UNIVERSITY OF CAPE COAST

AN AUDIT OF NURSES' CLINICAL DOCUMENTATION PRACTICES: THE CASE OF BAPTIST MEDICAL CENTRE, NALERIGU.

NYABA RAUF

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BY

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Thesis submitted to the School of Nursing and Midwifery of the College of Health and Allied Sciences, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Nursing degree

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature: ..... Date: ….....

Name: Nyaba Rauf

Supervisors' Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date: .....

Name: Dr Susanna Aba Abraham

ABSTRACT

Nursing documentation is an important routine in the practice setting with nurses required to record each and every care activity appropriately and adequately. It is worth mentioning, the coordination and continuity of patient care largely depend on communication between nurses, other members of the healthcare team of which nursing documentation play a key role. Notwithstanding the Ghanaian practice experience, the status of nurses' documentation has not been adequately examined. This study sought to assess the nurse's clinical documentation practices at the Baptist Medical Centre. A cross-sectional retrospective study was conducted using systematic random sampling method, 240 patient folders were selected from the Medical, Surgical and Paediatric wards. Data analysis was conducted using International Business Machines Corporation- Statistical Package for the Social Sciences (IBM-SPSS) version 21. Mean, Standard Deviation, Frequencies, Multiply logistic regression and One Sample t test were used to analyse the data. The study showed general percentage score of documentation at (n=145, 60.5%) which was at low level when compared with the standard practice as established. Major routines documentation reviewed revealed incidences of incomplete, illegible and not concise entries, (n=60, 25%) entries had date and time of nursing care activities documented (n=94, 39.2%). The results further shows that nurses documentation practices were above average compared to the standard for legal accuracy (M = 10.25, SD = 1.074). The use of the nursing process was (n=109, 45.4%) at alarming low level for care in the documentation. Nursing assessment documentation was below the acceptable standard (n=5, 2.1%), as with nursing diagnosis (n=208, 86.7%) and (n=154, 64.6%) been absent of entries for intervention documentation. Patient progress report was not documented for (n=134, 55.8%), education and discharge teaching were not documented at an alarming rate (n=234, 97.5%) and (n=237, 98.8%) of the folders reviewed. The study recommend for regular in-service training for the nurses to refresh their records keeping skills as well as the periodic monitoring and evaluation of the practices for improvement.

KEY WORDS

Nursing

Nursing documentation

Documentation standard

Nursing documentation review

Nursing documentation challenges

Baptist Medical Centre (BMC)

Nalerigu

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To my late mum, Nma Sambo Akurugu who in the middle of this journey left us to the maker, I say thank you for the values you bestowed on me with your years on earth. Thank you for making me whom I am.

DEDICATION

To my late mother Nma Sambo Akurugu

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LIST OF ABBREVIATIONS

ANA	American Nurses Association
BMC	Baptist Medical Centre
CLPNA	College of licensed Practical Nurses of Alberta
CNO	College of Nurses of Ontario
EHR	Electronic Health Records
MIS	Management Information System
NMCGH	Nursing and Midwifery Council- Ghana
NMCAT	Nursing and Midwifery Content Audit Tool
NZNO	New Zealand Nurses Organisation
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

Effective communication is a crucial part of the multidisciplinary health care system. An important tool for communication among health care workers is the medical and nursing records that indicate the care activities the patient received (Tornvall, 2008). Documentation in healthcare is a communication method that provides written proof of the interactions that occur between the health professionals, the patients and their families, and provides evidence to care activities carried out for the patient within a stipulated period (Hector, 2010b). The records documented also inform as well as direct patient related decision-making and ensure continuity of care (Marinič, 2015). Thus, the demand for high-quality, timely, patient-centred documentation is growing among health-care professionals (Elske & Spotl, 2009). In many health settings, nurses provide continuous care for the patients and therefore, become the key communicators of the patients' health state (Hector, 2010a). Nursing documentation has been described as a record of care provided to particular clients by registered nurses or other caregivers under the supervision of a qualified nurse (Urquhart & Currell, 2010). Data to be documented by nurses include the patient's condition, interventions rendered, the patient's reaction to the intervention, as well as the patient's result (Hector, 2010a).

Nursing documentation has evolved over the years and is traced back to the time of Florence Nightingale (Chelagat, Sum, Obel, Chebor & Priscah,

2013). According to Iyer, Leven and Shea (2006), the objective of documentation in the time of Nightingale's was to merely communicate the nurses' execution of the orders issued by medical doctors. The basis of nurses' documentation has changed over the years with the use of the nursing process as the basis of care to include in the documentation, the nurse's own assessments, diagnosis, implementation and evaluation of the patients' state of health (Iyer & Camp, 2005). This approach of documentation was introduced by the nurse theorist Virginia Henderson and described as the nursing process approach of care and documentation (Henderson, 1966). In recent times therefore, nursing documentation reflects the changes occurring in nursing practice, and is guided by regulatory agency and legal requirements (Chelagat, Sum, Chebor, Kipto, & Bundtich, 2013; Iyer et al., 2006).

The World Health Organization (WHO) in 1980 developed guidelines for medical record practice that indicated that documentation of individual patient records must help to ensure continuity of care and prevent unnecessary duplication of effort (World Health Organization, 1980). It is imperative therefore that nurses always and at all-time document every nursing activity to reflect the care given to patient and with the records carried out within standard of practice for documentation in the health care facility. Machudo and Mohidin (2015) viewed documentation as a written information about the patient by the nurse that describes patient status, the care or services provided by the nurse. The current practice of documentation is most often hand written traditional paper based or electronically generated; which is term electronic health records (Chelagat et al., 2013).

Proper nurse's documentation stipulates clear and concise notes with the patient at the centre of the records and an account of the nurse professional accountability in the care process. Nursing documentation forms a key aspect of patient care and important in cataloguing the care and responses to the treatment for the individual patients and a tool for valid and reliable information of the care (Asamani, Amenorpe, Babanawo, & Ofei, 2014).

It's significant to note that, nursing care documentation, facilitate communication and collaboration among health care team members, promotes visibility and continuum of care, enhances patient care decisions and as evidence in any legal process (Nakate, Dahl, & Drake, 2015). Documentation is said to be a benchmark for nursing practice evidence which reflect the nurse responsibility to the patients in the therapeutic contract (Phoebe & Lillian, 2017). Jefferies, Johnson, & Nicholls (2011) documentation ensures continuity and quality of care, supports the evaluation, efficiency and effectiveness of patient care as well as a point of reference for financial, research and ethical quality-assurance purposes. Above all, the purpose of clinical documentation is to outline the care patient received and guarantees as a tool for enhanced communication among health care team (Kuhn, Basch, Barr, & Yackel, 2015).

Documentation has been considered, an important part of professional routines since the time of Florence Nightingale and purported to account for 15-25 percent of nurses' time per shift (Gugerty, Maranda, Newbold, & Poe, 2007) and provide a reliable, full, and truthful account of what happened and when it happened and enable nurses to assess the quality of treatment by conducting a comprehensive analysis of the process (Phoebe & Lilian, 2017). For Kamil,

Rachmah, and Wardani (2018), the required standard of consistency and continuity in health care is achieved through good communication and written documentation plays an important role in achieving this key practice routine of continuity. However, with the numerous accounts as cited in literature about documentation and the critical role it plays in nursing practice, the challenge of current nursing practice in records writing (documentation) is reported to be crippled with gaps and inadequacies which sometimes obscure meaning and impedes communication with implication on the continuity and quality of care.

In a study to examine the quality of nursing documentation in patient medical records, (Paans, Sermeus, Nieweg, & Van Der Schans, 2010) revealed various levels of accuracy of nursing documentation with varied heterogeneity in it quality. College of Licenced Practical Nurses of Alberta, (2018) in an independent audit of nurse's documentation, reported inadequacies, inappropriate and significant gaps in nurses' documentation of care, with most entries reviewed failing to meet professional and legal practice standard.

In another study to evaluate the quality of nursing documentation on medical records of patients from a University Hospital in São Paulo, Brazil, (Setz & Innocenzo, 2009) reported only 8.7 percent of nursing notes to be of standard and 26.7 percent of been poor in quality. Similarly, in a study to assess nurses documentation, at a Baghdad Teaching Hospital, Iraq, (Abid, Majeed, & Mohammed, 2018), showed nurses have poor nursing documentation for patient care with no recorded time on reports (100%), response of patients to interventions (97.9%) and no recording of time of nursing care - (96.5%).

Machudo and Mohidin (2015), in a study in the Kingdom of Saudi Arabia, on educational needs assessment in the clinical area discovered that nurse's documentation lack clarity with no standard system of documenting in compliant with hospital policy and largely based on staff's discretions. Also, nursing documentation is reported to suffers from such issues as incompleteness, disruption, inappropriateness, inconsistencies, irregular charting and performed in styles largely based on the individual nurse experience (Cheevakasemsook, Chapman, Francis, & Davies, 2006). Phoebe and Lillian (2017) in a study in Kenya, incomplete charting was cited as a flaw in the nursing record with less than quarter of nurses' notes being reviewed found to been done accurately. Bad cancelation, illegible documentation, and poor charting were among the errors discovered, with all the charts on the patient records showing no evidence of continuity of care provided.

Asamani et al (2014) indicated that following an audit of nurses' notes, half of the patient care recorded by nurses in a Ghanaian hospital revealed incomplete entries, non-documentation of patient care after the first day of admission, and errors on the care documented in the form of unsigned entries, undeclared entries, incorrect cancellation, and no consistent structure or model on which nurses document patient care.

In Ghana, the current health care system of medical record and clinical documentation is similar with WHO-SEARO-2007, a guideline on clinical documentation and medical record. It stipulates documentation to be concise, clear, complete, patient centred, confidential, collaborative and comprehensive to assuring continuity of care, legal evidence of care, and support the evaluation of quality patient care (WHO-SEARO, 2007). For enhance patient

outcomes, adequate clinical information is required as vital and reliable source to be used for communication, research, quality improvement and policymaking. With this in mind, it is all time important for nurse's documentation of patient care to be carried out within standard of acceptability for promoting communication among professional and other health care team members for continuity of care.

Statement of the Problem

Despite overwhelming evidence that accurate patient care reporting is critical for nurses and other health professionals, this has not translated to actual practice in most health facilities. Incomplete records and unsigned entries (Abraham, Berchie, Okantey, Amoah, & Agyei-Ayensu, 2017); oral reporting (Randmaa, Mårtensson, Swenne, & Engström, 2015); illegible handwriting, unendorsed cancelation and use of unofficial abbreviations, as well as, absence of nursing records of patients' progress reports (Asamani et al., 2014), have been recorded in many studies in some health facilities in Ghana.

In spite of apparent evidence that registered nurses receive both pre-service and in-service training on documentation (Nursing and Midwifery Council of Ghana, 2015), the practice of incomplete documentation still persists and reflects negatively on the quality-of- care patients received. In the annual end of year performance review of the Ghana Health Service in the region in two consecutive years 2017, 2018 a key area of grave concern reported was the issue of improper nurses' documentation for communication in patient care. The practice was reported to be inadequately carried out, with potential consequence for the management of the hospital to grapple with; increase in the prevalence of patient dissatisfaction, loss in revenues, the threats of legal

action by some clients and the general complaints of inadequate nursing care in the facility (Ghana Health Service, Annual review, 2017).

In line with the dissatisfaction, the Quality Assurance Committees have been tasked to ensure that health care professionals conform to standard practice protocols including documentation that is universally acceptable and promote safe patient care.

However, the status on the actual practice of documentation has not yet been explored in the facility. The study therefore sought to review the registered nurses' documentation of in-patient care to inform the health facility of the prevailing situation of documentation and to underscore the development of approaches to improve the standard of nursing documentation.

Purpose of the study

The study sought to review the clinical documentation practices of nurses providing in-patient care and to determine if the documentation practices of nurses in the Baptist Medical Centre (BMC) meet internationally approved standards.

Research Objectives

The study specifically sought to;

1. assess the patient-related factors that influence nursing documentation of in-patient care at Baptist Medical Centre.
2. determine the extent to which nursing documentation of patient care satisfy the standards of documentation at Baptist Medical Centre.

3. determine the extent to which nursing documentation of patient care satisfies the legal requirements for documentation at Baptist Medical Centre.
4. assess the extent to which the nursing documentation reflects quality in-patient care at Baptist Medical Centre.

Research questions

1. What is the patient-related factors that influence nursing documentation of patient care?
2. To what extent does the documented care meet the standards of documentation?
3. To what extent does documented nursing action of patient care meet the legal requirement for documentation?
4. To what extent does nursing documentation reflect quality patient care?

Significance of the study

Documentation exists as a key function of the nurse in the clinical setting. The study sought to ascertain the prevailing practices in care documentation in making nurses work more visible and promoting communication. It serves to ignite the nurse's reflection on their documentation with a focus on the need to devoting attention to documentation as compare with direct patient care. With an overall intention to improving patient care record practices; promoting communication, continuity, individualised care and accountability. It sought to provide empirical evidence to nurses and the hospital management on the need to designing in-service training programs at the hospital level geared towards improving the quality of documentation. The study offers an opportunity for

nurses and nurse leaders to implement structured interventions aim at improving clinical documentation. The study provide basis for nursing education in terms of inclusion and highlighting documentation in the micro-curriculum for the training of nurses and as evidence to informing policy with reference to clinical documentation at the practice setting in terms of development of protocols and standard guidelines at hospital level and the wider practice setting. The impact of the study will also improve service delivery to a wide population.

It takes further and added to the frontiers of knowledge base on evidence and provoked a wider reflection on practice with a second look of what is written on the patients' folders.

Delimitations

The study was confined to the Medical, Surgical and Paediatric Wards of the Baptist Medical Centre in the North East region Nalerigu, Ghana. It covered audit of nurse's documentation of routine care in the patient folder, specifically the nurse's notes, vital signs charts medication charts and the 24-hour reports of patient who has spent not less than 24 hours in the ward and not more than a week spanning the period between Octobers to December 2019.

Limitations

The study reviewed nurses' documentation in three units (wards) of the hospital that varied patient conditions, staff- to-patient ratio, nurses' staff educational background and years of clinical practice experience. The influence of these variables was not assessed in the study. It did not cover or

make room for concurrent review of entries which makes it difficult to actually verify whether what has been documented was actually carried out only by the nurses. Clinical documentation by other health professionals in the patient records did not form part of the study as such drawing general conclusion on the entire clinical records was limited.

Also, the study did not cover all the major hospitals in the region as such generalization of the findings will be implausible. The issues of resource and time constraints did not allow for inclusion of all the units of the hospital for review.

Definition of Terms

Nursing documentation: is a written record or electronically generated information about a patient that describes the status and care rendered to the patient during the period of hospitalization, (College of Registered Nurses of Manitoba, 2017).

Documentation standard: are professional expectations concerning written or electronic generated information of patient care, (American Nurses Association, 2010).

Nursing record review: is a quality improvement measure which involves the formal evaluation of medical records to identify where a medical organization stands in relation to standards compliance (Mykkänen, Saranto, & Miettinen, 2012).

Organisation of the Study

The study is organised into five chapters. Starting from chapter One which deals with an introduction to the study. It captures background of the study,

problem statement, and purpose of the study, research objectives and questions, significance of the study, delimitations, limitations as well as definition of key terms.

