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Knowledge And Practice Of Nursing Documentation: A Cross-Sectional Study In Secondary Care Of King Khalid Hospital, Najran Area, Kingdom Of Saudi Arabia

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Abstract

Nursing documentation is extremely crucial for nurses. A healthcare service delivery system was examined using a conventional data collection method. As a result, nurses and other healthcare workers must ensure that their job is precisely and efficiently documented. This helps them defend themselves legally, provides better patient care, and increases communication among healthcare practitioners. However, there is insufficient study available on this subject. This study aimed to determine what nurses in emergency departments of government hospitals in the Najran area, Kingdom of Saudi Arabia, know and believe about nursing documentation.. A study was conducted in the emergency departments of government hospitals in the Najran area of Saudi Arabia. We utilized a simple way to collect numerical data. We collected data using a questionnaire and a review of records. Data collectors and supervisors had two days of training. We generated certain numbers to represent the data and then presented the results in the form of graphics, charts, and text. In this study, 400 individuals were enrolled, with a mean age of 31.77 years; 41.5% were men, 58.5% were females; the majority of participants were married (65.8%), 15.8% were single, 10.8% were divorced, and 7.7% were widows. In terms of education, 47.5% had a BSC, 26.5% had an MSC, and 26% had a diploma. 83% of participants had good knowledge of nursing documentation, while 17% had poor knowledge, with a mean total score of 7.5 and an average score of 0.83. We identified strong correlations between overall knowledge and personal variables, including age, gender, marital status, educational level, and work experience (p value <0.001). We identified significant relationships between overall attitude and personal data, including age, gender, marital status, educational level, and work experience (p-value < 0.001). This study found that nurses write down and record information more effectively than in previous studies. The researchers advise that nurses should be more aware of, have a positive attitude toward, be conversant with, and devote adequate time to nursing documentation practice. Furthermore, it is essential to monitor and compare nursing paperwork in order to perform future research.

Keywords: *Nurse, Documentations, Knowledge, Attitude.*

1. Introduction

Nursing documentation is an important record of patient information kept by nurses as they go about their daily duties. To guarantee that nursing actions are effective, nurses must record their work or the health progress of their patients. This documentation focused on the patient's conditions and responses, which were directed by set standards. As a result, it has the potential to improve workplace communication [1]. To provide appropriate healthcare to patients and the community, nurses must record and track their patients' information and care. As a result, it is the responsibility of nurses in direct patient care or leadership positions to keep clear, precise, and consistent records based on established norms [2].

It is critical for nurses to communicate effectively with other healthcare professionals, insurance firms, legal authorities, government officials, organizations that assess and

accredit healthcare facilities, and researchers. Global health experts argue that nurses should get more information and education so they can help enhance the healthcare system and adhere to national and global policiesThey should devote roughly 15-20% of their time at work to documentation. done" Documenting procedures and work is critical since it demonstrates that tasks have been accomplished. Without paperwork, there is no confirmation that the work took place." [3]. Nursing care documentation occurs when nurses record crucial information about their patients. This allows them to better care for their patients and make informed judgments. It also allows them to learn from their mistakes and become better nurses. Good documentation practice entails adhering to guidelines for properly documenting things. This includes using the proper standards, correctly identifying the patients, conducting a thorough nursing assessment based on both what the patient tells you and what you observe, writing the date and time, using words that everyone can understand, writing neatly so others can read it, keeping track of events in the order they occur, using allowed abbreviations and symbols, and signing your name when you finish [4]. According to the World Health Organization (WHO), approximately 98,000 people in the United States die in hospitals each year as a result of medical errors. Furthermore, healthcare personnel in low- and middle-income countries were responsible for 60% of deaths from unsafe and poor care. If nurses do not properly record crucial information, it might be difficult for them to communicate with one another. This can result in mistakes in care, longer hospital stays, more trips back to the hospital, patients being unhappy, more bad things happening to patients, delaying treatment and diagnosis, giving the wrong treatment, forgetting to do things for the patient, and increasing medical costs [5]. Several investigations discovered that nursing records were not kept accurately in various parts of the world. For example, in the Netherlands, just 95% of records were correct. In the United States, it was 67.7%, whereas in African countries like Ghana, it was 26. Accuracy percentages varied across Ethiopia: 48.6% in Jimma, 48.7% in Tigray, and 62.6% in Gondar. Furthermore, the things that affected how nursing documentation was done included not having enough sheets for writing, not having enough time or staff, supervisors not encouraging or motivating the nurses, not having clear expectations, having to write a lot, not having consistent guidelines at the hospitals or places where nurses worked, and the nurses not knowing enough or having the right attitude. [6]. As a result, nursing records serve as the primary means of demonstrating what nurses accomplish and determining how effectively they meet expected goals. Nurses, doctors, and hospitals can use nursing records to monitor patients' health in the hospital. Nursing documentation is a major issue for both affluent and poor countries [7]. So, this study intended to find out what nurses in the emergency departments of government hospitals in the Najran region of Saudi Arabia know and believe about nursing records..

