P-ISSN: 2617-9806
E-ISSN: 2617-9814

Impact Factor: RJIF 5.2
www.nursingjournal.net

International Journal of Advance Research in Nursing

Volume 4; Issue 2; Jul-Dec 2021; Page No. 245-247

Received: 17-06-2021
Accepted: 21-07-2021

Indexed Journal
Peer Reviewed Journal

Assess the knowledge and attitude practices regarding nursing care documentation among staff nurses in SMCH

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Abstract

Nursing documentation is a crucial part of the nursing process as it is the essential way of communication within the health care team regarding patient care. Nurses' knowledge about documentation is important as it is a legal requirement and main responsibility of nursing staff.

Objectives: To assess the level of knowledge and attitude regarding nursing care documentation on staff nurse.

Methods: Descriptive research design was adopted for the study with 60 samples which met the inclusion criteria were selected by convenience sampling technique. Demographic variables data were collected by using a multiple-choice questionnaire followed by assessing the knowledge and attitude regarding nursing care documentation.

Result: The findings of the Out of 60 samples that frequency and percentage of poor knowledge 1.78% average28.82% good knowledge 69.41% and frequency is poor knowledge 10 average knowledge 20 and good knowledge 30.

Conclusion: The staff nurse who are working in Saveetha medical college and hospital had good knowledge and attitude regarding Nursing care documentation.

Keywords: Documentation, records and reports, staff nurse, knowledge, attitude

Introduction

Nursing is a profession that requires specialized skill and knowledge pertinent to the duties to be executed. Role of professional nurses is to be a care provider, communicator, an educator, and counsellor. Therefore, nurses have a complex role in providing patient care and preserve quality needed in the hospitals. According protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in health care for individuals, families, communities and populations [1].

Documentation is a written evidence of interactions between and among health professionals, clients, their families, and health care organizations. Since the era of Florence Nightingale, documentation has been a critical and fundamental part of nursing practice. Largely, physicians were the only one accountable for medical care given. This scenario has changed, as patients are now aware of the various roles of nurses in healthcare. Nursing activities now is not only limited to taking physician promotion but also documenting the care given. Documentation has now become an integral part of the nursing duty [2]. Documenting nursing care is inclusive of nursing assessment, nursing care plan, which highlights the healthcare needs and outcomes, along with interventions and discharge advice notes [3].

The history of nursing care documentation has been started since the early days of Nightingale and deained as the record of nursing care that is planned and given to individual patients and clients by nurses [4]. The quality and coordination of care depend on the communication between nurses with each other, with other members of the healthcare team for continuity of care about their patients.

However, its value as an important source of reference in the health-care system is undermined because there is much confusion and lack of knowledge about the exact nature of quality nursing documentation [5].

A number of frameworks are currently available to assist nursing documentation including narrative charting, problem orientated approaches, clinical pathways and focus notes. However, many nurses' still experience barriers to maintaining accurate and legally prudent documentation like poor attitudes, lack of knowledge towards nursing documentation, time shortage and workload. This brings in-sufficient cooperation between health care team members and services that have a negative impact on nursing care documentation [6].

Nurses should document what they see, not what they think. Nurses bear a large burden in both managing and implementing the interdisciplinary team's plan for documenting the care and progress towards goals since documentation is a working framework which provides a comprehensive account of care provided to a patient [7]. As many studies indicated globally most of nurses had inadequate attitude, knowledge regarding documentation as well as insufficient information and their actions are either

not documented or not properly documented and thus creates a great problem when it comes to evaluation of client care [8].

Documentation is a written evidence of interactions between and among health professionals, clients, their families, and health care organizations. Since the era of Florence Nightingale, documentation has been a critical and fundamental part of nursing practice. Largely, physicians were the only one accountable for medical care given. This scenario has changed, as patients are now aware of the various roles of nurses in healthcare [9]. Nursing activities now is not only limited to taking physician promotion but also documenting the care given. Documentation has now become an integral part of the nursing duty. Documenting nursing care is inclusive of nursing assessment, nursing care plan, which highlights the healthcare needs and outcomes, along with interventions and discharge advice notes [10].