Chapter Two presents the review of relevant and related, up-to-date literature on the topic. It includes the conceptual framework that guides the study. Chapter Three focus on research methodology and covers such areas as the research design, study area, population, sampling procedure and techniques, data collection instrument, data collection procedures as well as data processing and analysis. It also deals with issues of ethical considerations and clearance for conduct of the study.

Chapter Four of the study focuses on the results and the discussion of key findings in the study.

Chapter five which concludes the entire write-up and presents; summary, conclusions, recommendations as well as suggestions for future studies.

Chapter Summary

The chapter presented the study background with emphasis on the role of documentation to quality patient care and the prevailing weaknesses in practice by nurses. The problem statement with the study purpose were also presented.

Also presented, are the research objectives and questions to be answered by the study. This study sought to assess nurse's clinical documentation practices; using the Baptist Medical Hospital in Nalerigu as a case study. The findings of which are expected to provide empirical evidence on what exist in terms of the clinical documentation practices by the nurses in the hospital, and proffer

recommendations targeted at improving practice. The study outcomes are expected to be of significance to nurses, midwives and other health care team members, the Baptist Medical hospital, Ghana Health service, the Ministry of Health, nurse researchers and educators.

The chapter also outlines the delimitations, limitations, operational definition of terms and the organisation of the study. The study is limited to only patient medical records of nurses at the Baptist Medical hospital-Nalerigu.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter presents review of current literature on documentation in nursing practice. A review of literature involves the systematic search, identification, examination and summary of the written documents that contains information on a research problem. For this study, a computer-generated search was carried out on Google scholar, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Medline. The literature generated is organised around the objectives of the study under the following sub-sections:

- Documentation as a nursing procedure, which highlights the types/system, timing and importance of nursing documentation;
- Documentation in nursing care
- Nursing documentation for Communication
- Documentation Standard;
- Legal requirements of nursing documentation;
- Nursing documentation and quality in-patient care;
- Short falls with documentation.

The theoretical framework underlining the study is also discussed under a subsection.

Documentation as a Nursing Procedure

Nursing documentation is a key routine and an integral part of nursing practice (Mediarti, Rehana, & Abunyamin, 2018). This assertion is given credence by several studies conducted across many settings. For instance, in a quantitative non-experimental study conducted in 10 Slovenian hospitals using a sample of 592 respondents, they found that nurses with a minimum of secondary education perceived nursing documentation as an integral part of their work recording a Pearson correlation of $p < 0.001$. They attributed this to the fact that documentation improves communication ($p = 0.034$), improves the visibility of nursing care activities ($p = 0.015$), improves patient safety ($p = 0.001$), and enhances continuity of care ($p < 0.001$). The study was however limited by the non-probability random sampling approach and the low return rate of questionnaire that impacted the generalizability of the findings (Petkovšek-Gregorin & Skela–Savič, 2015).

Similarly, in a qualitative study in a Danish hospital that sought to explore nurses' perception of the value of documentation, nurse leaders and frontline clinical nurses interviewed identified nursing documentation as a core task that can be made meaningful to nurses. The study found that the value of documentation was embedded in the documents serving as communication tools between various sectors and colleagues, as well as promoting continuity of care, security and quality patient care by serving as a tool for reflections (Olivares Bøgeskov & Grimshaw-Aagaard, 2019).

In an action research project at the CURE children hospital in Uganda, aimed at improving nurses documentation of assessment in patient record, (Kalikwani, Okaisu,Wanyana, Grace & Coetzee, 2014), revealed inadequate

documentation of nursing care and relevant patient information for promotion of continuity. This they attributed to nurses employed at the hospital not having the requisite training and experiences in documentation. The study alluded to nurses' perceptions and attitudes towards documentation as crucial to impacting the quality of how and what to document. The study asserted documentation role at portraying the tasks completed in patient's care experience and reveals the contribution or otherwise of nursing interventions towards patients 'recovery and wellbeing.

In a cross-sectional study in Indonesia, a retrospective review of 240 randomly selected medical records conducted to identify nursing care activities in categorising nursing care patients received under; assessment of functional and biological status, formulation of nursing diagnosis, determination of patients' home care needs, quality of life, drug administration, monitoring, rehabilitation, and outcomes. The study pointed to insufficient nursing care activities (below 80% of the standard in Indonesia) for care activities rendered to the patients on a daily basis while on admission, the reliability coefficient kappa > 0.80 and validity of *r Alpha* of > 0.90 of the study instrument give some credence to the findings (Asmirajanti, Hamid, Tutik, & Hariyati, 2019). Søndergaard et al. (2017) aptly summarises the documentation as the procedure that reflects nursing by showcasing the patient care activities that are performed and completed.

Paans, Sermeus, Nieweg, and Van Der Schans (2010) in a study to review nursing documentation of patient care in Netherlands, with the aim to quantifying the adequacy of (i) admission data, (ii) record structure and legibility of reports (iii) nursing diagnosis, (iv) interventions, (v) progress and

outcome evaluations. The study pointed out inadequacies in nursing intervention documentation, high accuracy scores for admission report, progress and outcome evaluations. It reported that, 50 percent of patient admission information was complete and contained reasons for admission and care rendered, 34 percent capture all stages of the nursing process. The study concluded however that, the overall nurse's notes were inadequate and consisted with sentences which were informal and could be misinterpreted with the potential for compromising quality.

- **Documentation in Nursing Care**

Nursing documentation takes varied types in the clinical setting depending on the institutional protocol and frame work for recording client information. Patient data are recorded using a number of documentation systems. The manual or traditional paper form, the clinical information system - electronic health record(EHR) (Kay & Yearous, 2011) are the major systems for documentation of patient information. Worldwide, there is a progressive shift from the paper base to clinical information system for recording and keeping of patient care information. The collection, processing and dissemination of data in clinical information systems used in health care come with both challenges as with the paper base.

Depending on the health care organization, the type of documentation framework adopted by an institution may be ; charting by exception, narrative charting, source-oriented charting, problem-oriented charting, focus charting, critical pathways, and narrative charting (College of Registered Nursing of Manitoba, 2017). Any of the frameworks as mentioned may inform

institutional practice standard for documentation of care and can be adopted for both paper base and electronic documentation.

- **Nursing documentation for Communication**

Documentation or record keeping is a fundamental part of clinical practice. It demonstrates the clinician's accountability and records of professional practice which form the basis for communication between health professionals (WHO-SEARO, 2007).

Nursing documentation is an essential routine in the practice of nursing with wide significance. Quality nursing documentation provides evidence of care and communication, supports service delivery, clinical judgements, decision-making, communication and effective sharing of information between the multi-professional healthcare team (Benbow, 2011).

As a procedure, nursing documentation serves multiple purposes (i) evaluation of quality of patient care ; (ii) legal evidence of the process and outcomes of care; (iii) continuity and quality of care through communication ; (iv) research, finance and ethical quality-assurance purposes; (v) database infrastructure for the development of nursing knowledge; (vi) benchmarks for the development of nursing education and standards of clinical practice; (vii) avenue for appropriate reimbursement; (viii) database for planning future health-care; and (ix) providing the database for other purposes such as risk management, learning experience for students and protection of patients' rights (Cheevakasemsook et al., 2006). Patients' records serve as a trace of the care processes that have occurred and are further used as communication amongst nurses for continued management of patients (Mutshatshi,Mothiba,

Mamogobo, & Mbombi, 2018). Patient's information in health records are important database for information on treatments and for research purposes. Recording of care by nurse's aide in the proper monitoring of the health, planning and treatment of the patient. For Marinič (2015) documentation is a tool to measuring patient rights both civil and legal, as well as the exercise of rights relating to privacy in the caring process and for the assessment of health status. In a timely manner, good nursing documentation communicates observations, actions, and results of care accurately (Blair & Smith, 2014) .

Asamani et al., (2014) described nurses notes as the reservoir of information about patient care that assist healthcare professionals pertaining to information on patient status and evidence of professional accountability in the patient-nurse interaction. This information is necessary in decision making and crucial for provision and management of health care which would not have been possible without nursing documentation. It is indispensable in the care and key to describing the care processes in the patient - nurse encounter.

Nursing documentation is important for supervision, evaluation of clinical interventions, and care activities (Hector, 2010b). This help promote information sharing relevant to nurses care activities for improve client care outcomes and a reference point for care continuity. According to New Zealand Nurses Organisation, (2017) nurses documentation show evidence of clinical judgement and evaluation of the care provided and suggested that care not recorded, is assumed not to have been carried out. For Akhu-Zaheya, Al-Maaitah, and Bany Hani (2018) nursing records provides insight into best practices and limitations to improving practice and patients' outcomes with

adequate, complete and accurate documentation facilitating the evaluation of patient's progress toward desired outcomes.

College of Nurses of Ortario (2008) pointed out the crucial role of nursing documentation with the assertion that, when documentation are carry out poorly, provides no picture of quality of care. For Björvell, Wredling, and Thorell-Ekstrand (2002) the main benefits of documentation is for the improvement of communication between healthcare professionals for the continuity of individualized patient care without which nursing care tends to be merely institutional routines or schedules. It is worth emphasizing, documentation as very essential in all medical setting to reflects various aspects of the care including the awareness level of nurses in their roles in providing health services in good quality (Alkouri, Alkhatib, & Kawafhah, 2016).

- **Documentation Standard**

There are no universal standards for documentation of patient care by nurses across many settings, however every nursing documentation is expected to be complete and accurate containing key nursing action for patient in the therapeutic interaction and carry in a way to promote communication.

Even though nurses as part of their training are taught the skills of reporting and communication (Nursing and Midwifery Council of Ghana; Curriculum for Nurses Training, 2015) the style and frequency of what is generally recorded is much base on the institution and individuals' discretion.

The NMC-UK (2009) on it hand book "guide to record keeping"; observed good record keeping as crucial to nurses work, and key for safe, adequate care

and should not be considered as an optional extra to be carried out if circumstances allow.

Adequate documentation of client's status is critical to proper nursing treatment. Meticulous nursing documentation is an important part of multi professional patient care. The delivery of care and the ability to communicate effectively among professional lies on the quality of documented information available (Mykkänen et al., 2012). This is achieved when documentation is carried out within universal accepted guidelines and widely acclaimed principles in patient care.

Proper documentation contains accurate, high-quality information of assessment, planning, delivering and evaluation of nursing care. It reflects elements of the nursing process with evidence of communication with family, significant others, health education or psychosocial support, discharge planning and information (Asamani et al., 2014).

The client's condition at discharge, teaching or education for self-care and follow up appointments or referrals are key in care documentation (College of Registered Nurses of Manitoba, 2017). Additionally, it should be clear, concise, accurate and legible devoid of use of unapproved abbreviations with the potential for misinterpretation, and avoidance of excessive space/blank lines in-between records (American Nurses Association, 2010). Nurses and patient interactions are required to be recorded chronologically with date and time for each professional contact, including signature, designation and appropriate use of institutional approved abbreviation (College of Registered Nurses of Manitoba).

It should paint a picture of the client and the care provided from the time the client entered the health-care system till discharge. It is argued that vague documentation interferes with continuity of care and with the potential for misrepresentation. Commonly, guidelines imperative for meeting the documentation standards emphasise the need for nurses to document concisely, legibly, correct spelling and grammar, appropriate correction of errors or late entries, correctly signing entries with name and designation, entries identifying patient while maintaining confidentiality of the records (College of Nurses of Ortario, 2008).

For Jefferies, Johnson, and Griffiths (2010), nursing documentation should include elements of ; patient-centeredness; the actual work of the nurse; reflection of clinical judgment; written in a logical sequence; record variances in care; fulfils legal requirements and above all be able in assisting health-care professionals to detect changes in patient's status. It must be clear enough to present a picture of the patient's experience and demonstrates the nurse understanding of the patient's condition and problems evident in the caring process. Chronological the records show the entry journey of the client in the ward (admission) to the time of discharge with each step of the care. It is require that entries made by nurses be in line with the care given, not leaving blank lines or excessive space in-between each entry and consistent with the care provided with dates, time and signature of the nurse making the entries (Prideaux, 2011). Records must be clear and legible for handwritings that are difficult to decipher meaning can contribute to delays and mistakes in care. Coherent and universal nursing terminologies need be incorporated in documentation consistent with standards with the avoidance of meaningless

phrases and substandard abbreviation that may not be understood beyond the facility (College of Nurses of Ortario, 2008).

Recording of all patient care in the patient documentation forms, need to adhere to the basic principles of hand written documentation which stipulates, handwritings to be legible and permanent, entries signed or initialled or with a legible name, entries dated and timed, the entries be in chronological order, concise, comprehensive, and avoiding blank spaces in-between entries (Benbow, 2011).

Complete documentation should follow workplace policies on documentation with correct date and time, client's correct name, institutional approved medical terms and abbreviations and as much as possible reflect the exact words of patient in describing problems or complaints. The patient's perception of the condition and response to care should be the basis of content of nursing documentation (Jefferies, Johnson, & Griffiths, 2010). To emphasise, quality nursing service cannot be provided without the documentation of important information about patients. These documentation should contain a baseline assessment of the client's health status, nursing goals in relation to the actions and intervention, and the evaluation and adjustments to care (Mtsha, 2009).

For adequate nursing care, all essential information about the patient as well as nursing interventions should adequately documented (Kebede, Endris, & Zegeye, 2017).

Documentation should be clear, succinct, consistent, correct, timely, comprehensive, collaborative, patient-centred, confidential, patient-focused,

and based on professional observation and assessment (WHO-SEARO, 2007). According to the College of Licensed Practical Nurses of Alberta (2018), identified common deficiencies in nursing documentation in such forms as; illegible or messy handwriting, unsigned entries, failure to record nursing actions and medication given, failure to record patient medication reactions, failure to document discontinued medication, not providing adequate detail of progress of the client's condition, and incomplete records. Nursing documentation must provide an honest account of what and when events occurred accurately and as well as identify who provided care. The documentation should be organized and compliant with standards both professional and institutional for enhanced communication (Chiejina, 2019). Phoebe and Lilian (2017) noted that, blank areas on charts not only fail to give essential information, but also create ambiguity.

In conclusion, nursing documentation should give an accurate, objective and sufficiently comprehensive record of a patient's condition and care to support the oral explanations a nurse might be required to provide in work routines and in a legal context.

Legal Requirements of Nursing Documentation

High quality records and recordkeeping involves not only addressing the content and style, but also the legal issues in the documentation of care as medical records are considered a legal document. Documentation of care in the patient health record is an important component in the professional nursing function and key to proving the nurse accountability as well as a legal evidence to satisfying the care (Prideaux, 2011). It is assume that if care is not done, is not documented with the implication that failure to document means

that there is failure to provide care (Marinis et al., 2010). One of the most important role of nursing records is it legal aspect; the best witness to show the interventions provided for patients in case of any litigation (Hameed et al., 2014). Client's medical record are potent source of evidence in any claim of malpractice in a court proceedings or in a professional conduct proceeding. For these reasons, such records should be perform in a way that protect the patient and that of the nurse. It serves as proof of care as well as a medico-legal necessity for nurses (Phoebe & Lilian, 2017). Every entry must include the date, time, and name of the person who made the entry, as well as a signature using the nurse's title to clearly identify who made the entry. The nurse should sign the paper with his or her initials and a complete signature in the proper location for legal protection and accountability as the care provider (Phoebe & Lilian).

