Opinions of Nurses and Nursing Students About Nursing Documentation: A Comparative Study

Hemşirelerin ve Hemşirelik Öğrencilerinin Hemşirelik Kayıtlarına İlişkin Görüşleri: Karşılaştırmalı Bir Çalışma

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ABSTRACT Objective The nursing documentation is essential because it provides the continuity and evaluation of care, it is the main source of communication among the health care providers and provides data from the aspect of legal issues for both the care giver and care taker. Although the importance of the nursing documentation is emphasized during the nursing education, it is seen that the nursing documentations are held in a different quality. The understanding of the reason of this difference is important for practice and education. The aim of this study was to compare the opinions of nurses and nursing students about the documentation. The results are expected to take the necessary precautions for unfavorable factors of nursing documentation and to contribute to preparing undergraduate and postgraduate educational programs. **Material and Methods:** The study was descriptively planned. All the participants were recruited from the same nursing school and affiliated training hospital. The data were acquired by a data-collecting form, which included 10 questions followed by multiple choices. The forms were replied by the nurses (n= 168) and the nursing students (n= 72). **Results:** The study has shown that: (1) nurses regard the documentation as a protector against legal issues while the students think that consistency of the patient care is more important; (2) both groups reported the excessive workload as the reason of not documenting; (3) for improving the documentation, the nurses think that clinics-specific forms are necessary while the students lay emphasis on the computer-based documentation; (4) opinions about the content of the forms were similar. **Conclusion:** The nursing students, unlike the nurses, reported that the first aim of the documentation is to provide the continuity of the care. Taking the reasons of not documenting listed by the nurses into consideration from the aspects of practice, management and education is thought to increase the quality of care.

Key Words: Documentation; nursing; nurses; students, nursing

ÖZET Amaç: Hemşirelik kayıtları; bakımın sürekliliğini ve değerlendirmesini sağlaması, sağlık ekibi arasında bakım konusunda temel iletişim kaynağı olması, hem bakım veren hem de alan için yasal açıdan veri sağlaması gibi nedenlerle oldukça önemlidir. Hemşirelik kayıtlarının önemi hemşirelik eğitimi sırasında vurgulanmasına rağmen, mezuniyet sonrası hemşirelik kayıtlarının farklı nitelikte tutulduğu görülmektedir. Bu farklılığın nedenlerinin anlaşılması uygulama ve eğitim açısından önemlidir. Bu çalışmanın amacı hemşirelerin ve hemşirelik öğrencilerinin hemşirelik kayıt konusundaki görüşlerini karşılaştırmaktır. Sonuçların hemşirelikte kayıt tutmayı olumsuz etkileyen faktörlere ilişkin önlemlerin alınmasını sağlayacağı ve mezuniyet öncesi ve sonrası eğitimlere katkıda bulunacağı düşünülmektedir. **Gereç ve Yöntemler:** Çalışma tanımlayıcı olarak planlanmıştır. Bütün katılımcılar aynı hemşirelik okulundan ve bu okulu destekleyen aynı eğitim hastaneden alınmışlardır. Veriler, çoktan seçmeli yanıtları bulunan 10 soru içeren bir veri toplama formu ile elde edilmiştir. Formlar hemşireler (n= 168) ve hemşirelik öğrencileri (n= 72) tarafından yanıtlanmıştır. **Bulgular:** Çalışma sonuçları göstermiştir ki; (1) hemşireler kayıt tutmayı, yasal konularda bir koruyucu olarak görürken, öğrencilere gore hasta bakımının devamlılığını sağlamak daha önemlidir; (2) her iki grup da kayıt tutmamanın en önemli nedeni olarak işyükü fazlalığını bildirmişlerdir.; (2) kayıt tutmayı geliştirmek için hemşireler kliniklere özel formların gerekli olduğunu belirtirken, öğrenciler bilgisayar tabanlı kayıt tutmanın gerekli olduğunu belirtmişlerdir; (4) formların içeriği konusunda her iki grup da benzer görüş bildirmişlerdir. **Sonuç:** Hemşirelik öğrencileri,hemşirelerden farklı olarak kayıt tutmanın ilk amacının hasta bakımının devamlılığını sağlamak olduğunu bildirmişlerdir. Hemşirelerin kayıt tutmama nedenleri olarak sıraladıkları nedenlerin, uygulama, yönetim ve eğitim alanları açısından dikkate alınarak giderilmesinin hasta bakımı kalitesini arttıracağı düşünülmektedir.

