ASSESSING THE KNOWLEDGE, PRACTICE & ATTITUDE AMONG NURSES ABOUT THE DOCUMENTATION PROCESS OF MEDICAL RECORDS IN A TERTIARY CARE HOSPITAL

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

In

Hospital and Health Management

By

Mohit Agarwal

Under the supervision and Guidance of

Dr. Dhirendra Kumar

2022

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **"Assessing the Knowledge, Practice and Attitude Among Nurses About the Documentation Process of Medical Records in a Tertiary Care Hospital"** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Mohit Agarwal

Mohit Agarwal

24th June 2022

Global Health
Limited

Date: 17th Jun- 2022

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mr. Mohit Agarwal** has completed his **Internship** in the department of **Quality** from 23.03.2022 to 17.06.2022 with Global Health Ltd. (GHL) Medanta – The Medicity.

We wish him all the best for his future endeavors.

For GLOBAL HEALTH LTD

MEDANTA-THE M
Sector-38, Gurugram
Haryana

Ashish Adhikari

Deputy General Manager- Human Resources

CERTIFICATE

This is to certify that dissertation titled **"Assessing the Knowledge, Practice and Attitude Among Nurses About the Documentation Process of Medical Records in a Tertiary Care Hospital"** is a record of the research work undertaken by (Name of Student) in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur
Date

School Dean
IIHMR University, Jaipur
Date

Abstract

Background – Health records or medical records can be used interchangeably for systemic documentation of a patient's medical history and current treatment. It contains observations, drug administrations, surgical interventions, plans of care, consents, dietary charts, and the names of all health care providers involved in the patient's care. Medical documentation is an essential component of safe, ethical, and effective practice. Among health professionals, patient health and care are of the utmost importance, and inadequate documentation affects both patient care and outcomes.

Method – This descriptive observational study was done at a multi superspeciality Tertiary care hospital with sample size of 107 nursing staff.

Results – the knowledge assessed was found to be acceptable which was around 55%, however both knowledge and attitudinal area showed scope of improvement.

Conclusion – Regular audits, Gap analysis, continuous Training & refresher Training sessions needs more focus to improve the knowledge, practice, and attitude towards the documentation process.

Key Words – Knowledge, attitude, Practice, Documentation, Medical records

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I extend my gratitude towards all the people at the hospital who took part in the study and my organizational mentor for providing me the opportunity to conduct this study at the hospital."

I am extremely indebted of all the professors at, Indian Institute of Health Management and Research, Jaipur without their teachings, and support the study wouldn't have been possible."

It is indeed a pleasure to thank all my friends and family who persuaded and encouraged me to take up this task.

Mohit Agarwal

MBA HM- 25

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Abbreviations

Abbreviation	Meaning
JCI	Joint Commission International
B.sc	Bachelor of Science
GNM	General Nursing and Midwifery
ID	Identity
IPSG	International Patient Safety Goals
MRD	Medical Records Department
TS	Tricuspid Stenosis
UHID	Unique Health Identification
WHO	World Health Organization

CHAPTER 1

Introduction

The Term health records, or medical records can be used interchangeably which aims to systemic documentation of patient's medical history as well as present care. A medical record comprises of observations, drug administrations, surgical interventions, plan of care, consents, dietary chart etc. with names of all the healthcare providers associated with the Patient.[6]

Documentation is an important & necessary component of safe, ethical & effective medical practice. The health & care of the Patient is the most important concern among health professionals & it is known that inadequate documentation impacts both patient care and outcomes.

As per JCI guidelines & IPSG standards the medical records should contain sufficient information to identify the patient, support the diagnosis, justify the treatment & document the course & results of treatment. It is important to maintain complete records not only to comply with licensing & accreditation requirements but also to enable a healthcare provider to establish that the patient received adequate care.

Health professionals are Required to Document & keep records of their professional practice under the standard of practice & organizational policies & procedures. It is necessary to document all relevant clinical and non-clinical information not only for future Reference but also for making medical decisions and continuity of care specially when multiple healthcare providers are involved with a single patient.[4]

Proper filling of patient's documentation records ensures easy retrieval & contributes to decreasing patient waiting time.

1.1 Research Question:

What is the attitude of the Nurses towards documentation of patients' health records?

1.2 Objectives

- Determine the level of knowledge of Nurses on accurate documentation of patient health records.
- Assess the attitude of Nurses on documentation of patient health records.
- Find out the causes of improper documentation of patient health records among Nurses.
- Determine the impact of improper documentation of patient health records among Nurses.
- Identify challenges faced by the Nurses during documentation.

