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

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

Documentation is an important & necessary component of safe, ethical & effective medical practice. Proper filling of patient's documentation records ensures easy retrieval & contributes to decreasing patient waiting time

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

Research Question

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

Study 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

Determine the impact of improper documentation of patient health records among Nurses.

Identify challenges faced by the Nurses during documentation.

Find out the causes of improper documentation of patient health records among Nurses

Methodology

Study Design: Descriptive Observational study

Study Area: Multi-super specialty Tertiary Care Hospital

Study tool: Self-Administered Questionnaire

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

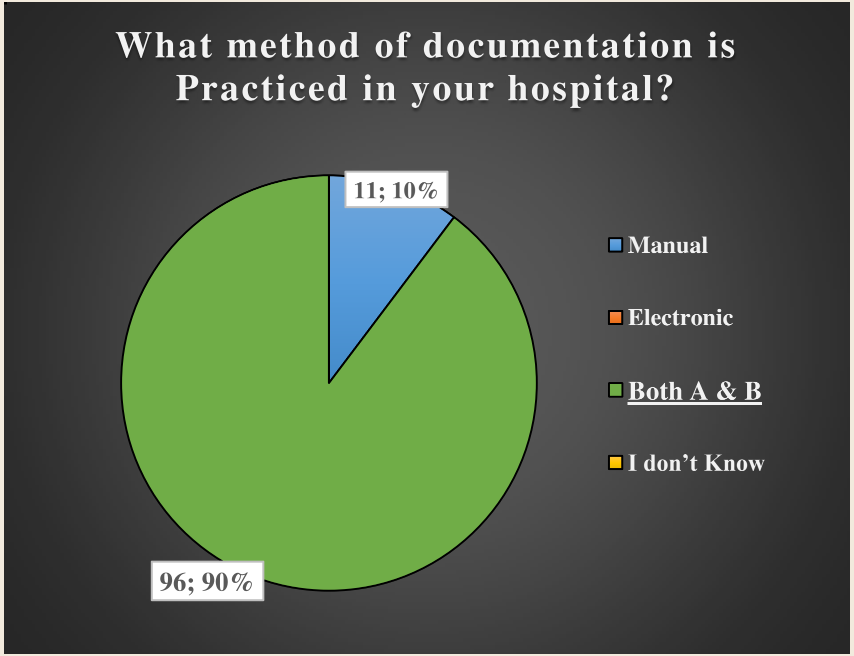
Sampling Technique: Convenient sampling

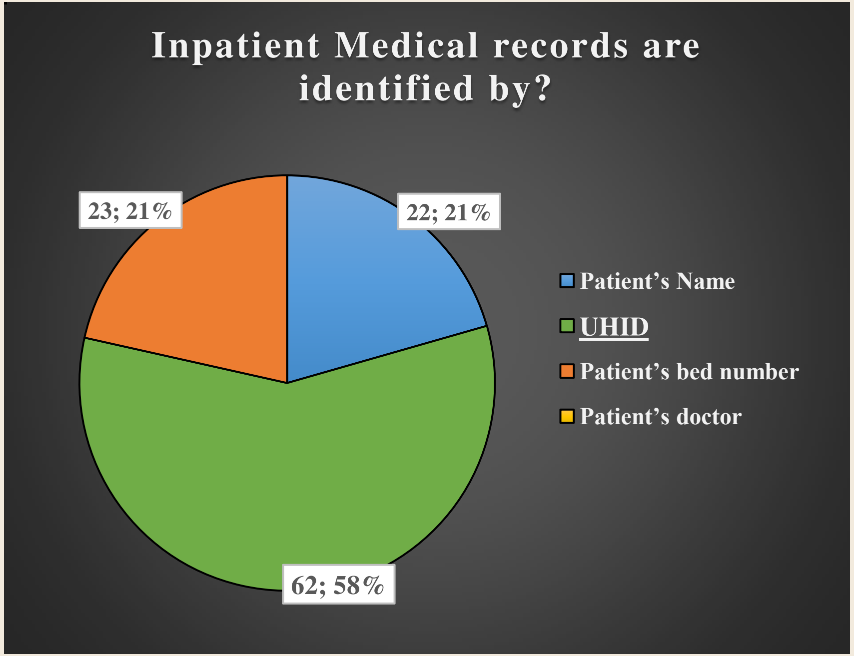
Sample size: 107 Nurses

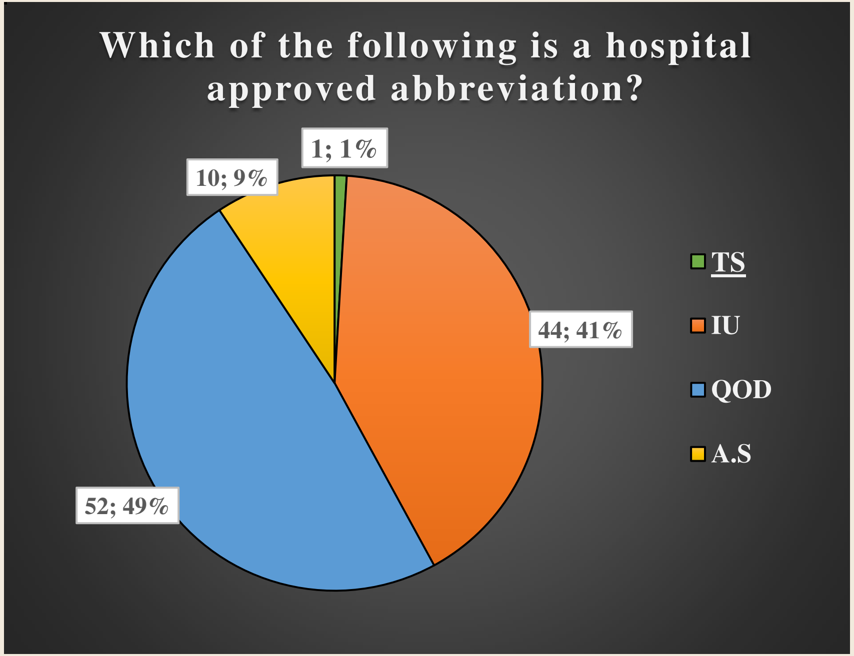
Socio demographic characteristics of the respondents

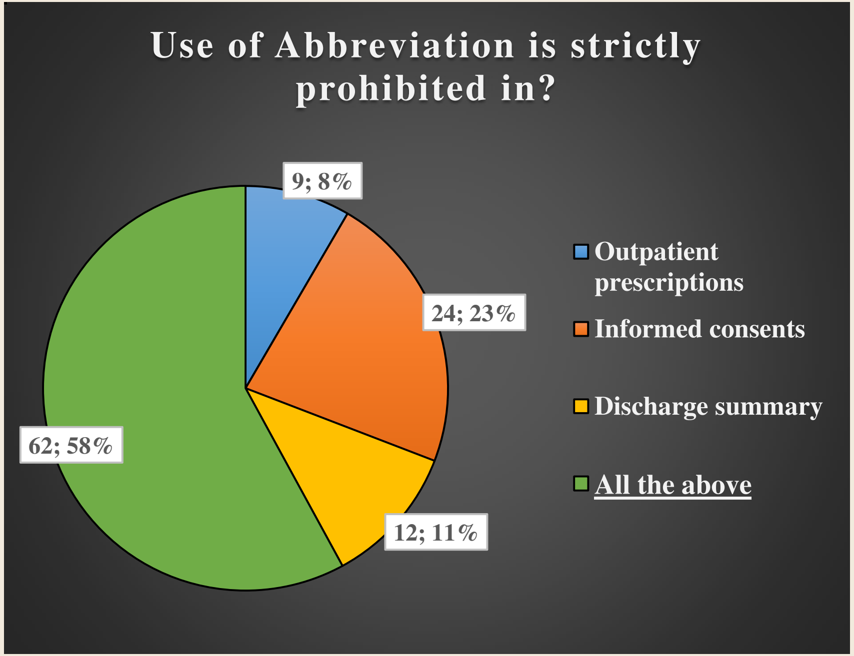
VARIABLE	FREQUENCY	PERCENTAGE %
Age		
22-24	60	56.07
25-27	20	18.69
28-30	21	19.63
31 & above	6	5.61
Sex		
Female	76	71.03
Male	31	28.97
Education Qualifications		
B.sc (basic)	70	65.42
B.sc (Post basic)	5	4.67
GNM	32	29.91
Years of Experience		
0-2	68	63.55
3-5	18	16.82
6-8	17	15.89
9-11	4	3.74
11 &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

