [17] and it continues to be cited as a major cause of adverse events for patients [18]. Poor nursing documentation can place patients, staffs as well as organizations at considerable risk of physical and legal harm [19]. It can negatively affect the effectiveness, quality, and visibility of nursing work [17]. 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 [8].

Documentation is the tip of an iceberg of patient care issues that could expose care provide to medico-legal suits and other forms of disciplinary action [19]. So let down to document appropriately creates a great problem when it came to the evaluation of client care [9] and is a key factor in miscommunication among nurses and physicians, delayed, repeated or omitted care that will preventable, a medical error which may potentially affect patient outcomes [19].

Several studies showed that the act of nursing documentation remains challenging due to lack of training resources, comprehensive nursing education, time, high patient-to-nurse ratio, poor knowledge, attitude, and lack of support from nursing leadership [1, 6, 11, 19].

As per the review of available literature, there is paucity of information about nursing documentation knowledge, attitude and practice in our study area.

Therefore, this study provides additional baseline evidence that helps to plan intervention programs for poor nursing documentation practice.

1.3 Significance of the study

Documentation is not independent and not optional from treatment. Documentation quality is necessary to improve efficiency, individual client care. Poor nursing documentation practice can be a significant challenge for giving of quality health care. Nurses are required to maintain reliable and complete records of patient care not only to monitor client progress but also to safeguard themselves 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. So, emphasizing nursing documentation will protect legal implication of documentation and assist nurses in the provision of safe, ethical, and effective care.

In addition to the above reason, the problem studies conducted across the country are not adequate and no research is conducted in the study area. Therefore, a finding of the study would be important for policymakers including managers of the hospital to enable them to design evidence-based practice and important sources for further studies. The finding of the study also add value for nurses toward improving knowledge about nursing documentation based on available resources of the hospital, find means of uplifting standards of nursing documentation, and make the nurses realize the benefits of documentation in their daily practice. Also, it increases patient safety and enhances the quality of nursing.

2. Literature review

Review of available literature about nursing documentation knowledge, attitude, and practice. Despite the importance of nursing care documentation, available evidence showed limitations in its practice [1].

The low KAP of nursing care documentation by nurses have adverse effects on patients' health care, healthcare workers and are associated with the issue such as inappropriate or double medication management and absence of medications, [1].

2.1 Nursing documentation practice

Nursing documentation is one of the medical records that are written by nurses and it helps to communicate their observation, decision, intervention, and outcome of the intervention for the patient. Although nursing documentation can be practiced either through a written or electronic method, a study indicated that an electronic system has a better health care outcome as compared to a paper-based system [20].

A 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 [21].

In a study conducted in Canada on nursing documentation in the long-term care setting the maximum proportion of symptoms documented in nursing notes is 53.5% [22]. Besides, a study conducted among nurses in the Papuan province of Indonesia reported that a documentation practice level is 37% [23].

Another study conducted in eastern Ghana on nursing documentation of inpatient care indicated that all nursing care given to the patient was recorded is 54.2 % and 46 % of care given to patients was not recorded [7].

A study showed in Nigeria, good Nursing documentation was practiced by 70%, and the Majority of respondent's 96.7% document anytime a case is rendered, 3.3% documents 3-4 times in a shift, 88% of respondents document by going to the patient s bed, 84.8% by sitting at nurse's station and reading what they have written to make corrections respectively and 7.4% check the previous information and formulate theirs [9].

According to a study conducted in Gondar, Ethiopia indicated that slightly more than one-third (37.4%) had good nursing care documentation practice [1]. According to a study conducted in Ethiopia's Central and North Gondar zones public hospitals the nursing care documentation practice of nurses was poor through chart review compared to the health sector transformation in

quality standards. In this study, only 30.4% (95% CI: 25.7%–35.3%) of nurses have good nursing care documentation practice. A study conducted in Harare regional state and Dire Dewa administration eastern Ethiopia 47.5% of nurses were found to have good nursing documentation practice whereas out of 421 reviewed medical records good nursing documentation was found to practice on 38.5% of them [19].

Similar studies conducted to Tigray, Jimma and Gojjam Ethiopia, indicated that 47.8%, 48.6% and 47.5% of nurses have good nursing documentation practice respectively [2, 8, 14].

2.2 knowledge of nursing documentation.

Nurses' knowledge and understanding of documentation principles significantly influence the quality and accuracy of nursing documentation. Adequate education and training programs empower nurses with the skills necessary to document effectively, including proper use of terminology, charting guidelines, and legal requirement. Continuous professional development and competency assessments are essential to address knowledge gaps and ensure adherence to best practices in documentation [10].

A quantitative study done in Iraq showed a moderate level of knowledge regarding what must be documented (59%); how to document (38%); who should document (60%) and when to document (67%) whereas, none of items had got high level of knowledge. Regarding the purposes of documentation, 71% of them said it is helpful for communication and continuity of care; 67% of them said for professional accountability; 50% said for legal interest and 100% of them said it is useful for quality improvement of patient care and for funding. Study conducted in Ethiopia showed that more than half of the participants (58.3%) had a good knowledge of nursing documentation [1].

In a study conducted in West Gojjam Zone public hospitals in Ethiopia, it was found that approximately 54.6% of respondents exhibited good knowledge regarding nursing care documentation [14]. Notably, 85.4% acknowledged the importance of documenting nursing care according to guidelines, with 40.2% acquiring this knowledge from hospital management. Moreover, 91.7% of respondents were aware of the potential consequences of inadequate documentation.

Another study in Ethiopia revealed that 43% of participants demonstrated good knowledge of nursing care documentation. Among the findings, 59% recognized the importance of adhering to documentation guidelines, 67.8% understood the principle of completeness in documentation, and 76.8% acknowledged the role of documentation in enhancing the quality of care. Additionally, awareness was noted regarding the necessity of documenting patient assessment data (65.4%) and the consequences of poor documentation on the nursing profession (57.1%) [33].