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A number of frameworks are currently available to assist nursing documentation including narrative charting, problem orientated approaches, clinical pathways and focus notes. However, many nurses' still experience barriers to maintaining accurate and legally prudent documentation like poor attitudes, lack of knowledge towards nursing documentation, time shortage and workload. This brings in-sufficient cooperation between health care team members and services that have a negative impact on nursing care documentation [12].

Materials and methods

A non-experimental design was used to assess the level of knowledge regarding nursing documentation among staff nurse a total of 60 samples who met the inclusion criteria selected by using convenience sampling technique for the study. After selecting the samples, the researcher introduced himself and explained the purpose of the study to the staff participant. Inform consent was obtained after assuring confidence. Each staff nurse was assessed on the wards. The demographic variables were collected by using multiple choice questionaries. The self-structured questioners of Nursing care documentation will be assessed. The data were tabulated and analysed by descriptive and inferential statistics.

Table 1: Frequency and percentage distribution of demographic variables of staff nurses who had available during study period. N=60

S. No	Variable	(f)	(%)
1	Age in years		
	20-25	40	65.29
	26-30	8	29.41
	31-35	10	4.11
	>35	2	1.17
2	Gender		
	a) Male	10	4.7
	b) Female	50	95.29
3	Educational qualification		
	a) GNM	40	23.52
	b) BSc nursing	10	67.64
	c) PBBSc nursing	10	8.23
	d) MSc nursing	-	0.5
4	Place of work		
	a) General ward	30	81.17
	b) High density unit	10	1.76
	c) Private ward	20	17.05
5	Year of clinical experience		
	a) Less than 1 year	30	34.11
	b) 2-5 years	10	58.23
	c) 6-10 years	10	6.47
	d) Above 11 years	10	1.17

Table 2: Frequency and percentage distribution of test level of knowledge and attitude regarding nursing care documentation.

Knowledge score	Grading	Frequency	Percentage
0-9	Poor	10	1.78%
10-14	Average	20	28.82%
15-20	Good	30	69.41%

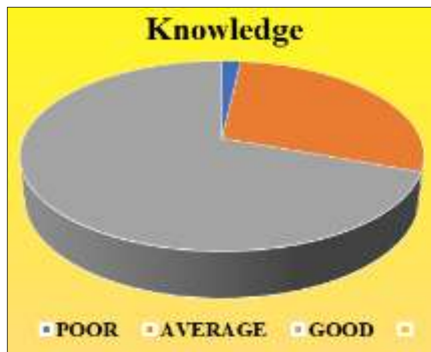

Fig 1: It shows that frequency and percentage of knowledge

Result and discussion

Section-A

It shows that frequency and percentage of poor knowledge 1.78% average 28.82% good knowledge 69.41%. and frequency is the first objective of the study to assess the level of knowledge regarding nursing care documentation on staff nurse. The first objective reveals that in the age group 20-25 65.5% gender 4.7 %male 95.29% female GNM23.3% BSc(n)67.64 PBBSC 8.3% general ward 81.7%high density unit1.76%0 experience less than 1 year 34,4%,5years experience 58.6% above 11year experience 1.17%.

The present study finding is supported Karkkainen (2004:268) did a theoretical study on documentation of care in which she started off by stating that the attitude of caring depends on the approach to the basic questions of existence or ontology. The second objective of the study to identify whether procedures regarding current documentation are being carried.

Secction-B

The second objective of the study reveals that frequency and percentage of poor knowledge 1.78% average28.82% good knowledge 69.41%. and frequency is poor knowledge 10 average knowledge 20 and good knowledge 30.

The present study finding is supported Langowski (2015:124) conducted the research she did online on nursing documentation systems that nurses' satisfaction increased by 20% because their perception was that less time was available for direct patient care. There was significant improvement in quality of nursing documentation. Online nursing documentation offers prompts, alerts and a customised screen to obtain required data. Information is documented in real time and health care decisions are made with the entire patient information available.

The third objectives of the study to assess explore the perceptions of the nurses regarding the current documentation.

Conclusion

The staff nurse who are working in Saveetha medical college and hospital had good knowledge and attitude regarding Nursing care documentation.

Acknowledgement

Authors would like to appreciate the participants who actively participate in the study and extend their cooperation to compete the study successfully.

Conflict of interest: Authors declare no conflict of interest.

Funding support: No funding.

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