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KAMUZU COLLEGE OF NURSING

FACTORS THAT CONTRIBUTE TO POOR DOCUMENTATION OF NURSING CARE IN SURGICAL UNITS OF LILONGWE CENTRAL HOSPITAL, MALAWI.

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF A BACHELOR OF SCIENCE IN NURSING EDUCATION

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DATE: 14th APRIL, 2000

DECLARATION

I declare that this work is entirely my own effort. It has not been accepted or concurrently submitted in candidature of any degree.

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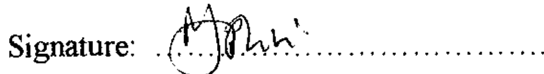

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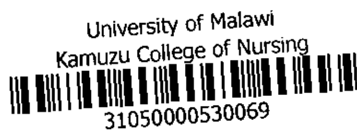
Supervisor's Name:

Signature: Mr. A. N. K. Simwaka Date: ....

DEDICATION

This research report is dedicated to my only beloved husband Hope Phiri for accepting me to undergo the course and his endurance from my absence during the time he needed me most. My parents Langtone and Loveness Mwangala for taking care of my son Hope junior during the two years that I was away.

Brothers and sisters need to be remembered too. The love, support and understanding which was shown by the mentioned people helped me to concentrate much on this work and without them the two years of study would have been impossible.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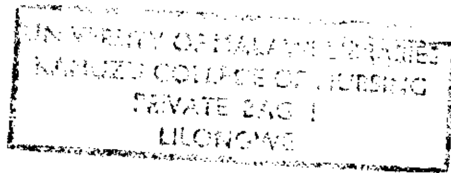

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MEANING OF ABBREVIATIONS

MRN:	Malawi Registered Nurse
MRM:	Malawi Registered Midwife
mmHg:	Millilitres of Mercury
CHAM:	Christian Health Association of Malawi

ABSTRACT

The researcher's experience through working in different hospitals of Malawi, showed that nurses do not like to document their interventions or nursing care done on the patient. This descriptive quantitative study was designed to discern the factors that contributed to poor documentation of nursing care in surgical units of Lilongwe Central Hospital, Malawi. The study focused mainly on documentation and the nursing process.

Literature revealed that this area of nursing practice was not researched on extensively in Malawi and other countries. In the study, Fischbach's model of documentation was used, comprised of three major concepts, namely; Communication skills, Nursing process skills and Documentation standard skills. A convenience sample of twenty Enrolled and Ten State Registered Nurse midwives from ward 1A, 4A, 4B and Children's ward was utilised. This was done to meet the proposed sample size. A pilot study was conducted to ensure validity and reliability of the structured questionnaire and checklist developed by the researcher. The main study was conducted from 6th to 18th December 1999. The subjects were requested to answer and fill the structured questionnaire with open and close-ended questions after gaining their consent. Furthermore, a checklist was used to find more on the documentation practices in the files of January and February 1999. Data analysis was done manually and using the Statistical Package for Social Sciences to validate the findings.

Open-ended questions were analysed by content analysis by Waltz et al (1991) and then categorised in themes to gain insight of the meaning of the findings.

Descriptive statistics were used to describe the findings. Results are presented in frequency tables, descriptions, percentages and ratios. The results revealed that some nurses documented their nursing interventions effectively. The majority did not because of shortage of staff and stationery. This report is written to disseminate the findings of the study.

CHAPTER ONE

INTRODUCTION

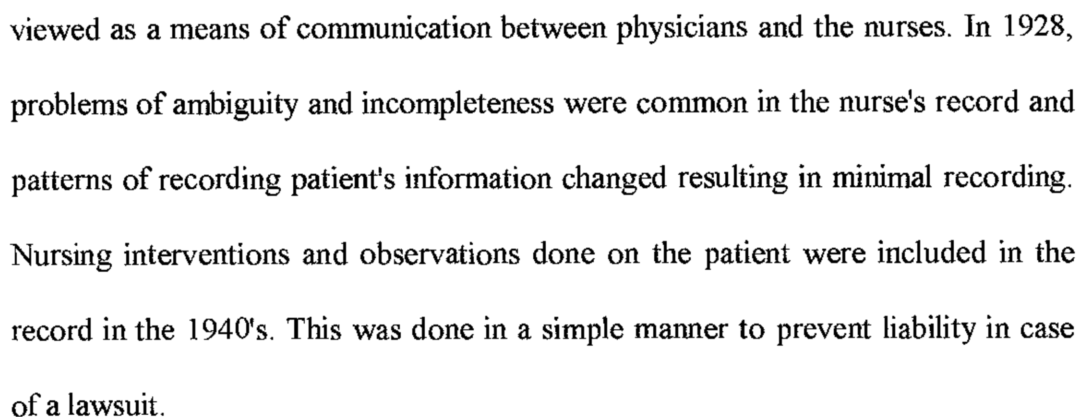
Documentation is a system which requires preparation, storage and dissemination of written information for easy access and efficient use (Fischbach 1991). On the other hand, nursing is a profession which aims at prevention of illness, promotion of life, rehabilitation from disability and helping patients to a peaceful dignified death if all nursing and medical interventions fail. Nursing involves caring by assisting individuals sick or well, in performance of those activities contributing to health or its recovery. For nursing care to be known and appreciated by other people (professionals), documentation plays a major role. Though such is the case, nurses have had difficulties with this activity because the quantity and quality of information documented still remains poor (Ibid).

The main purposes of documentation are to ensure that there is a systematic approach to nursing care through utilization of the nursing process. Documentation of accountability for nursing actions and effective communication implies the need for this exercise in the nursing profession. Special occurrences and provision of a permanent record for future reference signifies the need for nursing documentation. Documentation is essential in describing the care provided and patient's response to that care. Increased lawsuits following democracy in Malawi have created the need for nurses to have a written document for nursing care. The document is a legal record which can be used in a variety of legal proceedings to protect the patient, the hospital, or health team professionals.

Furthermore, documentation to nurses serves the purpose of communicating necessary information regarding the patient resulting in continuity of care. In nursing care, documentation is also vital in obtaining reimbursement from the government and insurance companies following injury or disability, which directly depends on what, is recorded in the patient's file. The researchers experience in some maternity wards of Malawi revealed that following poor documentation some women ended up with ruptured uteruses and then fresh still births (death in utero at nine months gestation). This resulted from poor or no recording of fetal condition and progress of labour. For some of the reasons given, the researcher intended to discern if nurses documented nursing care properly and the factors (reasons) that hindered effective documentation. The study was conducted at Lilongwe Central Hospital (L.C.H) surgical units (wards), which was a convenient place in terms of affordability. In the study the major concepts of documentation and the nursing process were investigated.

1.1 Background of the Study

Documentation is not a new concept in the nursing profession. According to Fischbach (1991) documentation started during the time of Florence Nightingale (1820-1920), who is viewed as the founder and originator of modern nursing. In Nightingale's era, the need to document environmental and nutritional needs of the patient was emphasized. Documentation was viewed as the core of the nursing profession with an aim of collecting, storing and retrieving data necessary for the patient's management. During the twentieth century, physicians taught nurses how to carry out medical orders and keep records. Documentation at that time was



viewed as a means of communication between physicians and the nurses. In 1928, problems of ambiguity and incompleteness were common in the nurse's record and patterns of recording patient's information changed resulting in minimal recording. Nursing interventions and observations done on the patient were included in the record in the 1940's. This was done in a simple manner to prevent liability in case of a lawsuit.

Furthermore, charting of the patient's response to actual nursing interventions was indicated in the record in mid 1950's. This time the nurses were accountable for their actions as a result everything done on the patients was included in the record. Though documentation was practiced, no observations of the patient's response to the procedures or interventions performed were recorded in the patient's file. Some of the tools that were used in recording the patient's information were flow sheets, checklists and care plans.

In the 1970's accountability for the nurses was emphasized much. Accurate and timely recording of both initial and continuous assessments was the focus of recording. In addition, patient care plans and documentation of nurse's activities was included. Documentation styles that were used included Narrative, Problem-Oriented, Focus and Charting by Exception only to cite a few. The styles cited are still in use up to date. Currently nurses spend more than fifteen percent of their time in documentation of nursing care activities (Camp and Iyer, 1995). What is documented reflects the character, competence and the caring of the nurse (Ibid.).

Although documentation is essential in nursing not all nurses value it as such. Feutz and Sheryl (1989) stressed the need for increased attention in this area of nursing practice, an indication that factors contributing to poor documentation have not been looked into at length.

1.2 Statement of the Problem

Poor documentation of nursing interventions is a problem in the hospitals of Malawi. Through experience it was revealed that nurses did not like to document nursing interventions and patient's response to nursing and medical management because of lack of knowledge and bad attitudes. A few nurses documented inadequately what they had done on the patients because of lack of time, skill, negligence, increased workload and lack of necessary resources, for example stationery.