2.3 Attitudes of nurses towards nursing documentation.

According to a study conducted in Indonesia, only 48.1% of nurses had favorable attitude [23]. A study done in Nigeria showed that all respondents (100%) think it is important to document nurses‟ care and 45.8% of the respondents liked documenting because it ensures continuity of care, 21.7% because it serves as a legal backup and 1.5% because it helps to detect problem [26]. In another study conducted in South Africa, a predominantly positive self-reported attitude was evident towards record keeping (71.7%) [28].

According to a study conducted in Gondar (Ethiopia), majority of the respondents (60.7%) had a favorable attitude towards nursing care documentation [1].

In a study done in Gojjam (Ethiopia), over half (53.8%) of the participants strongly agreed on the equal importance of nursing care documentation compared to other patient documentation. However, only 42.5% agreed with the importance of nursing care documentation to other healthcare providers [14].

Another study done at Hawassa (Ethiopia) found that 58.8% of respondents exhibited a favorable attitude towards nursing care documentation in Ethiopia. Many respondents strongly agreed on various aspects, including the positive impact of nursing documentation on patient safety (55%) and its equal importance to other patient documentation (51.3%). However, a small percentage disagreed with certain aspects related to documentation's visibility of nurses' work and its benefits [33]. In study done at Amhara region, Ethiopia shows 50.8% (95% CI: 45.6% to 56.0%) of the study participants had a favorable attitude toward nursing care documentation [32].

3. Objective of the study

3.1 General objective

- To assess Nursing documentation knowledge, attitude and practice among nurses who are working, WUSH, central Ethiopia 2024.

3.2. Specific objectives

- To assess the knowledge towards nursing documentation, among nurses who are working in WUSH, Central Ethiopia, Ethiopia, 2024
- To assess the attitude towards nursing documentation, among nurses who are working in WUSH, Central Ethiopia, Ethiopia, 2024.
- To assess the practice of nursing documentation among nurses who are working in WUSH, Central Ethiopia, Ethiopia, 2024.

4. Method

4.1. Study area and period

The study was conducted in WUSH. It is a referral hospital located in Gubre sub city, Wolkite ,Gurage zone. Its city Administration is Wolkite town which is located 158 km far from Addis Ababa and Gubre sub city is located at about 12 km away from Wolkite town in South West direction. Based on the 2007 census conducted by the Central Statistical Agency of Ethiopia (CSA), Gurage has a total population of 1,280,483.Gurage Zone is bordered at the southwest by the Hadiya and Yem zone, on the northwest by Kebena special woreda, on the northeast by Oromia Region on south east by Silte. According to the statistics obtained from Wolkite's Town Municipality, the population was 70,796 out of which 35, 848 were males and 34,948 females. Wolkite university specialized teaching hospital (WUSTH) was established on Hamile 29 2011EC. This hospital provided full health care service for population Gurage zone and its surrounding in Oromia region such as silk amba and keta wayu as their primary catchment areas. The total number of staff of the hospital was 406 including 11 surgeon, 5 gynecologist-obstetrician, 9 internist, 8 pediatricians, 59 residents, 23 general practitioners, 10 health officers, 9 anesthetists, 1 dentist, 2 psychiatrist, 2 ophthalmologist, 2 radiologist, 1 pathologist, 138 nurses, 25 laboratory technologists, and 24 pharmacists. The study was conducted from November 18, 2024, to December 06, 2024.

4.2. Study Design

Institutional based cross-sectional study**.**

4.3. Population.

4.3.1. Source population

For nurses: All staff nurses working in WUSH.

For document: All patient records from (medical, surgical, gyn/obs, pediatrics, ophthalmology psychiatry and OPD) units or wards during the study period.

4.3.2. Study population

For nurses: Selected staff nurses of WUSH.

For document: selected patient records from (medical, surgical, gyn/obs, pediatrics, ophthalmology, psychiatry and OPD) units or wards.

4.3.3 Study unit

The study unit will be selected nurses who are working in WUSH.

4.4 Eligibility criteria.

4.4.1. Inclusion criteria

Nurses working in the inpatient wards and out-patient departments of WUSH with work experience of at least 6 months and Nurses who provide free service for more than 6 months in the hospital will be included because in Ethiopia newly employed nurses (till 6 months) cannot be allowed to perform their duty alone and have no full responsibility.

4.4.2 Exclusion criteria.

Nurses who were on annual leave, maternity leave, unable to participate in the study due to illness and those who are on education at the time of data collection were excluded.

4.5 Sample size determination

The sample size (n) required for the study will be calculated using the formula to estimate a single population proportion.

$$n = \frac{[(Za/2)^2 P (1-P)]}{d^2}$$

Where

Assumption; with assumption of 95 % confidence interval 5% desired precision

n = is the required sample size.

N=total number of nurses in WUSH

Za/2= critical value for normal distribution at 95 % confidence level which is equal to 1.96.

(Z value at alpha =0.05.).

P = 0.304 established prevalence of nursing documentation practice from previous study 30.4% [19].

d = 0.05 an absolute precision.

$$n = \frac{(1.96)\,(1.96)\,(0.304)\,(0.696)}{(0.05)2} = 325.$$

Since our sample size is less than 10,000

n=no/(1+(no/N))

n=325/(1+325/138)=97

10% non-response rate added 97+(97x0.1)=108

P=0.583 knowledge of nursing care documentation from previous study is 58.3% [1].

$$n = \frac{(1.96)(1.96)(0.583)(0.417).}{(0.05)2} = 374$$

n=374/ (1+374/138) = 101

n=101+10.1 =111

P=0.607 favorable attitude toward nursing documentation from previous study was 60.7% [1].

$$n = \frac{(1.96)(1.96)(0.393)(0.607).}{(0.05)2} = 367$$

n=367/(1+367/138) =100

n=100+10 =110

We used the largest sample size which is 111

4.6 Sampling procedure

List of all nurses working in the out-patient departments, as well as in-patient wards, was obtained from the nursing leaders of the Hospital, then number of samples in each ward was selected according to proportional allocation formula as follows: (n f x n) /N or (Sample final × number of nurses in each ward)/number of total nurses, Where N=138.Simple random sampling technique was used to select nurses from sampling frame (lists with serial number) received from

nursing leaders or matrons. In addition, document review (patient chart) was conducted by using nursing care standard checklist which adopted from FMOH (40).

