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

Susanne W. Booyens, Leana R. Uys

Opsomming

'n Ondersoek is onderneem met die doel om standaarde vir die dokumentasie van verpleegsorg daar te stel. Verpleegsorgrekords in die mediese en chirurgiese afdelings van privaat- en algemene hospitale in die PWV-gebied en die Kaapse Skiereiland is geouditeer. 'n Aansienlike getal tekortkominge in die daaglikse verpleegrekordering is geïdentifiseer.

Summary

An investigation was undertaken with the aim of establishing standards for the documentation of nursing care.

Nursing care records in the medical and surgical units of private and general hospitals in the PWV-area and the Cape Peninsula were audited. A considerable number of deficiencies were identified in the daily record keeping of nursing care.

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 hospitalised 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 (61%) 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 form*. 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

TABLE 1.

The sample of hospitals used for the survey

	Cape Peninsula			PWV-area		
	Number	Ratio	Sample	Number	Ratio	Sample
Large hospitals (500 + beds)	5	1	1	11	1	1
Medium size hospitals (200 — 499 beds)	7	1	2	15	1	1
Small hospitals (20 — 199 beds)	15	3	2	22	2	2
Total	27	5	5	48	4	4

TABLE 2

The main characteristics of the entries per patient record

Characteristics	Average number (N = 459)
Number of entries	20
Dated	18
Time indicated	18
Legible	20
Signed	19
Signed with a clear registration added	7
Number of corrections	5
Number of corrections done correctly	1
Number of abbreviations	15
Number of abbreviations done correctly	7
Total number of pages of record	23
Number of pages containing the patient's name and number	17

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 document 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.

TABLE 3

The documentation of basis line data on the nursing record

	Percent (N = 459) Yes	No	Total
Temperature	95	5	100
Pulse rate	97	3	100
Respiration rate	86	14	100
Blood pressure	67	33	100
Mass	40	60	100
Skin colour	44	56	100
Pupil reaction	40	60	100
Mental state	46	54	100
Patient's description of health problem	60	37	97*
Name and/or telephone number of a contact person	91	9	100

* In 3% of cases the item was not applicable.

TABLE 4

The documentation of diagnosis and treatment on admission in the nursing record

	Percent (N = 459) Yes	No	Not applicable	Total
Documentation of the medicines the patient is already taking?	59	23	18	100
Confirmation of this information by the patient?	20	25	55	100
Confirmation of patient's medication by the medical record?	49	36	15	100
Documentation of the medical diagnosis for the hospitalisation?	82	18	—	100
Confirmation of the medical diagnosis on the medical record?	81	15	4	100
Documentation of the medical diagnosis of chronic conditions?	29	51	20	100
Confirmation of the diagnosis of chronic conditions on the medical record?	60	20	20	100

TABLE 5

The documentation of other important admission data on the nursing record

	Percent (N = 459) Yes	No	Not applicable	Total
International homeostatis needs, e.g. blood pressure, pulse	68	32	—	100
Hygiene needs	59	41	—	100
Activity/mobility and rest needs	57	43	—	100
Learning needs	33	66	1	100
Communication and psycho-social needs	66	33	1	100
Intake needs	71	29	—	100
Output needs	62	38	—	100
Safety needs	66	34	—	100
Comfort needs, including pain	64	36	—	100
Spiritual needs	27	73	—	100

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's 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 multi-disciplinary 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)

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

TABLE 7

Documentation of visits to the patient as well as movements of the patient out of the unit

Percent (N = 459)

	Yes	No	Not applicable	Total
Are visits from doctors recorded?	70	30	—	100
Are visits from physiotherapists recorded?	12	75	13	100
Are visits from occupational therapists recorded?	1	79	20	100
Are visits from other members of the multidisciplinary team recorded?	2	82	16	100
Are patients' movements out of the unit for investigation or treatment purposes recorded?	43	48	9	100

TABLE 8

Documentation of new or changed nursing activities

Percent (N = 459)

Nursing activities	Yes	No	Not applicable	Total
Are all new or changed nursing actions indicated on the medical record documented?	39	33	28	100
Are new or changed nursing actions indicated on the flow charts documented?	24	26	50	100
Are new or changed nursing actions expected due to diagnosis or treatment documented?	69	28	3	100
Are new or changed nursing orders documented in general?	74	24	2	100

TABLE 9

The documentation as a reflection of the reality

Percent (N = 459)

Nursing Care Activities	Yes	No	Not applicable	Total
Were scientific terms used?	20	20	60	100
Does the record address the central problems of the patient?	72	28	—	100
Is the record a chronological report of the sequence of events?	78	22	—	100
Was any false statement recorded?	6	94	—	100

Although doctor's visits to patients were recorded in 70 percent of the cases, the visits of other members of the multidisciplinary team were hardly, if ever, recorded.

In Table 8 the documentation of new or changed nursing activities are shown. This table shows a real problem as far as documenting changes in nursing action goes. If the records where this was not applicable are excluded, the percentage of specific actions not recorded is 43%.

Medications given to patients were documented in 51% of the cases, but the patient's reactions to medication were only documented in 13% of the cases. In only 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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S.W. Booyens, D. Litt et Phil (Unisa)
R.N., R.M., Dip. Intensive Care.
Associate Professor, Department of Nursing, University of SA.
L.R. Uys, D. Soc.Sc.,
R.N., R.M., P.N., D.N.E., D.H.A.
Professor and Head Department of Nursing, Natal University