CHAPTER 2

Review of Literature

S.no	Title	Author(s)/ Year	Study location	Description
1	Assessing completeness of patient medical records of surgical and obstetric patients in Northern Tanzania	William Lodge, Gopal Menon, Salome Kuchukhidze, Desmond T. Jumbam, Sarah Maongezi, Shehnaz Alidina, Boniface Nguhuni, Ntuli A. Kapologwe & John Varallo (2020)	Tanzania	This study aims to measure incidence of surgical site infections, sepsis, maternal sepsis in surgical and obstetric patients A sample size of 157 patient was taken, where 67% of patient's medical record had documentation of SSI and sepsis which concluded strengthening record-keeping and data quality is essential for healthcare staff, continuity of care patient safety.
2	Medical Audit of Documentation of Inpatient Medical Record in a Multispecialty Hospital in India	Madhav M Singh, Saroj Patnaik, Bhandaru Sridhar (2017)	India	This study aims to assess the existing documentation procedure with accordance to hospital's established policy & to find the gap in the same with provisional solutions. A sample size of 320 case sheet were taken 5-10% case sheet from each department did not have food orders mentioned in medical records, 25% case sheets of Gynaecology department did not have name, date sign for the entries. Leaving against medical advice patients were discharged without the unwillingness of the treatment certificate, with recommendations like sensitizing the staff on importance of complete and correct medical records, standardization of

				record keeping procedure, quarterly medical audit
3	Nursing documentation: Frameworks and barriers	Wendy Blair & Barbara Smith (2014)	New Zealand	his article states about various barriers nurses' encounters during documentation such as time constraints, lack of clear guidelines mismatched information between 2 health care providers etc. The authors also investigate focus charting as a method of nursing notes documentation and suggest the same as recommendation for improving the documentation process within their Facility.
4	How to keep good clinical records	Alexander Mathioudakis, Ilona Rousalova, Ane Aamli Gagnat, Neil Saad, Georgia Hardavella (2016)	United Kingdom	This article aims to discuss about various dos and don'ts for entries in clinical records, accuracy, and legibility of the content and legal obligations like Confidentiality and patient's access to their medical records
5	Improving the quality of nursing documentation: An action research project	Elisha M. Okaisu Florence Kalikwani Grace Wanyana Minette Coetzee (2014)	Uganda	This study aims to improve nurse's documentation of their patient' assessment with 3 phases of training, orientation and system changes resulting in improved assessment techniques, through organizational culture change and redesign the forms and employment policies.

CHAPTER 3

Methodology

3.1 Study Design: Descriptive Observational study

3.2 Study Area: Multi-super specialty Tertiary Care Hospital

3.3 Study tool: Self-Administered Questionnaire

3.4 Study Period: 3 months (March-June,2022)

3.4 Sampling Technique: Convenient sampling

3.5 Sample size: 107 Nurses

- **Inclusion criteria:** Nursing Staff carrying out the documentation of admission, progress report, discharge process etc.
- **Exclusion criteria**: Staff who have no participation in the document handling process.

3.6 Data Collection Procedure: Data will Be collected through Well-structured Self-Administered questionnaire to assess the knowledge, practice, and attitudes among the nurses.

3.7 Operational Definitions:

- **Documentation:** "Is an orderly written account containing the patient's identification data, history of health, physical, laboratory findings, treatment, including surgical procedures etc."
- **Health:** "According to WHO, health is the state of complete, physical, mental, social, and emotional well-being and not merely the absence of disease or infirmity."
- **Health care facilities:** "Places that provide health care. They include hospitals, clinics, outpatient care centers etc."
- **Medical records:** "are the document that explains all detail about the patient's history, clinical findings, diagnostic test results, pre and postoperative care, patient's progress, and medication."
- **Improper documentation:** "It is a situation when the information gathered about a patient is incomplete, inaccurate, and incorrect."

- **Patient:** "A person receiving or registered to receive medical treatment, Patient health record: It is the collection of health-related information about a patient that is documented and maintained by health professionals it pertains to."

3.8 Ethical Considerations:

- Throughout the study data confidentiality was maintained
- Personal Information of employees were kept private
- Data collected was used for dissertation purpose Only.
- Participation was voluntary for this study.

CHAPTER 4

Results

Table 4.1: Socio demographic characteristics of the respondents (n=107)

VARIABLE	FREQUENCY	PERCENTAGE %
Age		
22-24	60	56.07
25-27	20	18.69
28-30	21	19.63
31 & above	6	5.61
Sex		
Female	76	71.03
Male	31	28.97
Education Qualifications		
B.sc (basic)	70	65.42
B.sc (Post basic)	5	4.67
GNM	32	29.91
Years of Experience		
0-2	68	63.55
3-5	18	16.82
6-8	17	15.89
9-11	4	3.74
11 & above	0	0.00

The above table 4.1 shows that 22-24 years of respondent were in majority i.e., 60(56.07%) while respondents 31 & above remained in minority 6(5.61%) more than half of respondents were female 76(71.03%) and rest were male 31(28.97%). 70(65.42) respondents were B.sc (basic) holder followed by 32(29.91) holding GNM and 5(4.67) B.sc (Post basic), With respect to years of experience majority of the respondents have their years of service between the year 0-2 years i.e., 68(63.55%).