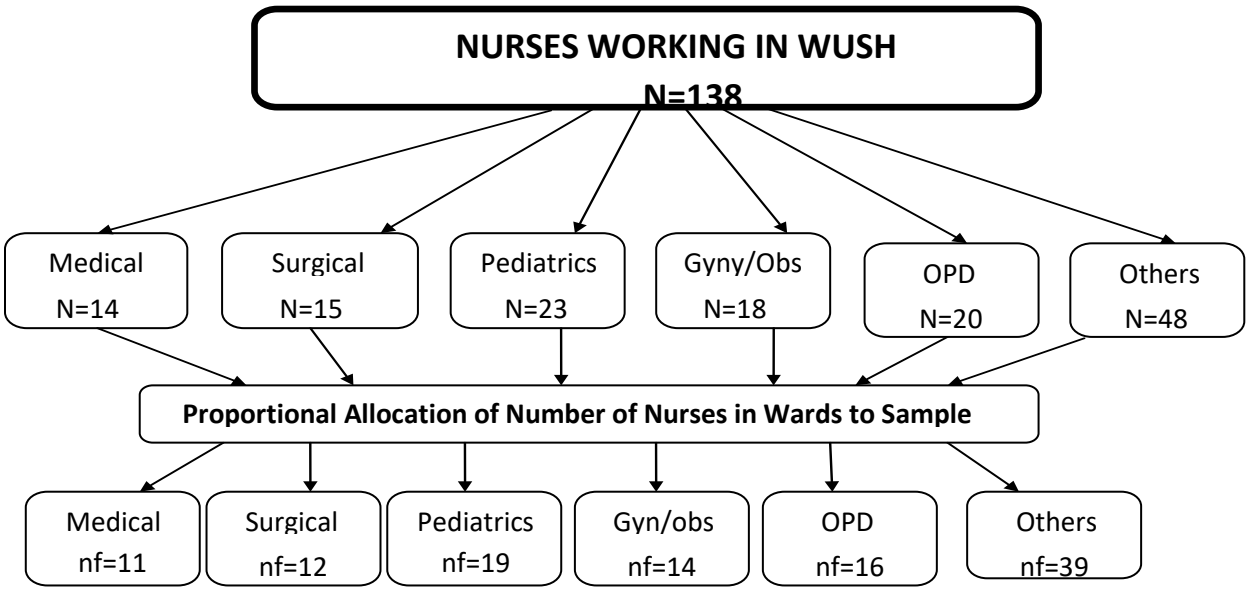

Figure 1: Schematic presentation of the sampling procedure used in the study KAP of nursing documentation, Gurage zone, Central Ethiopia, Ethiopia 2024.

4.7 Study variable

- Documentation practice
- **Socio-demographic variable**
  - ✓ Age.
  - ✓ Sex.
  - ✓ Educational status.
  - ✓ Year of experience.
  - ✓ Marital status.
  - ✓ Salary.
- **Organizational variable**
  - Inadequate staff.
  - Lack of time.
  - Fatigue.
  - Familiarity with an operational definition.
  - Motivation from supervision.
  - In-service training.
  - Promotion.
  - Availability of documenting materials.
  - Working setting.
  - Lack of continuous monitoring and evaluation.
- Knowledge towards nursing documentation.
- Attitude towards nursing documentation.

4.8. Data collection tool and procedure

Data was collected using a structured and pre-tested self-administered English version questionnaire which was developed from previous similar studies [1, 2, 6, 8, 19]. The questionnaire comprises five sections: (1) Questions regarding socio-demographic background of participants; (2) questions assessing about organizational factors (3); Questions regarding the practice of nurses on documentation (4); Questions concerning about knowledge of nurses on documentation and (5) Questions assessing the attitude of respondents towards nursing documentation. The purpose of the study was clearly being explained to the participants and their consent was obtained before data collection. Data was acquired from nurses working in

the inpatient admission wards and out-patient departments by using a structured self-administered questionnaire prepared in the English language. To minimize the non-response rate, questions was kept as short and clear as possible, avoid leading questions, avoid or break down difficult concepts.

4.9. Operational definition

- **Nursing documentation: -** is a clinical record written by nurses and the total written information concerning a patient's health status, nursing needs, nursing care, and response to nursing care.
- That includes assessments, nursing diagnosis, planned care, nursing interventions, patient teaching, patient outcome, and interdisciplinary communication [1].

- **Good knowledge: -** refers to respondents with individual knowledge scores of mean and above [2, 6]. 10 questions were used to asses knowledge.
- **Poor knowledge: -** refers to respondents with individual knowledge scores below the mean score [6].
- **Good Practice**: Refers to those study participants who scored to practice questions above or equal to the mean value [2, 14]. 11 questions were used to asses practice.
- **Poor Practice**: Refers to those study participants who scored to practice question below mean value [2, 14].
- **Favorable Attitude**: Refers to those study participants who scored greater than or equal to the mean of attitude questions [2]. 9 questions were used to asses attitude.
- **Unfavorable Attitude**: Refers to those study participants who scored less than the mean of attitude questions [14]
- **Familiarity with operational standard:** Those respondents who knew the availability of an operational standard regarding nursing documentation in their hospital [6].
- **Unfamiliarity with operational standard**: Those respondents who did not know the availability of operational standard regarding nursing documentation in their hospital [6].

