THE QUALITY OF NURSING DOCUMENTATION IN SOME PRIVATE AND PROVINCIAL HOSPITALS IN THE CAPE PENINSULA AND THE PWV-AREA

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INTRODUCTION

During 1987 a research project was undertaken to establish standards for nursing care in the Republic of South Africa. This research was supported by an HSRC-grant. As part of this project, an investigation was undertaken to establish standards for the documentation of nursing care.

The aims of the study were the following:

- to formulate standards which all nursing-care records had to comply with, if nursing care of a satisfying quality had to be rendered. (These standards had to be valid for use by registered nurses of the different cultural groups in the medical and surgical units of all the general hospitals in the RSA)
- to design and standardize an evaluation instrument for nursing-care documentation according to the standards
- to investigate the effectiveness of the current nursing-care documentation of hospitalized patients in the PWV-area and the Cape Peninsula using a quantitative survey
- to identify the factors which influence the documentation of nursing care significantly.

In this article the findings of the survey will be dealt with.

METHODOLOGY

The sample

The hospitals in the PWV-area and the Cape Peninsula were stratified into three groups and a random sample was drawn from each group.

In each hospital the units to be used were selected at random and in each unit 20 percent of the patient files were randomly selected until a figure which represented 10 percent of the total number of hospital beds was reached. Each selected file to be evaluated had to represent a patient who had been hospitalised for at least four consecutive days.

Field workers

Two registered nurses were appointed as field workers, one for the PWV-area and one for the Cape Peninsula. The field workers were trained by the researchers and the first five evaluations were done together with them. Thereafter the researchers discussed and solved problems with the field workers after every 40 evaluations.

Data collection

The selected records were audited by the field workers according to the criteria as set out in the evaluation instrument developed by the researchers. To be able to evaluate a record, the field worker had to read through the nursing record and the doctor's record, and also had to make some observations.

A total number of 459 patient records were audited. In the large hospitals 325 records (71%) were audited; in the medium sized hospitals 72 (16%) and in the small hospitals 62 (13%).

The instrument

The standards with their relevant criteria were grouped under three headings in the instrument, namely:

- The document complies with legal requirements.
- The document is a complete record of the condition of the patient and his nursing care.
- The document is an effective record of reality.

FINDINGS AND DISCUSSION

Standard 1

The document complies with legal requirements

The record is kept in a permanent format

In 98% of the cases it was indicated that the records were kept in a permanent format.

Entries

In Table 2 the main characteristics of the entries per patient record are shown. From this it is clear that nurses do not consistently add their professional registration when they sign their names (only 37% of the signatures...
had clear indications of registration. Only 1 out of every five corrections was correctly done. (Correctly done in this case means that one line is drawn through the incorrect entry and it is initialed.) Only 50% of the abbreviations were correct, acceptable abbreviations which appear in a dictionary.

• Confidentiality of the records
It was indicated that in 99% of the cases records were kept confidentially between the patient and the multidisciplinary team.

• Documentation of life supporting apparatuses
It was seen that when patients were connected to monitors, ventilators or infusion pumps, these apparatuses were only identified in 30-50 percent of the cases. This is very important in case something goes wrong with the patient and the apparatus has to be tested for functionality.

• Were any entries made before the intervention took place?
This illegal practice was identified in six (1.3%) of the records.

The documentation reflects a complete picture of the condition of the patient and his nursing care.

Admission data
From Table 3 it is noticeable that the mass, skin colour, pupil-reaction and mental state of the patient on admission were only recorded in 40 percent of the cases.

Standard 2
The document is a complete record of the condition of the patient and the nursing care rendered
Table 4 shows how often other important admission data were recorded. Data on allergies is not given, because the item was found to be confusing, and was changed in the final instrument.

In this category of admission data the presence of chronic conditions are poorly recorded (only in 29% of cases). Another important aspect of the data reflected in this table is how often the information documented by the nurse conflicts with what is reported by the patient or in the medical record (between 15 and 25% of entries).

In Table 5 the documentation of the assessment of the patients’ basic needs by the nurse is indicated.

The two aspects of basic needs which were most often not assessed, is spiritual and learning needs. The other eight basic needs were addressed in an average of 64% of the patients.

• Was the assessment of basic needs done within 24 hours of admission?
This was done in only 42% (192) of the cases. It was thought that the large number of emergency cases admitted to hospitals partly accounts for this finding.

The documentation of the patient’s problems, plans for treatment and changes in the treatment plan in the nursing record is shown in Table 6. Changes in the condition of patients as indicated on the flow charts were too frequently (40% of the time) not reflected on the progress records of patients. This is a very risky practice in terms of medico-legal problems, since the flow sheets are often discarded and does not become part of the permanent record.

In Table 7 the documentation of the visits of other members of the multidisciplinary team to the patient, as well as the patient’s movements out of the unit for treatment purposes is shown.
TABLE 6

Documentation of patient problems, treatment and changes in condition
Percent (N = 459)

<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were the patient's problems clearly identified?</td>
<td>74</td>
<td>26</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Were nursing care prescriptions recorded?</td>
<td>80</td>
<td>20</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Was the physician's plan for treatment available?</td>
<td>87</td>
<td>13</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Were all changes in the patient's condition indicated on the flow charts reflected in the record?</td>
<td>24</td>
<td>40</td>
<td>36</td>
<td>100</td>
</tr>
</tbody>
</table>

20% of the cases the records contained a summary of the patient's condition with regard to his problems on discharge and referrals for further care of unresolved problems were only documented in 11% of the cases.

Standard 3
The document is an effective record of reality
Table 9 shows the effectiveness of the record as a reflection of the reality. The 6% of records in which false statements were found, is disconcerting.

CONCLUSION
Although many nurses are of the opinion that the advent of the implementation of the scientific method in nursing would improve the documentation of nursing care considerably, it is obvious from this investigation that there are still many areas in nursing documentation which need to be improved.

Nurse managers might survey the nursing records in areas they supervise with reference to the deficient areas as identified in this study. In some cases the deficit might be the result of neglect of recording — such as in the case of identifying the life-support apparatus — and all that may be necessary is raising the awareness of nurses in this regard.

In other cases, the lack of recording may indicate that a certain aspect of nursing care is neglected — such as discharge planning. Well-planned continuing education programmes should then be planned to improve care.

Although the data reported in this study could be used by nurse-managers, they may prefer to use the Nursing Record Standard Sheet (obtainable from the publication section of SANA in Pretoria) to evaluate the recording done in their own area/institution.

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