2. Methods

2.1. Study design and area

A research study was conducted at the emergency departments of government hospitals in the Najran region of Saudi Arabia. The study employed numbers and interviews to collect information..

2.2. Source and Study population

All nurses that have served in the emergency department of government hospitals in the Najran area of the Kingdom of Saudi Arabia.

2.3. Inclusion and Exclusion criteria

The research comprised nurses who worked in the emergency departments of government hospitals in Saudi Arabia's Najran area. However, the research did not include contract nurses or volunteers..

2.4. Sample size determination

To determine the sample size for our study, we employed a calculation that considers the proportion of appropriate nursing documentation practices in the population (47.5%), the target confidence level (95%), and the acceptable margin of error (5%). For the second purpose, we determined the number of participants required based on criteria closely related to how nurses document their work. So, of all the sizes we computed, we picked the largest since the size we predicted for the second aim was less than 339. Finally, we have to account for the 10% non-response rate to arrive at a final sample size of 400. We did not decide how many participants to include in the research until we began collecting data. The data collection was completed after enough information had been obtained. We collected information through two group talks since we had adequate data.

2.5. Variables

Referring to the features of a person's social and economic background, often known as sociodemographic variables. This section discusses many variables connected to nurses and their attitudes about documenting information. These criteria include their age, gender, relationship status, religious views, how much money they earn each month, how long they have been working, their level of education, and the knowledge and mentality they have when it comes to capturing data.

2.6. Operational definition

Participants in this study were asked questions or given checklists to complete so that they could offer information on nursing documentation. Based on the average score, the self-administered questions and checklist resulted in two categories: excellent and bad practice. Nursing documentation is the activity of recording information about patients on a daily basis, in real time. This data is utilized as evidence to support the care offered to patients. When a score equals or exceeds the average, it indicates good practice. If you struggle with the practice questions, your performance will suffer. The researchers assessed the study participants' knowledge of nursing documentation by asking them nine multiple-choice questions.

The average score was used to split the overall score into two categories: excellent knowledge and poor knowledge. Having strong knowledge involves achieving an average or higher score on knowledge questions. If the score is lower than the average, it indicates weak knowledge. Opinion: The total score for how research participants felt about nursing documentation was calculated using a specific style of inquiry. The scores were classed as positive or unfavorable based on a single point. Positive attitude: a score indicates a positive attitude; otherwise, it denotes a poor attitude.

2.7. Data collection tools and procedure

We employed a written set of English questions, which participants answered individually..

- Part-I includes questions regarding the nurses' personal information, such as their age and history..
- Part II includes practice questions to assess understanding of recording information in nursing records..
- Part III assesses thoughts on nursing documentation using a Likert scale. People were asked to score their agreement or disagreement on a scale of 1 to 5, with 1 indicating significant disagreement and 5 indicating strong agreement. The chart review checklist included a score system of "1", "2", and "3" to denote "not", "partially", and "completely" replies..

2.8. Data quality control assurance

We utilized a questionnaire to gather information. Before collecting the real data, we evaluated the questionnaire on a small sample of nurses who were not participating in the study. The data collectors and their managers were trained for two days.

2.9. Data processing and analysis

After gathering data, we reviewed it, corrected any errors, and entered the information into a computer application called Epi data 3. 1. Then we took the Epi data and analyzed it using Stata 14. We looked at the data and presented the results using figures like how frequently something happened, the average of how spread out the numbers were, and visual aids like images and charts.