4.10. Data quality assurance.

To keep the quality of data structured questioners standardize individual nursing documentation practice by Ethiopian hospital service transformation guideline (EHSTG) tool was used [31]. Before data collection, all of the data collectors had a similar concept on the questionnaire.

After data collection, the collected data was checked for completeness and correctness of the information by team members and supervisors before data entry into the software and each the questionnaire which was decided to be entered into the software for analysis and properly coded before analysis. During analysis, data was cleaned carefully; incomplete questionnaires and missing values during data collection was handled not to be excluded in the analysis by double-checking during the data analysis.

4.11. Data processing and analysis

Data were coded, entered into Epi Data version 4.6, and then exported to Statistical Package for Social Sciences (SPSS) version 27 after being thoroughly checked for completeness. After data had been cleaned, descriptive statistics such as frequency, percentage, and mean were used to analyze the data. Variables was computed and recoded through the transform function of SPSS. Again transform function of SPSS was used to dichotomize the recoded variables. Summary measures, tables, and figures were used to present the processed information.

4.12. Ethical Consideration

The study was conducted after obtaining permission from Wolkite University College of Medicine and Health Sciences Department of Public Health. A formal letter, from the college of medicine and health sciences of Wolkite University, was submitted to the hospital administration to obtain their co-operation. The respondents' rights and dignity was also respected. Informed oral consent was obtained from the study participant to confirm willingness for participation after explaining the objective of the study. The respondents were notified that they have the right to refuse to fill the questionary. The information provided by each respondent was kept confidential throughout the research process.

4.13. Dissemination of result

The finding of this study will be presented to Wolkite University, the College of health science, department of public health. It will be present on seminar.

5. Result

5.1 Socio-demographic characteristics of result

Out of the 111 sampled nurses, all returned the questionnaire information making the response rate 100%. From 111 nurses who participated in this study, 59 (53.2%) were females and mainly 61(55%) fall within the ranges of 25-29 years age group. Most of them were single 59(43.2%). Most of the respondents were holding bachelor degree 109(98.2%). 55 % (61) of the study participants worked as a nurse for 5 years or less. Also 18% (20) of the respondents were working in pediatric followed by OPD 14.4%% (16) department in the hospital during the study period (See table 1 below).

Table 1 Socio demographic characteristics of nurses working in WUSH, Central Ethiopia, Ethiopia, 2024

Variables		N	%
Age group	20-24	17	15.3
	25-29	61	55
	30-34	28	25.2
	45-49	5	4.5
Sex	Male	52	46.8
	Female	59	53.2
Marital status	Single	59	53.2
	Married	52	46.8
Educational level of respondents	Bachelor degree	109	98.2
	MSc	2	1.8
Work experience(in years)	=< 5	61	55
	6-10	45	40.5
	>=11	5	4.5
Work setting of respondents	Medical	11	9.9
	Surgical	12	10.8
	Gyn/Obs	20	18
	Pediatrics	13	11.2
	OPD	16	14.4
	**Others	39	35.1

** Others (Radiology, Dental, Ophthalmology,Psychiatry,OR,ICU,Recovery)

5.2 Documentation practice result

Respondents were asked for their time preferences for documenting their care provision and 29 (26.1%), of them document the care any time when convenient 82 (73.9%) immediately or soon after the care provision. Among all nurses under the study, 99 (89.2%) of them check nursing notes written by their colleagues and majority of them 87 (87.9) said the notes are providing

adequate information. Concerning the system of documentation, all 111 (100%) of them reported for not applying computerized nursing documentation in their hospital.

Table 2 Practice of nursing documentation among nurses working in WUSH, Central Ethiopia, Ethiopia

Variables		N	%
Do you document the care you have done for every Patient	Always	71	56.3
	Sometimes	22	17.5
	Rarely	18	14.3
Time preference to document the care	Any time convenient	29	26.1
	Immediately or soon after the care	82	73.9
Ways to keep confidentiality	Access for authorized ones only	79	71.2
	Obtain informed consent	18	16.2
	Confidentiality continues after death	19	17.1
	I don't know	22	19.8
Read colleague's notes	Yes	99	89.2
	No	12	10.8
Colleagues notes provide adequate information (n=99)	Yes	87	87.9
	No	12	12.1
Documents health education given	Always	53	47.7
	Sometimes	40	36
	Rarely	4	3.6
	Never	14	12.6
Uses computerized documentation system	No	111	100
Reports any medical error voluntarily	Yes	64	57.7
	No	47	42.3
Way of error recording	No words like "error" or "mistake"	20	31.3
	Facts only	54	84.4
Documents patient response to care	Yes	60	54.1
	No	51	45.9

The mean score of respondents for practice questions was added up and dichotomized into two based on the mean score which was 1.58 (S.D ± .18) (See figure below)