The impact of poor documentation was that there was no continuity of patient care resulting in mismanagement, complications, death and increased lawsuits. Lack of quality assurance programs in the hospitals also contributed to poor documentation systems. Encompassed in the program was the nursing audit. This was one way through which nurses could have helped to satisfy the accountability that was inherent in the professional practice (Phaneuf 1990). Literature revealed a long-standing concern that information recorded about the patients was inadequate as stated by King and Macmillan (1994).

1.3 Significance of the Study

The findings of the study are of significance to nurse practitioners, managers, educators and researchers. Documentation is a complex activity that is demanding, challenges beginners and experts in the nursing profession and it require skillful writing habits, which contributes to accurate and complete records. Clear, concise and consistent expression of ideas avoids charting problems. Skillful writing habits enhance confidence and reduce stress that might be associated with documentation. The findings of the study will help the nurse practitioners gain insight to factors that affect quality patient care through documentation. The nurse practitioners will be in a position to identify their strengths and weaknesses and then improve where necessary.

To the nurse managers, they will be able to identify the factors that affect patient care and then make policies and standard guidelines of documentation for the nurses to follow. Furthermore, nurse educators will understand the need for emphasising the component of documentation in the nursing curricula and in the long run students will participate in the activity i n the clinical area and then improve patient care. In the clinical area, through documentation, the students will gain a comprehensive picture of patients conditions, related nursing care together with an understanding of the nursing process as an approach to patient problems. The students will learn to recognize the value of a complete nursing data base for planning, delivery and evaluation of patient care. Nurse researchers on the other hand will have well documented records to be used as a sample during a research

study. In addition, the information indicated in the files can help the researcher to identify the need for conducting research with the aim of improving patient care.

1.4 Purpose of the Study

Was to determine the factors that contributed to poor documentation of nursing interventions at Lilongwe Central Hospital Malawi (L.C.H).

1.5 Specific Objectives of the Study

(a) To find out if nurses documented their nursing interventions effectively.

(b) To discern the information which nurses documented.

(c) To determine the factors that the nurses perceived as facilitating documentation of nursing interventions.

(d) To identify factors that contributed to poor documentation of nursing care interventions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Documentation in Nursing

Today the demands on the nurse for documenting are varied and complex (Jones 1989). Under the old rules, nurses learnt,

"What is not documented is not done"(Ibid) p13.

The result of this mindset was narrative charting which related to all the things the nurse had done on the patient. Harters (1989) concur with Jones (1989) stating that, if an observation or action is not documented, the assumption is that it was not done or made. The words documenting, charting, recording and record keeping are used interchangeably but have different meanings (Fischbach 1991).

Documenting refers to the communication of essential written information with the aim of maintaining a continuous account of events over a period of time. It can also mean preparation and maintenance of accounts for some time. Furthermore writing the patient's assessment findings, plan, implementation and evaluation of response to care in the record is referred to as documenting. On the other hand, charting involves writing on the chart which, is a document that communicates useful patient and health care information. It can also refer to a table, which shows changes and variations such as temperature, pulse, respiration and blood pressure.

According to Fischbach (1991), a record is an account in writing in a temporary or permanent form and serves as evidence of an action, statement, transaction or proceedings. It can also mean information regarding facts or events preserved and handed down. Nurses' notes forms part of the document, they are units of writings recorded by nurses in the patient records such as progress notes and the nursing care plan. The notes vary in length and format. The nurse's notes include the patient's medical history, nursing diagnosis, care plans, nursing actions and patient care outcomes.

2.2 Studies Done in other Countries Related to Documentation

Heartfield (1996) conducted a related study on nursing documentation and nursing practice. The researcher indicated that nursing documentation must be objectively written to avoid value judgements, which make nurses have difficulties to translate the experience of caring into words. The study indicated that knowledge is essential for nurses to document their interventions effectively. In this study documentation is viewed as the daily reality of the nurse's work. Heartfield (1996) further indicated that one of the factors for no documentation, is that nurses deal intimately with events people do not want to know about. For example giving of unprescribed drugs. Lack of ethical, legal, medical and institutional guidelines have influenced poor nursing records. On the other hand, the tradition of oral knowing has grown in value for nurses (Doering 1992). Dissatisfaction with documenting nursing care has encouraged nurses to value oral communication that occurs in

hand over and undervalue the written word (Harters 1989). Lack of power which has an effect on the operation of social relationships between groups and individuals has contributed to poor documentation (Jones 1989). Power is something that is exercised rather than possessed and produces pleasure and forms of knowledge. Documentation of fragments of all the nursing observations and actions done on the patient have also contributed to poor documentation because the patient is not viewed as a whole being.

Resistance to change on the other hand has contributed to poor quality of documented information (Doering 1992). Camp and Iyer (1995) in their book indicated that increased acuity of patients and nurses' shortage have decreased the amount of time available for documentation. King et al (1994) indicated that upon spending more than 15% of time in documenting activities, nurses feel tired and frustrated at the end of the shift. The writer commented that despite the work done by the nurses, the profession exposes total commitment to the welfare of the patient and family by requesting the nurses to continue documenting despite the problems faced. In the long run this frustrates the nurses.

Hays (1989) in his study mentioned that nurses' write about observations and responses in a manner that is passive. Such intentions leave the record devoid of meaning as anything more than a record of information that assists the other health providers. The findings also indicated that there is no apparent knowledge that underpins what nurses are doing that differentiates them from assisting the doctor.

The records also lack the presence of the nurse to the readers because nothing is documented on them. Nickel (1983) as quoted by Davis et al (1994) argues that documentation may distract nurses from providing the nursing care as such it is not necessary document. Literature also revealed that poor following of the nursing process which provides guidance for documentation and promotes practicing within legally defined standards contributes to poor records (Cox et al 1993). In addition Carpenito (1991) indicated that nursing documentation is varied, complex and time consuming as such nurses do not favour it.

The severity of the patients/clients condition also determines charting time. However, the nurse spends time in repetitive charting of routine care and observations. Too often this results in missing the specific significant information. Findings of the study revealed that nurses write about observations and responses in a manner that is passive. Such intentions leave the record devoid of meaning as anything more than a record of information that assists the other health care providers. The findings also indicated that there is no apparent knowledge base that underpins what nurses are doing that differentiates them from assisting the doctor. The records also lack the presence of the nurse to the readers because nothing is documented on them by the nurses. Nickel (1983) as quoted by Davis et al (1984), argues that documentation may distract nurses from providing the nursing care as such it is not necessary to document.

Literature also revealed that poor following of the nursing process which provides guidance for documentation and promotes practicing within legally defined standards contributes to poor records (Cox et al 1983). In addition, Carpenito (1991) indicated that nursing documentation is varied, complex and time consuming, as such nurses do not favour it. The severity of the patient's/ clients condition also determines charting time. However, the nurse spends most time in repetitive charting of routine care and observations, resulting in lose of specific significant information. The other contributing factor to poor documentation is that doctors rely on oral communication among the nursing staff to transmit status reports of the patients, significant findings and nursing orders (Iyer and Camp (1995). Hunt et al (1981) added that few nurses for too many patients/clients contributes to poor documentation. Lack of commitment and fear of committing oneself on paper plays a role too. Hays (1989) agrees with this point that documentation is dangerous because it provides a permanent record as such it is evident of the nursing ethics and language involved during patient/client care. The writer further indicated that too little time and too much to do has been the traditional excuse for no documentation by nurses. Furthermore, Casey (1995) in his study indicated that lack of time was cited as the most common reason why staff nurses neglected to document patient education. Patient education is one of the components of patient care and need to be documented too to prevent duplication of the activity by the other nurses on duty.

Martin (1994) explained the case which he was handling as a lawyer and stated that a patient was admitted to deliver her third child. During pregnancy she gained 63 pounds, her blood pressure had risen from 100/70mmHg in her first trimester to 140/80mmHg at term, and an ultrasound done at 22 weeks showed placenta privea. Over the next four hours, she received ten units of Pitocin in five hundred millilitres of 5% Dextrose in Lactated Ringers solution. Documentation during this period was scant, her blood pressure was never recorded and there were only single notions of the foetal heart rate and how labour was progressing. The nurses failed to record either the baby's reaction to the drug or the nature of the patient's contractions. Suddenly, after complaining of nausea and epigastric pains the patient suffered a generalized tonic seizure. The patient's condition was so unstable that she could not undergo a ceasarian section, so her baby was delivered by low forceps. Following delivery she developed disseminated intravascular coagulation and required six units of whole blood within eight hours of delivery. The nurses documented nothing on the labour or delivery records or the progress notes. When the lawyer reviewed the unit's policy and procedure manuals, he could not find a protocol for administering pitocin and assessing the patient. At the very least, there should have been a Pitocin flow sheet to record vital signs, labour progress, fetal status and changes in the drug administration rate. Although the patient recovered, her daughter had seizures. The case was settled out of court for 45,000 Sterling Pounds with the nurse and the hospital responsible for one third of the amount; the doctor paid the rest.

