Ministry Of Higher Education

and Scientific Research

University of Babylon

College of Nursing

Nurses' Knowledge Regarding Nursing Documentation in Emergency Care Units

A graduation project submitted to the Faculty of Nursing University of Babylon as part of the requirements for obtaining a Bachelor's degree in Nursing

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وَقُلِ اعْمَلُوا فَسَيَرَى اللَّهُ عَمَلَكُمْ وَرَسُولُهُ وَالْمُؤْمِنُونَ وَسَتُرَدُّونَ
إِلَى عَالِمِ الْغَيْبِ وَالشَّهَادَةِ فَيُنَبِّئُكُمْ بِمَا كُنْتُمْ تَعْمَلُونَ

صَدق الله العلي العظيم

التوبة (آية ١٠٥)

Dedication

I dedicate this report first and foremost to Almighty God who has been there right from the beginning to this very point. I special dedication also to my ever supportive parents, for their relentless support and compassion towards me during the course of my university training.

Acknowledgment

I would like to extend my sincere and heartfelt thanks towards my Almighty God and to all those who have helped me in making this project. Without their active guidance, help, cooperation and encouragement, I would not have been able to present the project on time.

I extend my sincere gratitude ***prof. Dr. shatha saadi mohammed*** *for their moral support and guidance during the tenure of my project.*

List of contents

Abstract:-

Background:

- Nursing documentation is part of nurses' medical notes and a source of basic & essential information in health care, a patient record containing all written information about a patient's condition and needs, and nursing tasks as it serves many different purposes.

Objectives:

- To find out the demographical characteristic of the study sample
- To assess the nurses' knowledge regarding documentation in the Emergency unit.

Methodology:

- A non-probability purposive sampling approach that recruited (100) nurses from two public governmental hospitals (A-Imam AL-Sadiq hospitals & Al-Hilla teaching hospitals) at Babylon city, Nurse selected as specific sample because they are assign to provide direct core to patients .

Results:

- The results recorded that the most of sample 72(72.02) were between age group (24-27) years old.
- The results recorded that the good level of knowledge about documentation as general.

Conclusion:

- The statistical results recorded an overall poor level of knowledge regarding documentation at emergency units.

Recommendation:

Based on the results of the present study, the following recommendations were suggested:

- Staff development is urgently needed to improve nurses‟ knowledge and skills concerning nursing documentation.
- Nursing documentation must be covered widely and in-depth in nursing curriculum of nursing schools.
- Continuous teaching programs or sessions must emphasize on all aspects of nursing documentation.
- Such researches and studies must aim to assess or evaluate nursing records

Chapter one

Introduction

1. Introduction

Nursing documentation is part of nurses' medical notes and a source of basic and essential information in health care, a patient record containing all written information about a patient's condition and needs, and nursing tasks as it serves many different purposes (Inan & Dinç, 2013).

Documentation is one of the most important practices in nursing. It sounds that nothing can reflect the total amount of nursing care giving to the patients as documentation does. Therefore, with reliance of the facts previously mentioned and in order to identify nurse's knowledge regarding principles and purposes of nursing documentation, this study was carried out(Cheevakasemsook, A.,2006).

The goal of nursing documentation study is to show that the organization maintains written evidence for its planning, implementation, evaluation, and evaluation of patient care, it is also considered as a source of knowledge for aspiring nurses and possibly for the development of nursing theory (Wang et al., 2011). Whereas previous writings provided evidence of patient progress, this one should include rationale and basic critical thinking for clinical decisions, interventions, and nursing staff evaluations, as well as conform to established standards (Hameed & Allo, 2014).

Nursing documentation has been one of the most important functions of nurses since the time of Florence Nightingale because it serves multiple and diverse purposes .The intention of nursing documentation is to demonstrate that an organization maintains

comprehensive written evidence of its planning, delivery, assessment and evaluation of patient's care(Crisp T,et all, 2004) .

