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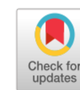
RESEARCH ARTICLE



The Accuracy of Documented Nursing Care Plan among Registered Nurses

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Abstract

Background **:** Nursing documentation is a record of care planned and provided by qualified nurses under the guidance of a competent nurse for each patient as well as the clients.

Objective **:** to provide published studies about accuracy of nursing documentation.

Methods **:** Searches were conducted using the following electronic databases: PUBMED, MEDLIN, CINAHAL, SAUDI DIGETAL LIBRALY and GOOGLE SCOLAR as gray data base. Search was limited to English-Language publication. And include study over 10year period.

Result: nursing documentations is inaccurate, lacking precision, and low in quality. Factors that influence nursing documentation differ but are also interrelated with each other. Shortage of employees, insufficient knowledge about the significance of documentation, patient load, lack of hospital education, and lack of support from nurse leaders are the reported challenges to documentation.

Conclusion: Most of the lecture revel the necessary need of nursing documentation practice. Affected factor and with several recommendations for improvement noted.

Keywords: ”nursing care plan, ” ”nursing documentation, ” ”accuracy of documentation” and ”nursing report.”

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2.1 INTRODUCTION

This review examines prior research on nursing documentation. The chapter covers the following topics: the importance of nursing documentation, factors affecting documentation practice, and strategies to improve nursing documentation practice.

2.2 Data Search Strategy

The adopted search strategy aimed to capture published studies about the accuracy of nursing documentation. Searches were conducted using the fol-

lowing electronic databases: PUBMED, MEDLIN, CINAHAL, SAUDI DIGITAL LIBRARY, and GOOGLE SCOLAR as gray databases. The following keywords were used in combination: ”nursing care plan,” ”nursing documentation,” ”accuracy of documentation” and ”nursing report.” The search was limited to English-language publications, and included studies over the last 10 years as much as possible; limited publication on the topic of interest enabled some classic literature to be included.

2.3 Accuracy of Nursing Documentation

Nursing documentation has been described as a record of patient and client care, planned and provided by qualified nurses under competent guidelines. It would be useful to explain the processes involved in nursing and the decision-making process by examining admissions, diagnoses, and procedures, as well as an assessment of progress, performance, and outcomes (Urquhart et al. 2009).

From the early 1970s in the United States of America (USA), diagnosis has become an important component of professional nursing practice and is referred to as a ‘clinical judgment’ perspective (Gordon, 1994). According to Lunney (2001, 2009), even though the recognition and analysis of the human responses is a complicated process that involves an interpretation of the behavior of a human that is related to health but the nursing diagnosis has developed to be a significant component of the nursing documentation. It has become vital for the selection and planning of interventions for delivering high-quality nursing care (Gordon, 1994) .

Accurate nursing diagnoses are those that are reported in terms of an etiology, a problem, and symptoms/signs, which are recognized as the PES structure. The content of the nursing diagnosis as explained by the PES structure is comprised of a problem label (P), an etiology or ‘related factors’ (E), and the signs and symptoms (S); intervention opportunities are implied by this diagnosis (Gordon 1994). It was in 1988 that the North American Nursing Diagnosis Association (NANDA) accepted as basis of a diagnostic concept in nursing.

The accurate documented interventions is planned interventions that are established based on knowledge, education, and sources of knowledge like handbooks, protocols, and clinical reasoning. Actions taken by nurses on the behalf of the patient to improve outcomes are described as nursing interventions (Johnson et al., 2007).

According to Johnson et al. (2007), nursing outcomes refer to changes in patients’ status, which may include their symptoms, state of knowledge, ability to function, and ability to take care of themselves. These documents constitute nurses’ progress evaluations and outcome reports. According to Wilkinson (2007) this provides nurses with the opportunity to appraise the kind of care that is offered and describe results.

For accountability, nursing documents must present a picture that is reliable, accurate, and legal. For this purpose, a handwritten or typed document should be maintained. The accuracy of nursing documentation could be improved using electronic patient records. (Lunney ,2008).

One of the major studies carried out in this field is Gencbas et al. (2018). They used a randomized controlled experimental design to determine the efficacy of nursing care plans for elderly women living in nursing homes. They examined relationships between the NANDA-I, the Nursing Outcomes Classification (NOC), and the Nursing Intervention Classification (NIC). The three measures were combined to construct the abbreviation NNN to provide comprehensive nursing care. In an experimental group, NNN linkages were prepared and applied for 12 weeks. Results show that between pre-test and post-test ratings, improvement was observed for all elderly women in the experimental group. The experimental group had a better quality of life and lower severity of symptoms than the control group. This indicated that nursing documentation is necessary to

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provide quality care, track patient progress and outcomes, and provide continued security for patients.