In addition Martin (1994) identified problems related to documentation such as not charting the correct time when eventsoccurred. He further indicated that failing to record verbal orders or to have them signed for have contributed to poor documentation. Charting nursing actions in advance to serve time was also identified a problem. Taylor and Togno (1992) in their study revealed that priority should be given to documentation of patient's health details. However in the study, there was sparse recording of physical, mental and other capabilities of the patients as a result it was difficult to make decisions for the patient's discharge from the hospital.

2.3 Studies Done in Malawi Related to Documentation

Chitsulo (1999) conducted a study on the effects of long hours of night duty on quality of nursing care at Lilongwe Central Hospital where 50 nurses were sampled. The findings indicated that all respondents reported documentation of patient's records. The most reported type of records was the nursing observations and patient's complaints, which was reported by 41.4 %. Forty-one of the respondents recorded intake and output, vital signs and doctors prescriptions.

Namate (1985) conducted a study on nurse's perceptions on quality of nursing care where forty nurses were sampled. The findings revealed that 76% of the nurses documented nursing care despite problems with staffing and time patterns but the quality of documented information was not looked into. Chitsulo (1999) and Namate (1985) agree that documentation of nursing care is practiced in some

hospitals of Malawi. The sample sizes utilized in the two studies were small for one to generalize the findings.

Zulu and Chalanda (1999) conducted a study on infection prevention and control in nursing practice at Lilongwe Central Hospital. The findings indicated that no documentation of the development of any infection following hospitalization was done. The stated examples gave the researcher the need to conduct a study in this area of nursing practice.

2.4 Documentation Styles In Practice

There are many methods of documenting nursing care, which have evolved over the years (Iyer and Camp, 1995).The choice of the documentation style depends on several factors like, knowledge of the documentation styles in place, time available for documentation, patient's condition and availability of resources like stationery or nurses. The most common method preferred by the nurses is Narrative charting. It is charting of the patient's care events during the shift in a story format. The events include patient's status, nursing interventions and the response or lack of response to nursing or medical care. On the other hand, Problem Oriented charting requires the nurses to use the Subjective data and Objective data, Assessment and Planning (SOAP) format. Subjective data stands for information given by the patient, guardians or family members to the nurses. Objective data is what the nurse finds out from the data given, physical assessment and laboratory tests.

In Focus charting , the narrative notes are organised to include Data, Action and Response for each identified problem (Iyer and Camp1995). Data stands for subjective or objective data that relates to the patients problem. Actions are the nursing interventions and responses; the outcome of the nursing interventions related to the patient's response to care.

Furthermore, Charting By Exception (CBE) is an abbreviated charting method in which the narrative portion of the record is used solely for the purpose of recording abnormal and significant findings rather than charting normal findings (Fischbach 1991). The system aims at developing clinical standards that describe acceptable norms. For example the nurse's assessment of the patient's respiratory status provides information on rate, bilateral breath sounds only to list a few. The information from this assessment falls within acceptable norms; therefore all that will normally be necessary for the CBE entry is a check mark and the nurse's signature or initials.

2.5 Documentation Guidelines for Quality Assurance

Fischbach (1991) states that all documentation should be completed per institutional guidelines. Date and time all entries. Sign all entries with initials or full signature. Use only institutional approved abbreviations. Supplement flow sheet documentation with Narrative entries if necessary. Refer to institutional standards of care and practice to guide documentation regarding the manner in which these standards are met. If possible, plan charting times to avoid interruptions. To

maintain timely, accurate and objective record keeping, complete documentation as soon as possible after the activity. Following the above stated points, the nurse is able to deliver good nursing care to patients/ clients and in so doing ensuring quality.

2.6 The Nursing Process and Documentation

The nursing process refers to series of dynamic, logical, progressive steps, which are taken in an orderly manner to reach a pre-planned goal (Miles 1984) p 28. Hallway was one of the first nurses to use the term nursing process in the early 1950's (Cox et al 1993). The major purpose of the nursing process is to provide a framework within which the individualised needs of the patients/ clients, family and community can be met through a comprehensive and quality health service (Miles 1984).

Cox et al (1993) further states that the nursing process is central to nursing actions in any setting because it is an efficient method of organizing the nurses thoughts, emotions, feelings, values, skills, and abilities necessary for clinical decision making and problem solving. Use of the nursing process is beneficial for both the patient and the nurse because it helps to ensure that care is planned, individualized and reviewed over a period of time that the patient and nurse have a professional relationship.

The process is comprised of five steps of Assessment, Nursing diagnosis, Planning, Implementation and Evaluation (Fischbach 1991). Documentation of nursing care interventions follows the same indicated five steps hence the relationship. From the description one can conclude that documentation is related to the nursing process and nursing care because they go hand in hand. Without the nursing process, the nurses will have nothing to document, as such care of the patient is not revealed to the other health care providers. With good documentation skills, the nursing process skills will be communicated to other professionals in ensuring patients continuity of care. Good nursing care is demonstrated by the absence of complications such as bed sores and drug overdose only to mention a few. Lastly nursing care is related to documentation and the nursing process because what the nurse documents in the file is what he/she has done to the patient/ client.

2.7 Summary of Literature Review

Literature review showed that documentation is necessary in the nursing profession. Depending on the documentation style chosen, several factors need to be considered for one to document effectively. It also revealed that this area of nursing practice had not been researched on effectively both in Malawi and outside countries.

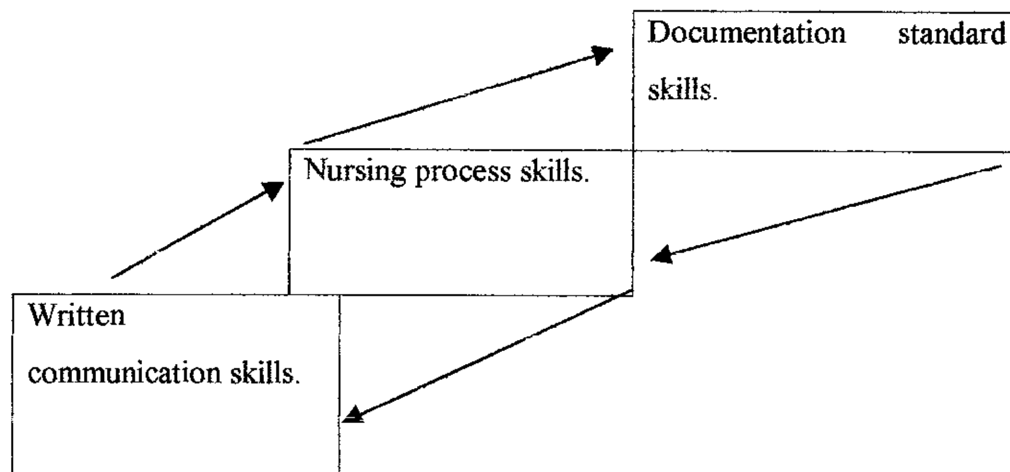
CHAPTER THREE

CONCEPTUAL MODEL

The conceptual model utilized in this study was that of Fischbach (1991). The model was developed from three major concepts which are (a) Written communication skills. (b) Nursing process communication skills (c) Documentation standard skills.

This model was chosen because the key concepts utilized were matching fully to the study. Communication is essential in nursing care and can be verbal or written. The model is then explaining how best the nurses can communicate through writing in the patients' file. In addition the nursing process documentation skills explain how nurses can communicate in a written form, utilizing the steps of the nursing process. Furthermore, documentation standard skills are focusing on the quality and quantity of documentation that is considered adequate for a particular situation. Through literature review, this was the only model identified for documentation. Fischbach (1991) states that the concepts of communication, nursing process and documentation standards are interrelated, interdependent and dynamic.

Figure 1: Fischbach's Conceptual Model for Documentation



Source: Fischbach (1991).

(a) Written Communication Skills

Communication is a two way process whereby nurses send and receive information necessary for patient management. The nurse requires skills necessary to communicate ideas, thoughts and feelings with other health personnel pertaining to patient's condition.

Good communication skills can be observed in records utilized by others in a meaningful way. The record conveys clear and understandable information. It indicates what has been done to the patient and the gaps to be filled by others. Furthermore, the written document indicates the roles the nurses can perform on their own and in collaboration with others. For example wound dressing and drug

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LILONGWE

administration. The roles will be evident in the interventions done and recorded in the file.

Accurate data from the patient's assessments as indicated in the record signifies good communication skills. Furthermore, the nurse's creativity is reflected in the written records through the development and implementation of a care plan. The good written record with the nurses skills will reflect patients' past health complaints, present and potential problems that may occur. Plan for, implementation and evaluation of care outcomes will be documented.

