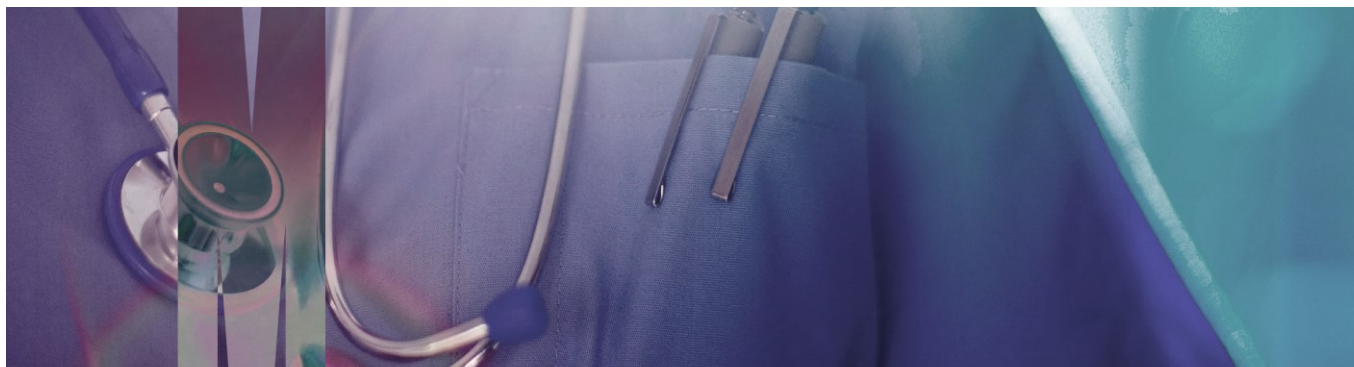


## Documentation Practice and Associated factors among Nurses Working in Jimma University Medical Center, Jimma Town, South West Ethiopia



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### ABSTRACT

Nursing documentation is an essential component of nursing practice that has a potential to improve the patient care outcome. Poor documentation among nurses has been shown to have negative impacts on the health care quality. However; little has been explored about nursing documentation practice in the study area. The purpose of this study is to assess nursing documentation practice and associated factors among nurses working in Jimma university medical center.

Institution based cross sectional study design was employed. Data was collected using a structured self-administered questionnaire and nursing care standard checklist. Pre-taste was done among 10 % of sampled nurses working in shenen gibe Hospital. Simple random sampling technique was utilized. Data was entered into Epidata version 3.1 and then exported to SPSS version 21 for analysis. Descriptive statistics and binary logistic regression was done. A p-value of less than 0.05 was used to declare statistical significance.

The study result showed 48.6% good nursing documentation practice. Adequacy of documenting formats, time, supervisors' motivation, training and familiarity with operational standard of nursing documentation were significantly associated with practice of nursing care documentation.

In conclusion, nursing documentation practice was poor (51.4%) among nurses under the study. The institution need to create awareness and close monitoring and evaluation and nursing leaders should motivate the employees to enhance the practice of documentation and avail the necessary documenting materials.

**Keyword:** Documentation, Documentation practice, Nursing care.

## I. INTRODUCTION

Nursing documentation is defined as any written or electronically generated information about a client that describes the care or service provided to that client including what occurred and when it occurred (CRNNS, 2012). It is a vital component of safe, ethical and effective nursing practice (Obioma, 2017). Nursing documentation has been accepted as a very important aspect of professional practice to nurses since the emergence of nursing as a profession (Edmonton, 2014).

Nursing documentation should fulfill the legal requirements since its consequence may end with malpractice suits. The old saying, 'If it wasn't charted, it wasn't done,' still holds today (Alkouri, Just and Kawafah, 2016).

Documentation also provides valuable data for research in Nursing, which have the potential to improve health outcomes. In addition to these, it may form the basis of teaching plans (CRNBCN, 2013). On the other hand, the level of contributions nurses do in the health care system can be witnessed through proper documentation of their roles (Case and Leonardi, 2015).

A nursing document should be client focused, consists of relevant information, accurate, chronologically written, clear and concise, permanent, confidential and timely (Case and Leonardi, 2015).

Although keeping a patient record is part of their professional obligation, many studies identified deficiencies in practice of documentation among nurses globally. It has been reported that nursing records are often incomplete, lacked accuracy and had poor quality (CRNNS, 2012), (Statements and Reading, 2006).

