"A STUDY TO ASSESS THE KNOWLEDGE AND PRACTICE OF DOCUMENTATION TECHNIQUES AMONG STAFF NURSES IN SELECTED HOSPITALS, AT LUCKNOW WITH A VIEW TO DEVELOP AN INFORMATION BOOKLET"

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ABSTRACT

Documentation ensures safety, quality and continuity of care of the patient. It is to improve, the time management, to avoid the numbers of error in the records, for the need of legal accountability, to make the nursing work visible and for the necessity of making nursing notes understandable to other disciplines. Staff nurses are educated through in-service education and computerized self study modules about complete and accurate documentation. The goal is to implement and evaluate standardized nursing record, positive perceptions of nursing documentation for further development to a nursing documentation including a holistic view of the patient. The focus of this study was to assess the knowledge and practice of documentation techniques among staff nurses in selected hospitals, at Lucknow with a view to develop an information booklet''. The overall analysis of level of knowledge of staff nurses regarding documentation technique showed that mean knowledge score obtained by the subjects was 9.32 (46.6%) with standard deviation of 3.744 and the obtained practice scorewas 10.68 (71.2%) with standard deviation 2.877. Findings showed that the obtained Pearson's correlation value 0.131 indicates the very low positive correlation between the knowledge and practice of Staff nurses regarding the documentation technique. Also it revealed that there was a significant association between the knowledge score with demographic variables like age, religion and marital status at the level of p<0.05.

KEY WORDS: *Knowledge; staff nurses; documentation technique; knowledge;practice.*

INTRODUCTION:

Documentation ensures safety, quality and continuity of care of the patient. It is to improve, the time management, to avoid the numbers of error in the records, for the need of legal accountability, to make the nursing work visible and for the necessity of making nursing notes understandable to other disciplines. Staff nurses are educated through in-service education and computerized self study modules about complete and accurate documentation. The goal is to implement and evaluate standardized nursing record, positive perceptions of nursing documentation for further development to a nursing documentation including a holistic view of the patient. The RN has a paramount responsibility to foreword information about the patient's needs and treatment to other health care professionals. Traditionally, this has been done verbally. However, today the information on the patient's condition, care and treatment has become more complex and the amount of individuals in need of this information has increased. Information technology has made its entrance into the health care system whereby verbal transfer of information is becoming obsolete. In an investigation of dimensions of nursing practice, 137 RNs were asked to rate 28 items describing nursing actions on a four-point scale ranging from essential to slightly important. Results showed that the action of 'Designing care plans in collaboration with the patient' received a mean score of 3.25, which ranked as the ninth most important nursing action. The action 'Use the nursing process as a basis for interventions' received a mean score of 3.24, which ranked eleventh. A study stated about "Advancing nursing documentation" in Department of Social and Welfare studies, Campus Norrkoping, Sweden. This was a prospective, stratified and randomized intervention study with one intervention group and one control group. A standardized nursing wound care record was designed and implemented in the intervention group for a

period of 3 months. Pre-and post intervention audits for nursing record [n = 102 and n = 92, respectively] were carried out and 126 district nurses answered questionnaires. As a result, the standardized nursing wound care record led to more informative, comprehensive and knowledge intensive documentation according to audit and district nurses' opinion. A study regarding "Nurses' assessment and documentation of peripheral edema"in USA stated that a variety of methods were used by nurses to assess edema and documented their assessments on a number of different forms. The result indicated that they were not proficient in assessment of edema and expressed the need for clear parameters to guide their practice. The knowledge of nurses regarding documentation is important in the planning and delivery of care towards the client. The nurses need to gain knowledge and practice skills in improving the documentation skills. There is little literature available regarding knowledge assessment of staff nurses on practice of documentation techniques in India. Incomplete and inaccurate documentation can affect the client care. Hence the researcher is motivated to conduct study to assess the knowledge and practice of documentation techniques among staff nurses and to develop booklet information for updating the knowledge.

HYPOTHESIS

Ho-There will be no significant association between knowledge scores of staff nurses regarding documentation techniques with demographic variables.
H1: There will be no significant association between the practice of documentation technique with the selected demographic variables
H2: There will be significant correlation between the knowledge and practice of staff nurses regarding documentation technique.

