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The Evaluation Of The Documentation Of Community Nursing Carein The Najran Region - KingdomOf Saudi Arabia

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Abstract:

Introduction*: Nursing documentation is very important for nurses. A healthcare service delivery system was evaluated using a standard way of recording information. Therefore, it is very important for nurses and other healthcare professionals to documenttheir work accurately and effectively. This helps protect themselves legally, ensures good patient care, and improves communication between healthcare providers. However, there is not enough research available on this topic. This study wanted to find out what nurses in emergency departments of government hospitals in the Najran region, Kingdom of Saudi Arabia, know and think about nursing documentation.*

Results*: Most of participants had good knowledge about nursing documentation. Regarding relation between overall knowledg[1]e and personal data we found that there was significant relations between age , gender , marital status , educational level and work experience p value <0.001.There was significant relations between age , gender , marital status , educational level and work experience p value <0.001*

Conclusion*: In this research, there has been an improvement in the way nurses write down and record information compared to earlier studies. The researchers suggest that it would be helpful for nurses to be more aware of, have a positive attitude towards, be familiar with, and allocate enough time for nursing documentation practice. Furthermore, it is recommended to observe and compare how nursing documentation is done in order to conduct future studies.*

Keywords: *nurse , documentations, knowledge, attitude.*

INTRODUCTION:

Nursing documentation is an essential record of patient information by nurses in the usual activities ofcaring. Nurses have to record their work or patients' health progress to ensure good nursing activities.This documentation focused on the patient's conditions and responses that have been guided under defined standards. Thus, it can promote staff communicationsin the working area.(De Groot K et al.,2022)

It is important to write down and keep track of patients' information and care in nursing to give goodhealthcare to patients and the community. Therefore, it is the duty of nurses in direct

King Khaled hospital.

patient care or leadership positions to create clear, precise, and consistent records based on proven practices. (Ernstmeyer K et al.,2021).

It is important for nurses to be able to communicate well with other healthcare professionals, insurance companies, legal authorities, government officials, organizations that review and certify healthcarefacilities, and researchers. Global health experts say that nurses should gain more knowledge and education so they can help improve the healthcare system and follow national and global policies. They should spend about 15-20% of their time at work on documentation. done" Documenting procedures and work is crucial because it provides evidence that tasks have been completed. Without documentation, there is no proof that the work actually took place. " (Wieke Noviyanti L et al.,2022).

Nursing care documentation practice is when nurses write down important information about their patients. This helps them take care of the patients andmake good decisions. It also helps them learn from any mistakes and become better nurses. Good documentation practice means following rules for how to document things correctly. This includes things like using the right standards, making sure youcorrectly identify the patients, doing a thorough nursing assessment using 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 inthe order they happen, using abbreviations and symbols that are allowed, and signing your name when you finish..(Urquhart C et al.,2018)

According to the World Health Organization (WHO),around 98,000 people in the United States pass away in hospitals every year because of mistakes made during medical treatment. Furthermore, healthcare workers in Low and Middle-Income Countries were responsible for causing 60% of deaths due to unsafe and substandard care. If nurses don't write down important information well, it can make it harder for them to communicate with each other. This can lead to mistakes in care, longer stays in the hospital, more trips back to the hospital, patients feeling unhappy, more bad things happening to patients, delaying treatment and diagnosis, giving the wrong treatment, forgetting to do things for the patient, and making medical costs go up. (Kohn LT et al.,2000).

Different studies found that nursing records were not accurately kept in various parts of the world. For example, in the Netherlands, only 95% of records were accurate. In the USA, it was 67. 7%, and in African countries like Ghana it was 26%. In different areas of Ethiopia, accuracy varied, with rates of 48. 6% in Jimma, 48. 7% in Tigray, and 62. 6% in Gondar Additionally, 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, needing 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. (Ayalew E et al.,2021).

Therefore, nursing records are the main way to show what nurses do and are used to see how well they meet the expected goals. Nurses, doctors, and hospitals can use nursing records to check on clients' health in the hospital. Nursing documentation is a bigproblem for both rich and poor countries. .(Toney- Butler TJ et al.,2023)

So, this study wanted to find out what nurses in the emergency departments of government hospitals in the Najran region of Saudi Arabia know and think about nursing records.

METHODS:

Study design and area

A research study took place at the emergency departments of government hospitals in the Najran region in Saudi Arabia. The study used numbers and interviews to gather information.