Poor documentation in nurses has been shown to have negative impacts on the health care of patients. The impact may lead to harmful consequences like exposing the care provider for medication administration error. Quality of patient care can also be hindered by an absence of sufficient documentation of data (Chelagat *et al.*, 2013). On the other hand, a good documentation improves credibility of the institution, and makes the nursing profession visible. This means that, the situation may lead to the extent that can affect the status of the health care facilities because health care facilities are evaluated by the quality of documents they keep in most cases (Molla, 2014).

The global trend of missed, inappropriate or incomplete documentation of nursing care is alarming and as with most developing countries such as Ethiopia, struggling with inadequate nursing staff and yet burdened with an increasing workload, the tendency for documentation errors cannot be ignored (Hussainat Taiye, 2015).

A study conducted in Jamaica showed high levels (98%) of good documentation by nurses at a referral hospital in Jamaica. ('Evaluation of registered nurses' knowledge and practice of documentation at a Jamaican hospital', no date). A study conducted among nurses in Papuan area of Indonesia also reported a documentation practice level of only 37 % (Mote, Rantetampang and Pongtiku, no date). A study conducted in Nigeria showed that good nursing documentation was practiced by 70% and majority of respondents (96.7%) document anytime a case is rendered, 3.3% document 3-4 times in a shift, 84.8% by sitting at nurses' station and reading what they have written to make corrections respectively and 7.4% check the previous information and formulate theirs ('Nursing documentation\_ Experience of the use of the nursing process model in selected hospitals in Ibadan, Oyo State, Nigeria - Ofi - 2012 - International Journal of Nursing Practice - Wiley Online Library', no date).

In Ethiopia, the Federal Ministry of Health Operational Standard for Nursing Care outlines that every nursing care provided must be clearly and correctly documented. Nevertheless, a study.

conducted in Gondar, North West Ethiopia indicated that slightly more than one-third (37.4%) had good nursing care documentation practice ('Nursing care documentation practice\_ The unfinished task of nursing care in the University of Gondar Hospital\_ Informatics for Health and Social Care\_ Vol 42, No 3', no date).

Good nursing care documentation was practiced by 52% of the total nurses in the wards of the hospital while more than half (52.8%) of the pediatric department nurses were observed to have good nursing care documentation practice. A study conducted in Felege Hiwot Referral Hospital also showed that nearly 87% of the medications provided had documentation errors committed by nurses (Engeda, 2016).

In the last few years, some significant trends in documenting patient care have become reality. These trends include changes in traditional care planning and effort to meet the need for increased documentation and improved communication while making charting less time consuming (Jansson, 2010).

According to a study done in Mosul of Iraq, there were significant statistical differences in nursing documentation with regard to educational level of nurses (Hameed *et al.*, 2014). A study done in Iran showed a strongly positive correlation between ages, gender, ward type or work setting and length of employment and female and younger nurses who had a mean of one to five years of nursing service practiced better nursing document in medical wards than in surgical wards ('Nurse's Knowledge and Practice of the Principles of Nursing Documentation at Hospitals of Kerman University of Medical Sciences - Iran Journal of Nursing - آیدران پژوهش های پرستاری', no date).

Even though the quality and effectiveness of nursing practice is mostly demonstrated by documenting the application of the nursing process, nurses may record patient visit registry in the outpatient departments (John Snow Inc., 2010). Therefore, the intent of this research is to assess the nurses' documentation practice of patient care and associated factors in the in-patient and out-patient departments of Jimma university medical center south west, Ethiopia.

## II. MATERIALS AND METHODS

**Study Setting :** The study was conducted in Jimma University Medical Center, in Oromia regional state Jimma zone, Jimma town. JUMC is one of the oldest public Hospitals in the country it was established in 1937 by Italian invaders 352 km to Southwest of Addis Ababa. Bed capacity of 800 and has more than 1800 staff, among these there are 550 nurses. It has been serving for a catchment population of 15-20 million residing Oromia, Gambella, SNNPR and Benishangul regions. Based on figures from the Statistics office of Jimma university medical center (2009) (Hailu, Worku Kassahun and Woldie Kerie, 2016)

**Study Design and period :** Institution based cross-sectional study design was employed from March 13 to April 6/2018

**Sample size determination :** The sample size was determined using single population proportion formula and a total of 396 nurses are recruited.