Anahtar Kelimeler: Kayıt tutma; hemşirelik; hemşire, hemşirelik öğrencisi

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The importance of medical records has been emphasized in medical history as earlier as the period of İbn-i Sina.[1] As a result of the evolution occurred in health care services, quality indices of health care have varied from mortality and morbidity, to more patient-centered concepts, such as patient safety, patient satisfaction and patient outcome. With the increasing sophistication of the health care services, the cooperation among the health professionals has also become more important. The patient-centered nature of the new indices has made the information provided by nurses more crucial for not only the other nurses but also for the other health professionals.[2,3] The transfer of this information to other professionals can only be possible by a comprehensive nursing documentation.

The nursing documentation is any written- or electronically-generated information that describes the planned or administered care. It is essential to many nursing activities, such as communication among nurses and other health professionals, protection against legal issues, consistency of patient care, education and constitution of a database for research and patient education.[4-6] It has a pivotal role in improving the quality of nursing care.

Nursing documentation is a means to establish the nursing database, which is an important component of whole health sciences database. From this point of view, it has a central role in bridging the gap between nursing as an art and nursing as a science.[7] The computer-based advances in technology of documentation have enabled the use of information by many people who may be quite far away from each other and also made the analysis of a bulk of data possible in a short time.[8-12] The nurses should be encouraged for using computers because computers introduces new nursing skills, enhances their knowledge, experience and judgment of descriptions of patient problems and care strategies.[13] A standard language in nursing documentation may also help the health professionals to understand the records held by nurses.[14,15] Another advantage of the standard language is that it increases the autonomy of the nurses in practices.[16] The efforts to make the documentation standard, organized and legible were firstly started by American Nursing Association (ANA). The ANA Houses of Delegates proposed to develop a computer-based nursing informatics system. In 1989, The Steering Committee on Databases to Support Clinical Nursing Practice was founded. This committee developed the criteria for assessing and defining nursing classification systems.[8,12,17] It should also be noted that the information systems that are used for documentation should be reviewed periodically because some deficiencies and contradictory issues may develop in time.[18]

There are many reports about the comparisons of the attitudes of nurses and nursing students. These comparisons help to make a comprehensive analysis of difference between education and practice area. Besides, the comparison between nurses and students is also valuable in preparing an effective curriculum and continuing education programs. Also, it provides information about how the nurses change in clinical settings. As far as we could determine, there is no study about the comparison of opinions of nurses and nursing students about nursing documentation. The documentation is included in the curriculum of the school of schools but there is no postgraduate education for nurses. The students learn the nursing documentation on theoretical basis in lectures and on practical basis in clinics. Because their knowledge is more updated than the nurses, the nursing students can compare the theoretical basis and practical basis of the nursing documentation in a better way. On the other hand, the nurses can combine the theoretical aspect with reality and may have different opinions. Accordingly, this study was designed to assess the differences between the opinions of the nurses and nursing students about the nursing documentation. We think that the results will help to make

a better curriculum and continuing education programs in future. We also think that the study will promote the nurse managers and directors of nursing schools to review the curricula of undergraduate and postgraduate continuing education programs.

MATERIAL AND METHODS

STUDY GROUP

The study was conducted in a training hospital in Ankara/Turkey. A randomly-selected sample of 300 graduate nurses in a training hospital and 122 nursing students (all students in the last semester of school of nursing) from a nursing school of nursing were invited to participate in study. There were 50 (41%) students and 132 nurses (44%) who were non-respondent. The statistical analysis included only the answers of the respondents. The school of nursing was affiliated by the same hospital; therefore, all the participants worked in the same hospital. The hospital was a training one, which presents opportunities for education of nursing students, medical students, medical and nursing specialty residents and emergency medical technicians. All the nursing students have entered their last year of pre-graduate nursing education. The nurses were randomly selected from those on day shift. The nurses have graduated from two types of school: two-year program and four-year program. All the participants were assured of the confidentiality about being anonymous throughout the study.