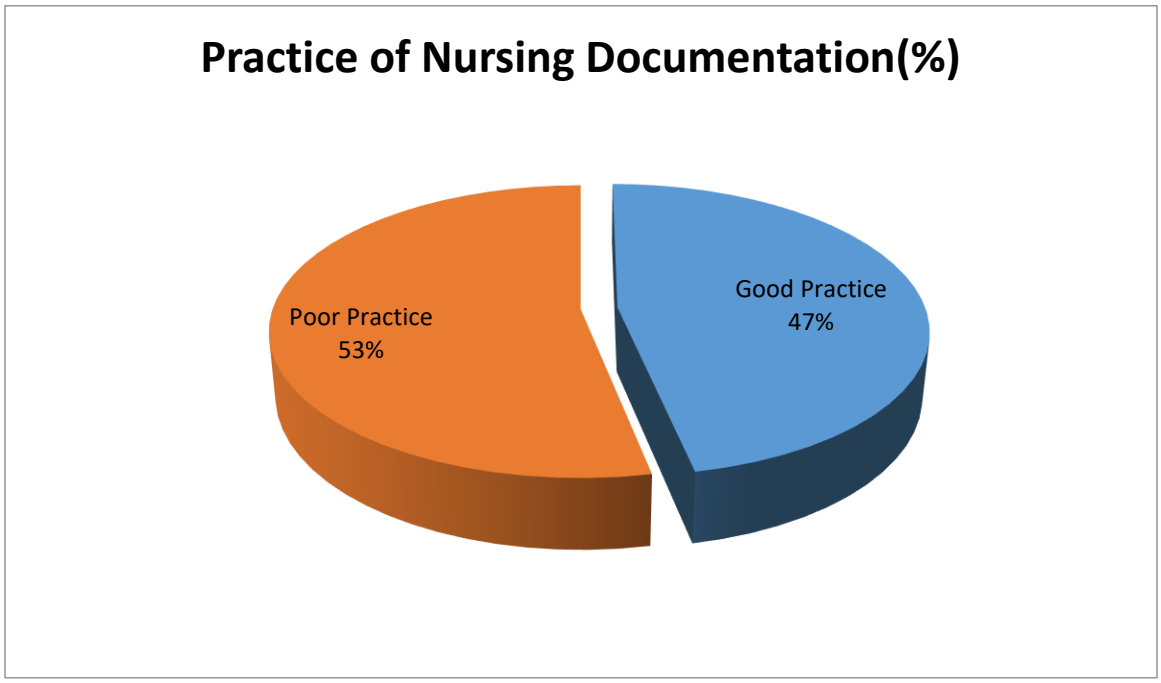

Figure 2 Level of nursing documentation practice on study of nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia, 2024.

Additionally the completeness of patient records (charts) was assessed in terms of nursing care plan, medication administration sheet, vital sign sheet, admission record and nursing activity sheet. Accordingly, the result showed that nursing care plan was completed for 5(8.33%) out of 60 sampled charts, medication administration format was completed for 45(75%), vital sign completed for 34(56.7), admission & discharge was recorded for 55(91.67%) and at last nursing activity sheet was completed for 4 (6.67%).

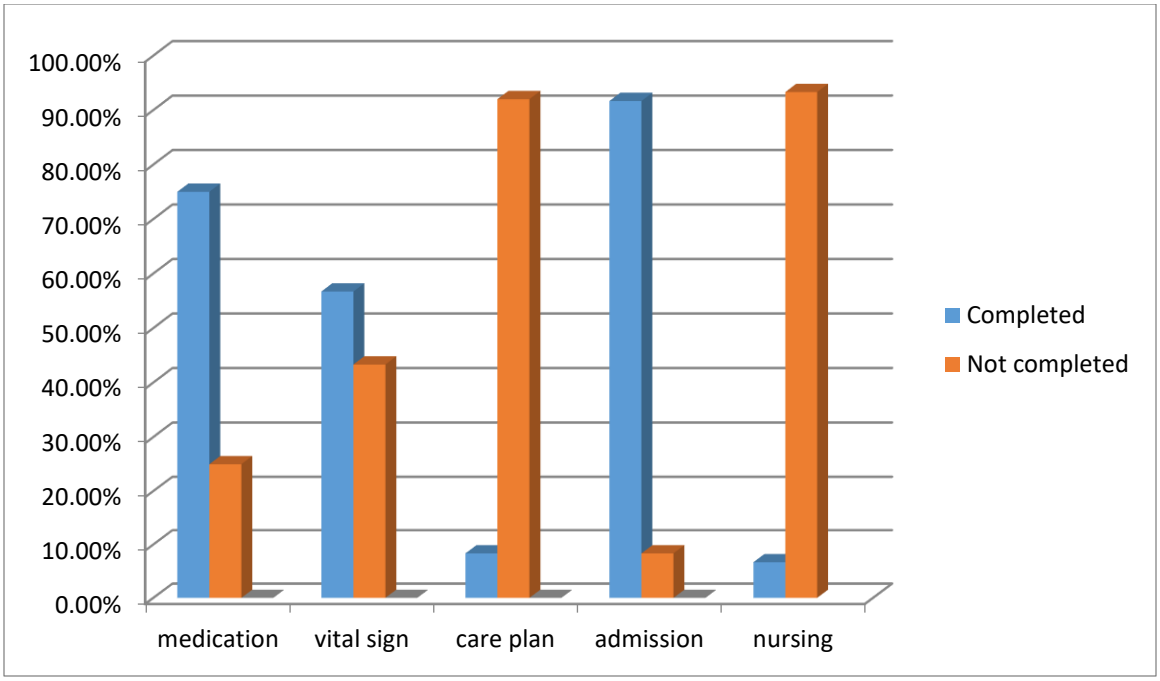

Figure 3: Completeness of documents on the study of nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia, Ethiopia.

Table 3 Result of document review on study of nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia, Ethiopia

Dimension	Indicators	Weight given(out of 100)	Observed result	Judgment parameter
Completeness	Medication administration	20	15	Poor if < 50% Good if = >50%
	Vital sign chart	20	11.34	
	Care plan	20	1.67	
	Admission discharge	20	18.33	
	Nursing activity	20	1.33	
Total		100	47.6%	

5.3 Knowledge of respondents towards nursing documentation

The mean score for knowledge questions which was 1.476 (S.D ± 0.168). Based on this cut-off point,30% (n=33) of the study participants had a good knowledge of nursing care documentation.

Out of total respondents who have participated in the study, majority of them 108 (97.3%) knew that documentation is a professional responsibility and their main source of information was from nursing school 47.2%(n=51), for 29.6% (n=32) the hospital management and friends from 19.4% (n=21). Regarding the responsibility of documentation, 86 (77.5%) of the nurses said the care provider himself should document while 25 (22.5%) said the observant.