For nursing records to satisfy the legal requirements, it must be in compliance with institutional standards and professional practice guidelines. As such, incomplete record keeping including but not limited to failure to document care given or other information important to the client's care or records that's inconsistent with the care given, falsifying a record, including but not limited to filling in someone else's omissions, signing someone else's name, and fabricating data constitute bridge of nurse professional conduct (Prideaux, 2011). Blank spaces on a chart fail in providing necessary information and create ambiguity which if patient use as basis to sues may have a case if treatment was not documented though provided or served no way to prove that treatment occurred.

Nursing documentation have practical and legal implications for practice with the need for nurses to understand that documentation of care can one day be scrutinised when there is a complaint or incident resulting in harm (Blair & Smith, 2014).

College of Registered Nurses of Manitoba (2017), posit that, in a court of law, adequate and timely documentation may lead to the conclusion of quality care given to the client and conversely, incomplete documentation of care, it may lead to the conclusion that care was not done or provided.

The use of labels in describing patient or a patient's behaviour in documenting care can have legal implication and nurse are encourage that rather than attaching labels, simply describe the patient's behaviour using direct quotes when appropriate (Austin, 2011). For nurses to document in the most prudent manner there is the need to avoid; late entries, entries not timed or dated, notes been incomplete, inconsistent, illegible writing, gaps and erasing or obliterating entries. Austin (2011), further noted lack of documentation of patient education and discharge instructions as potential red flags and may be used to prove a case in a court of law if documentation is evaluated. In nursing, delivering appropriate care can become an issue of contention when actions are undocumented, casually or inaccurately described, use of in-house acronyms or abbreviations that are not akin to standard and even worst, self-implicating for the nurse to perform a task but fail to describe these actions in documentation (Brown & King, 2008).

Furthermore, brief and often meaningless notes used by nurses in describing care may be interpreted as a self-written admission of inappropriate treatment which might have legal implication for the nurse (Brown & King, 2008).

Incomplete, or non-existent documentation, regardless of cause, may be considered negligence on the part of the nurse. Nurses must document in satisfying the legal requirement for institutional protocols. It's crucial to provide a written picture about the patient that is accurate and complete, reflecting the care patient received while under the watch of the nurse (Campos, 2009). It is therefore imperative to follow institutional practice guidelines to reducing litigations that might arise out of inappropriate documentation (Austin, 2011).

Nursing Documentation and Quality in-patient care

Adequate nursing documentation epitomise the standard of care and account of team member's interaction with the patient. It bears the duty to communicate with other health care team members adequate and clinically significant information about the progression of the patient (Benbow, 2011).

The adequacy of documented nursing actions is imperative to the quality of care (Machudo &Mohidin, 2015). It is believed that adequate nursing documentation plays an important role in effective communication between caregivers for facilitating continuity, individuality and safety of patients (Alkouri, Alkhatib, & Kawafhah, 2016). Hector (2010) noted that adequate documentation reflects not only standard of care but as evidence of health care member's accountability in caring for the patient. A written patient record must provide description of the patient's health status, as well as the services provided in the care and this must be recorded out in a manner that promotes continuity and inter disciplinary communication. Documentation as noted by Akhu-Zaheya et al. (2018) is a key indicator of patient care quality and plays an important role in clinical decision making and knowledge about the patient.

Good quality documentation is associated with the reduction of risks in the care of the patient, enable timely detection of complications, and a source of data for improving client outcomes (Cheevakasemsook et al., 2006).

The nurses notes written succinct, legible and legally prudent way reduce the risk of misinterpretation, adverse patient outcomes, protection of the nurse and with an overall improvement in the quality of care (Blair & Smith, 2014). Quality patients' care documented, provide a trace of care processes for efficient management of patients through continuity which is very important care (Mutshatshi et al., 2018). Provision of quality care is marked with increase patient satisfaction with reduced incidence of injuries and complaints with an overall quality of life, these is partly achieved with effective documentation by nurses. Records are the most important database for the treatment of patient. A consistent and complete record by nurses in patient's records proves of proper monitoring, planning and treatment.

For it's impossible to give continuity to quality nursing care if documentation is inadequate, absent, unreliable, and incapable of supporting clinical decisions. If nurses' entries in patient care documents are inadequate, inter-professional communication and evaluation of nursing care may be impaired (Asmirajanti et al., 2019). Poor documentation has the potential to negatively affect patient care and professional accountability (Blair & Smith, 2014). In a study to assessing the level of documentation practice and associated factors among nurses, inadequate nurses documentation of patient care was shown to have adverse impacts on health care outcomes (Gizaw,Yimam reta,& Mamo, 2018).

In a study to review and establish the impact of nursing record system and patient outcomes (Urquhart & Currell, 2010) identified good nursing care to be related to the adequacy of communication available to nurses with no measurable difference in care outcomes with nursing documentation.

However, with nursing documentation being recognise as tool for safe and effective care, it is somewhat not be given the needed attention it deserves as is often seen by nurses as not being important as hands on nursing care.

Documentation Short-falls

Despite the recognition of the importance of adequate nursing documentation, there are varied opinions as to what constitute good nursing documentation. There are variations in nursing documentation practices due to local institutional designs, documentation systems or frame work and technologies across health care settings (Wang, Hailey, & Yu, 2011). The individual's professional judgement is what is mostly used to decide what is relevant and necessary to record about the patient (Benbow, 2011).

For patient to receive the best of care, all essential information about the patient as well as medical interventions should be recorded guided by the fact that lack of quality nursing care documentation can lead to miscommunication among nurses and physicians with potential negative effect on care outcomes (Kebede, Endris, & Zegeye, 2017). Worldwide, the trend of inappropriate and substandard documentation is at all-time high (Cheevakasemsook et al., 2006). Literature is abound with evidence of inadequate nursing documentation due to the want of time and patient numbers which put pressure on nurses in many clinical environments (Blair & Smith, 2014). Inadequate nursing

documentation negatively affects patient care outcomes and professional accountability. In a cross-sectional study to examined the quality of nursing documentation in Jamaican hospital using 245 patient records, by reviewing; biological data, client history, assessment, discharge planning and teaching documentation, (Lindo et al., 2016), noted that less than a third of the folders audited recorded adequate documentation, 90 percent of records had a physical assessment completed within 24 hours of admission with entries timed, dated, and signed by a nurse. Less than 5 percent of the records had evidence of patient teaching, 13.5 percent had documented evidence of discharge planning conducted within 72 hours of admission. The study highlighted significant weaknesses in nursing documentation and the need for increased training and continued monitoring in reducing the short falls to enhancing better outcomes. However, the use of one institution in the study and the sample size limited generalization of any inferences about nursing documentation in the study. Gugerty et al. (2007) in a study to explore the pros and cons in documentation of the nursing care of patients, reported perceptions by nurses of seeing documentation as unnecessary or redundant routine that takes away crucial time in their ability to render direct patient care. 54 percent, of the study participants indicated spending between, 25 percent to 50 percent of their shift to completing patient documentation, 89 percent found the documentation process as redundant, with 55 percent routinely required to complete documentation for reasons other than recording and communicating pertinent clinical information. The emphasises on the need for significant attention on documentation for a more efficient and satisfying nursing practice has been well posited. However, this finding was limited by

the use of self-reporting survey which is susceptible to respondent bias. A retrospective descriptive study to examined the standard of nursing documentation on medical records in a university hospital in São Paulo, Brazil (Setz & Innocenzo, 2009) with focus of the review on the nursing progress notes, diagnoses, orders, demographic and background information, , medical orders, discharge documentation, and death. The study reported majority of nursing documentation to be acceptable at (64.7%). It reported only (8.7%) of the records to be of standard with (26.7%) being inadequate. The study further reported the difficulty in measuring nursing care outcomes in nursing documentation on the medical records. It posited the non-adherence of the nurses to the institutional protocols as key to it low standard.

Machudo and Mohidin (2015) in a study to assess the practice of nursing documentation with the aim to developing a project for improvement in a 980 bedded teaching facility in Saudi- Arabia, pointing on the principal themes of; assessment, planning, implementation and evaluation. Nursing records per day were assessed and analysed from all units within a period of two weeks between January to March. Findings revealed that nursing documentation was based on individual nurses' discretion without recourse to the institutional protocol or policy relative to the documentation. The study recommended nursing leaders to utilize multiple approaches to developing policies and guidelines pertaining to nursing documentation and provision of consistent training opportunities for nurses regarding effectiveness of documentation to enhance use of consistent standardized nursing language in communicating nursing care.

In a meta-study aimed at synthesize essentials elements for nursing documentation to guiding practice in Sydney, Australia (Jefferies, Johnson, & Griffiths, 2010) across clinical setting revealed that nursing documentation often represent nothing than a list of tasks performed by the nurse during a shift that often falls short of identifying the patient's condition and response to the care. The study identified seven themes in nursing documentation; patient centred; actual work of the nurses including education and psychological support; objective clinical judgment; presented in a logical and sequential manner; written as events occur; record variance in care and fulfil legal requirement. The study recommended that the first key issue in documentation is to encourage nurses to value and devote time to documentation of care in order to redefine and evaluate professional nursing practice by positioning the patient at the centre of the notes to focus attention on patient's perspective and to promoting a holistic view of the patient.

Priyanka (2016) in a qualitative study to identifying the challenges and impacts of paper-based nursing documentation noted documentation of patient care to be riddled with challenges that directly affect health care delivery in most developing countries, this was similar to a study by Nakate, Dahl, and Drake, (2015) in Uganda on the knowledge and attitudes of selected nurse where they identified shortage in the number of nurses, resources as well as workplace inadequacies been key contributors to the phenomena of inadequate documentation.

Additionally, the high demand for nursing care, insufficient number of nurses, lack of uniformity among same/different hospitals and health institutions, inadequate standard guidelines, low recognition of documentation as part of

routine nursing care, and the low level of refresher training amongst nurses on nursing documentation has been cited copiously. In an informal assessment undertaken to review documentation in one of the leading health care facilities in Kenya (Clinical audit report, 2011), (Chelagat et al., 2013) observed fragmented and incomplete information on patient care with lack of standardized method of documenting couple with insufficient time, acute shortage of staff.

Further, Jefferies, Johnson, and Nicholls (2011) in a study on nursing documentation; how meaning is obscure with fragmented language cited the incidence of use of unofficial abbreviations, expressions that do not give enough information on care, patient information that do not make clear of who is being cared for or who perform care at, 44.3%, 5.9 %, 4.5% respectively. The study reported how incomplete sentences in the entries, the use of abbreviations and language that is not quantifiable to give enough information for understanding care can become ambiguous with the potential for miscommunication and reduced patient safety.

In a qualitative study to examined the challenges encounter by nurses with regard to documentation at a number of public hospitals in the Vhembe district, Limpopo Province, South Africa (Mutshatshi, Mothiba, Mamogobo, & Mbombi, 2018), showed nurses documentation to be inadequate owing to lack of time for completion of the records, increased patients' admission numbers and shortage of recording material for the documentation of care. Without complete records, nurses are an able to prove care was provided to the patient, furthermore, poor record-keeping not only undermines patient care but makes the nurses more vulnerable to legal claims which may arise from

incomplete records (Mutshatshi et al., 2018). However, the study identified adequate documentation as important and requires continuous training, monitoring, evaluation, and the supply of adequate stationary with proper time management amongst nurses to improve practice.

Chiejina (2019) in a retrospective study using judgmental sampling technique in selected Hospital in Anambra State of Nigeria to investigate the efficacy of Nursing action documentations in the clinical settings, posited a myriad of issues surrounding nursing documentation; errors, legal accountability, the time spent, esteeming hands on care, the necessity of nursing notes serving as point of communication with other disciplines were identified as problems in the professional nurse documentation duties. Commonly, inadequacies in the documentation of patient care come with such issues as failure to record health or drug information of the patient, nursing actions, administered medications, documenting in the wrong patient's medical record, inability to record discontinued medications, drug reactions, and failure to record progress in the patient's health status, transcription errors and illegible or incomplete records.

Asamani et al. (2014), in a study to examined current practices of nursing care documentation in Ghana, identified abbreviations use among healthcare workers to be attributed with increased errors with many health care institutions lacking approved and acceptable list of abbreviation for use in documentation. The records revealed the standard of nursing care documentation to be at it lower ebb, partly owing to lack of guidelines, chronic shortage of personnel's, the low interest in the use of nursing care records manifested as care given to patients not recorded, progress notes not written for a good number of patient and unsigned entries in their

documentation practices. Blair and Smith (2014) revealed that nursing documentation often fail to show critical thinking behind clinical decisions and interventions for patient care, and problematic in providing evidence of the progress of the patient with many nurses experiencing obstacles to maintaining adequate and legally prudent documentation. The use of abbreviations and acronyms with no standardized meaning poses a clear risk for safety as misinterpretation within medical and nursing notes can lead to errors. Marinis et al. (2010) opined nursing documentation to be inadequate because they did not include all the caring activities carried out for the patient.

According to Taiye (2015) the attributes of compassion, commitment and caring are often missing in nursing documentation and that most of the nurses interventions are either not documented or if documented, is done inappropriately. Nurses have traditionally communicated information about their patients orally which has affected the mode of written communication. This has unfortunately affected nursing practice, with the oral convention obscuring the 'work' of nurses (Jefferies et al., 2010).

In a study to explore the issues with nursing documentation in Indonesia, (Kamil, Rachmah, & Wardani, 2018) showed competency issues, inadequate supervisions, and lack of motivation and confidence amongst nurses on documentation and suggested for continuous educational intervention and evaluations to promoting compliance to nursing documentation procedures. They suggested increase in-service training and monitoring for improvement of nursing skills as essential for the successful adherence to proper nursing documentation standards. Mtsha (2009) in a quantitative non-experimental study on current practices of nursing documentation in the King Faisal

Teaching Hospital Jeddah- Saudi Arabia, showed the nurses failure to recognise the benefits and importance of nursing documentation with lack of consistent record systems on routines couple with lack of time and support, institutional obstacles, non-standardized design forms and lack of continuity were identified as nursing documentation challenges among nurse at the facility.

Similarly, in an institutional base cross-sectional study in Jimma University Medical Centre, Ethiopia, to assessed nursing documentation practice and associated factors among nurses (Gizaw,Yimam reta, & Mamo, 2018) revealed 51.3% of nursing documentation was poor with 48.6% good nursing documentation practice. The result showed that nursing care plan was attached for only 30 (35.3%) and completed for 15 (17.65%) out of 90 sampled charts, medication administration forms 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 with nursing activity sheet attached for 25 (29.4%) and completed for 12 (48%). The study suggested the need for continuous monitoring, evaluation and motivation of nurses to encourage adequate practice in care records.

In a cross sectional descriptive study to examined the completeness and accuracy of nursing documentation at a Hospital in Kenya (Phoebe & Lilian, 2017) noted that documentation was not accurate nor complete with 95.7 percent of the charts did not have instructions to the patients on discharge. Less than 30 percent of the charts were complete and accurate, and 95.7 percent of the charts did not provide instructions for the patients on release, usage of non-standard abbreviations, and inappropriate cancellation of errors

that could not be utilized for legal purposes. The study indicated that nurses were more interested in indicating patients' names than their identifying numbers, with several patients having identical names, with 100 percent had patient names, 77.4 percent having admission numbers and names. 88.9 percent had the time dialysis begun indicated, 83 percent had dialysis instructions, 77.6 percent had intra dialysis vitals indicated with only 36.6 percent indicated post dialysis interventions. The study suggested continuous medical education and audits on documentation to improve practice amongst nurses. In a quantitative retrospective study using 240 medical records selected based on the 10 most common medical and surgical diseases with a hospital stay of more than 3 days in Dr Kariadi Hospital in Semarang (Asmirajanti et al., 2019), revealed nursing documentation activities in the delivery of care were inadequate for care promotion; intervention in drug administration (60.8%), vital signs monitoring (23.3%), monitoring of daily living activities (37.5%), mobilization/rehabilitation (37.5%), outcome (46.7%), and resume activities nursing (0.8%).