4.2 Knowledge & Practice

To assess the knowledge and practice among the nurses a questionnaire with Multiple choice Questions were given to them out of which 107 responses were received. Participation for this survey was voluntary.

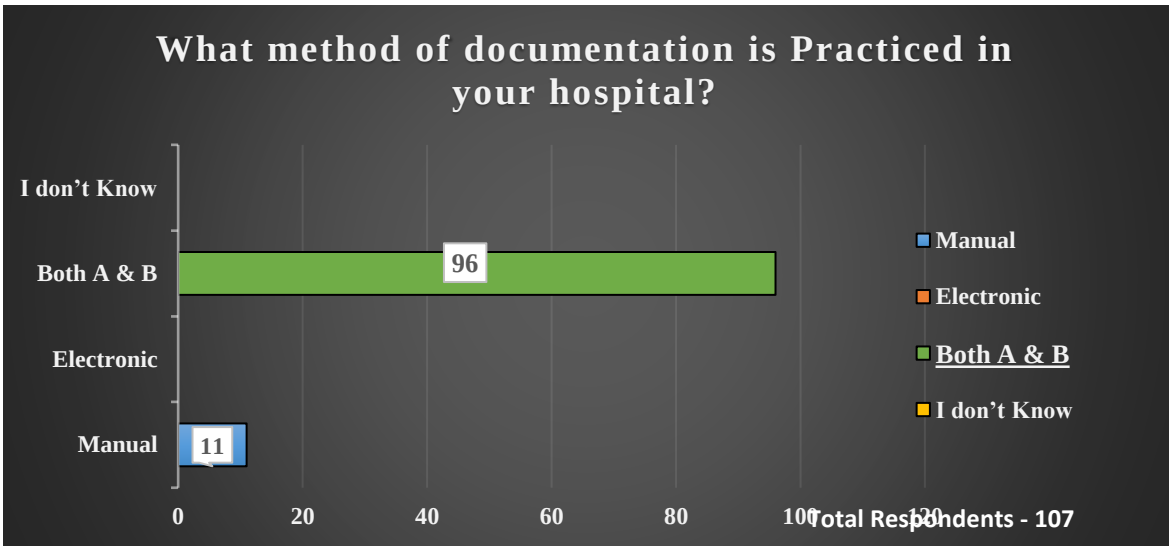

Figure 4.2.1: Method of Documentation practiced at the Facility

Out of 107 respondents 96(89.72%) gave the correct answer that both Manual and electronic mode of documentation is practiced at the facility, 11(10.28%) marked only Manual mode of documentation is practiced.

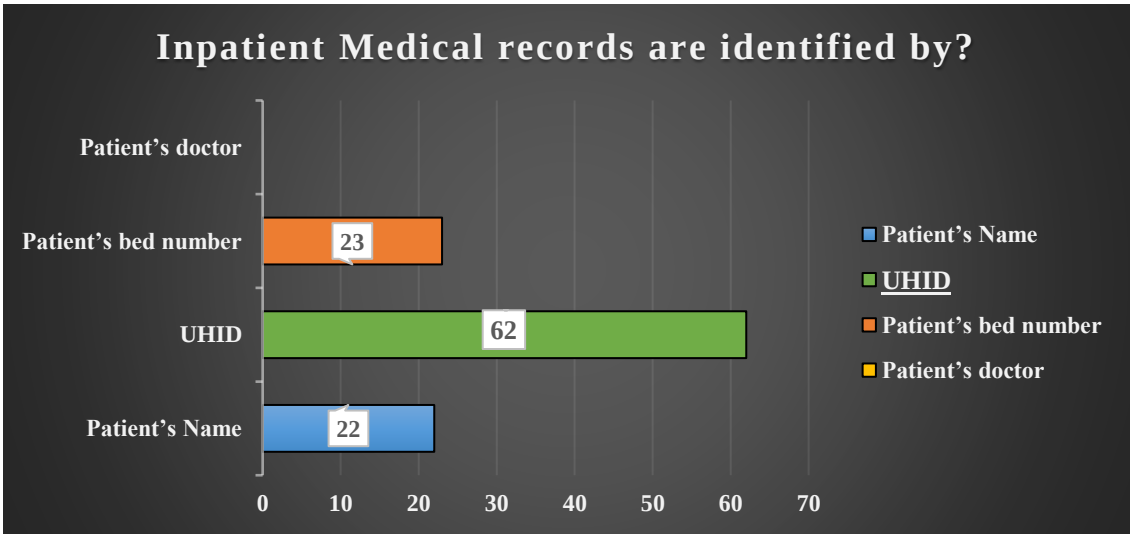

Figure 4.2.2: Identification of Medical Records

For this multiple question out of 107 respondents 62(57.94%) marked the correct answer UHID, 23(21.50%) marked by the Patient's Bed Number and 22(20.56%) by Patient's name & none of them for Patient's Doctor.