(b) Nursing Process Skills

Nursing process is the core of the nursing profession and documentation is part of it. Skills in documenting the nursing process are essential for nurses to write properly in the patient's record. The nursing process utilizes the steps of assessment, nursing diagnosis, planning, implementation and evaluation (Fischbach 1991). Skills in recording the nursing process requires the nurse to follow the stated five steps when documenting the interventions done on the patient. The process helps the nurses to make appropriate judgements in the delivery of patient care. Data are collected and recorded in the patient's file following the five steps as above.

Recording of the patient's information is done on specific time periods but the nurse is not restricted to document at certain intervals when need arises (Iyer and Camp, 1995).

The nurse makes nursing diagnoses basing on the data obtained during assessment. Nursing care plans are developed, implemented and maintained by the nurse. Revisions to the care plan are made according to the patient's response to the nursing interventions. Evaluation of the patient's outcome following implementation of care are documented at specific times and communicated to other care providers. The skills are indicated when the data are collected and written in the patient's file in a systematic way.

(c) Documentation Standard Skills

A standard is a measure to which similar activities/items should conform (Fischbach 1991). The standards can be found in nursing practice act, nursing schools, hospitals and unit policies. In meeting the documentation standards, the nurse acts in accordance with institutional policies. Thus approved abbreviations, signatures, methods of error correction and writing of incident reports are recorded per policy. The nurse follows institutional policies on how to document in relation to patient admission in the hospital, transfer from one unit to the other and discharge. Accountability and responsibility to the nursing profession standards are included in the patient's file, for example, giving of medications to the patients on time.

3.1. Summary of Fischbach's Conceptual Model of Documentation

Fischbach (1991) explains that through written communication nurses get information from other health personnel necessary for patient management. Written communication skills are needed to effectively document the nursing interventions.

The nursing process as the core of the nursing profession, provides a guide for the documentation of nursing interventions. Skills in the nursing process are necessary to identify, implement the steps of the nursing process and communicate the findings to others. Standards of documentation act as a basis for reference. Specific guidelines and policies are developed from them. The skills are necessary for evaluation of the recording practices in relation to time, completeness of the document and accuracy.

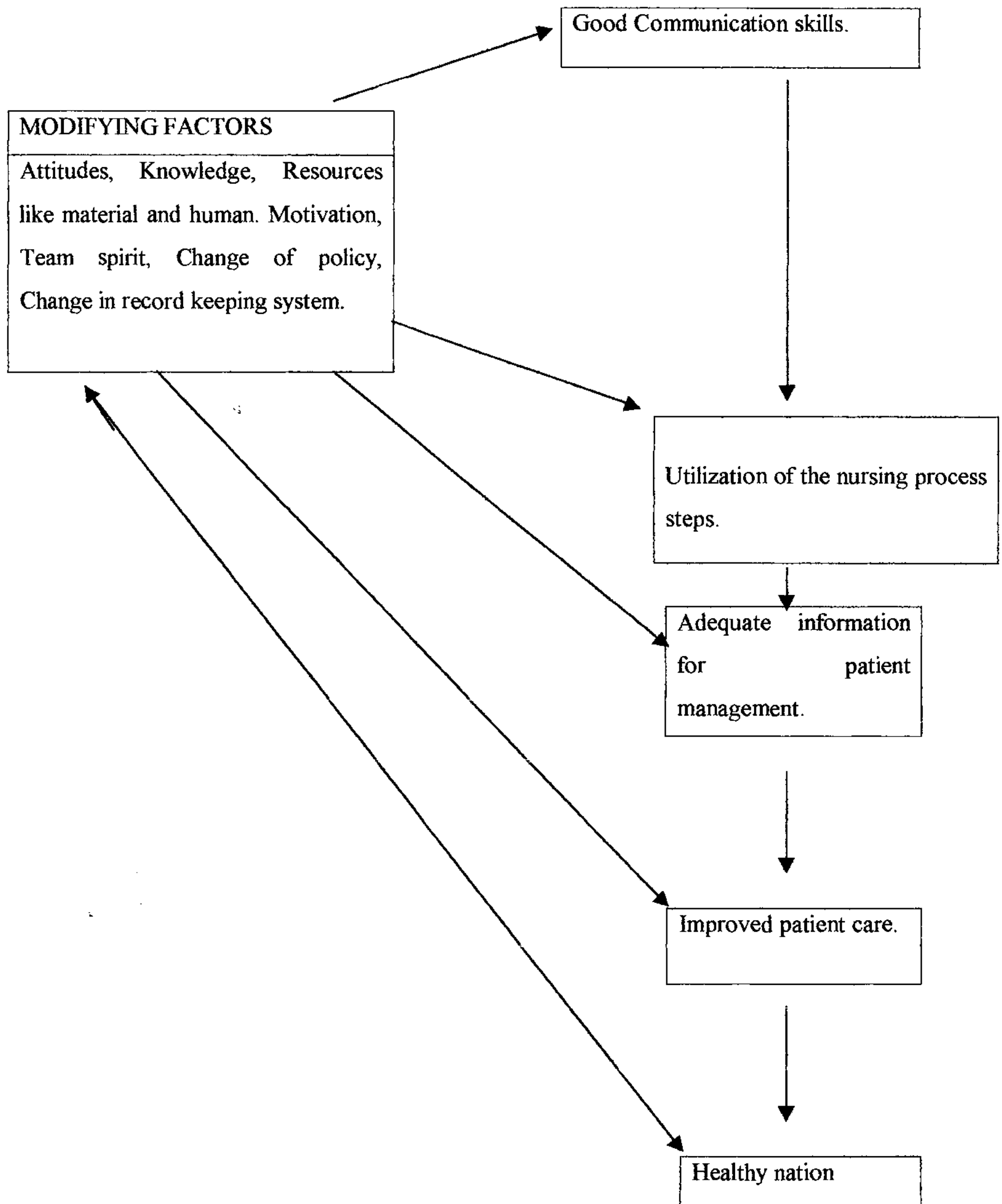
3.2 Relevance of Fischbach's Model to the Present Study

In the model, the concepts of communication, nursing process and nursing standards were adopted to develop a conceptual map suitable for the Malawi setting. A conceptual map is a diagram of the relationships among the variables under study (Chenitz and Swanson, 1989). The major purpose was to organise all information the researcher had about the study topic, to a clear statement of the relationship among the variables.

The modification factors of attitudes, knowledge, availability of resources, motivation, team spirit and change in record keeping had an impact on communication, nursing process and patient care. That is the factors can hinder or facilitate the implementation of nursing care. Good communication skills and documentation standards practiced by student nurses and nurse managers, researchers, educators and other health personnel utilising the nursing process will lead to adequate information necessary for patient management. Furthermore the use of adequate information will result in improved patient care.

This will reduce the medical care costs following re-admissions. Furthermore, lawsuits will be prevented because patients will have no complaints to take the doctors or nurses to court. The healthy personnel will make a productive nation and they will be recruited in the health institutions to be trained as doctors or nurses. These people will be responsible for providing medical and nursing care services to the entire nation. For a schematic diagram of the major concepts of the Fischbach's model (see figure 2 below).

Figure 2: Conceptual Map of Fischbach's Model of Documentation



Mwangala-Phiri (1999).

CHAPTER FOUR

METHODOLOGY

4.1 Study Design

The study was descriptive in nature, quantitative and qualitative research methods were utilized during data collection and analysis. The major purpose for using this design was to enhance the interpretability of the study results and to exert control on the external factors that could have affected the study results (Polit and Hungler 1989).

4.2 Sample and Setting

The study was conducted at Lilongwe Central Hospital in surgical units namely; 1A, 4A, 4B and Children's ward. The hospital was chosen for the study because it is a referral hospital for districts in the Central and Northern regions as a result it provides a wider population of surgical patients in need of good nursing care. The target population under study were nurses from the mentioned wards because they were the ones in close contact with the patients/clients and responsible for providing nursing care. The size of the sample was obtained by calculating 10 percent of the population and adding five extra as a rule for descriptive studies (Cantazaro 1988).Twenty Enrolled and Ten State Registered Nurses were the subjects of the study because they were a representative of the population under study. In the study accidental sampling technique was chosen because of its feasibility, practicality and relative inexpensiveness (Massey 1991). The weakness

of the sampling technique is that the subjects could have been atypical of the population with regards to the critical variables being measured (Polit and Hungler 1989).

4.3 Instrumentation and Data Collection

Through literature review the researcher identified concepts in the conceptual model, which were used in the development of the structured questionnaire and checklist(see appendix 1 and 2). Part of the structured questionnaire was adopted from the questionnaire utilized in a study on Infection prevention and control in nursing practice at Lilongwe Central Hospital. The tool was used to rectify or elaborate any difficulties encountered by the subjects in answering or filling the questionnaire. The tool also yields data for easy analysis using the computer (Polit and Hungler 1989). Furthermore, a checklist developed by the researcher was utilized to collect data from the records of January to February 1999. The checklist contained areas like communication skills, nursing process skills, styles of documentation in nursing and record keeping. The checklist was used to assess the documentation practices employed by the nurses at Lilongwe Central Hospital. Knowledge, skill and attitudes of the nurses towards the concept of documentation in nursing practice were also assessed utilising the same tools.