Table 4 Knowledge of nursing documentation on the study of nursing documentation knowledge, attitude and practice among nurses working in WUSH ,Central Ethiopia ,Ethiopia

Variables		N	%
Documentation is a professional responsibility	Yes	108	97.3
	No	3	2.7
Source of information about the responsibility (n=108)	Hospital management	32	29.6
	Nursing school	51	47.2
	Friends	21	19.4
	Others	4	3.7
Principles of documentation	Free from error	61	55
	Complete	76	68.5
	Easly readable	67	60.4
	Chronological	43	38.7
	Do not know	11	9.9
Advantages of documentation	Improves quality of care	97	87.4
	Better communication within staff	82	73.9
	For education and research	78	70.3
	For legal protection and planning	70	63.1
Main nursing activities to be documented	Assessment data	87	78.4
	Progress of patients	59	53.2
	Admission and discharge of patients	70	63.1
	evaluation of outcomes	67	60.4
Consequences of inadequate documentation	Possible imprisonment	43	38.7
	Lack salary increment	10	9
	Injury or death to the client	49	44.1

	Poor development of a profession	64	57.7
Effects of using non standard abbreviation	Leads to error	86	77.5
	Wastes time	49	44.1
	Causes confusion	80	72.1
	Don‟t know	11	9.9
Documentation that protects from legal suit	Record date and time of care	92	82.9
	Record performed actions only	51	45.9
	Record chronologically	80	72.1
	Make corrections clearly	42	37.8
	Record frequently	59	53.2
Components of medication administration	Names of medications	93	83.8
	Date and time of administrations	107	96.4
	Route and dosage of administration	97	87.4
	Name and signature of administrator	93	83.8
	Don’t know	4	3.6
Who should document a care	The care provider	86	77.5
	Observant of the care	25	22.5

5.4 Attitude of nurses towards nursing documentation

Attitudes were assessed via a Likert scale, with scores ranging from strongly agree (1) to Strongly disagree (5). Among all respondents, all 111 (100%) of them agreed that nursing documentation is an advantage in daily work; 111(100%) said it helps for patient safety; 103 (92.8%) said that quality documentation is important. On the other way, 106(95.5%) respondents did accept that a written report can replace oral shift report; 98(88.2%) agree Patients should participate in care planning to improve the quality of care and 42(37.8%) of them did not agree that nurses have sufficient knowledge of the documentation procedure. The mean score of respondents for attitude questions was added up and dichotomized into two based on the mean score which was 1.6716 (S.D ± 0.419).

Table 5 Attitude toward nursing documentation on study of nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia, Ethiopia.

Variables	Agree		Neutral		Disagree	
	N	%	N	%	N	%
Documentation helps for daily work	111	100				
Documentation helps for patient safety	111	100				
Quality documentation can add value to hospital	103	92.8	8	7.2		
Complete and accurate documentation is important	111	100				
A written report can replace oral report	96	86.5	10	9	5	4.5
Nurses notes are meaningful and give legal protection	106	95.5			5	4.5
Patients should participate in care planning to improve the quality of care	98	88.2	7	6.3	6	5.4
Nurses have sufficient knowledge of the documentation procedure	69	62.1	9	8.1	33	29.7
Nursing admission assessment should be completed within 1hr	79	71.1	19	17.1	13	11.7

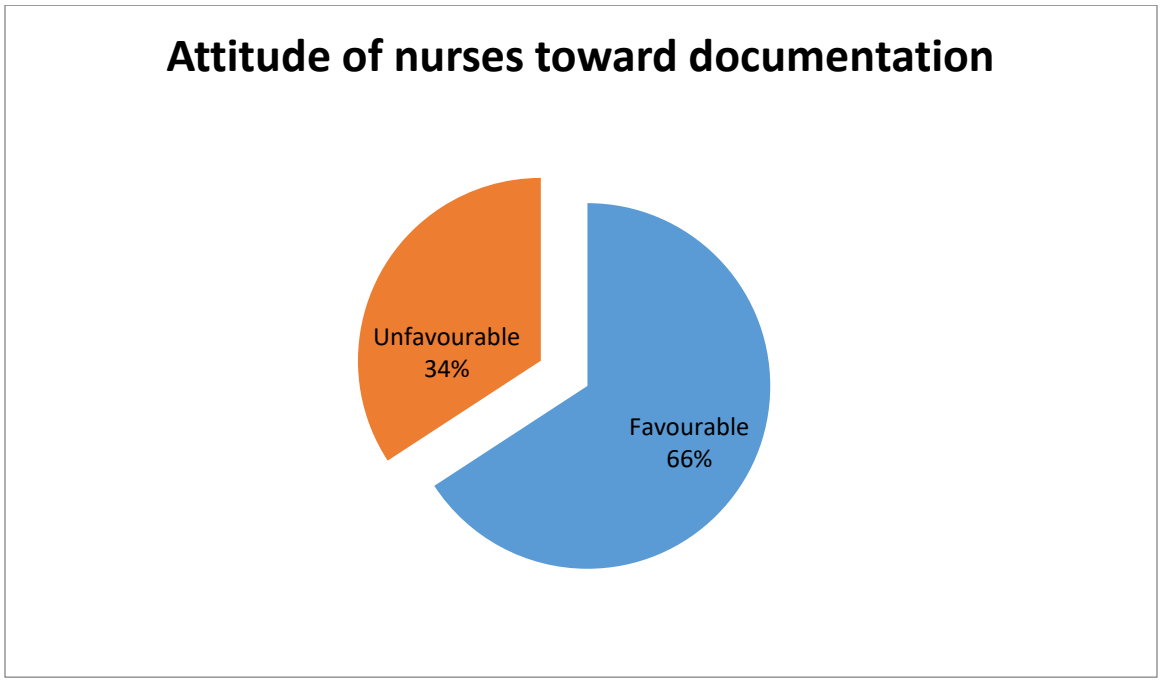

Figure 4: Attitude towards nursing documentation on study of nursing documentation knowledge, attitude and practice among nurses working in WUSH, Central Ethiopia, Ethiopia

6. Discussion

Poor documentation in nurses has been shown to have negative impacts on the health care of patients, the health care providers and on the profession in general. Various studies have shown that documentation problem is still a critical issue in both developed and under developed countries, especially in Sub-Saharan Africa including Ethiopia.