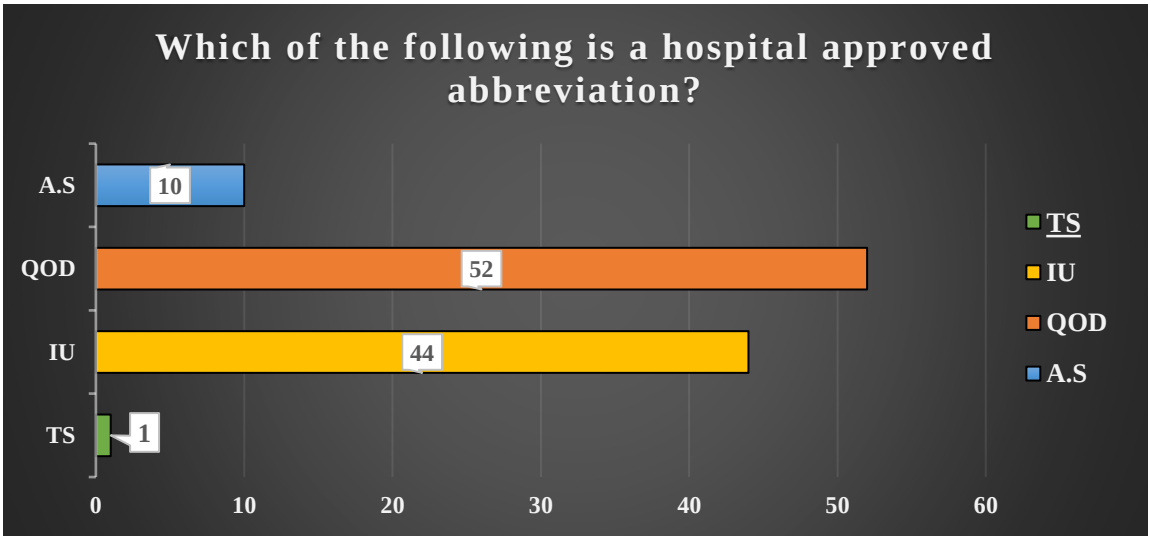

Figure 4.2.3: Hospital Approved Abbreviation

For this question out of 107 respondents only 1(0.93%) marked the correct answer TS stands for "Tricuspid Stenosis", 44(41.12%) Marked IU 52(48.60%) QOD & 10(9.35%) A.S respectively. Other than TS, rest of the abbreviations are mentioned in do not use Abbreviation list of Hospital's JCI handbook.

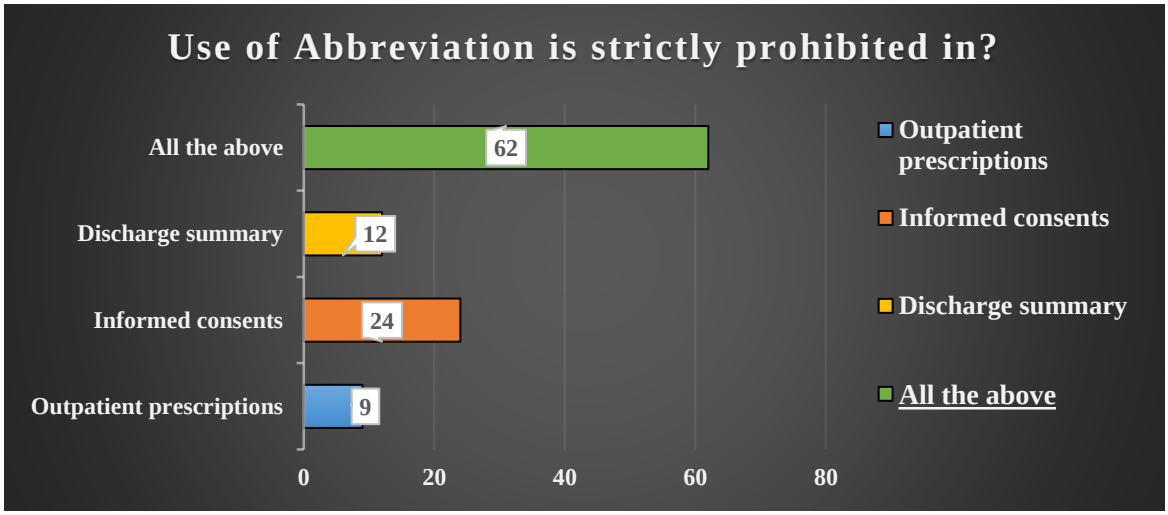

Figure 4.2.4: Use of Abbreviation according Document Type

For this question 62(57.95%) of respondents marked the correct answer i.e., All the above which were Outpatient Prescriptions, Informed consents & Discharge summary, marked 9(8.41%), 24(22.43%) & 12(11.21%) respectively.