THE DOCUMENTATION SYSTEM OF THE HOSPITAL

Both written and electronic recording system is used in the hospital but the nurses generally use the written forms. Some forms are standard in all clinics while some additional forms are used in certain units such as intensive care units. All the forms are kept in the patient file. In addition, a notebook is used for recording the drug administrations. The students are not authorized to record any data but they can use the recorded data whenever necessary. Besides, they are encouraged to inform the nurse if they notice something important to be recorded in the form.

DATA ACQUISITION

A data-collection form, which was prepared by the investigators, was used to collect the data. The data obtained from Pubmed® search, opinions of professors in the school of nursing and nursing management were taken into consideration during the preparation phase of the form. The form included ten questions. Six of them were about the socio-demographic data while there were 4 questions about the documentation system: (a) What are the aims of recording? (b) Which nursing data should be recorded? (c) What are the negative factors for recording? (d) Is the current recording system meeting the needs? Each question was followed by multiple choices. However, a choice of "other" was placed at the end of the choices in order to allow the participants to give their own opinions. The forms were delivered to the participants and asked to return them on the next day. To assure the confidentiality, the participants were asked to return the forms to the investigators, who had visited them on the next day. There was no name on the forms. This phase of the study lasted one week.

STATISTICS

The categorical variables were expressed as numbers and percentages while the continuous variables mean ± 1 standard deviation. Differences in the opinions of both groups were tested with Chi-square test. SPSS 11.0 (Chicago, IL) packed program in Windows XP was used for analysis.

ETHICAL ISSUES

The study was performed after the necessary permissions were obtained from the school and hospital management and the participation was based on willingness. Informed consent was obtained from all participants. The principles of Helsinki De-

cleration have not been violated in any stage of the disease.

RESULTS

The sample of the study included 168 nurses (all female; mean age= 31 ± 6 years) and 72 (all female; mean age= 21 ± 1 years) nursing students. The mean employment duration of the nurses were 10 ± 6 years and 64% (n= 107) were graduated from a two-year graduation program, while the remaining from a four-year baccaluarate program. The reasons of not responding were expressed as lack of time, possibility of not being able to return the form and unwillingness, in order of frequency.

The differences in the aims of the documentation according to the nurses and nursing students are shown in Figure 1. To protect nurse and patient against legal issues was the mostly expressed opinion of the nurses, while the students thought that the primary aim is to provide the consistency of the patient care. Except for the aim of determining consumption of device and to be protected against legal issues, all other aims were different between nurses and nursing students (p< 0.001).

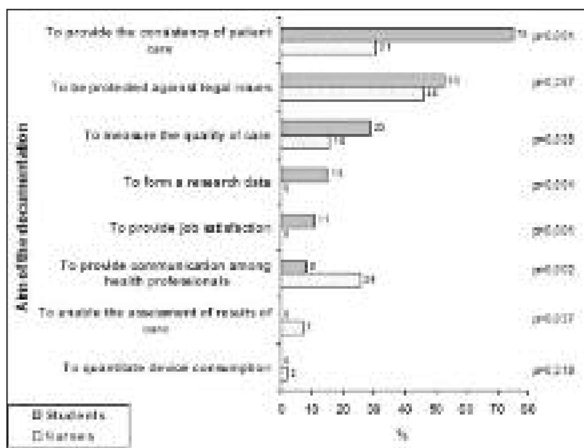

FIGURE 1: The differences in the aims of the documentation according to the nurses and nursing students.