Source and Study population

All nurses who have worked at the emergency department of government hospitals in the Najran region - Kingdom of Saudi Arabia

Inclusion and Exclusion criteria

The study included nurses working at the emergency department of government hospitals in the Najran region of Saudi Arabia. However, nurses who were hired on a contract basis and volunteers were not part of the study..

Sample size determination

To select the sample size for our study, we used a formula that takes into account the proportion of good nursing documentation practices in the population (which is 47. 5%), the desired confidence level (95%), and the acceptable margin of error (5%). For the second goal, we calculated the number of participants needed based on factors that are strongly linked to how nurses document their work. So, out of all the sizes we calculated, we chose the biggest one because the size we calculated for the second objective was smaller than 339. In the end, we had to include the non-response rate (10%) to make the final sample size 400. For the study, we did not decide how many people to include before collecting information. The data collection was done until enough information was gathered. We gathered the information by having two group discussions because we had enough data.

Variables

Referring to the characteristics of a person's social and economic background, referred to as socio- demographic factors.

This passage talks about different factors related to nurses and their attitude towards documenting information. These factors include their age, gender, relationship status, religious beliefs, how much money they earn each month, how long they have been working, their level of education, and the knowledge and mindset they have when it comes to documenting information.

Operational definition

In this study, participants were asked questions or given checklists to fill out themselves and provide information about nursing documentation. The final score from the self-administered questions and checklist was divided into two categories, good and poor practice, based on the average score. Nursing documentation practice is when nurses record information about patients every day, in real-time. This information is used as evidence for the care

provided to the patients..

Good practice is achieved when a score is equal to or greater than the average. If you don't do

well on the practice questions, your performance will suffer. The researchers measured how much the study participants knew about nursing documentation bygiving them nine multiple choice questions. The total score was then divided into two categories: good knowledge and poor knowledge, based on the average score. Having good knowledge means getting a score on knowledge questions that is equal to or greater than the average score. If the score is lower than the average, it is considered poor knowledge.

Opinion: The overall score for how study participantsfelt about nursing documentation was measured usinga specific type of question. The scores were classifiedas either favorable or unfavorable based on a specific point. Positive attitude: a score indicating a good attitude, otherwise it means a bad attitude..

Data collection tools and procedure

We used a written set of questions in English thatparticipants answered themselves.

Part-I asks questions about the personal information of the nurses, like their age and background.

Part II: Practice questions for measuring knowledgeof recording information in nursing records.

Part III involves assessing opinions about nursing documentation using a Likert scale. People were asked to rate their agreement or disagreement on a scale of 1 to 5, with 1 being strongly disagree and 5 being strongly agree. The chart review checklist used a scoring system of "1", "2", and "3" to represent "not", "partially", and "completely" responses.
Data quality control assurance

We used a questionnaire to collect information. Before collecting the actual data, we tested the questionnaire on a small group of nurses who were not part of the study. The people who collect data andtheir managers were trained for two days
Data processing and analysis

After collecting data, we checked, fixed any mistakes, and put the information into a computer program called Epi data 3. 1 Then we took the data

from Epi data and put it into another program called Stata 14 to analyze it. We looked at the data and summarized the results using numbers like how often something happened, the average with how spread out the numbers were, and visual aids like pictures and charts.

statical analysis
Data were fed to the computer and analyzed using IBM SPSS software package version 20.0**.** **(**Armonk, NY: IBM Corp**)** Qualitative data were described using number and percent. The **Kolmogorov- Smirnov** test was used to verify the normality of distribution Quantitative data were described using range (minimum and maximum), mean, standard deviation, median and Significance of the obtained results was judged at the 5% level.

The used tests were1 - Chi-square test

For categorical variables, to compare betweendifferent groups

2 - Monte Carlo correction
Correction for chi-square when more than 20% of thecells have expected count less than 5

RESULTS:
In current study 400 participants were included with mean age 31.77 years and 41.5% were males , 58.5% were females , majority of participants were married 65.8% and 15.8% were single , 10.8% were divorced
,7.7% were widow

As regard education 47.5% had BSC , 26.5% had MSC and 26% had diploma

Mean work experience period was 6.61 years with majority of participants had work experience for 5-
10. Years in 62.8% as shown in table 1

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**

Regarding knowledge 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, 92.3% said that nursing documentation provides necessaryinformation about the activities that took place while caring for patients