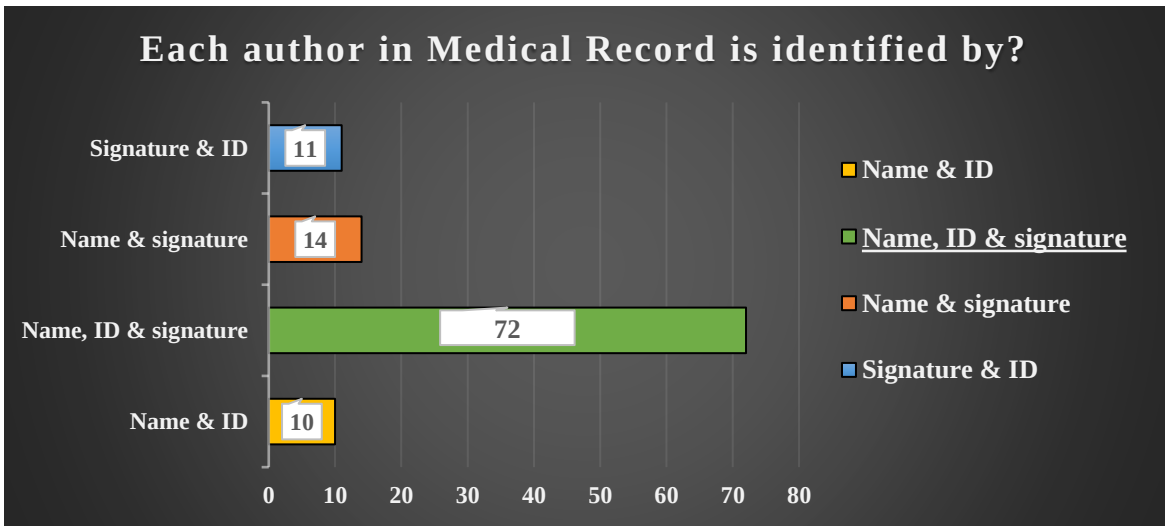

Figure 4.2.5: Identification of the Author in Medical Records

Out of 107 Respondents 72(67.29%) marked the correct answer Name, ID & Signature whereas 10(9.35%) marked only name and ID, 14(13.08%) only Name & Signature and 11(10.28%) Signature & ID.

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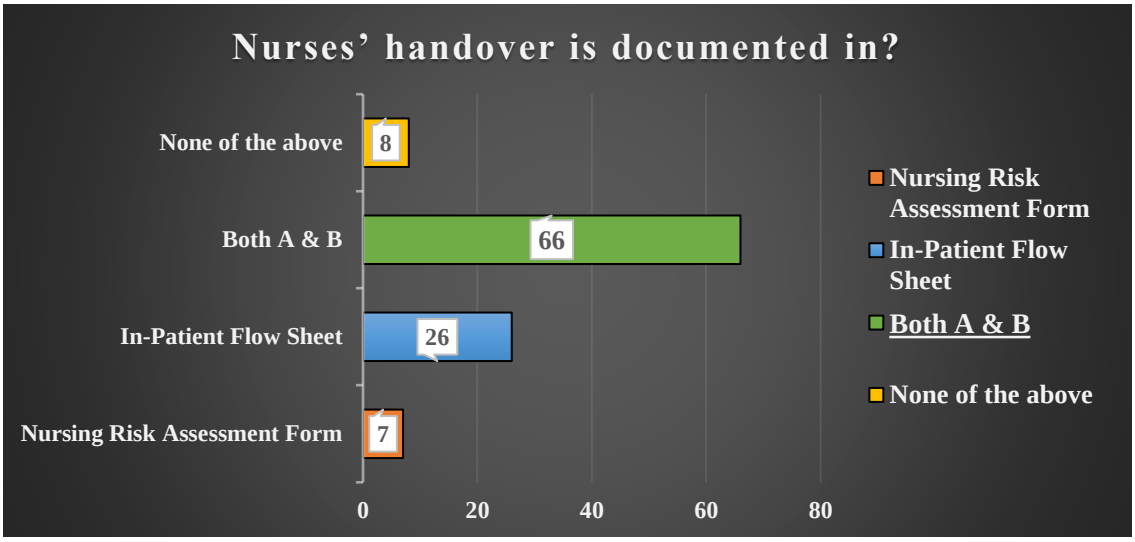

Figure 4.2.6: Handover of Medical Records Between nurses

For this multiple-choice question majority 66(61.68%) marked correct answer Both A & B which were Nursing Risk Assessment & In-Patient Flow sheet, marked 7(6.54%) & 26(24.30%) respectively and none of the above 8(7.48%).