2.10. Statistical analysis

Data were entered into the computer and processed with IBM SPSS software version 20.0. (Armonk, NY: IBM Corporation) Qualitative data were described using numbers and percentages. The normality of the distribution was verified using the Kolmogorov-Smirnov test. Quantitative data were presented using range (minimum and maximum), mean, standard deviation, and median. The significance of the acquired results was determined at the 5% level. The tests utilized were:

- **Chi-square test**

For categorical variables, to compare between different groups

- **Monte Carlo correction**

Correction for chi-square when more than 20% of the cells have expected count less than 5

3. Results

The current study comprised 400 participants with a mean age of 31.77 years; 41.5% were men, 58.5% were females; the majority of participants were married (65.8%), 15.8% were single, 10.8% were divorced, and 7.7% were widowed. Regarding schooling, 47.5% had a BSC, 26.5% had an MSC, and 26% had a diploma. The average length of work experience was 6.61 years, with the majority of participants having worked for 5-10 years. Years account for 62.8%, as seen in Table 1. Regarding understanding of nursing documentation 83% of participants said that the information available in health records provides actual and expected status of patients' needs and diagnoses; 86% said that nursing recording helps in knowing the extent of patients' response to critical medical care; and 92.3% said that nursing documentation provides necessary information about the activities that took place while caring for patients. 83% stated that the value of nursing documentation resides in research and tracing, 78.3% said that a blank space is left at the conclusion of the reports about nursing documentation, and 81.5% said that documentation is a legal document approved to accept responsibility and take the appropriate actions., According to Table 2, 75.3% believe that an accurate description of the patient's condition is one of the highest priorities in nursing documentation, 89.3% believe that nursing documentation is critical in documenting the impact of patients' responses to treatment, and 81.5% believe that verbal orders and instructions are documented in real time as soon as they are received. Table 3 shows that 83% of participants had strong knowledge of nursing documentation, whereas 17% had poor knowledge, with a mean total score of 7.5 and an average score of 0.83. In terms of nursing documentation attitudes, the majority of participants (37.3%) strongly agreed that the nursing documentation process reflects the skill of observing and monitoring the patient's condition and that the documentation process describes the procedures that were used with the patients. 52.5% strongly agree that nursing documentation process is positively reflected in the health care provided to patients. 52.3% strongly agree that nursing documentation process shows the patient's health status. Nursing documentation process contributes to making appropriate decisions while providing health care to patients. nursing documentation process promotes interaction and teamwork among members of the medical team as a whole, nursing documentation processes play an important role in reducing work stress among nurses, 58.5% strongly agree that should spend sufficient time documenting patient records and reports, nursing documents are considered legal documents on which they are based , nursing documentation assists in the recovery process for patients , nursing documents provide adequate information about the patients' condition to nurses, Nursing documents provide

protection for patients, nursing documentation enhances the professionalism of nurses, nursing documentation contributes to faster decision-making and improved health care, nursing documentation process contributes to the speedy detection of changes in the patient's condition to the medical staff and nursing documentation contributes to enhancing the knowledge of nurses and medical staff as shown in Table 4. 92.3% of participants had good attitude towards nursing documentation but 7.8% had poor attitude with mean score 66.56 and average score was 4.16 as shown in Table 5.
Table 6 shows strong relationships between overall knowledge and personal characteristics, including age, gender, marital status, educational level, and work experience (p value < 0.001). Table 7 shows a substantial relationship between overall attitude and personal data, including age, gender, marital status, educational level, and work experience (p value < 0.001).

4. Discussion

Nursing document practice is when nurses record crucial information about patients in order to better care for them in hospitals. This study investigated how nurses' knowledge and attitude influenced their ability to accurately document their nursing activities.

Table 1: Distribution of the studied nurses according to Part 1: personal data (n = 400).

	Personal data	**No.**	**%**
1	**Age**		
	21 – 25	92	23.0
	26 – 30	74	18.5
	31–35	135	33.8
	>35	99	24.8
	Min. – Max.	21.0 – 45.0	
	Mean ± SD.	31.77 ± 6.44	
	Median	32.0	
2	**Gender**		
	Male	166	41.5
	Female	234	58.5
3	**Material status**		
	Single	63	15.8
	Married	263	65.8
	Widow	31	7.8
	Divorced	43	10.8
4	**Education level**		
	MSC	106	26.5
	BSC	190	47.5
	Diploma	104	26.0
5	**Work experience**		
	<5	117	29.3

	5 -10	251	62.8
	>10	32	8.0
	Min. – Max.	2.0 – 12.0	
	Mean ± SD.	6.61 ± 2.99	
	Median	6.0	

SD: Standard deviation

Table 2: Distribution of the studied nurses according to Knowledge of nursing documentation items (n = 400).