**Sampling technique :** Simple random sampling technique and proportional allocation to the study units were applied.

**Data collection instruments :** Data was collected by using structured self-administered questionnaire, which contain both open and closed ended question. English version of the questionnaire was used. The questions are developed based on the national guideline prepared by the FMOH (EHRIG 2016) (Handbook, 2016), various books written on nursing documentation (CRNNS, 2012), (Russell, 2017) and literatures related to the topic ((Cheevakasemsook *et al.*, 2006), ('Nursing care documentation practice\_ The unfinished task of nursing care in the University of Gondar Hospital\_ Informatics for Health and Social Care\_ Vol 42, No 3', no date), (Mote, Rantetampang and Pongtiku, no date), (Nakate, Dahl and Drake, 2015). In addition document review (patient chart) was conducted by using nursing care standard checklist which adopted from FMOH (Managers, 2011).

**Data quality control :** Training for data collectors and supervisors, pre- tested and reliability test was done to keep data quality.

**Ethical consideration :** Ethical clearance was obtained from Institutional Review board of Jimma University. A formal letter from Institute of health science was given to JUMC and Shenene Gibe hospital to obtain their co-operation. All the study participants were informed about the objective of the study and their verbal informed consent was obtained. Additionally confidentiality and privacy of the information was kept confidentially.

### III. STATISTICAL ANALYSIS AND GRAPHICAL PRESENTATION

**Data processing and analysis :** The collected data was checked for completeness and cleanness and then entered into Epidata version 3.1 then exported to SPSS version 21 software for analysis. Descriptive statistics was done to describe the study variables. Bivariate analysis was performed to select candidate variables for multi variable logistic regression analysis. All independent variables with p-value less than 0.25 was taken as candidates for multivariable logistic regression model. Finally, p-value of less than 0.05 at 95% CI were used to declare statistical significance. The AOR from multi variable logistic regression were used to measure the strength of association.

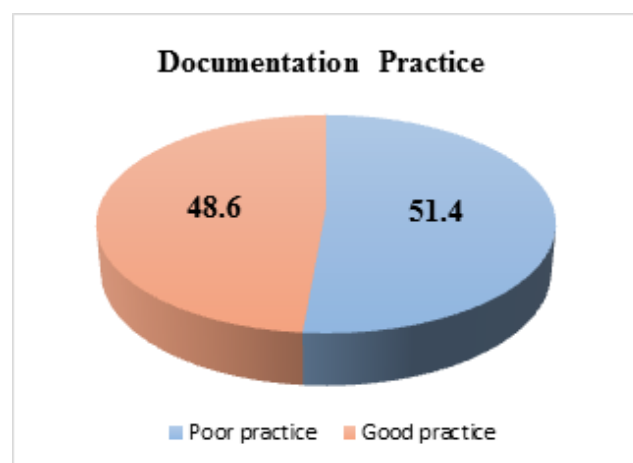
### IV. RESULTS

**Socio-demographic characteristics of respondents :** Out of the 396 sampled nurses, all returned the questionnaire and five was discarded due to incomplete information making the response rate 98.7%. From 391 nurses who participated in this study, 204 (52.2%) were females and mainly 236 (60.4%) fall within the ranges of 25-34 years age group. Majority of the respondents 173 (44.2%) orthodox religion followers and more than of the respondents were holding bachelor degree 275 (70.3%). Almost two third 79 % of the study participants worked as a nurse for 5 years or less. Also 24.3% (95) of the respondents were working in surgical followed by medical 21.2% (83) department in the hospital during the study period (table 1).

**Table 1: Socio demographic characteristics of nurses working in Jimma university medical center south west, Ethiopia, 2018 (n=391)**