The result of this study showed that level of nursing care documentation was practiced by 47% of nurses. This finding is lower compared to a study done in, Canada 53.5% [22]. This contrary might be due to that the current study included short period, but a previous study in Canada was conducted on prolonged period.

A study conducted among nurses in the Papuan province of Indonesia reported that a documentation practice level is 37% [23] which is lower than our result. A study showed in Nigeria, good Nursing documentation was practiced by 70%, and the Majority of respondent's 96.7% document anytime a case is rendered [9] while in our study level of nursing care documentation was practiced by 47% and majority of respondents 73.9% (n=82) soon after case rendered.

According to a study conducted in Ethiopia's Central and North Gondar zones public hospitals the nursing care documentation practice of nurses was poor through chart review 30.4%. In this study nursing care documentation practice of nurse was 47.6%.

A study conducted in Harare regional state and Dire Dewa administration eastern Ethiopia 47.5% of nurses were found to have good nursing documentation practice whereas out of 421 reviewed medical records good nursing documentation was found to practice on 38.5% of them[19] as compared to our study out of 60 reviewed medical record good nursing documentation was found to practice on 47.5 of them. The discrepancy in result might be due sample size differences.

A studies conducted to Tigray, Jimma and Gojjam Ethiopia, indicated that 47.8%, 48.6% and 47.5% of nurses have good nursing documentation practice respectively [2,8,14] which is almost comparable with our study.

A quantitative study done in Iraq regarding the purposes of documentation, 71% of them said it is helpful for communication and continuity of care; 50% said for legal interest and 100% of them said it is useful for quality improvement of patient care and for funding. In our study 73.9(n=82) of them said it is helpful for communication; 63.1%(n=70) for legal protection and planning and 87.4% (n=97) of them said it is useful for quality improvement of patient care.

In a study conducted in West Gojjam Zone public hospitals in Ethiopia, it was found that approximately 54.6% (in our study 30% (n=33))of respondents exhibited good knowledge regarding nursing care documentation [14]. Notably, 85.4% acknowledged the importance of documenting nursing care according to guidelines, with 40.2% acquiring this knowledge from hospital management [14]. In our study 97.3 %(n=108) acknowledged the importance of documenting nursing care, with 47.2% acquiring this knowledge from nursing school. Moreover, 91.7% of respondents were aware of the potential consequences of inadequate documentation while in our study 100% were aware of the potential consequences of inadequate documentation. Another study in Ethiopia awareness was noted regarding the necessity of documenting patient assessment data (65.4%) [33]. And in our study 78.4%(n=87) believed assessment data should included in documentation. The possible explanation for the discrepancy is the different cut-off points used in the research. This study used mean as the cut-off point to indicate good documentation practice, but the study done at Amhara region used a threshold of 100%.

Another possible reason for the contrary might be due to the differences in the number of hospital included in the study.

According to a study conducted in Indonesia only 48.1% of nurses had favorable attitude [23] while in our study 66% of them had favorable attitude toward nursing documentation. A study done in Nigeria showed that all respondents (100%) think it is important to document nurse's care which is similar with our study and 21.7%, of the respondents liked documenting because it ensures serves as a legal backup [26] while in our study it was 95.5% (n=106). Another study done at Hawassa (Ethiopia) and Amhara region found that 58.8%, and 50.8% [32, 33] respectively exhibited a favorable attitude towards nursing care documentation which is lower than our study. This discrepancy might be due to difference in sample size.

Limitation of the study

- ✓ Self- report may over/underestimation the level of documentation practice.

7. Conclusion

Nursing documentation practice was poor among nurses under the study. Knowledge towards nursing documentation was also poor among nurses under study. Nurses under study had favorable attitude towards nursing documentation practice.

8. Recommendation

It has been accepted that nursing documentation is a very important aspect of professional practice to nurses. Based on the finding of this study, the following recommendations are forwarded for:

1. For staff nurses: To improve their documentation practice

   To update their knowledge

2. For Administrative/ head nurses: To provide sustained continuing delivery of training and monitoring.

3. For researchers: Considering longitudinal study to examine actual practice and to carry out large scale studies in order to address the problem in wider context.

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Appendix

Appendix 1: Questionnaire English version.

Part I: Please circle the chosen option(s) or write the appropriate answer in the space provided.

Part I: socio-demographic characteristics.

S.NO	Question	Response	Remark
1.	How old are you?	---------	
2.	Sex	1.male 2.female	
3.	What is the highest level of Education you have attained?	1. College diploma 2. Bachelor degree 3. MSc and above	
4.	What is your marital status?	1= Single 2= Married 3= divorced 4 = widow/widower	
5	Years of experience	_____	

Section II Organizational factors.

Instruction-Please read the following questions carefully and encircle on the correct answer option.