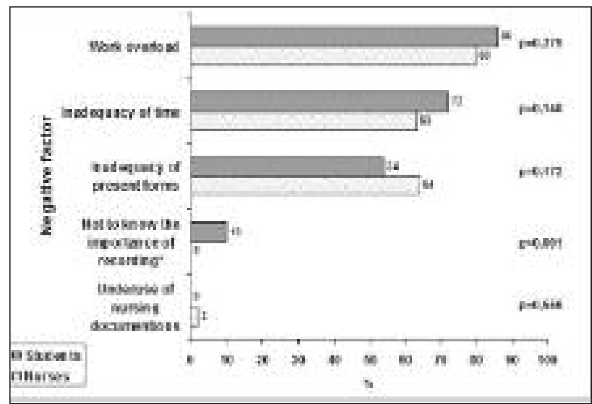

FIGURE 2: The negative factors that effect documentation according to nurses and nursing students.

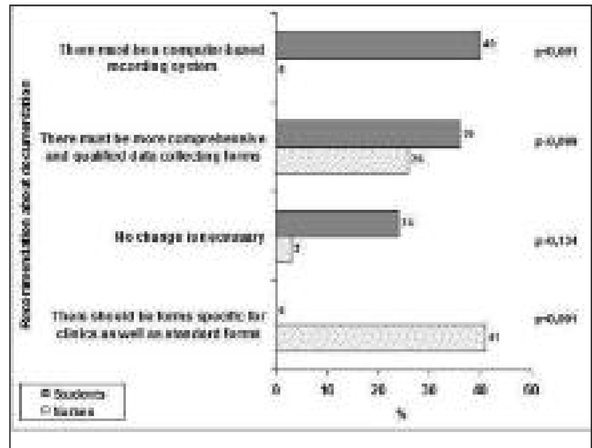

FIGURE 3: The recommendations of nurses and students about the present recording system.

The negative factors that effect documentation according to nurses and nursing students are shown in Figure 2. Both the nurses and nursing students thought that the work overload is the most important reason of not recording. The single difference between the opinions of nurses and student nurses was found in the item of "not to know the importance of recording" (p< 0.001). None of the nurses thought that this is a valid reason.

For nurses and students, health history, vital signs, medications, notes about the care are the necessary items to record in a nursing documentation. They also added that all the procedures performed after the patient had been hospitalized should also be recorded.

The recommendations of nurses and students about the present recording system are shown in Figure 3. The nurses think that clinics-specific forms are necessary while the student nurses think that a computer-based recording system will improve the sufficiency. Both groups think that the forms must be more comprehensive and more qualified.

DISCUSSION

Although there are a few studies examining the opinions of nursing students[19] or nurses;[20] we couldn't find any comparative study between nurses and nursing students in our country. Similarly, the disparity between opinions of nurses and nursing students about other issues has been discussed in a few studies in all over the world.[21,22] Defining the effectiveness of nursing education in various areas is an elusive goal in nursing education programs. Although the tests or quizzes held at school provide some information, the amount of converting the knowledge gained at school into practice in clinical settings is more important. The nurse educators should pay attention to the differences in attitudes or opinions of nursing students and nurses, because, not the education itself but the way it is converted to the practice is important. If there is a difference between what has been aimed at education and what has happened in real professional life, it means that there is something to change in the curriculum. In this regard, the differences between opinions of nurses and nursing students may be valuable for preparing a more effective education about nursing documentation.

The present study has shown that the opinions of nursing students differ from those of nurses. The most striking one was pertaining to the aim of nursing documentation. The nurses laid emphasis on the protection against legal issues while the students ranked the consistency of patient care uppermost. The nurse's opinion of protection against legal issues suggests that the nurses think that their or the administrators' needs are more important than the patient's needs. On the other hand, the students are more idealistic and think that the patient need comes first. It is true that the protective aspect of the recording system is one of the aims of documentation.[23] However, primary aim should be the protection of patient against unfavorable factors. This protection can only be possible by providing the clinical assessment and the consistency of care with a correct and complete recording.[24] To the best of all, the documentation system should be implemented as a system, which meets the needs of the clinics and management.[25] The subjects of future studies and educations about developing a documentation system should include the informational needs of the nurses about the aims of a documentation system.[26]

In this study, the students laid emphasis on the use of computer-based recording systems, while none of the nurses thought it as necessary, although both thought that the recording system should be improved. The computers has recently begun to be used such widespread, therefore, the new generation might appreciate its use better. Another factor may be that the school administrators are now giving more space to computer-based learning in their curriculum, making the students more familiar with computers.