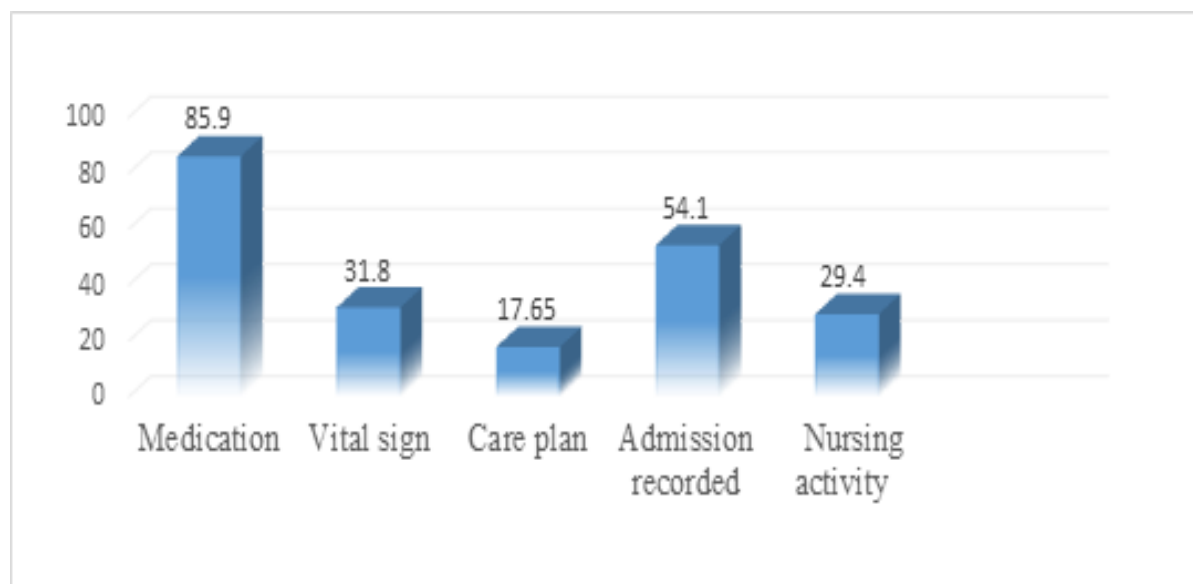
Variables		n	(%)
Age group (in a years)	≤ 24	83	21.2
	25-34	236	60.4
	35-44	55	14.1
	≥ 45	17	4.3
sex of respondents	Male	187	47.8
	Female	204	52.2
Educational level of respondents	College diploma	107	27.4
	Bachelor degree	278	71.6
	MSc and above	4	1.0
Religion of respondent	Orthodox	173	44.2
	Muslim	109	27.9
	Protestant	103	26.3
	Others	6	1.5
Marital status	Single	184	46.5
	Married	174	43.7
	Divorced	28	7.2
	Separated	4	2.3
	Widowed	1	0.3
work experience(in years)	<2	131	33.5
	2-5	182	46.5
	>5	78	19.9
Work setting of respondents (ward)	Medical	83	21.2
	Surgical	95	24.3
	Pediatrics	65	16.6
	Gyn/obs	73	18.7
	OPD	30	7.7
	**Others	45	11.5
Salary (income )	<3900	99	25.3
	3901-4550	181	46.3
	4551-5284	86	22.0
	≥ 5285	25	6.4

**\*\*others** (dialysis, endoscopy, radiology, Physiotherapy, maxillofacial, dental, ophthalmology)



**Figure 1: Level of nursing documentation practice on a study of documentation practice and associated factors among nurses working in Jimma university medical center south west Ethiopia, 2018 (n=391)**

Additionally the completeness of patient records (charts) was assessed in terms of nursing care plan, medication administration sheet, vital sign sheet, admission record and nursing activity sheet. Accordingly, the result showed that nursing care plan was attached for 30(35.3%) and completed for 15(17.65%) out of 90 sampled charts, medication administration format was attached for 90 (100%) and completed for 73 (85.9%), vital sign sheet was attached for 90 (100%) and completed for 27(31.8), admission discharge was recorded for 46(54.1%) out of 90 patient records and at last nursing activity sheet was attached for 25 (29.4%) and completed for 12(48%) (figure 1 and 2).



**Figure 2: Completeness of documents on the study of documentation practice and associated factors among nurses working in Jimma university medical center south west Ethiopia, 2018 (n=90)**

**Table 2: Result of document review on the study of documentation practice and associated factors among nurses working in Jimma university medical center south west Ethiopia, 2018**

Dimension	Indicators	Expected result(out of 100)	Observed result	Level
Completeness	Medication administration	20	17	Good if $\geq 50\%$ ,poor if $<50\%$
	Vital sign chart	20	6.36	
	Care plan	20	3.4	
	Admission discharge	20	10.82	
	Nursing activity	20	5.88	
<b>Total</b>		100	<b>43.46%</b>	

#### Factors associated with documentation practice

For analysis of the data, bivariate and multi variate logistic regression were done by using binary logistic regression. Crude and Adjusted odds ratio with 95% confidence interval was calculated to determine the strength of association and statistical significance between documentation practice and each independent variable.