Documentation takes up to 50% percent of nursing time per shift. It serves many significant functions, including communicating among healthcare professionals for care continuance (DeLaune & Ladner, 2011). Wirawan et al. (2013) emphasized that documentation must also be kept for a reasonable time period, and it must be succinct, transparent, complete, correct, and renewed. Appropriate documentation can facilitate the permanence of diagnosis, intervention, advancement, and outcome assessment by nurses. For accurate, clear, and complete documentation of nursing care, the head nurse is obligated to supervise

The Ministry of Health in Saudi Arabia (MOH) has consistently stressed the value of health documentation and continues to face obstacles to providing training on health care documentation methods (Al-Malki et al., 2011). Prideaux (2011) claims that in many countries the standard of nursing documentation is low for many of the reasons expressed by different authors.

The first official documentation education program for nurses in the Kingdom of Saudi Arabia (KSA) was the result of thorough collaboration between the MOH and the WHO revealed that the health care system in Saudia Arabia grew quickly due to changing health care demands as the population adopted increasingly affluent and developed health care (Al-Dossary et al., 2008).

The MoH proposed that a baccalaureate of nursing is the minimum degree appropriate to ensure professionalism and admission standards for nursing practice, including documentation. However, the MoH has established an updated bridging program for diploma students to enhance the occupational standard of Saudi nursing students entering the labor market, which aims to boost their careers (Al-Odwani 2010).

In the 1970s, nursing schools and hospital training programs around the world introduced a standardized method of planning, evaluating, and recording nursing care. This approach to nursing facilitates challenges, contemplation, and decision-making, leading to desired results (Gordon, 1994).

The challenges of reporting on clinical outcomes are internationally recognized. However, most of these results have been published in developed countries. Few reports are available on nursing documentation in developing countries relative to other issues such as inadequate nursing or occupational services (Nakate, Dahl, Petrucka, Drake, & Dunlap, 2015).

2.4 Factors Affecting Documentation Practice

Wilter (2011) highlighted how the factors which influence nursing documentation are positioned within domains and are interrelated to each other. For example, nurse knowledge depends partly on the education programs that are provided in the hospital. These courses are only beneficial if the workload is limited and there are clear expectations and interdisciplinary support for documenting accurate diagnoses.

A conceptual basis was proposed by Wilter (2011) to explain the reasons for intervention documentation and (in)accurate diagnoses. Two classes of factors that affect the documentation of nursing were illustrated. First, there are general factors that influence the documentation and reasoning process, which may include work allocation, work procedures, conflicting personal values, disrupting work conditions, knowledge of the patient, and motivation. Second, there are specific factors that affect the occurrence and correctness of the nursing diagnosis documentation, subdivided into four conceptual domains: (1) nurses as diagnosticians, (2) diagnostic education and resources, (3) complexity of the patient's situation, and (4) hospital policies and environment. All the factors that can affect nursing diagnoses must be taken into account.

Documentation issues include shortages, insufficient awareness of the value of documentation (Kebede et al., 2017), lack of support from nursing leadership, and patient load. In addition to endorsing and enhancing the amount of personnel, nursing leaders who affect nursing documentation by continues follow-up (Johnson 2011, Nakate et al. 2015).

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Studies in Kenya and Ghana have also shown that nursing documents are not systematic and have not been properly prepared (Johnson 2011). In Ethiopia,

there has been a problem with inadequate data collection and a lack of consistency (Feleke et al., 2015, Tola et al., 2017).

One of the biggest issues facing nursing regarding patient safety is the failure to identify nursing processes that are not documented and result in adverse outcomes. Poor communication technology could reduce the time required for nurses to provide direct care, and as a result, patient safety is badly affected (Carpenito-Moyet, 2008, Saranto & Kinnunen, 2009).

A retrospective cross-sectional strategy was utilized by Tuinman et al. (2017) to assess the accuracy of registered nurses' documentation. Data were obtained from six months of nursing notes in resident care. The D-Catch tool tested the accuracy of the material based on the phases of the nursing process. Deficiencies were found in the explanations of resident work requirements, recorded nursing diagnoses, and progress and outcome reports. Higher precision scores were measured in somatic and psychogeriatric units in comparison to residential care units. To improve the standard of nursing documents, it is necessary to reduce the number of hours worked, improve the cognitive skills of nursing personnel, and implement professionalism in compliance with legal requirements.