4.4 Validity and Reliability

To ensure reliability a pilot study was done before the main study from 2to 3 December 1999. Couchman (1991) defines a pilot study as a smaller version of

the proposed study, conducted to refine the methodology. Problems with the study design and data collection instruments were identified and resolved before the main study. On data collection days, consent was asked from individual nurses and they were requested to sign the consent form and then read and fill the structured questionnaire after explanations from the researcher for clarity of the expectations. Following this the respondents letters and questionnaires were distributed to the nurses who accepted participation in the study and agreed on the date and time to collect them. The checklist was utilized by the researcher to collect data.

4.5 Data Analysis

Data analysis was done manually and confirmed by using Statistical Package for the Social Sciences (SPSS). Open-ended questions were analyzed by Waltz et al (1991) content analysis methods and then categorised into common themes. Content analysis is a procedure for analysing written or verbal communication in a systematic and objective fashion with a goal of quantitatively measuring variables (Polit and Hungler 1991).

4.6 Ethical Considerations

A letter was written and forwarded to Ministry of Health and Population headquarters seeking consent to carry out the study. Permission was also sought from the Director of Lilongwe Central Hospital, attention the Principal Nursing Officer to conduct the pilot and main studies in their premises. Furthermore, the subjects to be included in the study were informed of the purpose of the study.

Thereafter they were requested to sign a letter of consent after reading through it. Anonymity of the subjects was maintained by using standardized structured questionnaires having code numbers. The subjects were informed not to use their names when filling the questionnaires. Confidentiality was maintained through out the data collection period by not allowing the subjects to confer when answering and filling the questionnaire. After data collection the questionnaires were kept in big envelops and accessible to the researcher and the supervisor only during data analysis.

4.7 Dissemination of the Results

After data analysis this report is written indicating the findings of the study. The copies of the report will be bound and one copy will be at Kamuzu College of Nursing library for students and public use. The second copy will be sent to Nkhata-bay District Hospital

Where the researcher works so that the other nurses could benefit from the study results. The results will also be presented at the in-service education at Lilongwe Central Hospital. One copy to the supervisor and one for the researcher.

4.8 Limitations of The Study

- Time was limited in such away that the study was done concurrently with other courses and on a specified time period.
- Sample size was small to generalise the findings.

- During data collection, nurses preferred to have the questionnaire administered by the researcher so this could have affected the results.
- The checklist proved a problem because it was difficult to analyse the information which was in the files to suit the stipulated criteria so the results could have been affected too.
- No studies pertaining to factors that contribute to poor documentation of nursing care were done in Malawi and outside countries so it was difficult to find literature during literature search.

CHAPTER FIVE

FINDINGS OF THE STUDY

5.1 Description of the Sample

Respondents were drawn from units of Children's ward (n=21, 70%), Male surgical (1A, n= 4,13.3%), Female surgical (4A, n = 2, 6.7%) and paying surgical (4B, n= 2, 6.7%). The respondents were nurses of three cadres; Technical Assistants (TA, n=15), Senior Technical Assistants (STA, n= 5) and Technical Officers (TO, n= 10). Their age ranged from 24-48 (TA's), 37-46 (STA's) and 22-42 (TO's). The findings further revealed that the five STA's did post basic courses, some combined community and psychiatry nursing. Only one respondent did a family planning course. This signified that the promotion of the nurses from TA to STA grade was based on merit. In the study nurses practiced nursing and midwifery for different lengths of time ranging from less than one year to over five years.

5.2 Training Institution and Knowledge of Documentation

The findings further revealed that 5 (16.7 %) of the respondents trained in the government, 12 (40 %) from CHAM and 10 (33.3 %) University had knowledge of documentation. At the same time 3 (10%) of the respondents from CHAM were not aware of the concept. Although the respondents indicated knowledge of documentation, there were mixed reactions on the definition of the concept. Fourteen (46.7 %) responded that, documentation meant putting down in writing

whatever was done on the patient at specified times. Seven (23.3 %) indicated putting down in writing whatever the nurse had done on the patient in the file, cardex and nursing chart. Furthermore, writing the findings or observations made on the patient meant documentation as indicated by five respondents (16.7 %). One (3.3%) mentioned of putting in writing all concerns and procedures done on the patient. In addition, three (10%) responded as recording and signing for all the nursing care done on the patient. The findings implied nurse's awareness of documentation though with different opinions. The findings further revealed that knowledge of documentation was not related to cadre (grade). The findings indicated that two out of the four respondents who had worked for four to five years had no knowledge of documentation, representing 6.7% of the sample. One (3.3%) respondent who had worked over five years did not know what documentation was. Furthermore, twelve (40 %) respondents who had worked for six months to one year documented their nursing interventions because their minds were still fresh and they were implementing what they leant at school but had different opinions on the documentation style used in the wards. Seven (23.3%) responded as using SOAP, three Narrative (10%), one Focus (3.3%) and one (3.3%) a combination of SOAP and Narrative styles of documentation. The findings revealed that the respondents had different backgrounds of nursing and midwifery education.

5.3 Nurse Patient Ratio

Table 1: Number of Nurses Against Number of Patients and Beds in the Units

Unit	Total Number of Nurses in the Unit	Total Number of Beds in the Unit	Total Number of Patients on Data Collection Day	Nurse Patient Ratio
Children's ward	39	217	684	1:18
Male surgical (1A)	8	60	97	1:12
Paying surgical (4B)	10	28	12	1:1
Female surgical (4A)	8	35	40	1:5
Total	65	261	876	-----

The nurse patient ratio in Children's ward and 1A was high in the ratio of 1:18 and 1:12 respectively. The wards were also congested in comparison to the number of patients and beds. The nurse patient ratio could even have been higher because the number of nurses on duty varied. Out of thirty-nine nurses, some were off duty, on sick leave, night duty and others on annual leave, as a result decreasing the number even more.

One to two nurses were on duty in ward 1A,4A and 4B while Children's ward had four to six nurses on duty during the data collection days. Paying surgical ward (4B), had twelve patients on the data collection day making a ratio of 1:1. In this ward, nurses documented their interventions utilizing the SOAP format. Guidelines for documentation were hanging on the wall an indication that documentation was emphasized. Nursing procedures were documented in the files. From this finding

one can conclude that number of patients contributed to nurse's documentation. Similarly, nurses in female surgical ward (4A) documented their interventions.

5.4 Documentation of Patient's Care Information

Table 2: Factors that Hinder Documentation of Nursing Care

Factors	Frequency	Rank
Shortage of nurses	17	1
Shortage of stationery	12	2
Increased number of patients	11	3
Lack of time to document nursing interventions	6	4
Lack of in-service education	5	5
Laziness	4	6
Lack/poor supervision and motivation from matrons and ward in-charges	4	7
Negligence	2	8

Table 2 indicates shortage of nurses (n=17) as ranking first indicating that it was the major factor contributing to lack of documentation of nursing care. Shortage of stationery (n=12) contributed too as ranked second. The increased number of patients was identified as another contributing factor to poor documentation (n=11). Furthermore, lack of time for documentation (n=60) was identified as a problem.

Time was related to number of nurses' and patients in the ward. Few numbers of nurses with few numbers of patients facilitated documentation. Increased number of patients provided an increased work load to the nurses as such they focused much attention on the provision of care and ignoring documentation of the care provided.

In addition, in-service education is essential for nurses to update their knowledge through sharing of current ideas and skills. Five respondents indicated lack of in-service education as a contributing factor to poor documentation habits. Laziness (n=4) on the other hand played a role on the provision of patient care. Lazy nurses failed to implement patient care and documentation inclusive. Laziness was brought about following demotivation, peer influence and personalities of the nurses who did not document. Supervision and support from ward in-charge/matrons acted a s a motivator to the nurses in the clinical area. Lack of support/supervision (n=4) contributed to poor documentation because the nurses felt isolated and not recognized for the good job done to the patients /clients. This demotivated and made them decline in the provision of care and in the long run the patients/clients suffered the consequences. Negligence (n=2) was also considered a contributing factor to poor nursing documentation. Negligence was related to the provision of care and documentation as part of it. The nurses who were negligent knew what they were supposed to do on the patient/clients and how effectively they could document the care they had provided on the patient but decided not to

do so. For this reason the other nurses on the shift had difficulties to follow patient care and evaluation for its effectiveness.