On bivariate analysis, work setting ,level of education , motivation from supervisors, knowledge towards documentation, adequacy of sheets ,adequacy of time , lack of skill , familiarity with operational standard of nursing documentation , in-service training and adequacy of staff were significantly associated with documentation practice to be candidates for multivariate logistic regression analysis (table 3).



**Table 3: Bivariate logistic regression analysis on study of documentation practice and associated factors among nurses working in Jimma university medical center south west, Ethiopia, 2018 (n=391)**

Variables		Good	Poor	COR(95%CI)	P-value
		N	N		
Age of respondents	< 24	40	43	1	
	25-34	115	121	1.022(0.619,1.685)	0.933
	35-44	27	28	1.037(0.524,2.050)	0.918
	≥ 45	8	9	0.956(0.336,2.717)	0.932
Sex of respondents	Female	100	104	1	
	Male	90	97	0.965 (0.69,1.435)	0.860
Level of education	<BSc	41	66	1	
	≥ BSc	149	135	1.777,(1.128,2.798)	0.013*
Work setting	OPD	10	20	1	
	Medical	47	36	2.611,(1.089,6.260)	0.031*
	Pediatrics	22	43	1.023,(0.409,2.559)	0.961
	Gyn/obs	39	34	2.294,(0.944,5.573)	0.067
	Surgical	53	42	2.524,(1.068,5.966)	0.035*
	Others	19	26	1.462,(0.558,3.826)	0.440
Marital status	Single	92	95	1	
	Married	84	92	0.943(0.625,1.423)	0.779
	Divorced	14	14	1.033(0.67,2.285)	0.937
Work experience	<2	63	68	1	
	2-5	86	96	0.967(0.617,1.516)	0.883
	>5	41	37	1.196(0.682,2.096)	0.532
Salary (income)	≤ 3900	42	57	1	
	3901-4550	91	90	1.372(0.838,2.248)	0.209
	4551-5284	47	39	1.636(0.914,2.928)	0.098
	>5285	10	15	0.905(0.370,2.212)	0.826
Knowledge	Poor	80	117	1	
	Good	110	84	1.915 (1.281,2.862)	0.002**
Attitude	Unfavorable	76	89	1	
	Favorable	114	112	1.192 (0.797,1.782)	0.392
Lack of sheets(formats)	No	180	139	1	
	Yes	10	62	0.125 (0.062,0.252)	0.000**
Inadequate Staff	No	170	132	1	
	Yes	20	69	0.225 (0.130,0.389)	0.000**
Time shortage	No	166	159	1	
	Yes	24	42	0.547(0.317,0.945)	0.000**
Lack of skill	No	169	149	1	
	Yes	21	52	0.356(0.205,0.619)	0.000**
Availability of motivation	No	34	112	1	
	Yes	156	89	5.774(3.631,9.181)	0.001**
Familiarity with standard	No	39	73	1	
	Yes	151	128	2.208 (1.402,3.48)	0.028*
In-service training	No	71	56	1	
	Yes	119	145	0.647(0.423,0.991)	0.045*

Based on findings from the multi variate binary logistic regression, nurses who are familiar with operational standard of nursing documentation were two times more likely to document their care than those not familiar with operational standard [AOR=2.165(95% CI (1.288, 3.641))]. On the other hand, those respondents who had no adequate documenting sheet were 64% less likely to perform good documentation than those who adequate documenting sheet [AOR=0.357(95% CI (0.159, 0.802))]. Similarly nurses who attend in-service training on nursing care documentation were 53% less likely to perform good documentation than those who do not attend in-service training [AOR=0.462, 95% CI (0.277, 0.771)]. On top of that, respondents who have been motivated from their supervisors were almost four times more likely to practice good documentation than non-motivated ones [AOR=4.237(95% CI: (2.437, 7.366))]. (See table 8)

**Table 4: Multi variate logistic regression analysis result on a study of documentation practice and associated factors among nurses working in Jimma university medical center south west, Ethiopia 2018 (391)**