The study has revealed that there is accordance in the opinions about the content of recording system. Both groups think that all the procedures should be recorded during hospitalization. The history, vital signs, medications and notes about the given care are important. McGeehan[27] have reported that the records provide the information about whole travel of the patient. However, this information is not meant to be restricted to care, results of care and laboratory tests.

This information should also include all the data collected from the patient. A standard recording system may help in decreasing the discrepancies between different nurse's documentation. In hospitals without standard recording systems, it is reported that the transition from one shift to the other is made by a brief statement of "no problem". This statement neither reflects what the nurse does[20] nor possesses the features of "accountability and assessability".[10] In hospitals without standardization in recording system, some clinics-specific forms are developed. Some of the participants of this study have also emphasized the need for clinic-specific forms. These forms provide a comprehensive and qualified documentation but, on the other hand, may lead to problems when the patient is transferred to another clinic or when hospitalized later. Therefore, everything about the patient care should be recorded but these records should be effective and more sensitive to the complexities of the nursing care. The studies have shown that such a recording system can be possible by using computer-based recording systems.[20,28]

Both groups thought that the excessive workload is the main negative factor in keeping a good nursing documentation. The insufficiency of the present forms and lack of time was other reasons. These results are consistent with the other studies.[29,30] Other reasons were underuse of records for nurses and not knowing the importance of recording for nursing students. In a study by Platin et al,[31] the nurses spend 12-15% their work time for documentation. This result suggests that documentation is not implemented simultaneously with the related nursing activity.[27,31,32] The literature search revealed that the lack of time is the main reason of not recording also in other countries.[32,33] It is paradoxical that both groups think everything about the patient should be recorded while they also think that workload is the primary negative factor for recording. It seems that they do not regard the nursing documentation as an element of workload.[24] It is important that nursing students agree with nurses. This result suggests that the emphasis on the importance of nursing documentation should be increased in curriculums of the nursing schools. The students should learn to regard the nursing documentation as important as the other nursing activities. They should also be taught that documentation is not an additional workload; instead, it is one of the components of the whole workload. Actually, all nursing activities should begin with documentation (as receiving the order) and end with documentation (as recording the result of activity). According to Rodden and Bell,[24] the motivation necessary for improving nursing practice enables the nurses to know the meaning of their own practice. In our study, the nursing students stated a similar expression as they regard not to know the importance of the documentation as an important negative factor. If the information gained from the nursing documents is influencing the nursing practice and if this is realized by the nurses, they may change their attitude towards the recording system.

In conclusion, the evidence from this study suggests that both nurses and nursing students do not regard the documentation as a part of their role in health care system. Although its importance is appreciated, documentation is considered as an additional workload. There is also evidence that a significant proportion of nurses think that the documentation help them protect against legal issues, while the nursing students regard it as a means to provide the consistency of the patient care. There is also a significant difference with regard to the recommendation for documentation between both groups. While the nurses lay emphasis on using clinic-specific forms; the students thinks that computer-based documentation is necessary.

SUGGESTIONS

1. The nurses should be convinced about the necessity of the nursing documentation in lectures

of Ethics. However, keeping in mind that protection against legal issues is also important; the primary aim should be the improvement of the patient care. It is important to emphasize that this is an ethical obligation.

2. The nurses should be educated so that they are more familiar with the computers. The advantages of computer-based documentation systems should be implemented in the education programs.

3. The content of the forms should be reviewed according to the recommendations of nurses and nursing students.

4. Other members of health care team should be informed about the use of nursing documentation.

5. Future research is needed to find out the interventions that make nurses and nursing students more eager to use nursing documentation.

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