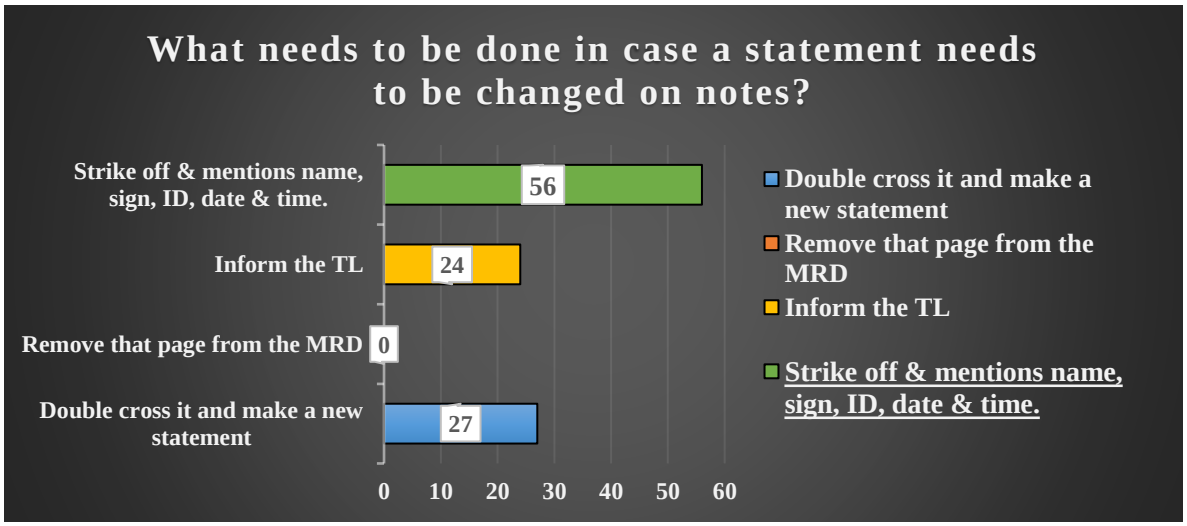

Figure 4.2.7: correction of notes

Out of 107 respondents 56(52.34%) marked correct answer Strike off & mentions name, sign, ID, date & time, 27(25.23%) marked Double cross it and make a new statement, 24(22.43%) Inform the TL & none of them marked Remove that page from the MRD.