Variables		Multi variate logistic regression			
		B	S.E	AOR(95%CI)	P-value
Lack of sheets (formats)	No	-	0.413	1	0.013**
	Yes	1.031		0.357,(0.159,0.802)	
Availability of motivation	No	-	0.282	1	0.000** *
	Yes	1.344		4.237,(2.437,7.366)	
Familiarity with standard	No	-	0.265	1	0.004**
	Yes	0.773		2.165,(1.288,3.641)	
In-service training	No	-	0.261	1	0.003*
	Yes	0.772		0.462,(0.277,0.771)	

\*\*\*P-value <0.001 \*\*P-value<0.01 \*P-value <0.05

## V. DISCUSSION

Poor documentation has been shown to have negative impacts on the health care outcome, the health care providers' effectiveness and on the profession in general. This study aimed to assess the level of documentation practice and associated factors among nurses. Accordingly, the result showed 51.4% and 48.6 % poor and good documentation practice respectively. This finding is almost similar with study done in England 47% (Law, Akroyd and Burke, 2010), Canada 53.5%(Voyer *et al.*, 2014) and Ghana 54.6%(Asamani *et al.*, 2015).

On the other hand, it is higher than findings from European Hospitals which was 28% (Ball *et al.*, 2013) and Iran 15 % (Bijani *et al.*, 2016). This discrepancy might be due to difference in sample size. A recent study conducted in the University of Gondar hospital also identified documentation practice of 37.4 % (Mihiretu Kebede, Yesuf Endris & Desalegn Tegabu Zegeye (2017)) and in Indonesia 37 % (Mote, Rantetampang and Pongtiku,). This might be related to the study design used ('Nursing care documentation practice\_ The unfinished task of nursing care in the University of Gondar Hospital\_ Informatics for Health and Social Care\_ Vol 42, No 3', no date) and difference in attitude level of the participants which is a known factor to affect documentation practice.

In contrast with this, satisfactory level of effective documentation was reported to be practiced in Jamaica 98%('Evaluation of registered nurses' knowledge and practice of documentation at a Jamaican hospital', no date), couple of studies from Nigeria 70%(Hussainat Taiye, 2015) and 77.4%('Nursing documentation\_ Experience of the use of the nursing process model in selected hospitals in Ibadan, Oyo State, Nigeria - Ofi - 2012 - International Journal of Nursing Practice - Wiley Online Library', no date) and in different hospitals of Cape town 68.3% (African *et al.*, 2011). These discrepancies might be related to familiarity of the nurses with the required documentation guidelines available on each ward ('Evaluation of registered nurses' knowledge and practice of documentation at a Jamaican hospital', no date) and adequate knowledge level of study participants regarding documentation as indicated in those studies.

Based on cross tabulation result of this study, respondents who had good knowledge practiced good documentation by 57.9% while those with poor knowledge practiced 42.1%. Similarly, those who were having favorable attitude had good practice of 60% than unfavorable ones (40%).

This study also identified that familiarity with operational standard for nursing documentation is one of the factors affecting nursing documentation which is comparable with a finding in Netherlands where knowledge of hospital policy regarding documentation was found to be one of the factors determining the prevalence of nursing diagnosis documentation (Schans *et al.*, 2011).

In this study, nurses who are motivated with their supervisors were four times more likely to perform good documentation which is similar with the study in Indonesia (Mote, Rantetampang and Pongtiku, no date) and also this study found that nurses who attend in-service training 44% less likely document care than those do not attend training, which is in contrast with the study of Gondar 2.6 times more likely document their care ('Nursing care documentation practice\_ The unfinished task of nursing care in the University of Gondar Hospital\_ Informatics for Health and Social Care\_ Vol 42, No 3', no date).

## VI. CONCLUSION

Nursing documentation practice was poor among nurses under the study. Adequacy of documenting sheet (p=0.013), presence of motivation (p=0.000), in-service training (p=0.003) and familiarity with operational standard of nursing documentation (p=0.004) were significantly associated with practice of nursing care documentation. Larger sample size and support with document review (compared to the study conducted in Gondar University Hospital). No adequate literatures were found on similar topic especially in Ethiopian context making it difficult for comparison. The responses might have been liable social desirability bias; Self report may over/underestimation the level of documentation practice.

## VII. COMPETING INTERESTS

The authors declared that they have no any competing interests.

## VIII. ACKNOWLEDGEMENTS

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