METHODOLOGY

- **Research Design-** In the present study the descriptive study design was adapted to assess the knowledge and practice of staff nurses regarding documentation techniques in Selected Hospital Lucknow.
- **Setting of the Study-**The present study was undertaken in Selected Hospital Lucknow. This setting was selected because of the geographical proximity, availability of the samples and permission to conduct the study.
- **Research variables:** In the present study knowledge and practice of staff nurses
- **Demographic variables:** Age, gender, religion, marital status, educational qualification, experience and attendance of in-service education program.
- **Population-** The target population for the present study comprised of staff nurses working in selected hospital Lucknow.
- **Sample-** Sample refers to the portion of the population which represents the entire population. In this study the sample consisted of staff nurses working in Selected Hospitals Lucknow. Sampling Technique
- **Sampling Technique-** Sampling refers to the process of selecting a portion of the population to represent the entire population. In this study, convenient sampling technique was adopted.
- **Sample Size-** The total sample size of this study is 60 staff nurses.
- **Plan for Analysis of Data-** The results were represented under following sections

Section I : Description of demographic characteristics of staff nurses.

Section II : knowledge and practice scores of the staff nurses regarding thedocumentation techniques.

Section III **:** Correlation between the knowledge and practice score of staff nurses.

Section IV **:** Association between knowledge scores and selected demographicvariables.

Table – 1: knowledge and practice scores of Staff nurses regarding documentation technique N = 60

Knowledge aspects	Number of Items	Maximum Score	Mean	Mean %	Median	SD

a. General aspect of Recording	5	5	1.75	35	1.5	1.035
b. Tools and methods of documentation	6	6	3.57	59.5	4	1.986
c. Directives of documentation	6	6	2.43	40.5	3	1.294
d. Use of technology	3	3	1.57	52.33	2	1.064
Overall	20	20	9.32	46.6	10	3.744
Practice score	15	15	10.68	71.2	10	2.877

Table 1 depicts that the maximum mean percentage obtained by the Staff nurses is in the aspect of Tools and methods of documentation (59.5%), followed by Use of technology (52.33%), Directives of documentation (40.5%) and least mean knowledge score (35%) found in the aspect of General aspect of Recording. Therefore overall knowledge scores of respondents were found to be 9.32 (46.6%) with standard deviation 3.744. The mean practice scores of respondents were found to be 10.68 (71.2%) with standard deviation of 2.877.