The medical record is a legally binding document that can be used for a variety of purposes. In legal terms, it is a critical component in defending against potential legal challenges arising from carelessness or professional misconduct. From admission to discharge, the medical record is the only permanent record of the patient's care (Wang et al., 2020). A well-maintained record aids healthcare providers in better managing patient care, but a poorly maintained record raises the chance of medical errors. Consider medication errors caused by illegible handwriting or a lack of documentation of a drug's administration. While the medical record can be used for a variety of purposes, its primary function is to facilitate patient care continuity. Always keep in mind that the patient is at the core of all you do (Johnson et al., 2010).

An aim of emergency care is to ensure that the episode is of as brief as possible (Department of Health [DoH]{England}, 2001). It is therefore, transient in nature with the plan to always move the patient on, whether to an inpatient destination, to outpatients, transferred to another inpatient facility including rest-homes, nursing-homes or respite care, discharged home for follow-up by their own general practitioner (GP) or Practice Nurse, district nursing, home-help networks or other support services or occasionally they die within the department.

1.2. Importance of the study:

Emergency units need adequate capacity to handle admitted cases and disaster situations properly. Special patient types maybe seen in this unit who requires specific emotional or psychological treatment, such as; major trauma, patients, child and adolescents, elderly patients, mental patient, victims of child abuse, sexual assault, domestic violence, patients with infectious diseases or who are immunocompromised.

Documentation is of great importance in the delivery of care services and through which we can develop the services provided to the patient as well as the changes that occur in the patient and know the extent of his or her response to nursing interventions and is viewed as a means of communicating with the patient Health team. Detailed care documentation in the medical record provides legal evidence that the care provided complies with recognized care standards (Choi, 2021).

Furthermore, it is regarded as a necessary matter in the profession of nursing, as it provides the structural, harmonic, and effective communication wanted for the submission of high-quality care for patients that meet legal and professional standards, where the nurses spend nearly (15%) to (25%) from each turn of duty for documenting patients' care (Wang et al., 2011).

Objectives:

To study demographical characteristic for study sample & to assess the nurses knowle dge regarding Documentation in Emergency unit.

Chapter TWO

Methodology

2. Methodology:

Descriptive study cross-sectional design selected to carry out the study directed to assess nurse's knowledge regarding nursing documentation in emergency care units which consider a scientific framework to solve nurses problems from the period between (15 Sep- 2022 to 25 April-2023).

2.1Setting

2.1.1. AL.Hilla teaching hospitals selected as arch field to collect the data to obtain the objectives of the study.

2.1.2. AL.Imam Sadeq teaching hospitals selected as arch field to collect the data to obtain the objectives of the study.

2.2 Administration regulation

For starting the study, project formal form declared from psychiatric nursing department assigned the group of researchers and the supervisor. The second step meeting assigned by the supervisor to crystalize the title and the objectives of study.

2.3 Sample of the study

A non-probability purposive sampling approach that recruited (100) nurses from two public governmental hospitals (A-Imam

Al-Sadiq hospital, and Al-Hillah teaching hospitals) at Babylon city,

Nurse selected as specific sample because they are assign to provide direct care to patients. nurses selected according to the following criteria.

1. assigned as s nursing in the emergency unit
2. Nurses agree to participate in study.

2.4. The questionnaire

In order to reach the objectives of the shady special questionnaire prepared after reviewing related literature divided to three parts as the following:

Part I: This part Content the demographical characteristics of the study Sample

part Ill: this part this include (20 items) regarding nursing documentation in emergency care units items, the rating and scoring system when adapted in the questionnaire assigned as agree answer scored (3) and neutral answer which scored as (2) and disagree answer (1).

2.5. Data Collection

The questionnaire was used to gather data through (interview and self-report). Researchers were collected data individually from each participant. Each interview lasts between twenty and thirty minutes.

2.6 Data analysis:

_Statistical Analysis:

The data was analysis by using sample statistical analysis, frequencies and percentages and inferential statistics .