The consequences of substandard records can be detrimental to both the patients and the nurses. Electronic health records in nursing care documentation have been proposed and being adapted progressively across health care institutions in Ghana. These new system is seen as key to minimizing if not eliminate the practice variation in care documentation. Clear accurate documentation is considered crucial to promoting adequate communication and necessary in risk reduction within the clinical setting and plays the role of aiding in establishing nursing autonomy and improving quality care.

Conceptual definition of Nursing Documentation

There are no universal standards for defining nursing documentation of patient care by nurses, however every nursing documentation is expected to be complete and accurate containing key nursing action for patient in the therapeutic interaction and carry in a way to promote communication. Various definition of nursing documentation standard dimensions has been discussed in promoting communication and safe care (American Nurses Association, 2010; CRNM, 2017; Jefferies et al., 2010).

These definitions stipulate expectations to be met for standard and adequate documentation of care; entries made by nurses be in line with the care given; leaving no blank lines or excessive space in-between each entry; provide dates; time and signature of the nurse making the entries; entries be clear; legible reflection of clinical judgement and fulfils legal requirements. It must be sufficiently comprehensive to present a continuous narration of the patient's experience and demonstrates how the nurse understood the patient's condition and problems evident in the caring process.

Although these working definitions provide the framework to commensurate with nursing documentation standard, most of the well-known definitions of nursing documentation tend to be more generic than detailed, as a result, a more diverse and less uniform approach to documentation quality assessment is possible in the context of a developing country.

In light of this, the study offers a workable definition based on a revision of one of the most generally referenced definitions of nursing documentation by the American Nurse Association (ANA, 2010) as well as incorporate the views

of Jefferies, Johnson, and Griffiths (2010) on documentation and the views from this study, to reflect documentation standard in the context of a developing country.

In this study, documentation is defined as follows:

> ''*A hand written record information of patient care that meets professional expectation of communication of the nurse's and the patient's interaction with reflection of the experience of the patient and the nurse accountability''.*

The definition is similar to Jefferies, Johnson and Griffiths (2010) as a result of the fact that documentation is the degree to which written information of patient care serve to communicate among nurses of the patient care. The operational definition stipulates documentation policies, procedures and protocols and guidelines as structural dimension to adequate documentation (ANA, 2010). The use of the nursing process model to outline documentation, patient progress, discharge teaching and education as process dimension, while outcome dimension involve how the documentation fulfil expectation of legal regulation to documentation.

One of the operational definition's major flaws is that it isn't comprehensive enough, allowing other crucial dimensions such as specific structure and format, context and outcome such as critical incidents and safety reports which are important indicators for adequate and safe practice documentation in quality health care to slip through. However, a major positive attribute the definition is based on the fact that is less generic compared with other definitions as stated.

Theoretical Framework of Nurses Documentation Standard

Guided by the working definition of nursing documentation, the study adapted the Nursing and Midwifery Content Audit Tool (NMCAT) to develop a conceptual framework of nurses' documentation, within the framework of Donabedian's structure-process-outcome quality model.

Theoretical Review of the Model

Donabedian pioneered the work of the model by proposing that we can measure the quality of health care by evaluating its structure, processes and outcomes as adapted from the concept of input–process–output in industrial manufacturing (Shaw & Kalo, 2002). He argued that "good structure increases the likelihood of good process, and good process increases the likelihood of good outcome" (Donabedian, 1988). Donabedian defined structure (or input) as the attributes of the settings in which care occurs and the resources needed for health care. This would include material resources (facilities, capital, equipment, drugs, protocols or guidelines etc.), intellectual resources (medical knowledge, information systems) and human resources (health care professionals). Structure is often easy to observe and measure and it may be the upstream cause of problems identified in process (Perrin, 2002).

Process measures explore the manner in which the health care provider interacts with the patient. Processes can be further classified as technical processes, what care is delivered, or interpersonal processes, which is the manner in which care is delivered (Donabedian, 1988). According to Donabedian, the measurement of process is nearly equivalent to the

measurement of quality of care because process contains all acts of healthcare delivery (Donabedian, 2002).

Outcomes describe the effects of health care on the health status of patients and populations and comprise outcomes such as mortality, morbidity, disability or quality of life, as well as intermediate outcomes, for instance, improved knowledge, satisfaction with care and others.

The model provides a framework for enquiry into standard of health care services and underpins measurement for improvement (Naranjo & Viswanatha Kaimal, 2011). The constructs of the model are interdependent with a causal relationship which provides the basis for measuring quality (Voyce & Santos, 2015). Figure 2.1 depicts the conceptual framework of quality standard of nursing documentation.

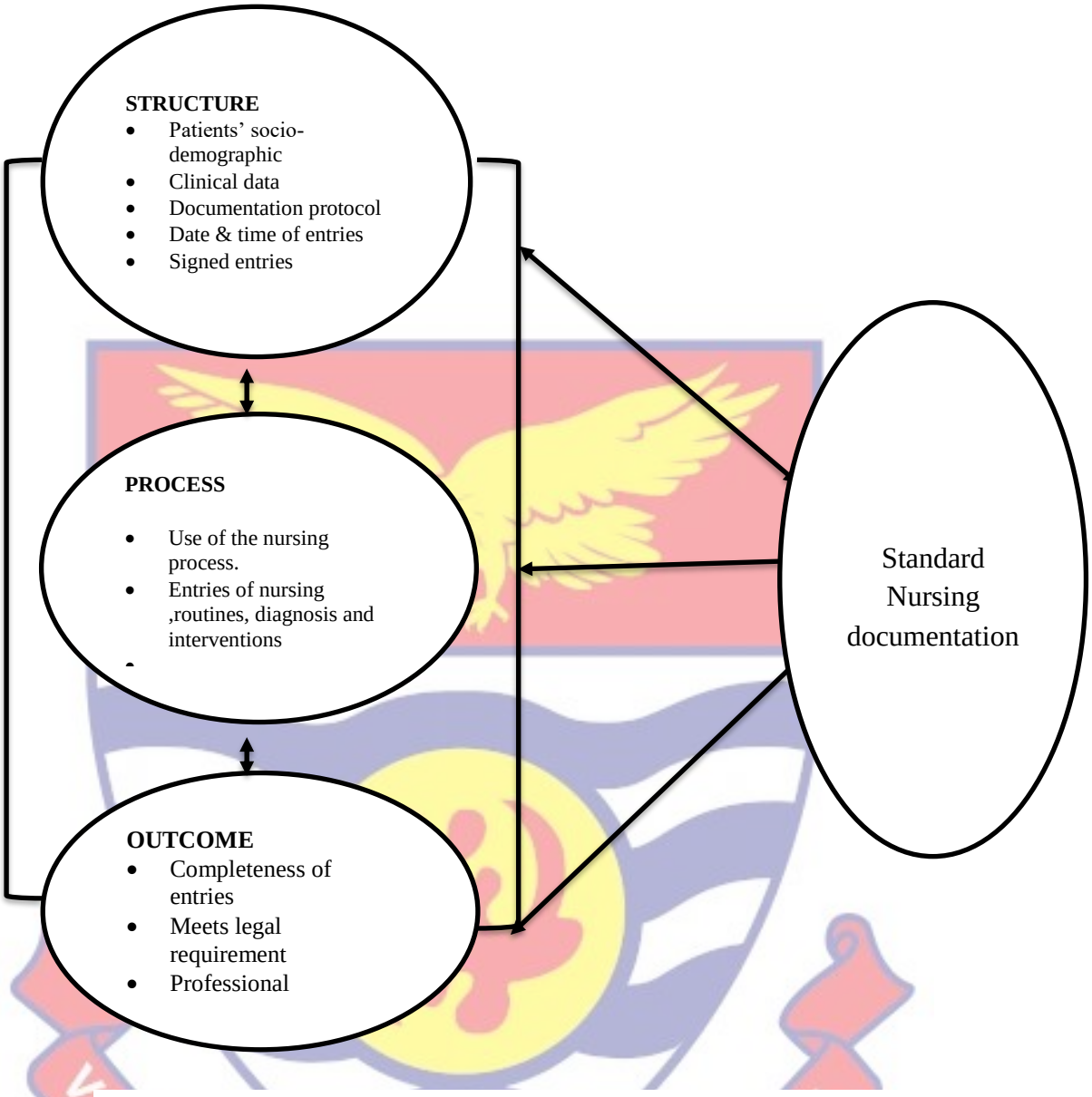

Figure 2.1: Donabedian framework on Nursing Documentation, 2021

Application of the Model to the Study

In line with the framework, the study assessed nursing documentation by putting the various dimensions of standard documentation practice into the categories of structural, process and outcome in line with Donabedian's model.

Structure dimension of nurses' documentation of care include the standard criteria for adequate documentation of nursing care in line with hospital protocols and guidelines, patient demographic factors, clinical data, use of

name and signature on entries with date and time. The framework posits that nursing documentation practices can be influence by the structure of the reporting sheets such as the Nurses' notes and report books and documentation protocol. In this study, the reporting structure requires the input of the patients' sociodemographic and clinical characteristics. Each entry is expected to include date and time and should systematically report nursing care activities conducted for the patient with entries using red and blue pens for night and day activities. Also, each entry is expected to be accompanied by the signature of the documenting nurse or supervisor.

Process dimensions include presence of aspect of the care documentation; the study sought to determine if the documentation included nurses' identification of patient problems, indicated nursing diagnosis where necessary, reported interventions and the patients' tolerance to those interventions as well as evaluation of the patient health state and progress report. The entries were assessed for outlining the key routine documentation for the care of the patient.

Finally, the outcome dimension focuses on the completeness of entries, and whether documentation meets legal and professional standards. The conceptual framework alludes to the fact that the quality of documentation can be influenced at the structure, process, and outcome levels.

Strengths and Weakness of the Model

The Donabedian model has been criticized on a number of grounds. The sequential progression from structure to process then to outcome has been described by some as too linear of a framework, and consequently has limited

utility for recognizing how the three domains influence and interact with each other (Carayon, Hundt, Karsh, Gurses, Alvarado, Smith, & Brennan 2006). According to Lau (1982) the relationship between structural and process variables are weak, inconsistent and paradoxical. As such the influence of one on the other may not be directly related due to the inherent weaknesses

There is a long-standing debate in the literature about the relative merits of process and outcome measures. Brook, Elizabeth, McGlynn, and Paul (2000) argue that process data often provide a more sensitive measure of quality than outcome data, since a poor outcome does not necessarily result from a failure in the provision of care (Brook et al., 2000). Outcomes are more generally perceived as poor measures of quality of care as they are only partially attributable to health services and may be more strongly influenced by other factors and that poor outcomes do not always imply poor quality.

Donabedian's model is limited by an inherent difficulty in establishing the relationship between structure, process, and outcome. Furthermore, there may be difficulty determining whether some factors are strictly part of structure and/or process or outcomes, as overlap between them may exist. Similarly, if quality of care criteria based only on structure are to be credible, it should be clear that variations in that structure may lead to differences in outcome. A measure of quality of care that includes all important meanings of the concept under consideration is more valid than one that only includes one of these dimensions (Liu, Singer, Sun, & Camargo, 2011).

However, the model approach makes quality assessment possible assuming structure influences process which intend influences outcome. The choice of the model allows for both researchers and policymakers to conceptualize the

underlying mechanisms that may contribute to poor quality. The Donabedian's approach to describing and evaluating the quality of care has been accepted widely, easily understood, one of the very few points of consensus in the field of quality (Donabedian, 1980).

Chapter summary

There is no doubt from the reviewed literature, that nursing documentation of patient care is a global standard expected of all registered nurses in the care setting. The proper documentation of patient care leads to the delivery of quality nursing care and improved patient outcomes. Adequate patient care documentation promotes critical thinking on the part of nurses, promoting continuity of care while ensuring professional autonomy and the building of the body of nursing knowledge and research.

However, despite the benefits and the key roles documentation plays in the delivery of patient care, several studies have shown varied levels of adequacy and quality across hospitals and countries context (Abraham, Berchie, Okantey, Amoah, & Agyei-Ayensu, 2017 ; Randmaa, Mårtensson, Swenne, & Engström, 2015; Asamani et al., 2014).

Despite the fact that quality nursing documentation is recognized as important, what constitutes good nursing documentation is not always clear. These variations in nursing documentation practices as cited relates to local institutional designs, documentation systems or frame work and technologies across nations and context (Wang et al., 2011). The individual's professional judgement plays a role in what is relevant and necessary to record about the patient. The challenge of work pressure, nurse's attitudes, shortage of

materials for documentation, inadequate guidelines for documentation was widely reported in literature to compromise adequate documentation practices.

All vital information about the patient, as well as nursing and medical actions, must be the basis of nurse's documentation and carried out guided by the fact that the Scarcity of good nursing care documentation will impair communication among nurses and physicians with potential negative effect on care outcomes.

CHAPTER THREE

RESEARCH METHODS

Introduction

The chapter reviews the method the researcher employed to answer the research questions and describes the methodological decisions made in the design of the study as well as the rationale underscoring those decisions. The chapter is divided into sub-sections as follows; research design, study area, population, sampling procedure, instrument for data collection and procedure for data collection, data processing and analysis. Following these subsections, the ethical considerations applied during the research is presented.

Research Design

A research design is the plan, procedure or structure of a study that guides the researcher in the research process. The design choice spans from the decisions of the researcher from general assumptions to data gathering and analysis in great detail (Creswell, 2014). It outlines the basic tactics that a researcher will use to respond to the research questions, test hypotheses and informs the kind of statistical test for use in the analysis of the data (Polit & Beck, 2010). In this study, a retrospective cross-sectional descriptive quantitative technique was use objectively to reviewed the status of nursing documentation of patient care at the Baptist Medical Hospital (Polit & Beck, 2010).

According to Creswell and Creswell (2017) the choicest of a particular research design is based on the researcher consideration of the following important elements; philosophical assumption, strategies of inquiry and the specific research method. For Polit and Beck (2010) the researcher

consideration in the choice of a design in any quantitative study is whether the method provide the most accurate, unbiased, understandable, and proof that can be replicated. It is reported that no aspect of a research method affects the quality of evidence as much as the design adopted for a study. Cross-sectional designs collect data at a single point in time. The collection of data on a phenomenon under study is carried over a single time period (Polit & Beck, 2010). The design is considered suitable for representing the state of a phenomenon or interactions between phenomena at a specific point in time with the advantage of been easy to apply, relatively economical, allowing judgment regarding the evolution of processes through time. However limited when use in inferring changes over time (Creswell, 2014). The merits of the cross-sectional design for this study included a faster and relatively cheaper data collection process (Rezac, Salkind, McTavish, & Loether, 2001) and although, it impacted the ability of the study to determine causal relationships, it afforded the researcher the opportunity to explore the state of nursing documentation in the BMC in relation to the standard practice expected (Hesse-Biber & Johnson, 2015).