83% said that importance of nursing documentation lies in research and tracing, 78.3% said that a blank pace is left at the end of the reports regarding nursing documentation, 81.5% said that documentation is a legal document approved to take responsibility and take the necessary measures, 75.3% said that one of the highest priorities in nursing documentation is an accurate description of the patient's condition, 89.3% said that nursing documentation is of paramount importance in documenting the impact of patients' response to treatment, 81.5% said that verbal orders and instructions are documented in real time as soon as they are received as shown in table 2

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 available in health records provides actual and expected status of patients' needs and diagnoses	68	17.0	332	83.0
2	Nursing recording helps in knowing the extent of patients' response to critical medical care	56	14.0	344	86.0
3	Nursing documentation provides necessary information about the activities that took place while caring for patients	31	7.8	369	92.3
4	The importance of nursing documentation lies in research and tracing	68	17.0	332	83.0
5	A blank space is left at the end of the reports regardingnursing documentation	87	21.8	313	78.3
6	Nursing documentation is a legal document approved to take responsibility and take the necessary measures	74	18.5	326	81.5
7	One of the highest priorities in nursing documentationis an accurate description of the patient's condition	99	24.8	301	75.3
8	Nursing documentation is of paramount importance indocumenting the impact of patients' response to treatment	43	10.8	357	89.3

9	Verbal orders and instructions are documented in real time as soon as they are received	74	18.5	326	81.5

83% of participants had good knowledge about nursing documentation but 17% had poor knowledge with meantotal score 7.5 and average score was 0.83 as shown in table 3

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	

As regard attitude of nursing towards nursing documentation majority of participants were strongly agree 37.3% that nursing documentation process reflects the skill of observing and monitoring the patient's condition and documentation processdescribes the procedures that were taken with thepatients, 52.5% strongly agree that nursing documentation process is positively reflected in the health care provided to patients, 52.3% strongly agreethat 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.**

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

	ıde of nursing guidance on nursing documentation	Strongly disagree		Disagree		Neutral		Agree		trongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
1	The nursing documentation process reflects the skill of observing and monitoring the patient's condition	54	13.5	61	15.3	62	15.5	74	18.5	149	37.3
2	The nursing documentation process is positively reflected in the health care provided to patients	54	13.5	31	7.8	62	15.5	43	10.8	210	52.5
3	The nursing documentation process describes the procedures that were taken with the patients	54	13.5	31	7.8	62	15.5	104	26.0	149	37.3
4	The nursing documentation process shows the patient's health status	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
5	The nursing documentation process contributes to making appropriate decisions while providing health care to patients	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
6	Nurses should spend sufficient time documenting patient records and reports	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
7	Nursing documents are considered legal documentson which they are based	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
8	Nursing documentation assists in the recovery process for patients	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
9	Nursing documents provide adequate information about the patients' condition to nurses	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
10	Nursing documents provide protection for patients	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
11	The nursing documentation process promotes interaction and teamwork among members of the medical team as a whole	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
12	Nursing documentation processes play an important role in reducing work stress among nurses	25	6.3	31	7.8	31	7.8	104	26.0	209	52.3
13	Nursing documentation enhances the professionalism of nurses	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
14	Nursing documentation contributes to faster decision-making and improved health care	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
15	The nursing documentation process contributes to the speedy detection of changes in the patient's condition to the medical staff	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5
16	Nursing documentation contributes to enhancing the knowledge of nurses and medical staff	0	0.0	31	7.8	31	7.8	104	26.0	234	58.5

92.3% of participants had good attitude towards nursing documentation but 7.8% had poor attitude withmean score 66.56 and average score was 4.16 as shown in table 5

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

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

Regarding relation between overall knowledge and personal data we found that there was significant relations between age , gender , marital status , educational level and work experience p value <0.001 as shown in table 6

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	113.353*	<0.001*
Married	37	14.1	226	85.9		
Widow	0	0.0	31	100.0		
Divorced	31	72.1	12	27.9		
Education level						
MSC	12	11.3	94	88.7	16.501*	<0.001*
BSC	25	13.2	165	86.8		
Diploma	31	29.8	73	70.2		
Work experience						
<5	56	47.9	61	52.1	112.099*	<0.001*
5 -10	12	4.8	239	95.2		
>10	0	0.0	32	100.0		