Chapter Three

Result

Results

Table 1: Demographical characteristics distribution of the sample

		Frequency	Percent
Age	20-23	20	20.0
	24-27	72	72.0
	28-31	8	8.0
	Total	100	100.0
Gender	Male	48.0	48
	Female	52.0	52
	Total	100.0	100
Marital status	Single	60	60.0
	Married	40	40.0
	Total	150	100.0
Educational status	Primary	11	11.0
	Diploma	33	33.0
	College	55	55.0
	post graduate	1	1.0
	Total	100	100.0
Residency	Urban	16	16.0

	Rural	84	84.0
	Total	100	100.0
Years of experience	less than 3 years	77	77.0
	4-7	23	23.0
	Total	100	100.0

Table (1): this table demonstrated the demographical characteristics of the study sample, the results recorded that the most of sample 72 (72..0%) were between age group (24-27)years old, also show the percentage 52(52.0) were female ,related to educational status most of study sample 55 (55.0) were college , 60(60.0) were single, related to residency the high percentage 84(84.0) were rural residency , also show the percentage 77(77.0) were less than for the 3 years of experiences 77% of the sample were less than 3 years experience.

Table 2: Distribution related to nurses knowledge regarding documentation in emergency units.

Items		Frequency	Percent	Mean	St .deviation	Level
1_Documentation is a written and legal record of interactions with a patient	disagree	2	2.0	1.84	.368	Fair
	neutral	6	6.0			
	agree	92	92.0			
	Total	100	100.0			

2_The primary purpose of documentation is communication between healthcare professionals.	disagree	6	6.0	2.67	.587	Good
	neutral	21	21.0			
	agree	73	73.0			
	Total	100	100.0			
3_Patient records serve as a legal document of the patient's health status	disagree	8	8.0	2.66	.623	Good
	neutral	18	18.0			
	agree	74	74.0			
	Total	100	100.0			
4_Nurses must use accepted standard terminology to communicate accurately.	disagree	8	8.0	2.65	.626	Good
	neutral	19	19.0			
	agree	73	73.0			
	Total	100	100.0			
5_Records and reports provide an accurate and detailed account of the treatment and care given.	disagree	11	11.0	2.63	.677	Good
	neutral	15	15.0			
	agree	74	74.0			
	Total	100	100.0			
6. Records must be truthful and complete.	disagree	10	10.0	2.66	.655	Good
	neutral	14	14.0			
	agree	76	76.0			
	Total	100	100.0			

7. Records and reports are effective means of communication between members of the health team.	disagree	13	13.0	2.58	.713	Good
	neutral	16	16.0			
	agree	71	71.0			
	Total	100	100.0			
8. Documents must be in compliance with professional and agency standards	disagree	11	11.0	2.58	.684	Good
	neutral	20	20.0			
	agree	69	69.0			
	Total	100	100.0			
9.Vital signs are measured every 4 hours.	disagree	8	8.0	2.59	.637	Good
	neutral	25	25.0			
	agree	67	67.0			
	Total	100	100.0			

Items		Frequency	Percent	Mean	St .deviation	Level
10.Blood transfusion is documented in TPR chart.	disagree	12	12.0	2.37	.691	Fair
	neutral	39	39.0			
	agree	49	49.0			
	Total	100	100.0			
11. Writes the medical diagnosis in the TPR chart.	disagree	9	9.0	2.43	.655	Fair
	neutral	39	39.0			
	agree	52	52.0			
	Total	100	100.0			