The study was also retrospective in nature. A retrospective study involve a systematic procedure to evaluation of events, practices, situations and phenomena that looks backward for cause or antecedent i.e. investigation of a previous occurrence of a phenomena, event, difficulty, or issue, and carried out on the basis that data is available for the period (Creswell, 2014). It was considered appropriate, because it afforded the researcher the opportunity to audit existing nurses' documentation of care in patient folders which was

readily available at any point in time with limited interference on the work schedules of the staff.

Study Area

The study was conducted at the Baptist Medical Centre, in the North East Region of Ghana. The hospital is a quasi-government health facility established by the International Mission-Board of the Southern Baptist Convention of the United States of America. The hospital is a secondary health facility that serve as a referral centre for the region's primary health facilities. It has a wide catchment area covering Nalerigu and its environs as well as most parts of the four regions of the North of Ghana, parts of Togo and Burkina Faso. Baptist Medical Hospital provides 24-hour health services including from general Medical-Surgical, Obstetrics/Gynaecological and Public health services. According to the Annual Report, the hospital is a 200-bedded capacity facility and attends to about 200 patients on an out-patient basis daily. The facility also records an annual average surgery at thousand (Baptist Medical Hospital- MIS, 2019). The hospital boasts of staff strength (nurses) of two hundred (200) with varied qualification and experience.

The facility was selected for this study because; it records a high bed occupancy rate in the medical-surgical and paediatrics unit necessary to gain enough records to improve the power of the study. Also, the facility serves as a clinical training centre for various cadres of nurse trainees, medical interns and other allied health interns or professionals.

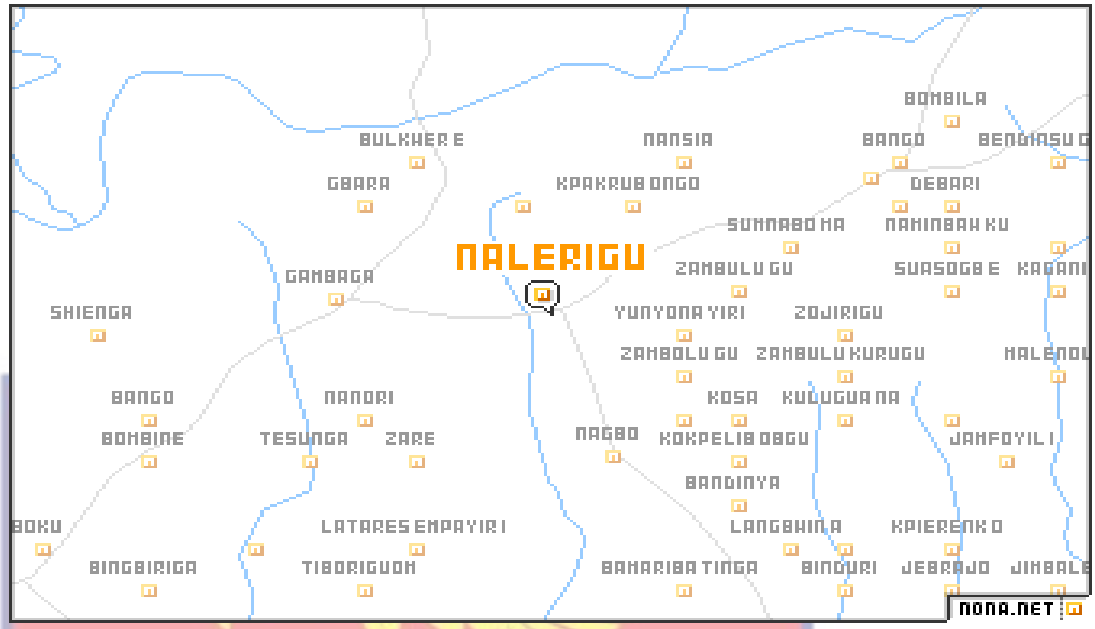

Figure 2: Map of Nalerigu

Population

A population is a collective of people or items who have similar identifying traits and fit the parameters for a study that a researcher is interested in. (Creswell, 2014). It may broadly involve tens of thousands of people/objects or a small group of a few hundred people depending on the criteria and the area of study of the researcher. In research, population is not restricted to human subjects but may include any object of interest (Polit & Beck, 2010).

The study population consisted of the nurses' records (folders) of patients admitted in the (Medical – Surgical and Paediatric) wards between the periods of 1st October to 31st December, 2019. The records were limited to the patient folders that contained the nurses' notes, temperature charts and treatment sheet. The number of patient folders accessible for this study, was four hundred and eighty (480) records(folders) with the medical and paediatric wards holding almost up to 50 % due to the high rate of patient admission to those wards in the facility (MIS- BMC, 2019). The size of the population of

the selected units for the study was deem representative to the entire wards of the hospital. This was based on the proportion of the number of admitted patients within the time period under consideration.

Inclusion Criteria

Folders eligible for selection into the study should have met these criteria:

- The folder should belong to a patient who had been admitted into the medical, surgical or paediatric units between 1st October to 31st December, 2019.
- The patient should have been on admission for not less than 24-hours but not more than seven (7) days.

Exclusion Criteria

Folders of patients with no entries indicating admission orders were excluded.

Sampling Procedure

Sampling is a critical part of the design of quantitative research, it creates room that allows the researcher to achieve statistical conclusion validity and for generalisation of findings in a study. The sample size of the study was determined as 240 patient folders to be drawn from the selected wards within the period under consideration from an accessible population of 480.

In sampling, a portion or units of the population is selected in representing the entire population in a study (Polit & Beck, 2010). It's a subset of the population that a researcher choose for a study based on the assumption that its primary features are very similar to those of the total population (Polit & Beck, 2010). Sampling is considered the most convenient and less costly

strategy in collecting data from a population; however, it risks the tendency of not adequately reflecting the entire population's traits which may lead to erroneous conclusions. According to Creswell and Creswell (2017), the larger the research sample the more accurate the inferences to be made, but however pointed that recruiting many participants in a study can be time consuming and costly. A stratified random sampling techniques was first use to select the units/ward into the study to enhance representativeness. Systematic random techniques was then applied in the selection of each folder for the strata in each ward.

Determination of the sample size

The researcher acquired the accessible population's medical record numbers from each ward using the "Admission and Discharge" (A and D) book within the period under study. A list of all eligible patient folders was then created based on the wards in which they were nursed. Consequently, a total of 480 patients' health records were eligible to be included in the study.

After that, Yamane's formula was used to determine the sample size. The formula is as follows;

$$(n) = \frac{N}{1+N(e)2}$$

Where n, is the sample size

N, is the study population size

e, is the level of precision desired, (Israel, 2009).

A confidence interval of 95% was estimated with *p* value set at 0.5. Base on the inclusion criteria, the accessible population was determined to be 480

patients' health records. Applying Yamane's formula, the sample size was estimated at - 218 folders as indicated below.

$$(n) = \frac{480}{1+480(0.05)2} = 218.$$

Israel (2009) recommends that an additional 10% of the determined sample should be added to the estimated sample size to cater for non-response. Hence, a final sample size of 240 was finally realised.

Determination of the Proportionate Sample Allocation

To begin with, the admitting wards or units were divided into three base on the number of inpatient admissions; medical, surgical and paediatric. Then, systematic random sampling technique was used to proportionally allocate to each unit, the number of records to be drawn. Using the formula, f $=n/N$, the sample fraction was estimated as 0.5. The estimated sample fraction; 0.5 was then applied to the population of patient records of each unit to determine the sample size to be drawn from each unit base on the proportion of patient admitted. Hence, 100, 50 and 90 were drawn from medical, surgical and paediatric wards respectively.

Table 1.0 Accessible Population and Sample for each Ward

Ward /Unit	**Accessible Population**	**Sample chosen**
Medical	198	100
Paediatrics	177	90
Surgical	105	50
Total	480	240

Selection of Patients' Records

The final phase of sampling involved the selection of patient's records into the study. Reverting to the list of eligible folders that was categorised based on the various units/wards, a systematic random sampling method was adopted to draw the selected files. Beginning with the medical unit, the list of eligible folders was arranged serially in an ascending order based on their folder numbers. The sampling interval was calculated by dividing the total estimated sample to be drawn from this stratum from the estimated eligible population in the stratum, hence 480/100 which was 5. The starting point was randomly selected at serial number two and subsequently the interval was applied until the total number of 100 had been arrived at.

The same strategy was applied in estimating the sample from the paediatric and surgical strata.

Data Collection Instrument

The systematic gathering of data relating to the study's purpose and objectives is known as data collection (Creswell, 2014). Following an extensive literature search, the Nursing and Midwifery Content Audit Tool (NMCAT) designed to reflect the standard of quality documentation by nurses was adapted for the collection of data. NMCAT is specifically designed to evaluate nursing documentation (Johnson, Jefferies, & Langdon, 2010). The audit tool was developed in the Sydney, Australia using a sample of 200 health care records with interrater agreement of 85%. Absent, present, always present, and not rated were the response types (Johnson et al., 2010). The NMCAT audit tool consists of a definitive list of elements and predefined categories of minimum

standards of nursing documentation that nurses are expected to include in a daily nurse note. Each category was checked and rated in terms of content by auditing patient charts. Corben (1997) set a 60% or lower level of achievement as an unsafe result for the criteria relating to the content of nursing documentation (Johnson et al., 2010).

The tool is divided into four sections: a time sampling method, an analysis of nursing documentation content, legal documentation requirements, and the text or real language used by nurses to indicate their areas of strength and weakness in documentation (Johnson et al., 2010). The score on each section are address individually with a percentage score of the total as an average, one rating per question is awarded and a percentage total then calculated. A higher percentage score of 95% and 90% reflects adequate documentation quality, while a 60% or lower- level score or achievement reflected an unsafe documentation practice Corben, (1997). The NMCAT criteria were designed to relate to the standard for quality nursing documentation (Jefferies et al. 2010) as more realistic as compare to the other instruments. The tool was useful, reliable and valid that clinicians, managers and educators can use to monitor aspects of nursing documentation for quality improvement and as a guide for development of documentation standard protocols.

However, to answer the research questions for the study, the tool was modified and enhanced in for the collection of data. The modified tool (Appendix A) was redesigned with the inclusion of folder demographic data and incorporation of the American Nurses Association documentation principles (American Nurses Association, 2010), College of Registered Nurses of

Manitoba (2017), best practices guidelines and many other relevant literature on documentation.

The tool was divided into four sections; Section A part of the tool contained five items to review patient and ward demographic characteristics; Section B, contained seven items on nursing documentation content that reviewed the standard criteria for documentation; Section C, contained seven items on some selected nursing routines or tasks documentation as a reflection of quality patient care, all in four Likert-scale responses. The last Section D, contained six item dichotomous responses which reviewed the legal aspect of the documentation.

Pre-test of the instrument

Following the modification of the instrument, pre-test was done at the Binde Government Hospital in June, 2020. The Medical and Paediatric units of the hospital were selected for the test because of their high bed occupancy and share similar characteristics with those of the Baptist Medical Hospital. The purpose of the pre-test, was to serve as a trial to determine whether the research instrument is suited in generating the desired information for the purpose of a study (Polit & Beck, 2010). It afforded the researcher the opportunity to administer the new instrument with the purpose to determine it quality using smaller groups, similar to those in the larger investigation (Polit & 2010). The researcher selected 24 patient folders for the pre-test. The exercise enabled the researcher to test the instrument for any inaccuracies, ambiguities and an opportunity to improve the instrument and be assured of the suitability of the tool to obtaining the data the researcher intended to find in the study. There was a 100% questionnaire return rate. The questionnaire

originally had 30 items. However, expunging of irrelevant items, modification of ambiguous ones, re-numbering and other corrections on the questionnaire after the pre-test, brought the final number of items to 25 intended to find in the study. There was a 100% questionnaire return rate. The questionnaire originally had 30 items. However, expunging of irrelevant

Validity and Reliability

Validity is a broad term that refers to the soundness of a study's evidence, such as whether the conclusions are compelling, convincing, and well-founded (Polit & Beck, 2010). In any study, establishing the validity of scores gives credence as to whether an instrument is suitable for use in the study.

The precision and consistency of data collected in a study are referred to as reliability (Polit & Beck, 2010). It seen as the consistency or repeatability of an instrument in giving same result in a same context under different scenario. An instrument consistency is measured by it Cronbach's alpha. Cronbach's alpha (α) is a measure of an instrument consistency that runs from 0 to1, with ideal values ranging between .7 and .9. (Creswell, 2014). The instrument has an overall Cronbach's value of 0.75 with the section at 0.6, 0.7 and 0.70 respectively.

To ensure validity of the modified instrument, Clinical nurse managers and academics reviewed the content of the modified audit tool to determine the content and construct validity of the instrument. Pretesting was done at the Binde government Hospital which shares similar characteristics with that of Baptist Medical Hospital to determine the suitability of individual items in the

instruments. The data was processed and analyze using version 21 of the Statistical Package for Social Sciences (SPSS).

The reliability of the instrument was estimated using data from the pre-test study. The data was statistically tested to determine normality of the data as well as its interrater reliability, it achieved 80% agreement with interrater reliability (Polit & Beck, 2010).The instrument was deemed reliable with a Cronbach's alpha greater than 0.70 (Radhakrishna, 2007).

Data collection procedures

After the study's ethical approval had been granted by the University of Cape Coast Institutional Review Board; (UCCIRB/CHAS/2020/79) (Appendix B), the researcher wrote to the management of the hospital for approval and to grant access to the selected units for the data. A series of meetings were held between the researcher and the unit heads as well as the management information system (MIS) officer with the sole purpose of drawing a schedule as to how to access the units' records (A&D book) without interfering with their normal schedule of work.

One research assistant was trained to assist the researcher in retrieving the patients' health records from the records department and to organise them accordingly. Using the folder numbers as a guide, the researcher captured nurses' documented activities from the nurses' notes and 24-hour report book using the modified NMCAT as a checklist. The data collection process took two weeks, with a daily audit of 15 folders. The time spend for audit of an entire individual folder was at 20 to 30 minutes on average with the reviewers validating each page of the folder with the relevant content of the nurses

records using the respective sections of the checklist. However, within the period of the collection, there was issues of missing folder numbers as sampled, the laborious process of selecting the folders with the record department was time consuming and sometimes futile.

Data Processing and Analysis

Data analysis entails "breaking up" data into understandable themes, models, and fashion in an attempt to grasp the various basic elements (Creswell, 2014). With statistical analysis, researchers make sense of quantitative data that would otherwise be meaningless or a chaotic mass of numbers (Polit & Beck, 2010). The process of analysis of the collected data, enable researchers to summarize, organize, evaluate, interpret, and communicate numeric information (Polit & Beck, 2010).

For this study, the data collected was first examined for completeness of responses. Thereafter, the checklist were counted and sorted based on the names of the wards from which the data was collected. A template for data coding was then, developed using Statistical Package for Social Science (SPSS) version 21. Two data entry personnel independently entered the data which was later screened for accuracy. The double entry was necessary to ensure that the data entered was accurate.

Data analysis begun with all continuous variables being re-coded into categorical variables. This ensured that the original entries for the continuous variable were retained while dummy codes were created for further analysis. Socio-demographic and clinical characteristics were analysed descriptively and presented with frequencies, and percentages. Further analyses were

computed using means, standard deviation, minimum and maximum values for each continuous variable.