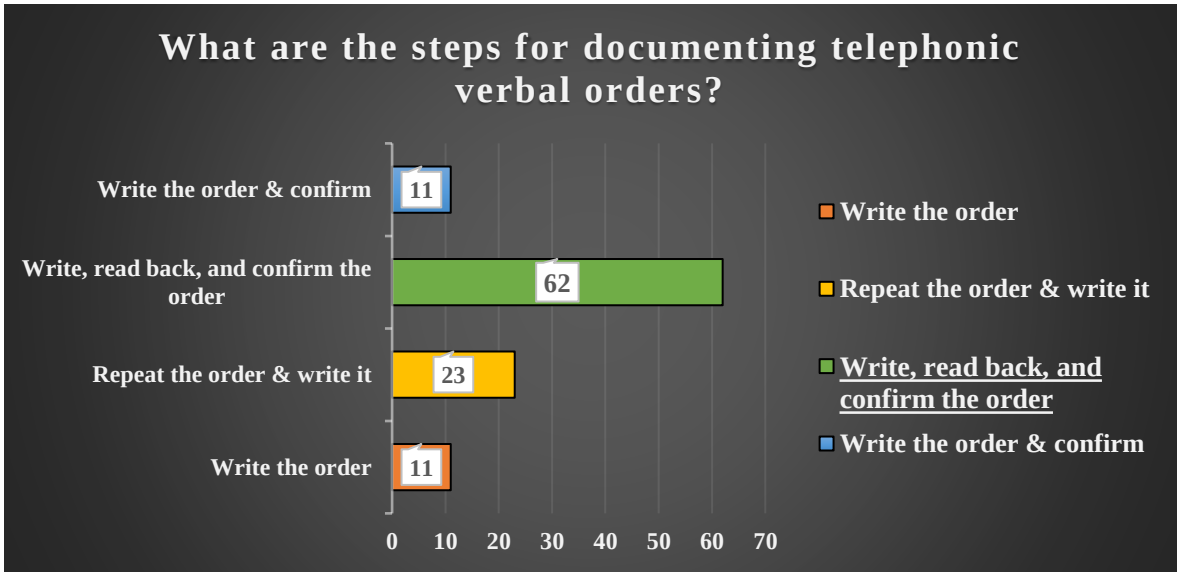

Figure 4.2.8: Documentation of telephonic verbal orders

For this multiple choice question out of 107 respondents 62(57.94%) marked the correct answer Write, read back, and confirm the order, 11(10.28%) marked Write the order, 23(21.50%) marked Repeat the order & write it, 11(10.28%) marked Write the order & confirm it.

4.3 Attitudinal

The Data was collected and analyzed based on 5-point Likert scale, based on these statements it was possible to understand the attitude, causes, Impact & Challenges of improper documentation among the respondents

Table 4.3.1: Attitude (n=107)

Domain	Rating Scale				
Attitude	**Strongly Agree**	**Agree**	**Indifferent**	**Disagree**	**Strongly Disagree**
Health information documentation help communication between the health care professionals	75%	22%	1%	2%	0%
Training required for the proper documentation process.	59%	34%	7%	0%	0%
Aggregate percentage %	62.45%	26.20%	3.93%	0.87%	0%

Table 4.3.1 depicts that 62.45% of respondents Strongly Agree & 26.20% of respondents agree with Training and usefulness of the Documentation process i.e., 97% Strongly agree or agree with Respect to usefulness of the documentation for communication between health care professionals & 93% strongly agree or agree with respect to Training required for proper documentation.

Table 4.3.2: Causes of Improper Documentation (n=107)

Domain	Rating Scale				
Causes of improper documentation	**Strongly Agree**	**Agree**	**Indifferent**	**Disagree**	**Strongly Disagree**
The inexperience of staff can affect the quality of documentation	66%	23%	3%	3%	5%
The inadequate motivation of health record staff may lead to improper documentation	67%	12%	7%	5%	8%
Improper documentation may arise when wrong data is being captured by a medical professional	79%	18%	1%	0%	3%
Aggregate Percentage %	66.09%	16.60%	3.49%	2.33%	4.95%

Table 4.3.2 depicts Different causes of Improper documentation where 66.09% strongly Agree and 16.60% Agree with Inexperience, inadequate motivation and capturing of wrongful data for improper documentation process among Respondents. Capturing of wrongful data received the most Agreement by 79% Strongly agreeing and 18% agreeing to it.

Table 4.3.3: Impact of Improper Documentation (n=107)

Domain	Rating Scale				
Impact of Improper documentation	**Strongly Agree**	**Agree**	**Indifferent**	**Disagree**	**Strongly Disagree**
Failure to document necessary information about a patient may lead to patient death.	7%	73%	5%	13%	3%
Improper documentation may lead to sanctioning of Documenting staff	14%	68%	9%	5%	4%
Improper documentation can lead to complications in patient health.	24%	59%	7%	10%	0%
Improper documentation can affect the continuity of patient care.	31%	64%	1%	5%	0%
Aggregate percentage %	17.69%	61.58%	5.02%	7.64%	1.53

Table 4.3.3 Depicts various Impacts of improper documentation of medical records where 17.69% Strongly Agree & 61.58% Agree with patient's death, sanctioning of documenting staff, complications in Patient's health & affect the continuity of care.

Table 4.3.4: Challenges (n=107)

Domain	Rating Scale				
Challenges	**Strongly Agree**	**Agree**	**Indifferent**	**Disagree**	**Strongly Disagree**
Inadequate knowledge, Training & Experience of the importance of documentation hinders staff from making proper documentation	14%	78%	4%	3%	2%

Table 4.3.4 depicts the challenge faced by the respondents, 14% strongly agree & 78% agree with inadequate knowledge, Training and experience hinders them from making proper documentation.

CHAPTER 5

Discussion

Knowledge, practice & attitude of the staff was observed to be acceptable.

The knowledge assessment of the staff indicates that 54.52% of the nursing staff have knowledge and information about correct documentation process to be followed, Whereas 57.94% of nursing staff uses the correct identification indicator for medical records (Figure 4.2.2: Identification of Medical Records) although around 99% of nurses were not aware about the hospital approved abbreviations (Figure 4.2.4: Use of Abbreviation) according Document Type which is important for its interpretation as multiple healthcare professionals are involved with one patient and each one can have different interpretation of the same abbreviation.