12. TPR CHART is a graphic chart.	disagree	17	17.0	2.33	.753	Fair
	neutral	33	33.0			
	agree	50	50.0			
	Total	100	100.0			
13. Wound abscess is documented in the I/O chart.	disagree	27	27.0	2.19	.837	Fair
	neutral	27	27.0			
	agree	46	46.0			
	Total	100	100.0			
14. Fluid loss through breathing is documented using the I/O chart.	disagree	25	25.0	2.25	.833	Fair
	neutral	25	25.0			
	agree	50	50.0			
	Total	100	100.0			
15.When a medical error occurs, the nurse draws a line across the error and writes the error inside it and overlapping it as well.	disagree	17	17.0	2.35	.757	Fair
	neutral	31	31.0			
	agree	52	52.0			
	Total	100	100.0			
16. Records must be kept under the protection and supervision of nurses.	disagree	9	9.0	2.63	.646	Good
	neutral	19	19.0			
	agree	72	72.0			
	Total	100	100.0			
17.Records should be arranged alphabetically and numerically.	disagree	19	19.0	2.51	.798	Good
	neutral	11	11.0			
	agree	70	70.0			
	Total	100	100.0			

18. All records are identified with the IP number of reviewers, and the documentation must be accurate and brief.	disagree	12	12.0	2.53	.703	Good
	neutral	23	23.0			
	agree	65	65.0			
	Total	100	100.0			

Items		Frequency	Percent	Mean	St .deviation	Level
19. Red ink must be used for documentation after 7 pm	disagree	4	4.0	2.72	.533	Good
	neutral	20	20.0			
	agree	76	76.0			
	Total	100	100.0			
20. Nursing documentation of the pulse is in TPR chart B.	disagree	14	14.0	2.20	.765	Fair
	neutral	18	18.0			
	agree	68	68.0			
	Total	14	14.0			

MS (poor knowledge =1-1.6, fair knowledge = 1.7-2.3, Good knowledge = 2.4-3)

Table (3): this table demonstrated the nurses' knowledge about documentation in emergency unit , the results recorded that the good level related to items (2,3,4,5,6,7,8,9,16,17,18 and 19) and fair level related to items(1,10,11,12,13,14,15,20),also recorded good level as general knowledge .

Chapter four

Discussion

Discussion:

Nursing must demonstrate that the care nurses deliver is connected with optimal patient outcomes, as well as a high degree of quality and safety, in the age of evidence-based healthcare. Nursing documentation is the process of generating evidence connected to nursing practice. It can be a useful measure of the quality of treatment given to patients in hospitals. Nursing documentation is so critical to providing high-quality, effective, and safe nursing care. Its quality, accuracy, and growth necessitate monitoring and evaluation, which can be accomplished through documentation.

Regarding the demographical characteristics of the study sample, the results recorded that the most of sample 72 (72.0%) were between age group (24-27) years old supported by K hattar, 2016 recorded 164(55%) between age (25_29) years old. Because of the nature of their duties, emergency wards require young nurses

Also show the percentage 52(52.0) were female similar to Khattak, I. U., 2016 recorded 277(92.3%) were female.

Related to educational status most of study sample 55 (55.0) were college this finding has not match the result conducted by (Aboalizm, et al., 2016). Who found that that approximately more than half of the study sample (55%) had diplomas.

Also this table show the high percentage 60(60.0) were single, another study conducted by Abd El Rahman, A. I.,2021 recorded 120 (75%)were married

Related to residency the high percentage 84(84.0) were rural residency,another study conducted by Abd El Rahman, A. I., 2021 recorded half of study were rural residency , also show the percentage 77(77.0) were less than 3 years related to years of experiences supported by Hameed, R. Y.,2014recorded (28.7 %) were ≤ 5 years

Regarding the nurses' knowledge about documentation in emergency unit , the results recorded that the good level as general knowledge another study conducted by Khattak (2016) recorded The knowledge of the nurses was assessed. 60%nurses reported that nursing documentation is maintaining, handling and taking over of patient's charts. 66% were strongly agreed that nursing documentation is main responsibility of nurse. 78% and 86% nursing staff reported that Nursing documentation is patient's flow chart and Patient's information respectively. 47% nurses Reported that nursing documentation is Communication between health care team.