S.NO	Question	Response	Remark
1	Where is your working setting?	1. Medical ward 2. Surgical ward 3. Pediatric ward 4. Regular OPD 5. Emergency OPD 6. Pediatric OPD 7. Gynecology Obstetrics ward.	
2.	Did you get Nursing standard training?	1. Yes. 2. No.	
3	If yes for Q 1. When did you get it?	---------	
4.	Did you have enough time for documentation?	1.Yes 2. No	
5.	Does your hospital have operational standard for nursing Documentation?	1.Yes 2. No	
6.	If "Yes" to Q 5, which of these Elements concerning documentation are included in the standard?	1. Begin with the date and time 2. The assessment, planning, diagnosis, implementation, and	

		evaluation of the patient care must be documented. 3. Ensure that any aspect of care delegated has been documented appropriately. 4. End with an authorized signature.	
7.	Nursing care plan sheets easily available in the nursing unit.	1.Yes 2. No	
8.	Motivation from a supervisor is available in your hospital?	1. Available. 2. Not available.	If not available to Q8, please Skip to Q 10 .
9.	What type of motivation is available in your hospital?	1. Reward system. 2. Recognition for a job well done. 3. Increase salary.	
10.	Promotion from hospital is available?	1.yes 2.no	
11.	On average how many patients do you see each day?	……..	
12	Do you feel fatigued during documentation?	1, yes 2, No	
13.	Does documentation guideline is available in your hospital?	1.Yes 2. No	

14.	Does your hospital have continuous monitoring?	1.Yes 2. No	
15.	Does your hospital have continuous evaluation?	1.Yes 2. No	

Section III- Documentation Practice.

Instruction-Please read the following questions carefully and encircle on the correct answer option. **Please note that more than one answer is possible**.

1.	Do you document the care you have done for every Patient?	1.Always 2.Sometimes 3.Rarely 4.Never	
2	If not "Always" to Q 1, what Were your reasons?	1. I could not find adequate documenting sheets 2. No adequate staff 3. Lack of time 4. I didn't know how to document 5. No obligation from the hospital. 6. No motivation from supervisors. 7. No promotion from hospitals. 8. I feel fatigued. 9. If others, please specify---------- ----------	
3.	Which time do you prefer to document care provided to the Patient?	1. Any time when convenient. 2. Immediately or soon after care rendered. 3. At the end of shift hours	

4.	How do you keep confidentiality of patient Records?	1. Maintaining patient charts to be accessed by authorized personnel only. 2. Keep passwords of computers safe (if electronic) 3. Obtain informed consent from the client to use or disclose information to others 4. The duty of confidentiality continues after the death of an individual 5. I do not know	
5.	Do you read your colleagues' Notes?	1.Yes 2. No	If "No" to Q 5, please Skip to 7.
6	If "yes" to Q 5 does your colleague's recording provide your adequate information?	1.Yes 2. No	
7.	Do you document education or advice you have provided to a Patient?	1.Always 2.Sometimes 3.Rarely 4.Never	
8.	Do you use computerized nursing care documentation system currently in your Hospital?	1.Yes 2. No	

9.	Do you voluntarily report any a medical error that occurs while Providing patient care?	1.Yes 2.No	If no to Q 9,please skip to Q 11
10	If “Yes” to question 9, how Do you record?	1.Do not use words like" error" or "mistake" in the patient’s chart 2. Record facts only 3. I don’t know	
11.	Do you document your patient's response to the care You provide?	1.Yes 2. No	

Section IV- Knowledge question.

Please read the following questions carefully and **encircle** on the correct answer option as honestly as possible. Please note that **more than one answer is possible** except for questions number 1 and 10.

1	Documentation of patients care is part of professional responsibilities	1.Yes 2. No	If "No" to 1, please skip to 3
2	If "Yes" to 1, who is your major source of information?	1. Hospital management 2. Nursing school 3. Friends from staff 4. Others----------	

3	What are some of the principles needed to be followed While documenting?	1. Error free 2. Complete 3. Easily readable 4. Chronological 5.I don't know	
4	What are the advantages of Patient care documentation?	1. To improve quality of care 2. For better communication with health care staff 3. For education and research 4. For legal protection and health planning 5.I don't know	
5	What are the main nursing activities you are expected to Document?	1. Assessment data 2. Progress of patients 3. Transfer and discharge of patients 4. Care provided and evaluation of outcomes	
6	What are the potential consequences of inadequate Documentation?	1. Possible imprisonment 2. Loss of salary increment 3. Severe injury or death of a client 4. Poor development of the nursing profession	
7	What are the effects of using non-standard abbreviations When documenting patient care?	1. Leads to errors 2. Wastes time 3. Causes confusion 4. I don't know	

8	Which of the following actions of documentation do you think Protects you from legal suit?	1. Documenting the date and time of care 2. Recording only what you saw or did 3. Recording in a chronological order 4. Putting a single line and correct clearly 5. Recording frequently 6. I don't know	
9	What are the components of documenting medication Administration?	1. Names of medications 2. Date and time of medications administered 3. Routes and dosage of medications administered 4. Nurses name and signature 5. I don't know	
10	Who should document a care provided to a patient?	1. An individual who has observed the care. 2. A colleague who has assisted the care. 3. The same individual who provided the care. 4. I don't know	

V Section Attitude

Instruction- Please read the following statements carefully and put a **checkmark** on the option that best agrees with your opinion. Tick **"Neutral"** if you don't want to agree nor disagree with the opinion.

S.NO	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.	Nursing documentation is an advantage in the 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 gives me 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 participate in care planning to improve the quality of care					

Appendix 2: Nursing care standard checklist

	Activities	YES	NO
1	Medication given		
2	Vital sign taken		
3	Patient demography (on all formats)		
4	Health perception and management		
5	Activity and exercise pattern		
6	Sleep and rest pattern		
7	Nutrition and metabolism pattern		
8	Elimination pattern		
9	Role and relationship pattern		
10	Copping and stress tolerance pattern		
11	Cognitive pattern		
12	Self-perception and self-concept pattern		
13	Sexual and reproductive pattern		
14	Belief and value		
15	Nursing diagnoses clearly stated		
16	Goal and outcome stated		
17	Nursing intervention		
18	Patient progress stated		
19	Input and output follow up		
20	Teaching plan stated		
21	Admission discharge recorded		
22	Nursing activity sheet		