The research question one sought to assess the patient-related factors that influence nursing documentation of in-patient care. Five patient-related demographic and clinical characteristics including sex, age, ward/unit, length of admission, outcome of admission were individually compared with the standards of documentation and analysis conducted using both descriptive and Inferential Statistical methods. The findings were presented as Mean, Standard deviation, and Logistic regression and Pearson correlation.

Research question two sought to identify the extent to which the documented care complies with nursing documentation standards. The written text of the nurses' documentation of patient care was examined to determine the content of healthcare documentation. A sum of 7 items measured on a four-point scale of absent, partially present, present and always present were computed to determine if the nursing documentation at the study setting met the standard categorisation set by Corben (1997). Descriptive statistics such as frequency, percentage, mean, and standard deviation, as well as regression, Pearson correlation test, were used to present the findings.

Research question three sought to assess the extent to which the documented nursing action of patient care meet the legal requirement for documentation. The written text of the nurses' documentation of patient care was examined to determine if they met the legal requirements for documentation. A sum of 6 items measured on a two-point scale of Yes and No were computed to determine if the nursing documentation at the study setting met the legal criteria standard categorisation set by Corben (1997). The data was presented

in the form of descriptive statistics such as frequency, percentage, mean, and standard deviation. The research question four sought to determine the extent to which nursing documentation reflect quality patient care. The nurses' documentation of patient care was examined to determine whether it reflected quality patient care. A sum of seven items measured on a four-point scale of absent, partially present, present and always present were computed to determine if the nursing documentation at the study setting met the standard categorisation set by Corben (1997). Results were presented as descriptive statistics such as frequency, percentage, mean, standard deviation while one sample t-test was also conducted.

Ethical Consideration

The concept of ethics and ethical adherence is a crucial subject in any research study (Creswell, 2014). Nursing research raises ethical considerations since the border between what constitutes normal nursing practice and the collecting of research data can sometimes become blurred (Polit & Beck, 2010).

In line with resolving ethical concerns, the University of Cape Coast Institutional Review Board provided ethical clearance (UCCIRB/CHAS/2020/79) (Appendix B), granting clearance for the study which was then used to obtained formal permission from the hospital management. The researcher ensured the study also followed the ethical considerations required for researches involving human subjects as detailed in the Helsinki declaration of scientific researches (World Medical Association, 2013):

Autonomy: Because the study did not involve the direct human contact with patients but their records indicating nursing care rendered to them while on admission, permission could not be sought from the patient. But the gatekeeper system (Almgren, 2013) was respected. Permission was sought from the hospital and unit managers after the purpose of the study had been explained to them and clarifications made where necessary.

Beneficence: Although, the study did not bring direct benefit to the patients whose records were reviewed, the information gathered from the research would contribute to the facility's quality improvement and nursing care documentation. Also, since most of the patients, were likely to access the facility in the future, they were likely to benefit from the improvements that the study will bring to the facility.

Non-maleficence: No harm was directly associated with reviewing of the patients' records. Furthermore, because, the data collection process was organised with the input of the gatekeepers, service delivery was not disrupted.

Risk: The research was associated with minimal risk to the patients' whose records were reviewed. This risk was identified as a possible breach in confidentiality during data collection and management. Hard copies of completed data collection forms were kept away from the study setting, in a locked cabinet while electronic versions were stored in password protected computer program accessible to only the researcher and supervisor. Patient record numbers were deleted once data capturing is completed to ensure the final data is anonymous.

Confidentiality: Patient records were kept confidential and private, and they were not taken from their original places. Patient names and medical record numbers (folders) numbers was de-identified using the assigned numbers by the researcher to work with for purpose of anonymity and right to privacy. The units from which the records were selected was also de-identify with the entries not tie to a particular ward or a nurse.

Chapter summary

The chapter presented the methodological steps involve in the study in meeting the research objectives. The study employed retrospective cross-sectional survey design with quantitative approach in answering the objectives set. A sample of 240 patient folders from three major wards was selected using multi stage sampling. Each folder in the specified unit was chosen using a systematic random selection process.

Data was collected using an existing Check-list for audit of documentation which was modified with reliability and content validity indices of 0.85 and 0.75 respectively. A return rate of 100% (240) was realised. For statistical analysis, the data was cleaned, coded, and entered into IBM SPSS version 21.0.

Descriptive analysis took the form of Mean, Standard Deviation with frequency and percentages while inferential analysis carried out using Multiple Logistic Regression Model at an alpha level of 0.05 and Pearson correlation test.

The retrospective nature of the study did not allow for the researcher verify whether what has been documented was actually carried out only by the

nurses. Clinical documentation by other health professionals in the patient records did not form part of the study as such could not draw general conclusion on the entire clinical records.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The outcomes of the data analysis for the study are presented and discussed in this chapter. This is presented in sections with consideration to the conceptual framework and research questions used. The study sought to assess nurses' clinical documentation practices using the BMC - Nalerigu as a case study.

Results

For the reviewed folders, data on the patient demographic/background characteristics such as, age, gender, the unit of admission, length of stay and outcome of admission was collected during the survey. Table 1.1 presents the distribution of patient-related and demographic characteristics of the reviewed folders. As shown, of the 240 folders reviewed, majority of the records (n=100, 41.7%) were drawn from the medical ward. Most of the records were for female patients (n=145, 60.4%). On the distribution of ages of patient as documented in the folders reviewed, majority (n=94, 39.2%) were below 10 years.

Regarding the length of stay, most of the patient (n=146, 60.8%) had stayed on admission for up to 96 hours. On the outcome of admission, (n=231, 96.3%) of the reviewed folders were for patients who has been discharge. This is shown in table 1.1.

Table 1.1 Frequency and Percentage Distribution of Patient related and Demographic of Reviewed folders

Characteristics		Frequency (N = 240)	Percent (%)
Unit/Ward			
	Medical ward	100	41.7
	Surgical ward	50	20.8
	Pediatric ward	90	37.5
Age of Patient (Years)			
	< 10	94	39.2
	10 - 20	33	13.8
	20 - 30	27	11.3
	30 - 40	27	11.3
	>40	59	24.6
Sex of Patient			
	Male	95	39.6
	Female	145	60.4
Length of Admission			
	>48<96	146	60.8
	>96	94	39.2
Outcome of admission			
	Discharge	231	96.3
	Death	9	3.8

Descriptive statistics of the patient demographic and related characteristics such as, the gender, age, length of admission, outcome of admission, and the unit of which patient was admitted and the standard of adequate documentation was analysed. Table 1.2 presents the mean and standard deviation of each of the variables. As shown for the 240 folders, Length of admission (M = 4.29, SD = 1.061), Unit/ward (M = 1.96, SD = .891), Age (M

= 24.31, SD = 22.875), Gender (M = 1.60, SD = 0.490) and documentation standard (16.97, SD= 2.220).

Table 1.2 Descriptive statistics of the documentation standard and patient related/demographic factors.

Item	Mean	Std. Deviation	N
Standard	16.97	2.220	240
Length of admission	4.29	1.061	240
Age of patient	24.31	22.875	240
Gender	1.60	0.490	240

Research Question 1.1: What are the Patient-related factors that influence Nursing Documentation of Patient care?

Multiple regression analysis with standard as the dependent variable and the unit/ward, age of the patient, sex, length of admission, and outcome of admission as independent variables. The regression model of the study was as follows:

$$Y = \alpha + \beta 1X1 + \beta 2X2 + \beta 3X3 + \beta 4X4 + \beta 5X5 + \varepsilon$$

Where Y represents institutional standard α is the constant, X1 unit/ward, X2 is the age of the patient, X3 is sex, X4 is the length of admission, and X5 is the outcome of admission. β1, β2, β3, β4, and β5 are coefficients of regression of the variables while ε is the error term.

Model Determination

The goodness of fit results is as displayed in Table 1.3. The regression model provided an R^2 value of 0.010. This implies that the predictors used in this model can explain only 1% of the variation of the dependent variable which is

highly insignificant. The remaining percentage can be accounted for by other variables other than those used in this study.

Table 1.3 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.101[a]	0.010	-0.011	2.232

Test of Significance

The test of significance was estimated using the Analysis of Variance (ANOVA) tool as indicated in Table 1.4. The model gave ANOVA regression sum squares of 11.919 and residual sum square f 29.499. The mean square for regression is 2.384 and a residual mean of 4.982. The output provided an *F*-statistics value of 0.478 with a *p*– value of 0.792.

Table 1.4 Analysis of Variance (ANOVA)

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	11.919	9	2.384	0.478	0.792[b]
Residual	29.499	234	4.982		
Total	1177.733	239			

This implies that all the variables used in the model namely; unit/ward, age of the patient, sex, length of admission, and outcome of admission are not significant in predicting standard. Therefore, from the results on the overall *p-value* of *F* – statistics given, it can be concluded that the model used in the study is not significant at 5%.

Coefficients of the Variables

The results of the regression coefficients of the variables are as indicated in Table 1.4.

Table 1.5 Coefficients of the Variables

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	18.168	1.611		11.277	0.000
Age of patient	-0.072	0.133	-0.053	-0.538	0.591
Sex of patient	-0.511	0.336	-0.113	-1.518	0.130
Length of admission	0.028	0.311	0.006	0.090	0.928
Outcome of admission	0.095	0.760	0.008	0.124	0.901
Unit/Ward	-0.181	0.260	-0.073	-0.697	0.486

From the result, it is clear the patient-related factors in this study do not significantly influence the standard of documentation at a 5% level of significance. This is evident with p-values of 0.591, 0.130, 0.928, 0.901, and 0.486 recorded for the age of the patient, sex of patient, length of admission, outcome of admission and unit/ward respectively which were all greater than 0.05. Therefore, from the findings it can be concluded that patient-related factors do not significantly influence the standard of documentation.

Research Question 2.0: To what extent does the documented care meet the Standards of nursing documentation?

The written text of the nurses' documentation of patient care was examined to determine the content of healthcare documentation. A sum of 7 items measured on a four-point scale of absent, partially present, present and always present were computed to determine if the nursing documentation at the study setting met the standard categorisation set by (Corben, 1997). Results were presented as descriptive statistics such as frequency, percentage, mean and standard deviation.

Table 2.0 Descriptive Statistics of Documentation Standards

	Total Scores	Expected Score	Percent (%)
Standards	4072	6720	60.5
N	240		

Table 2.1 One-Sample Test of documentation Standard

					95% Confidence interval of the Difference	
	t	df	Sig.(2-tailed)	Mean Difference	*Lower*	*Upper*
Standard	-76.999	239	0.000	-11.033	-11.32	-10.75

In terms of the individual standards, the results indicated that most of the entries are incomplete [Absent (1.3 %), Partial present (66.7%), Present (32.1%) and Always present (0%)]. These results are, significantly different

below what should be acceptable complete documentation [t (239) = 53.578, p =.001]. Similarly, the results show that the entries made by the nurses are often illegible and unconcise [Absent (1.3%), Partial present (21.7%), Present (68.8%), Always present (1.3%)] with [t (239) =39.414, p = .001] which is significantly different from the population normal legible score. The results further shows that most of the entries in the notes do not have dates and time [Absent (3.8%), Partial present (21.7%), Present (49.6%) and Always present (25%). These results are statistically significantly different from what is acceptable in documentation of care [t (239) = 20.536, p = .001]. Also, most entries in the notes are not signed or initialled by the documenting nurse [Absent (7.5%), Partial present (31.7%), Present (53.2%) and Always present (6.3%) which was significantly lower than the population normal standard score [t (239) = 30.118, p = .001]. Similarly, most of the entries do not contain standardized symbols and institutional approved abbreviations at a significant level from the standard [t (239) = 40.041, p = .001]. From the results, there were lack of use of patient own name in entries of care in the documentation at unacceptable level compared to the acceptable level of 61% and above (Corben, 1997), [Absent (52.9%), Partial present (33.8%), Present (12.9%), Always present (0.4%)]. These findings are statistically significantly below the acceptable with the population normal score [t (239) = 51.196, p = .001]. The results, further show that errors are improperly corrected [Absent (15.8%), Partial present (46.3%), Present (37.1%) and Always present (0.8%)].

From table 2.0, it could be seen that based on the aggregate percentage scores of the documentation standards, a score of 60.5% which could be

approximated to 61% was obtained as the level with which documentation standards were met. Comparing this result to the appropriate documentation standard of 61% and above established by Corben, (1997), it is evident documentation standard practices were met at average low level. (See Table 2.1, and 2.2).

Table 2.2 Frequency and Percentage Distribution of standard criteria for Documentation Standard.

Documentation Standard criteria	N	Absent (%)	Partial present (%)	Present (%)	Always present (%)
Entries are complete and shows chronology from admission to discharge.	240	3 (1.3)	160 (66.7)	77 (32.1)	0 (0)
Entries are legible and concise	240	9 (3.8)	3 (1.3)	165 (68.8)	3 (1.3)
There is recorded date and time on all nursing entries	240	9 (3.8)	52 (21.7)	119 (49.6)	60 (25%)
Entries are signed and initialled	240	19 (7.9)	76 (31.7)	130 (54.2)	15 (6.3)
Contain standardized symbols and institutional approve	240	5 (2.1)	94 (39.2)	139 (57.9)	2 (0.8)

abbreviation					
Patient is referred by own name in the nursing notes	240	127 (52.9)	81 (33.8)	31 (12.9)	1 (0.4)
Errors made are corrected appropriately with initial entry visible	240	38 (15.8)	111(46.3)	89(37.1)	2(0.8)

Research Question 3.0: To what extent does documented Nursing action of Patient care meet the legal requirement for documentation?

The written text of the nurses' documentation of patient care was examined to determine if they met the legal requirements for documentation. A sum of 6 items measured on a two-point scale of Yes and No were computed to determine if the nursing documentation at the study setting met the standard categorisation set by (Corben,1997). Frequency, percentage, mean, and standard deviation were used to describe the findings. See Table (3.0)

Table 3.0 Frequency and Percentage Distribution of Legal criteria for documentation.

Legal criteria	N	Yes (%)	No (%)
Record of patient name on each page	240	1 (0.4)	239 (99.6)
Health record	240	5 (2.1)	235 (97.9)

number			
Time and date of entries			
Evidence of use of approved abbreviation only	240	221 (92.1)	19 (7.9)
Name, signature of nurse	240	189 (78.8)	51 (21.3)
Appropriate correction of error	240	223 (92.9)	223 (92.)
Excessive blank space between entries	240	169 (70.4)	17 (7.1)

The results shows that nurses at BMC demonstrated documentation practices that met legal criterion for adequate or safe practices on the overall documentation practices since most of the criteria were met at a high level (over 70%) compared to the acceptable standard of 61% and above established by Corben, (1997). With the individual standard, the record of patient name and health record number on each page of the folder as documented by the nurses, [(0.4%, 99.6%), (2.1%, 97.9)], appropriate use of blank [(37.9%), (62.1%)] were at a low level compared to the standard. However, the record of time and date of care in care documentation [(92.1%, 7.9%)], entry of name and designation of nurse writing reports, [(92.9%), (7.1%)], use of approved

abbreviations [(78.8%), (21.3%)], appropriate correction of errors [(70.4%), (29.6%)] were all met at high level.

Research question 4.0: What is the extent to which nursing documentation reflect quality patient care.