Another study is the first to provide valuable data on knowledge and practice of nurses regarding nursing documentation in Peshawar, KPK. The knowledge of nurses regarding nursing documentation is relatively low, as documentation is the main responsibility of the nurse. Literature suggests that maintenance of patients' documentations is the main responsibility of a professional nurse. It is a priority for nurses that they document each and every intervention that they do. Documentation is the confirmation of completed intervention.11 Health records should demonstrate good patient care. There is a range of legislation, policy and guidance that should determine what nurses write about and how they share and store that information.(Beach J,2014).

Chapter five

Conclusion and Recommendations

Conclusion:

- The results of this research shows that most of the sample were females, their age group were between 24-27 years old, graduated from the nursing colleges. The overall assessment for the documentation of the nursing staff in the emergency units was poor related to items(Wound abscess is documented in the I/O chart ; Fluid loss through breathing is documented using the I/O chart).
- Whereas a good level of documentation were found in (Records and reports are effective means of communication between members of the health team; Records should be arranged alphabetically and numerically) .

Recommendation:

Based on the results of the present study, the following recommendations were suggested:

- Staff development is urgently needed to improve nurses‟ knowledge and skills concerning nursing documentation.
- Nursing documentation must be covered widely and in-depth in nursing curriculum of nursing schools.
- Continuous teaching programs or sessions must emphasize on all aspects of nursing documentation.
- Such researches and studies must aim to assess or evaluate nursing records

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وزارة التعليم العالي و البحث العلمي

جامعة بابل

كلية التمريض

معارف الممرضين فيما يتعلق بالتوثيق التمريضي في وحدات الطوارئ

مشروع تخرج مقدم الى كلية التمريض جامعة بابل ضمن متطلبات الحصول على درجة البكالوريوس في التمريض

إعداد الطلبة

بنين عقيل كاظم

تبارك حبيب علي

تبارك سالم داخل

بإشراف

ا.د. شذى سعدي محمد

٢٠٢٣ م ١٤٤٤هـ

الخلاصة

- التوثيق التمريضي هو جزء من الملاحظات الطبية للممرضين ومصدر للمعلومات الأساسية و الضرورية في مجال الرعاية الصحية ، وهو سجل للمريض يحتوي على جميع المعلومات المكتوبة حول حالة المريض واحتياجاته ، ومهام التمريض لأنه يخدم العديد من الأغراض المختلفة.

الأهداف:

- التعرف على الخصائص الديموغرافية لعينة الدراسة وتقييم معارف التمريضيين فيما يتعلق بالتوثيق في وحدات الطوارئ.

المنهجية:

- اتبع أسلوب أخذ العينات الهادف غير الاحتمالي الذي قام بجمع (١٠٠ عينة) ممرض وممرضة من مستشفيين حكوميين (مستشفيات الإمام الصادق ومستشفى الحلة التعليمي) في مدينة بابل ، تم اختيار الممرض كعينة محددة لأنهم مكلفون بتقديم رعاية مباشرة للمرضى لهذا الغرض.

النتائج:

- سجلت النتائج أن معظم العينة (٧٢,٠٢) كانت بين الفئة العمرية (٢٤-٢٧) سنة.
- سجلت النتائج أن المستوى الجيد بصفة عامة.
- الاستنتاجات:
- سجلت النتائج الإحصائية مستوى عدم الرضى في بعض ا لفقرات المتعلقة بالتوثيق في وحدات الطوارئ.

التوصية:

بناءً على نتائج الدراسة الحالية ، تم اقتراح التوصيات التالية:

هناك حاجة ماسة لتطوير الموظفين لتحسين معرفة ومهارات الممرضات بخصوص وثائق التمريض.

_. يجب تغطية وثائق التمريض على نطاق واسع ومتعمق في منهج مدارس التمريض

_ يجب أن تركز البرامج أو الدورات التعليمية المستمرة على جميع جوانب وثائق التمريض .

_ يجب أن تهدف هذه الأبحاث والدراسات إلى تقييم أو تقويم سجلات التمريض