61.68 % of nurses are documenting their handover on correct document (Figure 4.2.7: Handover of Medical Records Between nurses) and 67.29% using correct identification markers for themselves in the records (Figure 4.2.5: Identification of the Author in Medical Records). It is although utmost import to document the correct information on correct piece of paper to avoid confusion and interference in continuity of care.

Only 52.34% of staff new what needs to be done when a wrong or incorrect statement or entry is made in the records (Figure 4.2.7: correction of notes), when an incorrect statement is made it is highly important for the author to highlight the statement and cancel it followed by mentioning their credentials at that very page, a wrong information and intervention can lead to consequences which can be lethal for the patient.

57.94% of the nurses knew the correct steps for taking a verbal order over the phone (Figure 4.2.8: Documentation of telephonic verbal orders), when patients are under observations and doctors are not around the first point of contact are nurses who also are the medium between patients and doctors so in case when a medical orders needs to be taken over the phone the correct steps to be followed to avoid wrong action to be taken with respect to plan of care.

With respect to attitudinal it was found 42.82 % of staff strongly agreed or agreed with different domains – attitude, causes, impact, & challenges towards improper documentation. Most nursing staff did agree with usefulness of the documentation process, but the numbers were comparatively low in impact of improper documentation, although the greatest number of nursing staff did agree on challenges for improper documentation which was inexperience, inadequate knowledge, and training for the same for the staff.

CHAPTER 6

Conclusion

There is need of more attention to be paid towards knowledge, practice & attitude with respect to correct information to be used, correct place to be filled & rectification if a mistake has been made. A special attention is required to change the attitude of the nursing staff by making them understand the responsibilities and consequences of the documentation process.

Young and inexperienced staff found to be the major reason for low attitude and knowledge for the documentation process of the medical records. 53.07% of nursing staff at the hospital was found to be between age of 22- 24 and 63.55 had experience of only 0-2 years (Table 4.1: Socio demographic characteristics of the respondents) Proper training and experience do play an important role for all nursing staff, yet alone for documentation process complete understanding of Nurse's role and implications of their actions should be highlighted time to time.

6.1 Recommendations

- ✓ More audits for documentation process and medical records
- ✓ Provide quarterly Training and Refresher training sessions
- ✓ Providing incentives and motivation factors to nurses for satisfactory & beyond performances.
- ✓ Hire more experienced nursing staff
- ✓ Change organizational culture through Action & consequences.
- ✓ Gap analysis of documentation process.

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Annexures

Questionnaire-

INSTRUCTION: please tick (√) where necessary.

Section A: Socio-demographic data

1. Age:…….

2. Sex:

a) Male

b) Female

3. Educational qualification:

a) B.sc (basic)

b) B.sc (Post basic)

c) GNM

d) Others, **specify…….**

4.Year of experience:……

SECTION B: Knowledge & Practice of respondents on patient documentation.

1. **What method of documentation is Practiced in your hospital?**
   a) Manual
   b) Electronic
   c) A & B
   d) I don't know
2. **Inpatient Medical records are identified by**
   a) Patient's name
   b) Patient's bed number
   c) UHID
   d) Patient's doctor

3. **Which of the following is a hospital approved abbreviation?**
   a) TS
   b) IU
   c) QOD
   d) A.S

4. **Use of Abbreviation is strictly prohibited in**
   a) Outpatient prescriptions
   b) Informed consents
   c) Discharge summary
   d) All the above

5. **Each author in Medical Record is identified by**
   a) Name & ID
   b) Name, ID & signature
   c) Name & signature
   d) Signature & ID

6. **Nurses' handover is documented in**
   a) Nursing Risk Assessment Form
   b) In-Patient Flow Sheet
   c) Both A & B
   d) None of the above

7. **What needs to be done in case a statement needs to be changed on notes?**
   a) Double cross it and make a new statement
   b) Remove that page from the MRD
   c) Inform the TL
   d) Strike off & mentions name, sign, date & time.

8. **What are the steps for documenting telephonic verbal orders**?
   a) Write the order
   b) Repeat the order & write it
   c) Write, read back, and confirm the order
   d) Write the order & confirm it

SECTION C: Attitudinal

S.NO	Questions/statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Health information documentation help communication between the health care professionals					
2	Training required for the proper documentation process.					
3	The inexperience of staff can affect the quality of documentation					
4	The inadequate motivation of health record staff may lead to improper documentation					
5	Improper documentation may arise when wrong data is being captured by a medical professional					
6	Failure to document necessary information about a patient may lead to patient death.					
7	Improper documentation may lead to sanctioning of Documenting staff					
8	Improper documentation can lead to complications in patient health.					
9	Improper documentation can affect the continuity of patient care.					
10	Inadequate knowledge, Training & Experience of the importance of documentation hinders staff from making proper documentation					

--End--