The nurses' documentation of patient care was examined to determine whether it reflected quality patient care. A sum of seven items measured on a four-point scale of absent, partially present, present and always present were computed to determine if the nursing documentation at the study setting met the standard categorisation set by Corben (1997). Results were presented as inferential and descriptive statistics such as frequency, percentage, mean and standard deviation.

Table 4.0 One-Sample Statistics of Documentation and Quality care

	N	Mean	Std. Deviation	Std. Error Mean
Quality	240	10.3	1.789	.115
Nursing process	240	6.13	1.189	.077
Vital signs	240	13.00	2.488	.161
medication	240	5.90	.295	.019

Table 4.1 One-Sample Test of Documentation reflecting Quality Care

					95% Confidence interval of the Difference	
	t	**df**	**Sig.(2-tailed)**	**Mean Difference**	***Lower***	***Upper***
Quality	-152.119	239	0.000	-17.567	-17.79	-17.34
Nursing process	-128.584	239	0.000	-9.867	-10.02	-9.72
Vital signs	-18.584	239	0.000	-2.966	-3.33	-2.68
Medication	215.109	239	0.000	-4.096	-4.13	-4.06

Table 4.0 shows the results of the extent to which the documentation reflects quality care. As shown in the table, nurses at BMC exhibited documentation practices (M = 10.43, SD = 1.789) that are significantly below the standard criteria for quality patient care [t (239) = 152.119, p = .001]. For the individual standard for quality patient care on the utilization of the nursing process in the documentation (M= 6.13, SD = 1.189), the results was significantly lower than the acceptable standard [t (239) = 128.584, p = .001]. The documentation of nursing assessment was below the acceptable standard [Absent (29.2%), Partial present (68.8%), Present (2.1%) and Always present (0%)]. Nursing diagnosis documentation not related to the nursing process [Absent (86.7%), Partial present (12.1%), Present (2.1%), and Always present (0%)] was lower. Similarly, intervention documentation related to the diagnosis was far from the standard [Absent (16.3%), Partial present (64.6%), Present (19.2%), and Always present (0%)]. Also, evaluation of nursing intervention documentation in the nursing process indicated, that most of the entries did not show any

evaluation [Absent (79.6%), Partial present (17.9%), Present (2.5%), and Always present (0%)]. The nurses do not document patient progress report in between shifts [Absent (25.4%), Partial present (30.0%), Present (44.2%) and Always present (0%)]. Further, the documentation of relevant patient education on admission on condition and discharge teaching was below the acceptable standard [Absent (97.5%), Partial present (0.4%), Present (2.1%), Always present (0%)], [Absent (98.8%), Partial present (0%), Present (2.1%) and Always present (0.4%)] respectively.

For the documentation of vital signs, the nurses exhibited (M = 13.00, SD = 2.488) that are significantly lower than the acceptable documentation standard for quality care [t (239) = 18.657, p = .001]. For the individual standard, temperature, Pulse, Respiration and Blood pressure was shown to be inadequately documented [Absent (0.8%), Partial present (3.3%), Present (42.1%), Always present (53.8%); pulse [Absent (0.4%), Partial present (4.6%),

Present (41.7%), and Always present (53.3), respiration [Absent (0.4%), Partial present (4.2%), Present (41.3%) and Always present (54.2)], blood pressure [Absent (37.5%), Partial present (3.3%), Present (26.3%) and Always present (32.9%) respectively. Similarly, medication documentation by the nurses exhibited (M = 5.90, SD = .295) at statistically significantly lower than the acceptable standard [t (239) = 215.109, p = .001]. These are shown in Table (4.1 and 4.2).

Table 4.2 Frequency and Percentage Distribution of Nursing process and selected routines Documentation and Quality care.

Nursing process	N	Absent (%)	Partial present (%)	Present (%)	Always present (%)
Assessment	240	70 (29.2)	165 (68.8)	5(2.1)	(0)
Diagnosis	240	208 (86.7)	29 (12.1)	3 (1.3)	0 (0)
Interventions	240	39 (16.3)	155 (64.6)	49(19.2)	0 (0)
Evaluations	240	191(79.6)	43 (19.9)	6(2.5)	0(0)
Patient progress	240	61(25.4)	72 (30)	106 (44.2)	1 (0.4)
report	240	234 (97.5)	1 (0.4)	5 (2.1)	0 (0)
Patient education	240	237 (98.8)	0 (0)	2 (0.8)	1 (0.4)
Discharge teaching					
Vital signs					
Temperature	240	2(0.8)	8(3.3)	101(42.1)	129(53.8)
Pulse	240	1 (0.4)	11(4.6)	100 (41.7)	128 (53.8)
Respiration	240	1(04)	10(4.2)	99(41.3)	130(54.2)
Blood pressure	240	90 (37.5)	8(3.3)	63(26.3	79 (32.9)

Discussions of Results/Key findings

The discussion for the study is organised and guided mainly around the research questions set for the study. These findings are interpreted with reference to current literature in the area of nursing documentation. This permits for drawing of sound conclusions and recommendations.

Research Question 1: What are the Patient-related factors that influence Nursing Documentation of Patient care?

The study shown no significant relationship between the documentation standard and patient related/demographic factors. On the specific, the length of admission [r = 0.11, p > .05] was of no statistical significantly related with the documentation. Also, statistical association with no significance was identified between the ward/unit [r = 0.11, p > .05]. The age of the patient [r = 0.11, p > .05] was shown to have no statistically significant relationship with the documentation standard, so well as the gender and outcome of admission [r = 0.064, p > 0.17], [r= 0.571, p > 0.912]. This finding can be attributed to the fact that patient factors are generic and not directly link with operational standard procedure or guidelines for nursing documentation of care. The factors might have no major influence on the policies and procedure for documentation and that the standard of documentation could be influence by other factors either than the stated of which the researcher did not assessed. Also the Unit in which patient was admitted could be an influence in the practice of the nurse's base on the guidelines or protocol specific to each unit, however there was no reported difference in this regard. The ward/Unit specialty did not have an influence per se in the policies and procedures pertaining to documentation of nursing care because documentation guidelines

are generic. However, the findings was inconsistent with Dehghan et al. (2013) who reported significant difference between the standard of documentation and the unit in which nurses work. Further, the study was in contrast with that of Tasew et al. (2019) and Asamani et al. (2014). Tasew et al. (2019) reported nursing care documentation practice to be significantly influence by familiarity with documentation standard protocols, inadequate time, and workload and the attitude of the nurses to documentation. In a Ghanaian study, Asamani et al. (2014) attributed chronic shortage of nurses, lack of guidelines, and inadequate use of nursing care records as influences on nursing documentation practices. It is expected that, documentation practice standard is influence by the experiences of the nurses and the policy guidelines and the condition of the patient for safe care, this was however not related to the age, duration of admission.

Research Question 2: To what extent does the documented care meet the Standards of documentation?

The study found an aggregate scores of the documentation standard at 60.5% as the level with which documentation standards were met. Comparing this result to the appropriate documentation standard of 60% and above established by (Corben, 1997) the documentation did not meet the minimum criteria for standard practice. It was found that (32%) of all the folders reviewed has complete entries, concise and legible (1.3%), dated and time (25%), (0.8%) of the notes has correction properly done, use of standardized and approve abbreviation (0.8%) and use of patient name in entries (0.4%). The lack of documentation protocols, shortage of nurses, limited monitoring and evaluation of documentation, work burden and the nurses' attitudes to

documentation with the nurses seeing documentation as time consuming and less important as compare to direct patient care can be attributed to the study findings.

Similarly, Asamani et al. (2014) Tasew et al. (2019) Kim et al. (2011) and Gizaw et al. (2018) reported poor documentation practices of nurses in their respective studies. Asamani et al. (2014) in a study on documentation practices in parts of eastern Ghana, acknowledged alarming errors and incomplete documentation of care problematic for care continuity and safe practice. Tasew et al. (2019) observed similar practices amongst nurses in public hospitals in the Tigray region, of Ethiopia, the study reported adequate documentation practices at 47.8%, with almost half of the nurses not documenting most nursing care activities carried out for patient. Kim et al. (2011) reported nurses' documentation fails to deliver sufficient and accurate data to represent nursing care. Gizaw et al. (2018) in a study in Jemma West hospital in Ethiopia, reported poor nursing documentation practices with low number of nursing care for most routines completed at (17.65%), medication charts completed for (85.9%), and vital sign sheet completed for (31.8%), admission discharge record (54.1%) and discharge activity documentation (29.4%). Similarly, Asmirajanti, Hamid, Tutik, and Hariyati (2019), reported low standard of nurses documentation of patient care activities with majority of the nurse not reflecting key nursing routines carried for the patient in their documentation. Wong (2009) corroborated this findings in a chart audit to improving nursing documentation in a teaching hospital in Calgary, where the study reported inconsistent, timeless, and inappropriate use of terminologies, with some components of documentation frequently missed or not completed.

These findings are inconsistent to the findings of Lindo et al. (2016), Taiye (2015), Chiejina (2019), Jefferies, Johnson, and Griffiths (2010), Setz and Innocenzo (2009). Lindo et al. (2016) in a study in three public hospitals in Jamaica, found nurses adherence to documentation standard with all of the entries time and dated (99%), initialled or signed (100%), entries legible and concise (88%), and consistent use of standard terminologies. Taiye (2015) in assessing nurses documentation practice reported (70%) of nurses documented nursing care adequately. Jefferies, Johnson, and Griffiths (2010) in a meta-study to synthesise essential components quality nursing documentation, reported essentials themes in documentation of patient care activities that satisfies the standard of nursing care documentation; patient centred, timeous, concise and logical, and record of patient education, standardised abbreviation use, and record of date on every nursing entries . Setz and Innocenzo (2009) in a study to evaluate patient medical records in Brazil, reported adequate and acceptable quality of nursing care documentation at (64.7%) and (8.7%) respectively.

Research Question 3: To what extent does Documented Nursing action of Patient care meet the legal requirement for documentation?

The legal aspects of nursing documentation were fairly average, demonstrating that clinicians had a fair understanding of the importance of ensuring that the patient was identified by their name (label), health care record number and date of birth on every page, and that no entry was made on behalf of another person. The results shows that nurses at BMC demonstrated documentation practices that met legal criterion for adequate or safe practice with the overall requirements for legal standard met to a high level (85%) compared to the

score of 60% achievement of minimum requirement. Most of the criteria were met to a high level (85%) or more and established by Corben (1997). From table 3.1, the documentation of patient name and health record number on each page of the folder [(0.4%, 99.6%), (2.1%, 97.9)], appropriate use of blank [(37.9%), (62.1%)] were problematic compared to the standard. The record of time and date of care [(92.1%, 7.9%)], entry of name and designation of nurse writing reports, [(92.9%), (7.1%)], use of approved abbreviations [(78.8%), (21.3%)], appropriate correction of errors [(70.4%), (29.6%)] were all met to high level. The nurses' awareness of the implication for litigation with documentation inappropriateness could be accounted to the findings.

The finding of the study are inconsistent to Taiye (2015) who reported nursing documentation for legal protection as been inadequate and incomplete, similarly inconsistent in a study by Jasemi, Zamanzadeh, Rahmani, Mohajjel, and Alsa (2013) reported nurses documentation to be inadequate and insufficient for use in litigation. Blair and Smith, (2014) in a systematic review of nursing documentation of patient care reported nurse's inability to maintain accurate and legally prudent documentation owning to the attitude of the nurses towards documentation, work load and absence of protocols to documentation for legal protection.

Research question 4: What is the extent to which nursing documentation reflect quality patient care.

The documentation of patient care by nurses was found to be inadequate in representing high-quality care. The nurses exhibited documentation practices that are significantly below the standard for quality patient care [t (239) = 152.119, p = .001]. The nurses' documentation of care on the basis of use of

the nursing process was inadequate, patient progress report documentation, patient teaching and discharge education documentation was incomplete. Vital signs, a key routine in monitoring of patient was inadequately documented with various aspects incompletely carried for care continuity, however, contrary was patient medication documentation. The concerns of the documentation been inadequate for quality care is consistent with the findings in other studies in Uganda and Jamaica (Lindo et al., 2019; Okaisu, Kalikwani, Wanyana, and Coetzee, 2017) in audit of documentation which revealed gaps, missed and incomplete routines documentation with implication for quality of care. Nurses' failure to appropriately portray the use of the nursing process in documentation a foundation for quality treatment and the basis of scientific nursing care if not use may be problematic. Asmirajanti et al. (2019) corroborated the findings when they revealed in a study in Ethiopia of documentation of patient assessment been inadequate for quality care, the nurses' documentation on some nursing activities were below minimum requirement; assessment (0.4%), formulation of nursing diagnosis and plan of care (20.8%), drug administration (60.8%), and vital signs (23.3%). Asamani et al. (2014) corroborated the findings of this when they reported high level of nurses not documenting patient progress report after first day of admission. Paans et al. (2010) reported inaccurate and incoherent practice for quality patient care, the study showed 28% of nursing entries follow steps of the nursing process, 34% was less structured according to the nursing process stages with 38% largely based on the nurse discretion, however the same study reported progress, admission and outcome documentation to be optimum for patient care. Further, Braaf, Riley, and Manias (2015) exploring

communication failure among nurses in Melbourne, Australia, revealed patient safety compromise, delayed treatment and resultant inadequate care with the nurses documentation.

Inconsistent with the findings, Taiye (2015) in a study to determine nurse documentation practices and care outcome, reported high standard of clinical care amongst nurses at a university hospital.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

Introduction

The need for quality patient care experience in the hand of nurses is much desired by the populaces and health managers at all level. In line with this clarion need for better patient experience, the study sought to assess the clinical documentation practices of nurses at the Baptist Medical hospital as a tool in contributing to quality nursing care.

The study set out to provide empirical evidence to inform nurses, nurse managers, and key stakeholders on the reality of documentation in the health care setting, an important practice for promotion of quality most especially at the Baptist Medical centre. The study sought to reveal the status of the documentation through the formulation of four specific objectives. A cross-sectional retrospective survey of 240 patient records drawn from three major wards of the hospital where the documentation by the nurses was reviewed using a Check-list containing Likert scale items, in July 2020. Systematic random sampling technique was used to retrieve 240 patient medical records from a strata of three wards; medical, surgical and paediatric ward with a proportionate distribution of 100, 50 and 90 patient folders with a questionnaire return rate of 100%.

The data was measured at the ordinal level with few non-categorical measures. The data was entered into IBM-SPSS version 21.0 for descriptive and inferential analyses. For inferential analysis of the data, ordinal variables were

transformed into dichotomous variables to allow for better communication of findings.

Standard descriptive statistics of Mean, Standard Deviation was use describe the variables with Multiply Logistic Regression used to test for association of significance amongst variables.

The study found that nurses' documentation standard was not influenced by any patient related factors. This could be attributed to other factors of which the researcher did not advent to with documentation standard, also the assumption that patient factor was of no determiner of nurses adhering to documentation guidelines and having adequate knowledge to document appropriately. The study revealed the documentation was inadequate for standard practice. A large number of the folders reviewed showed incomplete, missed entries, with inappropriate use of abbreviations, cancellation, illegibility, unsigned entries with absent of time and date of entries. This could be attributed to the lack of documentation practice guidelines, inadequate knowledge on documentation, workloads, lack of frequent monitoring on documentation on the part of hospital management, and nurse attitudes towards documentation.