	Knowledge of nursing documentation	**No**		**Yes**	
		No.	**%**	**No.**	**%**
1	The information contained in health records reveals the current and predicted state of patients' needs and diagnosis.	68	17.0	332	83.0
2	Nursing recording assists in understanding the extent of patients' responses to vital medical treatment.	56	14.0	344	86.0
3	Nursing documentation offers important information regarding the actions that occurred while caring for patients.	31	7.8	369	92.3
4	Nursing documentation is important for research and tracking purposes.	68	17.0	332	83.0
5	A blank area is left at the end of the reports on nursing paperwork.	87	21.8	313	78.3
6	Nursing paperwork is a legal document allowed to accept responsibility and implement the appropriate steps.	74	18.5	326	81.5
7	One of the top concerns in nursing documentation is an accurate statement of the patient's condition.	99	24.8	301	75.3
8	Nursing documentation is extremely important in recording the impact of patients' reaction to therapy.	43	10.8	357	89.3
9	Verbal orders and instructions are logged in real time as they are received.	74	18.5	326	81.5

Table 3: Distribution of the studied nurses according to overall Knowledge of nursing documentation (n = 400).

Knowledge of nursing documentation	**No.**	**%**
Poor (<50%)	68	17.0

Good (≥50%)	332	83.0
Total Score (0 – 9)		
Min. – Max.	0.0 – 9.0	
Mean ± SD.	7.50 ± 2.67	
Median	9.0	
Average Score (Mean ± SD.) (0 – 1)	0.83 ± 0.30	

Table 4: Distribution of the studied nurses according to Regarding attitude of nursing guidance on nursing documentation items (n = 400).

	Regarding the attitude of nursing direction towards nursing documentation.	**Strongly disagree**		**Disagree**		**Neutral**		**Agree**		**Strongly agree**	
		No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
1	The nursing documentation procedure shows the ability to observe and monitor the patient's status.	54	13.5	61	15.3	62	15.5	74	18.5	149	37.3
2	The nursing documentation procedure reflects positively on the health care offered to patients.	54	13.5	31	7.8	62	15.5	43	10.8	210	52.5
3	The nursing documentation process summarizes the processes that were used with the patients.	54	13.5	31	7.8	62	15.5	104	26.0	149	37.3
4	The nursing documentation procedure reflects the patient's health state.	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
5	The nursing documentation process helps make informed judgments when delivering health care to patients.	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
6	Nurses should devote appropriate effort to compiling patient records and reports.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
7	Nursing papers are legal documents on which they are founded.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
8	Nursing documentation helps patients recover better.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
9	Nursing papers offer nurses with appropriate information regarding their patients' conditions.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5

10	Nursing documentation offer protection to patients.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
11	The nursing documentation process encourages contact and collaboration among members of the medical team in general.	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
12	Nursing documentation methods have an essential role in minimizing job stress for nurses.	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
13	Nursing documentation promotes nurses' professionalism.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
14	Nursing documentation promotes speedier decision-making and better health care.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
15	The nursing documentation procedure leads to the timely detection of changes in the patient's condition by the medical team.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
16	Nursing documentation helps improve the understanding of nurses and medical professionals.	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5

Table 5: Distribution of the studied nurses according to overall of regarding attitude of nursing guidance on nursing documentation (n = 400).

Regarding attitude of nursing guidance on nursing documentation	**No.**	**%**
Poor (<50%)	31	7.8
Good (≥50%)	369	92.3
Total Score (16 – 80)		
Min. – Max.	32.0 – 80.0	
Mean ± SD.	66.56 ± 14.34	
Median	68.0	
Average Score (Mean ± SD.) (1 – 5)	4.16 ± 0.90	

Table 6: Relation between level of overall Knowledge and personal data (n = 400).

Personal data	**Knowledge of nursing documentation**				χ^2	**p**
	Poor (n = 68)		**Good (n = 332)**			
	No.	**%**	**No.**	**%**		
Age						
21 – 25	0	0.0	92	100.0	156.362*	<0.001*
26 – 30	12	16.2	62	83.8		

31–35	0	0.0	135	100.0		
>35	56	56.6	43	43.4		
Gender						
Male	12	7.2	154	92.8	19.200*	<0.001*
Female	56	23.9	178	76.1		
Material status						
Single	0	0.0	63	100.0		
Married	37	14.1	226	85.9	113.353*	<0.001*
Widow	0	0.0	31	100.0		
Divorced	31	72.1	12	27.9		
Education level						
MSC	12	11.3	94	88.7		
BSC	25	13.2	165	86.8	16.501*	<0.001*
Diploma	31	29.8	73	70.2		
Work experience						
<5	56	47.9	61	52.1		
5 -10	12	4.8	239	95.2	112.099*	<0.001*
>10	0	0.0	32	100.0		

χ^2: **Chi square test**
p: p value for comparison between the studied categories
*: Statistically significant at $p \leq 0.05$.