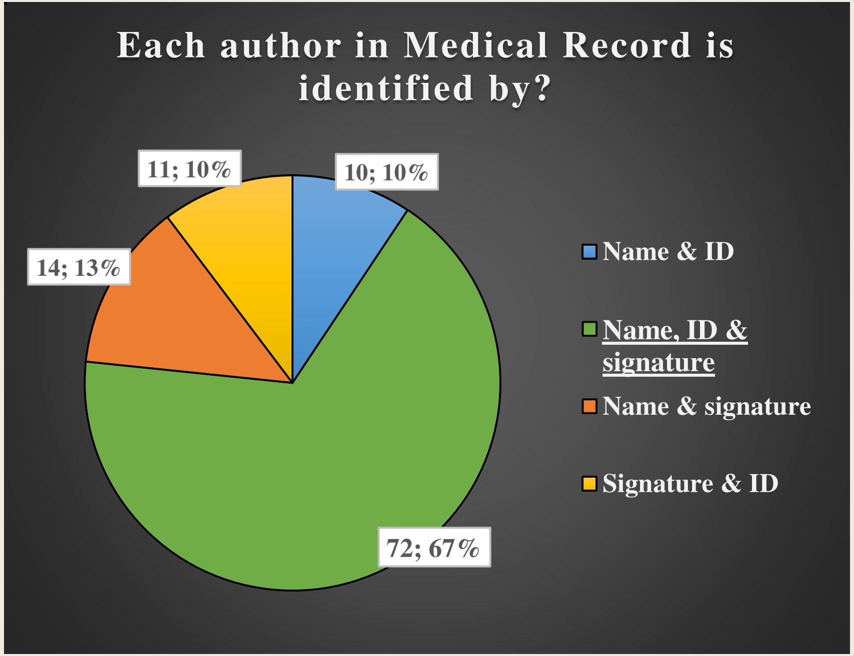
Knowledge & Practice

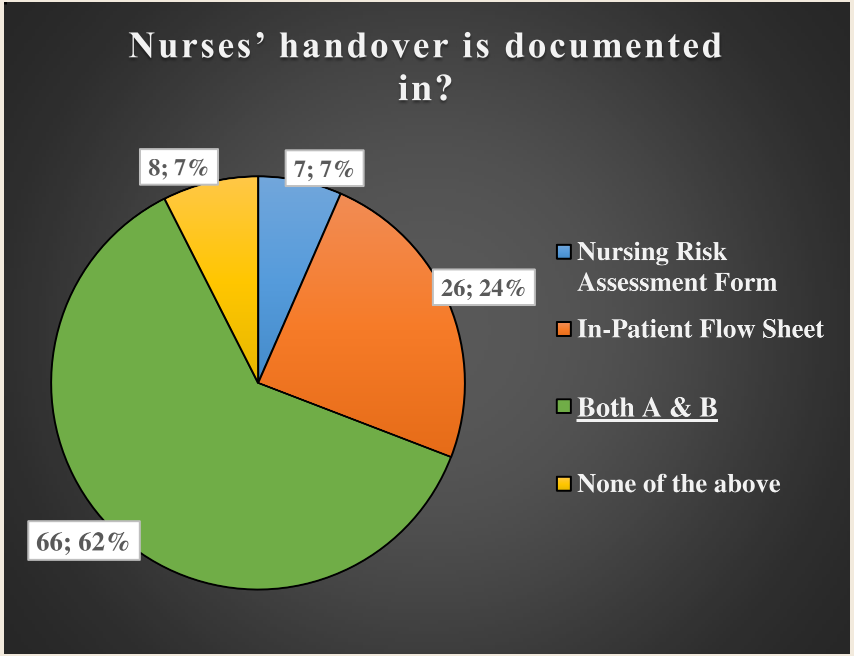


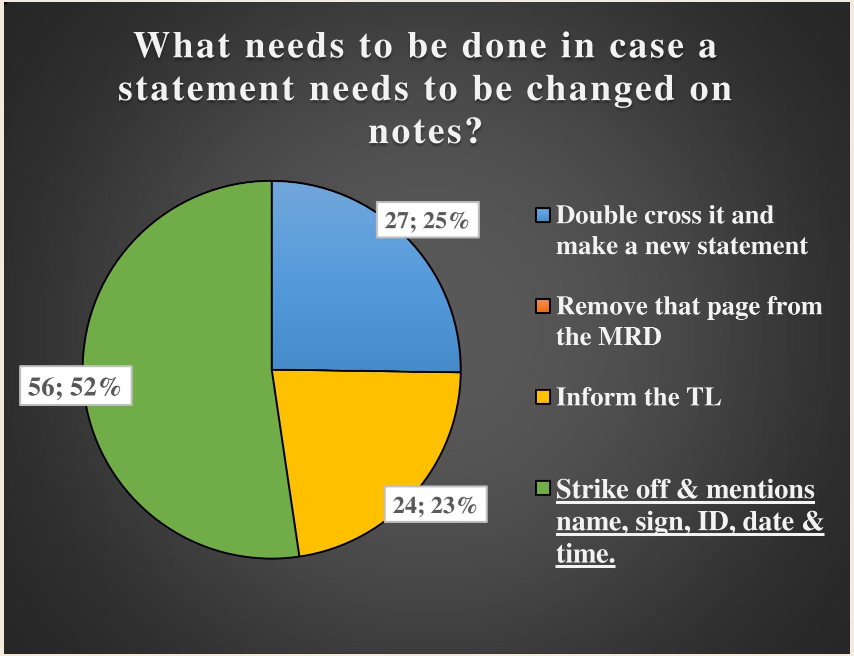


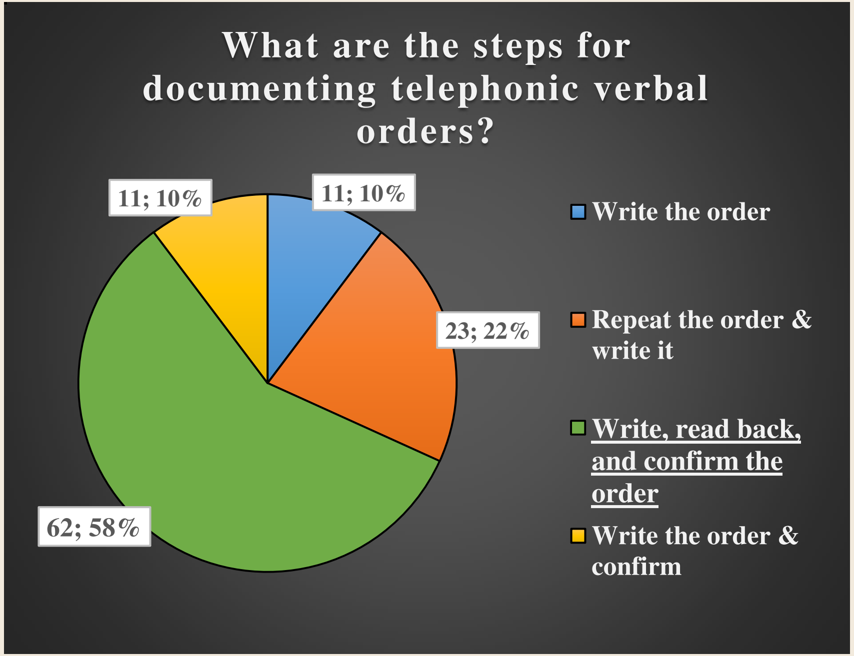

Which of the following is a hospital approved abbreviation?
1; 1%
10; 9%
44; 41%
52; 49%
TS
IU
QOD
A.S


Use of Abbreviation is strictly prohibited in?
9; 8%
24; 23%
62; 58%
12; 11%
Outpatient prescriptions
Informed consents
Discharge summary
All the above


Each author in Medical Record is identified by?
11; 10%
10; 10%
14; 13%
72; 67%
Name & ID
Name, ID & signature
Name & signature
Signature & ID


Nurses' handover is documented in?
8; 7%
7; 7%
26; 24%
66; 62%
Nursing Risk Assessment Form
In-Patient Flow Sheet
Both A & B
None of the above


What needs to be done in case a statement needs to be changed on notes?
27; 25%
56; 52%
24; 23%
Double cross it and make a new statement
Remove that page from the MRD
Inform the TL
Strike off & mentions name, sign, ID, date & time.


What are the steps for documenting telephonic verbal orders?
11; 10%
11; 10%
23; 22%
62; 58%
Write the order
Repeat the order & write it
Write, read back, and confirm the order
Write the order & confirm

Attitude

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%

Causes of Improper Documentation

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%

Impact of Improper Documentation

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

Challenges

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%

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 although around 99% of nurses were not aware about the hospital approved abbreviations 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.

Discussion Contd.

Only 52.34% of staff new what needs to be done when a wrong or incorrect statement or entry is made in the records, 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.

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.

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.

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.

References

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