The study further, found that the documentation practices was of moderate standard for legal accuracy. The nurses demonstrated overall documentation practice that are optimum for legally acceptable documentation. Once again, the lack of appreciation of the implication of legally prudent documentation as well as the institutional level lack for legal documentation guidelines policy with increasing workload could be assigned to these findings.

The study also revealed that, the nurses exhibited documentation practices that are below the standard for quality patient care. It found the nursing process documentation the frame work for nursing practice almost completely absent in care documentation. Daily review and shift reports on the progress of the patient toward recovery an important routine for care evaluation was not written for majority of the folders, likewise, patient education needs and discharge information, an important routine for self-care was not shown in the folders/documented to have been carried by the nurse. Vital signs documentation a basic routine in practice was not adequately documented per the hospital protocol. However, patient medication documentation interestingly has majority of the folders reviewed shown to have been adequately carried out.

Conclusion

According to the findings, nurses at the Baptist Medical Centre engaged in practices that were below the standard for providing quality patient care.

Nursing documentation has been acknowledged as an important routine and a critical component of the patient's record in providing safe care. Nurses spend the most time with patients of any health care professional, and as a result, they collect a lot of data from each contact, which is used by members of the health team to make decisions about patient. The need of clear, concise documentation along with efficient communication in the clinical setting has long been emphasized.

Unfortunately, the Baptist Medical Centre does not appear to be at its best in documentation. To summarize, the impact of these inadequate practices on

patient safety and quality of treatment is significant, because quality of care is enhanced by adequate patient information that can be shared to and among members of the health team. The analysis discovered nursing documentation practices at BMC that have the potential to jeopardize communication with implication for quality care.

The documentation failed to provide a continuous picture of patient admission through to discharge with some of the entries been incomplete and unconcise. The use of abbreviations with ambiguous interpretation with the potential for misinterpretation was widely discovered in the notes, entry of time and date for nurses' activities was mostly not done. The nursing process framework, the scientific back bone of nursing practice was almost missing in the documentation and if carried was not entirely base on the structure. The documentation of vitals sign was not without incidences, there was incomplete entries of all the key components in the charts. The review of patient discharge education was missing as well as education on condition. Interestingly, medication documentation shows a moderate adequacy for quality care. Also, for legal accuracy the study discovered insufficient practice standard for meeting legal prudent documentation and protection of the nurse against potential litigation in scenarios where such may arise.

The study revealed the true state of nurses' documentation in the hospital, arousing the awareness of this critical practice routine malpractice that appears to have been overlooked, despite the fact that it has been extensively documented in literature.

Recommendation

The following recommendations are provided for the attention of nurse professionals, the institution, the Nursing and Midwifery Council Ghana, and other important stakeholders based on the study's findings.

The Nurses:

1. Encourage mentorship within the hospital on expertise nurses in coaching up in coming staffs on nursing documentation competency.
2. The needs for nurses and nurse managers to organise regular workshops/ in-service training for staff members on the rudiment of nursing documentation protocols.

The Hospital

3. The need for the facility to develop, adopt and communicate best practice guideline or standard protocol on clinical documentation.
4. The study suggests for the facility as part of quality Assurance measures carry out periodic monitoring and evaluation of the documentation of the nurses at the hospital.

Nurses and Midwifery Council

5. A call on the Nursing and Midwifery Council of Ghana in reviewing the curriculum for training design a stand-alone course on documentation in clinical practice.
6. The Nursing and Midwifery Council should facilitate and enforce continuous professional development course on clinical nursing documentation for nurses as a key requirement for annual professional license renewal.

7. The Ghana Health service/ Ministry of Health are call upon to consider with stalk holders' consultation in formulating a National clinical documentation policy in health care.

Suggestions for Further Research

The researcher recommends that further studies be conducted into the following identified areas to get a better understanding of the nursing documentation in Ghana:

1. A qualitative study to explore the challenges of nursing documentation.
2. Action research on nursing clinical documentation.
3. More research into nurses' knowledge and attitudes towards nursing documentation is needed.
4. Also, a quantitative research on the impact of nursing documentation on patient care.
5. A qualitative study to explore the effects of nursing documentation on clinical outcome.

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APPENDICES

Appendix A: Data collection instrument

RESEARCH AUDIT TOOL

Topic: Audit of Nurses Documentation Practices: The case of Baptist Medical Centre.

Check list for Evaluation of Nurses' Documentation Practices.

A:Patient/ward characteristic		**Outcome of admission:**	
Unit/ward:			
Age of patient:		**Diagnosis:**	
Length of admission:			
Section B: Nursing routines.		**Yes**	**No**
1.	Admission report		
2.	Patient progress /24 hours report		
3.	Observation; vital signs		
4.	Patient medication administration		
5.	Patient response to medication		
6.	Patient education		

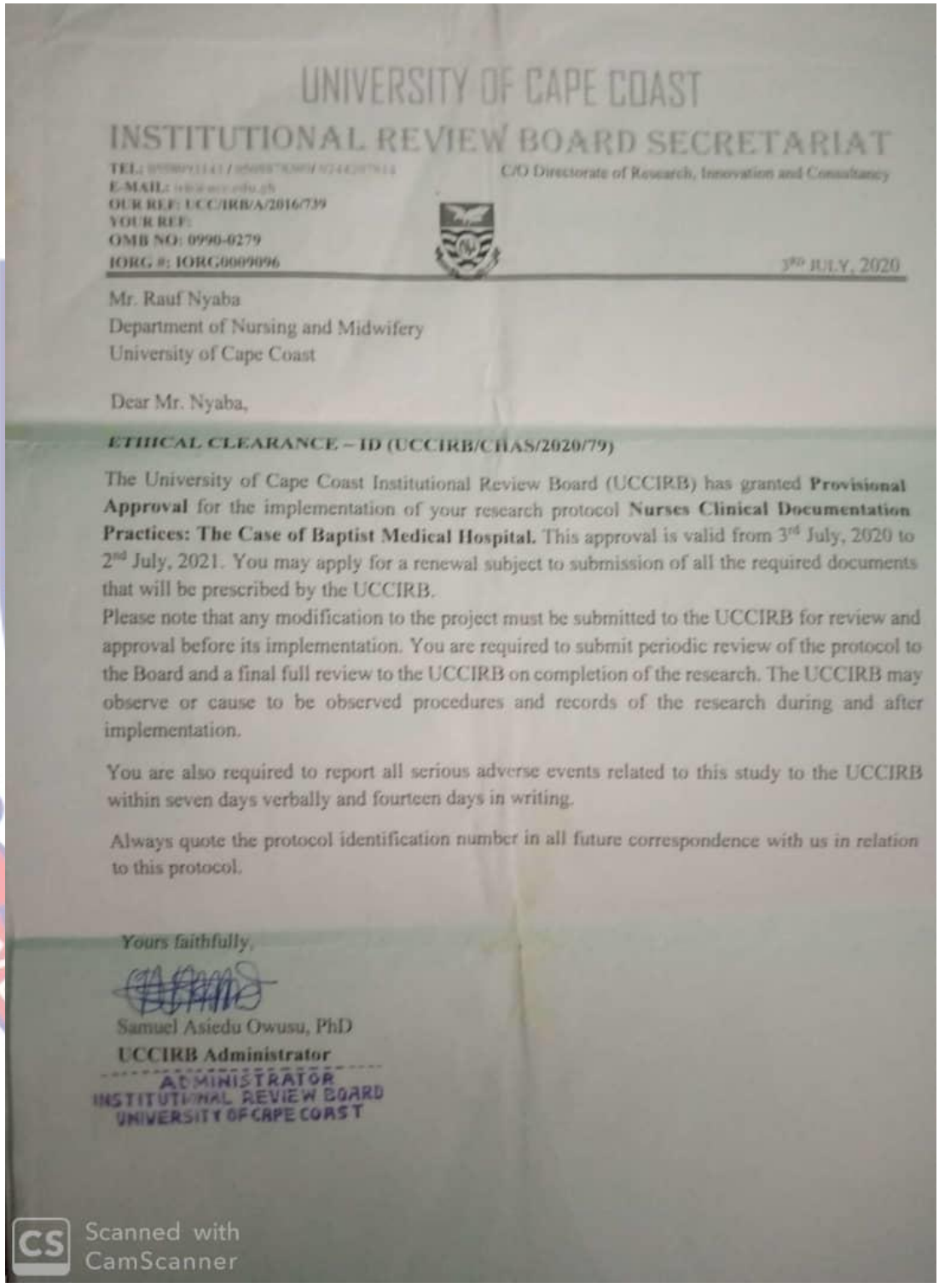
	Section C:Documentation standard/principle	Absent	Partial present	present	Always present
7.	Entries show chronology of events from admission to discharge.				
8.	All nursing entries are legible and concise.				
9.	Entries errors are properly corrected				
10.	There are recorded date and time on every nursing entry in the nurses' note				
11.	All entries in the notes are signed/initialled.				
12.	Entries contain standardizes symbols/institutional approved abbreviations only.				
13.	Patient is referred by name in the nursing entries on progress notes.				
Section D; Quality inpatient care					
14.	Entries reflect use of the Nursing process in care of patient				
15.	Entries of patient condition and observations made by the nurse				
16.	Entries of patient own complaints/ relevant statements using client "quotes'' to illustrate objective observations.				

17.	Records of patient response to nursing care.				
18	Record of discharge teaching/education on self-care.				

Section E:Legal aspect of Documentation		**Yes**	**No**
19.	Was the following recorded in each page		
a.	Patient name		
b.	Health record number		
20.	Time and date of entry		
21.	Evidence of use of abbreviation from the official list of approved abbreviation only		
23.	Name, signature and designation of the nurse writing the report are written legibly at the end of each entry		
24.	Correction of errors ensures that the original information remains visible/retrievable.		
25.	All excessive white space has lines throughout the space		

Appendix B:

UCC-IRB Ethical Clearance Letter



UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: [illegible] C/O Directorate of Research, Innovation and Consultancy
E-MAIL: [illegible]
OUR REF: UCC/IRB/A/2016/739
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

3RD JULY, 2020

Mr. Rauf Nyaba
Department of Nursing and Midwifery
University of Cape Coast

Dear Mr. Nyaba,

ETHICAL CLEARANCE – ID (UCCIRB/CHAS/2020/79)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Nurses Clinical Documentation Practices: The Case of Baptist Medical Hospital.** This approval is valid from 3rd July, 2020 to 2nd July, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

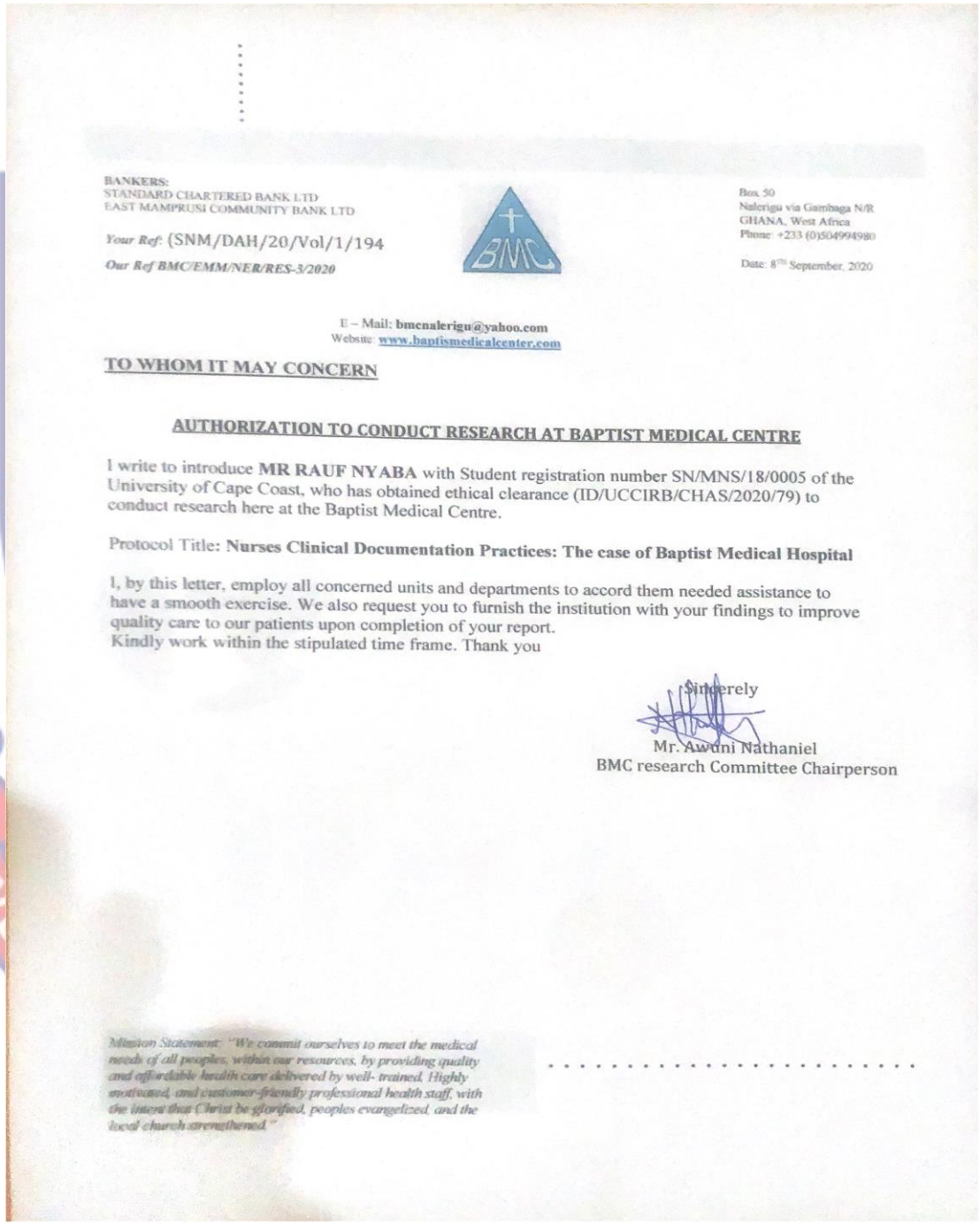
Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

APPENDIX C:

Letter of Clearance to Conduct the Study in Baptist Medical Centre



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Your Ref: (SNM/DAH/20/Vol/1/194
Our Ref BMC/EMM/NER/RES-3/2020

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Date: 8TH September, 2020

E – Mail: bmcnalerigu@yahoo.com
Website: www.baptismedicalcenter.com

TO WHOM IT MAY CONCERN

AUTHORIZATION TO CONDUCT RESEARCH AT BAPTIST MEDICAL CENTRE

I write to introduce **MR RAUF NYABA** with Student registration number SN/MNS/18/0005 of the University of Cape Coast, who has obtained ethical clearance (ID/UCCIRB/CHAS/2020/79) to conduct research here at the Baptist Medical Centre.

Protocol Title: **Nurses Clinical Documentation Practices: The case of Baptist Medical Hospital**

I, by this letter, employ all concerned units and departments to accord them needed assistance to have a smooth exercise. We also request you to furnish the institution with your findings to improve quality care to our patients upon completion of your report.
Kindly work within the stipulated time frame. Thank you

Sincerely

Mr. Awuni Nathaniel
BMC research Committee Chairperson

Mission Statement: "We commit ourselves to meet the medical needs of all peoples, within our resources, by providing quality and affordable health care delivered by well- trained, Highly motivated, and customer-friendly professional health staff, with the intent that Christ be glorified, peoples evangelized, and the local church strengthened."