Table 3: Time for Documentation of Nursing Care (n= 30)

TIME OF DOCUMENTATION	NUMBER AND PERCENTAGE OF NURSES
Before the procedure	2 (6.7 %)
Soon after the procedure (5-30) minutes	22 (73.3 %)
After the procedure (A day or more)	5 (16.7 %)
Do not know	1 (3.3 %)
Total	100

On the time when documentation should take place nurses had different opinions, this indicated lack of knowledge on when the activity should take place if it was to serve the purpose of communication of care. Two (6.7 %) respondents indicated before the procedure, which was not ideal because assuming the nurses forgot what they were supposed to document pertaining to patient care then the patient could have suffered the consequences. Twenty- two (73.3%) indicated soon after the procedure (5-30 minutes) which was the ideal because the nurse could not have missed any information. Five (16.6 %) indicated after the procedure which was after a day or two, this was not serving the purpose of communicating patient care. One nurse indicated she did not know when to document a sign that she never documented.

Table 4: Reasons for Documentation

REASON	NUMBER OF NURSES	PERCENTAGE
Communication	18	60
Continuity of care/ Follow up of care/ Evaluation of patient's care	8	26.7
Record keeping	2	6.7
Baseline information	1	3.3
Total	30	100

All the respondents indicated that the patient's file was necessary for patient management in nursing though they had different views on the reasons. In the table above, 18 (60%) of the respondents indicated the patient's file was documented for the purpose of communicating information to other health care providers.

Eight (26.7 %) mentioned of continuity, follow up and evaluation of patient care because no information would be missed out on the patient's response to medical or nursing care. Record keeping as a reason for documentation was indicated by 2 (6.7%) of the respondents. One (3.3%) respondent mentioned of having base line information. This also helps in continuity of care and evaluation of the patient's outcome to medical and nursing care interventions.

5.5 The Nursing Process and Documentation

The nursing process as a core of the nursing practice was used by some of the nurses. The process as already indicated consists of subjective data, objective data,

Assessment implementation and evaluation. Twenty- seven (90%) respondents expressed knowledge of the nursing process. Sixteen of them (4.3%) out of the twenty- seven respondents indicated they used it in providing care to the patients. Three (10%) of the respondents indicated they had no knowledge of the nursing process. Surprisingly, out of the twenty-seven respondents, eleven (40.7 %) did not utilize it in the provision of care though they knew it. It was evident that though they knew the nursing process they had different answers as to what it was. Thirteen (50%) respondents expressed understanding of the nursing process as steps which nurses followed when dealing with patients from admission until discharge. Fourteen respondents (51.9 %) had different views of the nursing process. Two (14.3%) of the respondents who knew the process, labelled it as what nurses do when caring for a patient from time of admission. One (7.2 %) indicated it meant writing the nursing notes on each patient after management, which was confused with the definition of documentation. Seven (50%) indicated it was the arrangement of the nurse's work to be done on the patient. This was not clearly expressed because it could have meant assembling of the equipment for a nursing procedure. Two (14.3 %) indicated the skills nurses used for each patient according to his/her problems, giving appropriate treatment and assessing the condition for change of treatment or discharge as the nursing process. This was the ideal though the respondents gave the outcome of the process but still there was knowledge of the process.

One (7.2 %) respondent knew the nursing process as following of all the orders requested by the doctors, clinical officers and medical assistants and applying the proper nursing care suitable for the patient. This finding implied the nurses' subservient role to the other health care professionals.

The nurses who did not utilize the nursing process (n=11) in patient care management gave several reasons. One (9%) mentioned of lack of stationery for her to document. The respondent indicated that most of the time stationery was not available in the hospital/ward and if available it was provided in short supplies as a result she had no where to document. This finding was also related to the use of the care plans. Five (62.5%) mentioned of shortage of staff, meaning the number of patients against the number of nurses did not tally. This resulted in increased workload as a result the nurses had no time to document rather than providing the care in a haphazard way. Two (25 %) of the respondents, mentioned that documentation was time consuming as a result nurses were depriving the patients of the necessary care required. Lack of in-service education on the other hand contributed to poor documentation because through in-service education nurses updates their knowledge and make improvements on the skill during the delivery of patient/client care.

Utilising the checklist, files from the mentioned wards were assessed for the nurses' knowledge and documentation practices. Twenty files observed, out of one hundred and sixty- two files indicated the Subjective data of the nursing process

step. It was revealed that nurses transferred information from the clinical officers or doctors write up as their own. This also formed part of their subjective data on the SOAP format, which they had indicated that they use.

On Objective data, temperature was the most documented vital sign (n=128). Though temperature was valued as the most important vital sign to measure on the patient, it was not done on daily basis. For example in Children's ward there was a patient, involved in a road traffic accident, stayed in the ward for fourteen days but temperature was done once on admission day. Another patient stayed in the ward for seventeen days but temperature was done once. In addition, one patient stayed in the ward for ten days but it was done once.

This was a clear indication that not all nurses valued temperature checking and recording as very important for quality patient care. Ten files from 4A and 4B had the nursing interventions which were effectively documented, for example the patient's admission history and nurses observations only to list a few. Blood film results were recorded in twenty- nine files from Children's ward which facilitated the provision of patient care because the doctors and clinical officers had a chance to view the results and prescribe the right treatment for the patients on time and then preventing complications.

Furthermore, on Assessment step of the nursing process, 124 files in Children's ward indicated the date and nine files, time when assessment of the patient/client was done. In ward 1A, twenty- eight files indicated the date when the patient was

admitted. Two files out of twenty-eight had time when the patient's assessment was performed. This revealed that the files indicated baseline information for future reference and continuity of care.

On the Planning and Implementation steps of the nursing process, the findings revealed that no care plans were available in 1A and Children's wards indicating no planned care to patients. The effects of no patient care planning was that the care was provided haphazardly and at times important areas to cover on the patients care could have been missed out resulting in mismanagement. Sixty-two files out of one hundred and twenty- four from Children's ward had correct nursing observations done like checking of bleeding from an operated wound only to cite a few. Only three files from ward 1A out of 28 indicated this activity. Seven files from Children's ward indicated evaluation of patient's care while nil evident for ward 1A.

5.6 Facilitating Factors of Documentation as Perceived by the Nurses

Table 5: Facilitating Factors of Documentation

Factors	Frequency	Rank
Adequate nurses for the number of patients/clients	14	1
Adequate stationery	9	2
Handover through ward reports and doctors rounds	7	3
Patient's condition	6	4
Dedication/commitment	4	5
In-service education	4	6
Fear of supervisors/Law-suits	4	7
Supervision and motivation	2	8
Availability of time	2	9
Availability of space in the patient's file	1	10

All respondents answered the question though with different responses. Adequate nurse patient ratio (n=14) and enough stationery (n=8) ranked first and second respectively. However, respondents had other reasons which they perceived as facilitating documentation. Ward reports and doctors' rounds made nurses to document with an aim of having sequential information to communicate to fellow nurses on the other shifts. The patient's condition also facilitated documentation. The patient's who were critically ill had their files well documented following the nursing process steps to ensure continuity of care. Dedication/ commitment on the other hand facilitated documentation. This was related to the nurses, motivation towards their work. The nurses who are dedicated perform to their best capability

with the aim of ensuring quality nursing care to patients/ clients. Education through in-service education contributes to quality care, documentation inclusive.

CHAPTER SIX

DISCUSSION OF THE FINDINGS

6.1 Description of the Sample

In the study all TA's, STA's and ,TO's did a nursing course but out of five (TO's, n=4) and (TA, n=1) did not do a midwifery course but the reasons were not highlighted. However this had no bearing on the documentation practices. Furthermore, poor allocation of courses was evident in the findings. This could have contributed to nurse's demotivation then poor documentation practices if to compare the number of STA's and TO's who went for post basic courses. In addition, demotivation could also come in following too much workload and long hours of working in the wards. On the other hand nurses who attended post basic courses could have been exposed to the concept of documentation as such enabling them to do the act. Taulo (1995) agree with this finding that knowledge is a prerequisite for quality care.

6.1.1 Training Institution and Knowledge of Documentation

The findings revealed that documentation was taught in the nursing and midwifery schools under the government, CHAM and University but to what extent the respondents were exposed to the concept could not be discerned. Although the respondents indicated knowledge of documentation there were mixed reactions on the concept a sign that either they were confused or they did not know the meaning implying that it was

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KAMUZU COLLEGE OF NURSING
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not practiced. On the other hand it could be that the nurses forgot what they learnt at school.

Furthermore, in the study, work experience did not marry with knowledge of documentation. The trend of the results signified the extent of emphasis on the topic of documentation could have declined in the nursing schools because the less the years one had practiced nursing/ midwifery, the less the knowledge of documentation. In addition it could be that the nurses in the mentioned wards stopped documenting nursing interventions, so that the newly qualified nurses found the trend and followed suit.

On the documentation style used in the units nurse's had different styles signifying that there was no standard way of doing it a sign that each nurse was doing what she thought was right. The documentation styles highlighted in the findings are all allowed but the nurses using them need to weigh the advantages and disadvantages then choose the one they feel comfortable to use. Five nurses of TA and STA grades considered Narrative style of documentation as detailed and ideal. Barbara et al (1994) and Camp and Iyer (1995) disagree with the finding that narrative charting takes much of the nurses time . Hunt at al (1981) has a different view that nurses should be allowed to use the documentation style they are comfortable with because they went through different training institutions with different experiences.