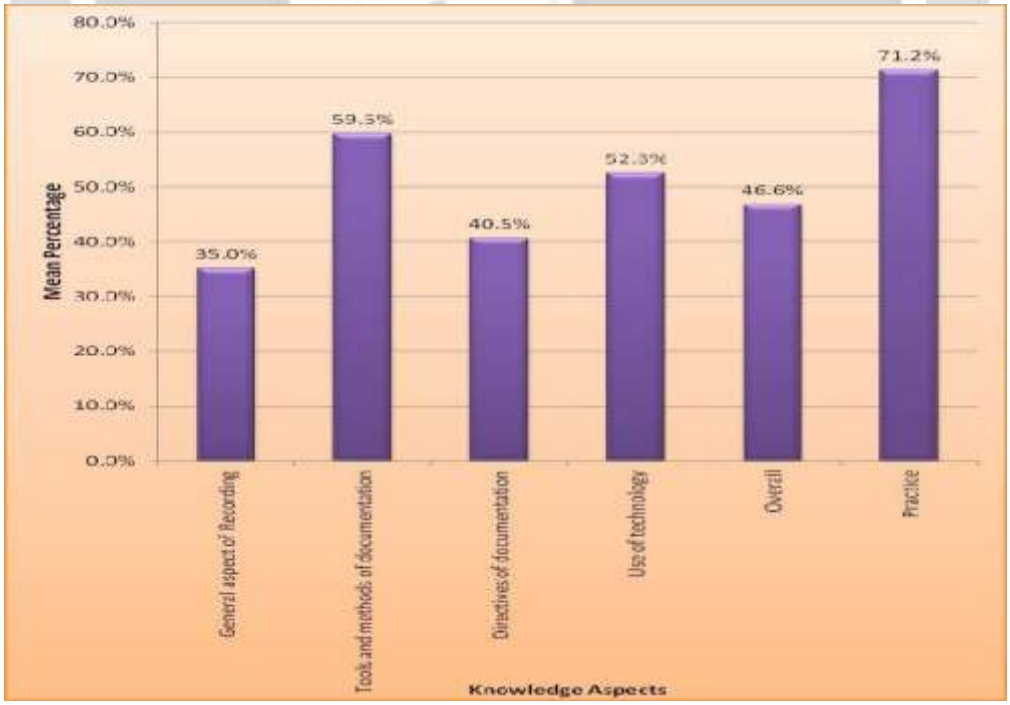

Figure 1: Bar diagram shows the area wise knowledge and practice scores ofstaff nurses

Table – 2: Association of knowledge score of staff nurses with the demographic variables.

N=60

Variables	Below Median	Median and above	Chi square	df	P value (0.05)	Inference
1. Age in years						
a. 21-30 years	5	12	24.668	3	7.82	S
b. 31-40 years	18	2				
c. 41-50 years	2	14				
d. 51-60 years	3	4				
2. Gender						
a. Male	6	11	1.233	1	3.84	NS
b. Female	22	21				
3. Religion						
a. Hindu	18	20	7.755	2	5.99	S
b. Muslim	5	0				
c. Christian	5	12				
4. Marital status						
a. Married	13	13	20.608	3	7.82	S
b. Unmarried	4	19				
c. Widow/Widower	7	0				
d. Divorcee	4	0				
5. Education						

The table 2 shows $\chi 2$ value computed between the knowledge level of Staff nurses on documentation technique and selected demographic variables. Variables such as age, religion, marital status and years of experience were significant at 0.05 level Thus the hypothesis stated there will be no significant association between knowledge level of the Staff nurses and selected demographic variables is rejected.

CONCLUSION

This chapter presents the conclusions drawn, implications, limitations, suggestions and recommendations.
The focus of this study was to assess the knowledge and practice of Staff nurses regarding documentation technique at the Selected hospital, Lucknow, Uttarpradesh. A non experimental descriptive design was used in the study. The data was collected from 60 samples through convenient sampling technique. The data collected was subjected to analysis using descriptive statistics in terms of frequencies, percentage and inferential statistics like 't' test and chi

square test to find the association. Nurses are the key persons of the health team, who play a major role in health promotion and maintenance. The nursing personnel need to record and report the information regarding the patient care and their needs accurately and precisely. The records should be clear and understandable that can be referred by any health professional. Maintaining patient and hospital records is an integral part of nursing services. As a nurse educator, there are abundant opportunities for nursing professionals to educate the Staff nurses regarding documentation technique.The study emphasize significance of short term in-service education programmes for nurses related to maintenance of patient and hospital records. Nursing personnel working in hospitals as well as in community areas should be given in-service education. Nursing administrators should take interest in motivating the nursing personnel's especially nurses in all the hospital to improve their professional knowledge and skill by attending the health conferences, workshops, seminars and training program on documentation technique. The nursing administrator should arrange regular in-service education program on documentation technique. Research provides nurses credibility to influence decision making, policy and protocol formulation regarding documentation technique among Staff nurses. Findings of the present study suggest that educators and administrator should encourage nurses to read, discuss and conduct research studies so as to enable the nurse to make data based decision and maintaining health records.

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The main benefit of documentation is improvement of the structured communication between healthcare professionals to ensure the continuity of individually planned patient care. Without an individualized care plan that is closely followed, nursing care tends to become fragmentary, being based predominantly on institutional routine and schedules. The care plan defines the focus of nursing care not only to the nursing staff but also to the patients and their relatives. By documenting the agreement between patients and RNs, an opportunity is provided for the patients to participate in the decision-making process of their own care. Moreover, the documentation of expert nursing provides an important source of knowledge to the novice RN and a potential motivating force for the further development of nursing theory. The care plan yields criteria for reviewing and evaluating care, as well as financial reimbursement and staffing .

OBJECTIVES

1. To assess the knowledge of staff nurses regarding documentation techniques.
2. To assess the practice of staff nurses regarding documentation techniques.
3. To correlate the knowledge and practice of staff nurses regarding documentation techniques
4. To find the association between knowledge and practice with selected demographic variables.
5. To prepare and provide an information booklet.