Table 7: Relation between level of overall attitude and personal data (n = 400).

Personal data	**Regarding attitude of nursing guidance on nursing documentation**				χ^2	**p**
	Poor (n = 31)		**Good (n = 369)**			
	No.	**%**	**No.**	**%**		
Age						
21 – 25	31	33.7	61	66.3		
26 – 30	0	0.0	74	100.0	112.501*	<0.001*
31–35	0	0.0	135	100.0		
>35	0	0.0	99	100.0		
Gender						
Male	31	18.7	135	81.3	47.370*	<0.001*

Female	0	0.0	234	100.0		
Material status						
Single	0	0.0	63	100.0		
Married	31	11.8	232	88.2	18.774*	^{MC}p= <0.001*
Widow	0	0.0	31	100.0		
Divorced	0	0.0	43	100.0		
Education level						
MSC	0	0.0	106	100.0		
BSC	31	16.3	159	83.7	37.142*	<0.001*
Diploma	0	0.0	104	100.0		
Work experience						
<5	0	0.0	117	100.0		
5 -10	31	12.4	220	87.6	19.948*	<0.001*
>10	0	0.0	32	100.0		

χ^2: Chi square test, MC: Monte Carlo, p: p value for comparison between the studied categories, *: Statistically significant at $p \leq 0.05$.

Out of those questioned, 400 individuals were enrolled, with a mean age of 31.77 years; 41.5% were men, 58.5% were females; 65.8% were married, 15.8% were single, 10.8% were divorced, and 7.7% were widowed. In terms of education, 47.5% had a BSC, 26.5% had an MSC, and 26% had a diploma. 83% of participants had good knowledge about nursing documentation, while 17% had poor knowledge, with a mean total score of 7.5 and an average score of 0.83. The study by Similarly et al. in Saudi Arabia used a method to examine nursing 'Focus Chart' materials. The hospital reviewed the paperwork completed by two nurses each day for two weeks in all units. The study's findings revealed that 980 nurses provide direct care to patients while simultaneously documenting their information on charts. Out of 16 units, 50% have begun using focus charts. Ten units use narratives, whereas six units use alternative kinds of documentation. A package was produced to improve the documentation, and measures were taken to address the documentation issues. Similarly et al. conducted a study in Saudi Arabia that examined nursing 'Focus Chart' materials. For two weeks, the hospital reviewed all units' paperwork, which was done by two nurses daily. The survey found that 980 nurses deliver direct care to patients while also documenting their information on charts. Out of the 16 units, 50% have started utilizing focus charts. Ten units employ narratives, while six use other forms of documentation. A package was created to improve the documentation, and steps were taken to resolve the documentation concerns. These nurses were primarily concerned with performing life-saving surgeries and may not have been as concerned with recording everything as modern nurses are. Furthermore, the majority of the study participants (90%) had earned a

bachelor's degree or higher in schooling. This means they are more likely to use nursing documentation in their daily responsibilities. Furthermore, a specific agency is in charge of reviewing and regulating how nurses document their care practices for each patient for whom they are responsible, all while being thoroughly monitored on a daily basis. However, this has previously failed for a variety of reasons. The study discovered significant relationships between age, gender, marital status, educational level, and work experience (p-value < 0.001). We identified significant relationships between overall attitude and personal data, including age, gender, marital status, educational level, and work experience (p-value < 0.001). This is reinforced by research conducted in Harari [13]. One of the possible reasons could be that the practitioners are older, have more work experience, and are experienced with nursing documentation practice, which has become a part of their daily work routine. This is consistent with a qualitative finding. One of the issues for newly hired nursing documentation workers is their lack of knowledge with the practice. Because their skills are not fully established, new employees are unaware of nursing documentation practice. To address such issues, the firm should plan training sessions for newly hired employees."

5. Limitations

Because the information was gathered using a tool that people utilized independently, it is possible that the participants' responses were impacted by a desire to appear socially desirable. We received permission to check the charts from the nursing coordinator, although this may influence the independence of the study participants.

6. Conclusions and recommendations

This study found that nurses write down and record information more effectively than in previous studies. The researchers advise that nurses should be more aware of, have a positive attitude toward, be conversant with, and devote adequate time to nursing documentation practice. Furthermore, it is important to monitor and compare how nursing documentation is completed in order to perform future studies.

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