6.1.2 Hindering Factors of Documentation

Nurse-Patient Ratio

The study revealed that nurse patient ratio was very high in Children's ward and 1A respectively. This detoured the care rendered to the patients and documentation inclusive. The nurse's in the two wards had too much workload. In table 2 shortage of nurses supported the finding for ineffective documentation of nursing interventions. Hunt et al (1981) reported that nurses have difficulty giving high priority to documentation of patient/client care because of shortage of nurses related to too many patients. Magai (1991) found a similar problem in the study of the role of the family in the care of their sick relatives in the hospital where the nurse patient ratio was 1:25-30. This was evident because of the acute shortage of nurses in the hospital especially TO's because of one training institution in the country. Namate (1985), Taulo (1995), Zulu and Chalanda (1999) also found shortage of nurses as inhibiting the quality of patient care, documentation inclusive. However, for the nurses to perform as required their was need for reasonable numbers of patients against nurses but nurses were few compared to patients. This enabled nurses to provide the care and not documenting because of time or exhaustion .

Shortage of Stationery

Twelve respondents indicated shortage of stationery as a factor for poor documentation. This finding disagrees partly with the findings on

communication skills as indicated through the nursing process. Utilising the checklist, nurses documented only the selected entities of the required information for example temperature yet stationery was available.

On the other hand, it could be true that stationery was a problem at times especially with the financial constraints that the hospitals were facing as it was observed by the writer the time she was practicing in the clinical area.

Lack of Time for Documentation

Six respondents identified lack of time as contributing to poor documentation Time was related to the nurse patient ratio. The increased number of patients in the ward made nurses to value delivery of care than documentation. Similarly Casey (1995), identified time as a reason why staff nurses neglected documentation of patient education. On the other hand, some nurses were unaccountable and irresponsible for the actions done on the patient though they had time to document. However, Carpenito (1991) and Davis et al (1994) supports the finding that documentation is time consuming therefore nurses should not document their actions done on the patients or clients.

In-Service Education

Lack of in-service education demotivated the respondents because their knowledge was not updated. Therefore, they could not suit the changing

environment and new trends in the nursing profession. In a study by Namate (1985) in-service education was identified as a contributing factor to the quality of nursing care. The findings revealed that if nurses were given a chance for continued education through in-service, documentation practices could have improved. Zulu and Chalanda (1999) supports this finding because knowledge is essential for nurses to provide their care effectively and be able to assess the patients condition for improvement or deterioration. Chinkhata (19990 further indicated that nurses need to keep up to date with current trends in the community by attending in-service education.

Laziness

The findings indicated that four respondents considered laziness as an inhibiting factor to quality patient/client care through documentation. In the study by Zulu and Chalanda (1999), a similar problem was identified as contributing to poor monitoring of nosocomial infections on the patients in the clinical area . Following the delivery of patient/client care nurses were supposed to document their interventions. Laziness is also related to lack of motivation following bad salaries and bad working environments. Mostly as it was observed by the writer the time she was working in the clinical area, nurses became lazy after peer influence and demotivation. The hard working nurses were influenced by what the other nurses perceived as

not necessary for patient care and in the long run lost the vigour to document.

Supervision and Motivation

Four respondents mentioned of lack of supervision and motivation from the matrons and ward sisters (TO's). Following poor supervision the nurses felt demotivated because they perceived it as lack of support from their superiors. Furthermore, following poor supervision nurses relaxed and had time to do what they perceived as right to them and then jeopardizing patients/clients care. Supervision on the other hand acted as a motivator to some nurses because during supervision problems with the nurses performance could have been identified and corrections made to ensure quality care.

In addition, through supervision the matrons/ward sisters could have identified the problems which the nurses were encountering in the delivery of patient care and then plan for in-service education to improve on the weaknesses. The matrons/sisters are also able to identify patients/clients problems requiring urgent attention and this could help them during budget formulation. Through experience supervision in the clinical area was inadequate because of few matrons and ward sisters. This resulted from high attrition rate to higher salary paying institutions. Furthermore,

supervision was inadequate because the supervisors were demotivated too, so it was difficult to influence change and motivate fellow staff members.

Negligence

Two respondents mentioned of negligence as contributing to poor quality patient/client care secondary to documentation. Negligence boils back to demotivation as already indicated.

6.1.3 Documentation of Nursing Interventions

On the reasons for documentation, the findings implied that nurses knew the sore purpose of documentation of nursing care done. The nurses who documented soon after the procedure knew what they were doing because they could not have missed out any information on what was done on the patient. The nurses who documented after the procedure were wrong because it meant after hours or days as a result forgetting what they did to the patient at the same time not communicating effectively to the other health personnel pertaining to the patient's condition. Documentation before the procedure was not ideal because the nurse could have forgotten to implement what was documented. Mandell (1994) disagrees with the practice of documenting before the procedure for the same reason.

6.1.4 The Nursing Process and Documentation

On the nursing process, the mixed responses which were given by the respondents implied that they were not sure of what the nursing process was. It also meant that they had forgotten or they had never used it during patient care because it was very difficult to forget what one was using. This implied that patient's care was not individualized. Cox et al (1993) supports the finding. Similarly in the study of Magai (1991), the documentation regarding assessment and care planning suggested that the nursing process was poorly understood and used by the nurses. No care plans were included in the patient's file a sign that they were not used. Davis et al (1994) found a similar problem in the evaluation of the nursing process documentation where 12 documents out of twenty only documented unplanned care. This disagrees with the finding of Namate (1985) where nurses documented nursing care plans in the ward where the study was conducted. The nursing process was necessary to be followed because it helps the nurse to clarify the overall needs of the patients. It allows the nurse to develop a plan of care using nursing diagnosis and interventions as a basis for care. The care plan also enables the nurse to recognise gaps in assessment, knowledge and his/her practical capabilities Boyle (1989).

Furthermore, through the nursing process, there is continuity of patient care (Charalambous (1992). This supports the finding which nurses

indicated as one of the reasons for documentation. Charalambous further states that the key to effective nursing care is accurately assessing a patient with the framework of the nursing process. Any documentation is good for true commitment to planned individualized nursing care. Six nurses from all the cadres in the study agree with this reason that commitment is one of the facilitating factors of documentation.

Furthermore, in the study 22 subjects indicated that they used the SOAP format of documentation which follows the nursing process steps in documenting patient care. On objective data, blood film results were recorded in 29 files in children's ward. Mandell (1994) supports the idea that if a laboratory finding is important to the doctor, report it in writing. Harters (1989) concurs with Mandell (1994) stating that it is also important to record the time when the laboratory test was performed. Martin (1994) supports the idea that documenting the correct time of the activities done on the patient is the best way to refute charges of malpractice.

In addition 128 files from children's ward and 20 from 1A had temperature documented in them. This was very important to detect problems and early signs of infection from the patients. Correct nursing observations like bleeding from the wound, patient's level of consciousness following anaesthesia were documented in 62 files from children's ward. Correct nursing observations helped the nurses to evaluate the patients response to

medical or nursing care. Chitsulo (1999) identified a similar finding in a study done at Lilongwe Central Hospital where the effects of long hours of night duty were considered in relation to patient care. Forty one of the respondents indicated that they documented nursing observations and patient's complaints.

6.1.5 Facilitating Factors of Documentation as Perceived by the Nurses

For effective documentation the nurses perceived the opposite of the hindering factors of documentation as essential. In addition, handover played a role for good documentation of the nursing interventions. Nurses could document to have information for handover to fellow nurses on the shifts. Fear of law-suits could make nurses document to have a record for future reference. Dedication and commitment are the major motivators for the nurses to document their activities done on the patients/clients.

6.1.6 Other Observations which were made on the Files

In the files it was revealed that patients' stayed in the wards for a range of 1-19 days in Children's ward, 2-56 days in 1A, 7-28 days in 4A and 5-15 days in 4B. This had a bearing on the care provided because nurses could have been tired of doing routine care and documentation inclusive. Nurses could have lost interest also because of the patients conditions which were not improving /terminal and perceived as not necessary to continue documentation in consideration to the scarce resources.

All files indicated that nurses administered medications to patients. This was essential because they were carrying their dependent role. Namate (1985) and Magai (1991) found a similar activity performed by nurses in the hospital. In 20 files, the patient's time of admission was not indicated. This was not considered as a very important activity to document but it was necessary for the purpose of knowing when the patient was admitted and drugs administered. Three files also indicated "no complaints raised patient had a fair night". This was not giving enough information to judge the patient's condition. There was need to explain more on what the meaning was to give a clue to the next nurse on duty know what the patient was like and the nursing care necessary for quick recovery from the illness.