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

Regarding relation between overall attitude and personal data we found that there was significant relations between age , gender , marital status , educational level and work experience p value <0.001 as shown in table7

Table (6): Relation between levels of overall attitude and personal data(n = 400)

Personal data	**Regarding attitude of nursing guidance on nursing documentation**				$\square^2$	**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		$MC_{p=}$
Widow	0	0.0	31	100.0	18.774*	<0.001*
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 $p \leq 0.05$

DISCUSSION:

Nursing document practice is when nurses writedown important information about patients to help take care of them in hospitals. This study looked at how nurses' knowledge and attitude affected their ability to properly document their nursing practices. Out of those surveyed, 400 participants enrolled 400 participants were included with mean age 31.77 yearsand 41.5% were males , 58.5% were females , majority of participants were married 65.8% and 15.8% were single , 10.8% were divorced ,7.7% werewidow. As regard education 47.5% had BSC , 26.5% had MSC and 26% had diploma , 83% of participants had good knowledge about nursing documentationbut 17% had poor knowledge with mean total score
7.5 and average score was 0.83 , 83% of participants had good knowledge about nursing documentationbut 17% had poor knowledge with mean total score
7.5 and average score was 0.83.

The study by Similarly et al in Saudi Arabia used a method to look at the nursing 'Focus Chart' documents. The hospital looked at the paperwork done by two nurses every day for two weeks in all of the units. The results of the study revealed that 980 nurses are taking care of patients directly and also documenting their information on charts. Out of 16 units, 50% have started using focus charting. 10 units are using narrative and 6 units are using other methods for documentation. A package was created to make the documentation better, and steps weretaken to fix the documentation problem. They reviewed the nursing care plan, patient assessment, and activity flow sheets. They suggested that the nursing administration use a multidisciplinary approach to create policies and guidelines for nursing documentation. To ensure nurses keep improving their skills in documenting, they offer ongoing training.

The current study revealed that nursing documentation practice was higher compared to previous studies done in Gondar at 37.4%, (KebedeM et al.,2017), West Gojamm at 45.7% (Andualem Aet al.,2019), Uganda at 32% (Namayanja B et al.,2016), and Nepal at 6% (Gurung N.,2022).Ourstudy finding was similar like a study conducted in the USA (80%) (Moody L. E et al., 2004).

The reason for the difference is because of the length of time people studied, the group of people they studied, and how many people they studied. The reason is different for studying for a long time. Most of the people who participated in the study had diplomas and certificates. Furthermore, there used to be a shortage of nurses which resulted in fewer nurses taking care of each patient. These nurses were primarily focused on performing life-saving procedures and may not have been as concerned about documenting everything, unlike the nurses today. In addition, most of the people in the study (90%) had completed a bachelor's degree or higher in education. This means that they are likely to regularlyuse nursing documentation in their daily tasks.

In addition, a specific organization is in charge of overseeing and regulating the way nurses document their care practices for each patient they are responsible for, while being closely monitored every day. However, in the past, this did not work for various reasons

In the current study regarding relation between overall knowledge and personal data we found

that there was significant relations between age , gender ,marital status , educational level and work experiencep value <0.001., Regarding relation between overall attitude and personal data we found that there was significant relations between age , gender , marital status , educational level and work experience p value
<0.001

This is supported by studies done in Harari (Tamir T et al.,2021). The possible reasons might be the higher age of the practitioners they might be more working experience and had familiarized with nursing documentation practice that becomes usual work activities in their workplaces. This is also maintained with a qualitative finding "….Being unfamiliarity with nursing documentation practice is one of thechallenges of young recruited staffs for nursing documentation. Since the new staffs have no awareness of nursing documentation practice sincetheir skill is not well developed. To solve such challenges, the organization should prepare training sessions for newly recruited staff."

Limitations
Because the information was collected using a tool that people used on their own, there is a possibility that the responses given by the participants were influenced by a desire to appear socially desirable. We got permission to review the charts from the nursing coordinator, but this might affect the independence of the study participants.

CONCLUSION AND RECOMMENDATION:

In this research, there has been an improvement in the way nurses write down and record information compared to earlier studies. The researchers suggest that it would be helpful for nurses to be more aware of, have a positive attitude towards, be familiar with,

and allocate enough time for nursing documentation practice. Furthermore, it is recommended to observe and compare how nursing documentation is done in order to conduct future studies.

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