Assessment of Practice On Documentation among Staff Nurses

*Dr.Kamalam.S. **Geetha.C

Abstract:

Documentation is anything written or printed that is relied on as a record of proof for authorized persons. Effective documentation reflects the quality of care and provides evidences of each health care team members, accountability in giving care. The ***objectives of the study*** *were ,to assess the Practice regarding Documentation among Staff Nurses and to find out the Association between the Practice of Staff Nurses on Documentation with Selected Demographic Variables.* ***Materials and methods****:A Quantitative research approach and Descriptive design was adopted and carried out in MGMC & RI at Pillaiyarkuppam, Puducherry. The sample consisted of 60 Staff Nurses working in different area of MGMC & RI. A Non probability convenient sampling technique was used to select the samples.* ***Major findings****:It revealed that 20(33.3%) of them haD Satisfied Practice, 40(67%) of them had Good Practice and none of them were having Poor Practice on Maintenance of Documentation. There is no significant association was found between practice and demographic variable.Keywords: ZIKA Fever, Structured Teaching Programme.*

Key words: Documentation, Practice, Record, Report and staff nurses

INTRODUCTION

Documentation is the vital aspect of nursing practice. Generally health personal communicate through Discussion, records and reports. Nursing Documentation has been one of the most important function of nurses since the time of Florence Nightingale because it serves multiple and diverse purposes. Current health care systems require that documentation ensures continuity of care, furnishes legal evidence, and evaluation of quality patient care.[3]

The purpose of Documentation is to convey information. In order to convey information, the person must understand first .Documentation is defined as anything written or printed that is relied on as a record of proof for authorized persons.[2] Effective documentation reflects the Quality of care and provides evidence of each health care team member's accountability in giving care. A report is an oral, written or computer based communication intended to convey information to others. The process of making an entry on a client record is called recording, charting or Documenting.[1]

*Former Principal, **Asso.Prof, Kasturba Gandhi Nursing College, Puducherry

The knowledge on practice regarding Documentation is an important issue for nurses both nationally and internationally. The issues in Nursing Documentation and Record keeping is an essential part of nursing practice with clinical and legal significance. Good quality record keeping is linked with improvements in patient care, while poor standards of documentation are regarded as contributing to poor quality nursing care.

The aim of the project is to identify the practice regarding documentation that would encourage critical thinking and provide evidence of the rationale for nursing actions, utilizing a problem based approach in order to provide accurate evidence of patient progress. In order to enhance their awareness regarding practice, documenting and protocol about Documentation of registers and charts in hospitals this study was undertaken.

METHODOLOGY:

Quantitative research approach was used to find out the practice regarding Documentation among Staff nurses. A Descriptive Design was developed for the study as it was intended to assess the practice on Documentation among Staff nurses. The study setting was conducted in the Mahatma Gandhi Medical College and Research Institute hospitals where majority of the sample were Staff nurses working in clinical area. The Target Population for this study include Staff nurses working in General and Critical Ward in Mahatma Gandhi Medical College and Research Institute, Puducherry. The Sample was 60 Staff Nurses who were working in General Ward & Critical Care Unit at MGMC& RI, Puducherry. The sample who met the criteria during the Data Collection period was selected by using Convenient Sampling Method.

SELECTION CRITERIA

Inclusion criteria:

Staff nurses, Who have completed Professional Qualification Diploma & B.sc[N].Who were working in General &Critical care ward at MGMC&RI. willing to participate in the study.

Exclusion criteria:

Staff nurses, who have completed ANM, not willing to participate in the study, not available at the time of Data Collection and completed M.sc [N] and Higher Studies in nursing.

DEVELOPMENT AND DESCRIPTION OF TOOL:

The tool is organized into two parts.

Part-I:
Demographic Variables of Staff nurses.

Part-II:
Check list to assess the practice for Staff nurse on Documentation.

Scoring:

Scoring is based on the checklist for Documentation among staff nurses. The practice of each area of Documentation carries **'1'** mark and not Practicing carries **'0'** mark. The scoring level of practice for the Staff Nurses includes:-

Good -70%,
Satisfactory-40-70%
Poor- 40%

RESULTS

Table1: Percentage Distribution of Principles Followed in Documentation among Staff Nurses

n=60

S.no	Principles Followed	No of staff nurses	Percentage %
1	Poor	4	6.7%
2	Satisfied	32	53.3%
3	Good	24	40%

TABLE-1 The Analysis of the Staff Nurses Regarding Principles Followed in Documentation. It Revealed that 32 (53.3%)of them have Satisfied Practice, 24(40%) of them had Good Practice and 4(6.7%)of them were having Poor Practice on Maintenance of Documentation.

DISCUSSION:

The first objective was to assess the Practice regarding Documentation among Staff Nurses, the Practice regarding Documentation among Staff Nurses was assessed through the Check list method. Data Showed that overall 40 (67%) of them had Good practice, 20 (33.3%)Of them had satisfied practice and none of them were had poor practice in maintenance of documentation.

The second objective was to find out the association between the practice of staff nurses on documentation with selected demographic variables: The finding of the study signifies that none of the demographic variables had no association with the level of practice among staff nurses on documentation

RECOMMENDATIONS:

The study can be replicated in large samples. To assess the knowledge and practice regarding Documentation among Staff Nurses working in hospitals .A longitudinal study can be conducted to evaluate the entire changes happening in Maintenance of Documentation.

Similar studies can be conducted regarding Maintenance of Documentation between Private and Government Staff Nurses.

CONCLUSION:

The Degree of Documentation is based on the judgment of the Individuals responsible for forming an opinion, the nature, and the adequacy and effectiveness of the Maintenance, Completeness and Accuracy, Clarity and Understanding, Pertinence, Logical Arrangement. The study concluded that out of 60 samples. In that nurses are samples 40 samples have Good Practice, 20 samples have Satisfactory and none have Poor Practice on Documentation.

This shown that there is No Significant association between the practice of Documentation and the selected Demographic Variables. The study finding enables the nurse educator to plan and implement various plan teaching program for the staffs and help them to maintain 100% of practice on proper maintenance of Documentation.

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