The work environment can lead to poor documentation. Consistency of documentation is compromised by heavy workloads, laborious documentation requirements, languages, insufficient sources of service, and the hospital community (Prideaux, 2011; Jefferies, Johnson & Nicholls, 2011).

In 2019, Tasew et al. performed a quantitative, descriptive, cross-sectional study to examine documentation practice and associated variables in a group of nurses working in public hospitals in Ethiopia. Findings showed that knowledge of nursing reporting's organizational quality, limited time, and insufficiency of paperwork sheets had a large influence on nursing practice. Incomplete documentation of nursing care practice was common. Lack of time and sheet scarcity were leading variables that negatively impacted nursing paperwork.

2.5 How to Improve Nursing Documentation

Accurate nursing documentation follows seven requirements according to Jefferies, Johnson, and Griffiths (2010): (1) it is patient-centered; (2) it contains the actual work of the nursing staff; (3) it reflects the professional opinion of the nurses; (4) it follows a rational sequence; (5) it is written in a real-time sequence; (6) it records treatment variances; and (7) it fulfills legal requirements.

Katsaragakis, Patiraki, Dreliozi, and Prezerako (2017) developed a quasi-experimental study to test the efficacy of a home nursing care training program. The study consisted of 19 registered nurses serving in primary healthcare settings. Based on Chatzopoulou's (2010) doctoral thesis, the nurses engaged in an educational program, using a standardized questionnaire. The results indicated that the program strengthened their abilities in the designation, correct formulation, and individual autonomy of distinguishing characteristics in nursing diagnoses.

Balang, Burton, and Barlow (2017) conducted a qualitative study to examine nursing professionalism in Malaysia, particularly regarding nursing reporting. A total of 40 semi-structured interviews were conducted with nurses who participated in the completion of the nursing record. The results indicated that the documentation did not reflect the nurses' understanding of the nature of professionalism. Research findings recommended stressing the importance of quality of documentation in nursing practice, in addition to the importance of education for enhancing skills among nurses in Malaysia.

A common approach has been to train nurses to develop awareness, expertise, and documentation practices. For example, to improve documentation quality, Jefferies et al. (2012) used a written program. Training has also been shown to improve through the use of written procedure guidelines (Tornvall, Wahren & Wilhelmsson, 2009).

In conjunction with improvements to health care delivery, the nursing reporting process has improved, and emerging technology has shaped its standards. Records standards reflect traditional clinical practice and are competent and secure health care indicators that must be timely, diligent, and reliable to meet the obligatory requirements. Research evidence has

underlined the claim that adequate nursing documentation demonstrates the treatment given (Collins et al., 2013; Yeung et al., 2012).

To encourage structured, effective, and consistent communication (Wang et al., 2011), it is necessary to maintain consistency and best practice in nursing documentation for compliance and patient safety (Wang et al., 2011; Prideaux, 2011). The consistency of documentation represents the nurses' standard of practice, which can suggest professional and healthy treatment of nurses (Prideaux, 2011).

Analysis has established that nursing reports must be prompt, comprehensive, and reliable to conform to registered nursing standards and avoid legal intervention due to inaccurate or inadequate documentation (Barriers, 2012; Paans et al., 2011; Wang et al., 2011).

Nursing management is encouraged to use a collaborative method to create health care documentation strategies and guidelines and to provide nurses with staff development programs on the effectiveness of documentation. They should also implement policies to encourage the daily use of standardized healthcare languages. Quality documentation and reporting are needed to improve customer service (Daskein et al., 2009).

More research is needed on nursing data accuracy, factors that contribute to variation in practice, record quality defects, and their effects on nursing practices and patient outcomes.

2.6 Conclusion

Nursing documents can be used for other purposes, such as quality assurance, legal reasons, care management, resource utilization, and nursing research/development. A review of the literature revealed that nursing documentations is inaccurate, lacking precision, and low in quality. Factors that influence nursing documentation differ but are also interrelated with each other. Shortage of employees, insufficient knowledge about the significance of documentation, patient load, lack of hospital education, and lack of support from nurse leaders are the reported challenges to documentation.

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