Record keeping was considered a problem in 1A, 4A and Children's wards. Files were kept by the patients or guardians in case of the mentioned wards. This was necessary for easy access in case of urgent needs. It was also a bad system because confidentiality of the patient's information was not ensured if guardians and other visiting personnel wished to read what was in the file apart from the one caring for the patient.

6.2 Summary of the Findings

The subjects were drawn from surgical wards of Lilongwe Central Hospital. All the nurses did a nursing course but some combined it with a post basic course (s). Nurse patient ratio was the major contributing factor to poor documentation. Time when documentation was done contributed to poor documentation too. For documentation to be effective nurses had different opinions for example adequate stationery. The nursing process was poorly followed during documentation as such patient care was provided haphazardly by some nurses. In all documentation was performed at a minimal.

6.3 Conclusion of the Study

The study has revealed that documentation was not a new concept to nurses in 1A, 4A, 4B and Children's wards of Lilongwe Central Hospital. The word documentation was understood by nurses differently meaning that they lacked adequate knowledge of the concept. In the study, age and cadre did not affect the documentation practices of nurses. Nurse patient ratio was high in the wards and lack of stationery contributed to poor documentation too. Furthermore, length of stay in the unit did not warrant the nurses to know the documentation style in use. There were no standard documentation styles for nurses to follow in 1A, 4A and Children's wards. The study has also indicated that the nurses had inadequate knowledge of the nursing process. In addition, the study has revealed that nurses mostly did not function as independent individuals, able to make own professional judgements and decisions. The findings supports Fischbach's conceptual model

that nurses need to have communication, nursing process and documentation standards if they are to function effectively.

6.4 Implications of the Study

The findings of the study have implications to nurse Practitioners, Managers, Educators and Researchers.

6.4.1 Nurse Practitioners

The study has provided insight to the documentation practices employed by nurses in surgical wards of Lilongwe Central Hospital. The nurses have basic data for comparison following a change process on the documentation practices. In addition, critical and analytical thinking will be achieved during the delivery of patient/client care to ensure autonomy and independence.

6.4.2 Nursing Education

The study has identified a gap in the nursing education curriculum. This gap will be filled by ensuring that the component of documentation is well addressed in the curriculum. Nurse educators will put much emphasis during students teaching in the classroom and clinical area. In -service education will also be done and promoted to remind the nurses of the current issues and trends in the nursing profession, documentation inclusive.

6.4.3 Nursing Management

Nurse managers will be in a position to develop documentation standards and policies for nurses to follow during patient/client care. They will also ensure support, supervision and motivation of the nurses to facilitate the provision of quality patient care through documentation and the nursing process. Furthermore, the managers will provide adequate resources (material and human) necessary for patient/client care. A conducive working environment will also be ensured by good communication skills and the leadership styles practiced which allows free participation of the nurses.

6.4.4 Nursing Research

The study has identified shortfalls that need further research. Replication of the study in another setting can be the ideal utilising a qualitative design to explore on the attitudes and perceptions of the nurses towards the concept of documentation and the nursing process. The study can also be done on the doctors and clinical officers towards their role in nursing documentation to have an insight on the roles they have surrendered to the nurses which also have an impact to patient care and documentation.

6.5 Recommendations Of The Study

The recommendations imply to nursing practice, education, management and research.

6.5.1 Nursing Practice

- Enrolled nurses when on duty without the ward sisters, should be able to supervise the patient attendants to ensure that some basic nursing activities are done, like bed making.
- Matrons and sisters in-charge should see to it that stationery is ordered on time and provisions are made for times of crisis.
- Nurses should have an initiative to document their interventions in the patients' files.
- Nurses should ensure that the nursing process steps are followed in the provision of quality patient/client care for accountability and responsibility purposes.

6.5.2 Nursing Education

- There is need for refresher courses for the nurses to update their knowledge on documentation, the nursing process and other relevant courses to nursing related to the current trends in the profession.
- Matrons and wards in-charge should teach their subordinates to be assertive,

- autonomous and these components can be added to the nursing curricula of in-service education to help them stand up for their profession and do the right things for the patient's benefit.

6.5.3 Nursing Management

- Nurse managers in the hospital need to influence the government through Ministry of Health and Population to train and recruit more nurses to work in the government hospitals to improve the shortage which has a negative impact on quality patient care.
- Matrons and wards in-charge should encourage the existing nursing personnel to document nursing interventions done on the patients to prevent liability in case of a law-suit.
- Matrons together with wards in-charge should develop documentation standards and policies for the hospital and then educate the nurses on how to use them for easy evaluation.
- Matrons together with ward sisters and personnel from the Nurses and Midwives Council of Malawi should develop guidelines on the nursing standards in the hospital for nurses to follow and for easy evaluation of patient care.
- Supervision by the matrons and ward in-charges should be intensified to see to it that nurses are doing what they are supposed to.
- Matrons and wards in-charge should use appraisal forms to make sure nurses are providing quality care.

- Evaluation tools for the students at school and in the clinical area should have a component of documentation. If already existing, emphasize it more for the students to internalize it.

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Appendix 1

QUESTIONNAIRE.

CODE NO:

SECTION ONE: IDENTIFICATION AND BACKGROUND INFORMATION.

(Fill the blank space and tick the appropriate box).

(1.0.1) Hospital

(1.0.2) Date

(1.0.3)Unit

(1.0.4) Number of nurses in the unit

(1.0.5) Number of beds in the unit

(1.0.6) Number of patients in the unit on data collection day

(1.0.7) Age of respondent

(1.0.8)Position in the unit

(1.0.9) EDUCATIONAL QUALIFICATIONS.

(Tick the appropriate box)

(a) Junior certificate

(b) Malawi school certificate of education

(c) Diploma

(1.1.0) PROFESSIONAL QUALIFICATIONS

(Tick the appropriate box)

(a) Certificate in nursing

(b) Certificate in midwifery

(c) Diploma in nursing

(d) University certificate in midwifery

(e) Degree

(f)Others

(1.1.1) TRAINING INSTITUTION.

(Tick the appropriate box)

(a) Government ☐

(b) University ☐

(c) Christian Hospitals Association of Malawi (CHAM) ☐

(d) Others ☐

(1.1.2) YEAR OF QUALIFICATION.

(Tick the appropriate box)

(1) Nursing

(a) Between 1980-1990 ☐

(b) 1991-1998 ☐

(c) Before 1980 ☐

(2) Midwifery. ☐

(a) 1980-1990 ☐

(b) 1991-1998 ☐

c) Before 1980

(1.1.3) YEARS OF NURSING PRACTICE.

(Tick the appropriate box).

Between 1-2 years ☐

(a) 2-4 years ☐

(b) 4-5 years ☐

(c) Before years above ☐

LENGTH OF STAY IN THE UNIT.

Tick the appropriate box)

(a) Less than one month ☐

(b) Between 1-6 months ☐

(c) 6 months –1 year ☐

(d) Over one year ☐

SECTION TWO: DOCUMENTATION IN NURSING PRACTICE.

(2.00) Do you know the meaning of documentation or charting?

(Tick the appropriate box).

☐

(a)Yes

If yes, what is it? Explain in the space provided.

____

____

If no, go to question 2.0.1.

(2.0.1) The patient's medical record is a communication tool in nursing care.

(Tick the appropriate one).

(a)Yes ☐

(b)No ☐

(c) I do not know ☐

(0.2) Is it necessary to record all the information in the patient's file after assessment?

(Tick the appropriate box)

(a) Yes ☐

(b) No ☐

If yes, why is it necessary? Explain in two lines.

____

____.

If no go to question (2.0.3).

(2.0.3) Were you taught how to document in the patient's file at the nursing or midwifery school?

(Tick the appropriate box)

(a) Yes ☐

(b) No

(c) I have forgotten

If yes, how do you do it? Explain in two lines.

____

____

(2.0.4) When do you document/ record in the patient's file?

(Tick the appropriate box).

(a) Before the procedure ☐

☐

(b) During the procedure

(c) Soon after the procedure (5-30 minutes).

(d) After the procedure(a day or more)

(e) I do not know

(2.0.5) What documentation style are you using in the unit?

(Tick the appropriate box)

(a) Narrative

(b) Focus charting

(c) SOAP

(d) Others

(e) I do not know

(2.0.6) Why did you choose the documentation style you are using?

(Tick the appropriate box)

(a) Told by supervisors

(b) Routinely used

(c) Less time involved

(d) I do not know

(e) Other reasons (Indicate in the two lines provided).

____

____

(2.0.7) Do you know what the nursing process is?

(Tick the appropriate box)

(a) Yes

(b) No

If yes, explain briefly in two lines

____

____

(2.0.8) Do you follow the nursing process steps in the management of patient's in your unit?

(Tick the appropriate box)

(a) Yes

(b) No

(2.0.9) Do you have a written policy in your hospital or unit regarding documentation of nursing care?

(Tick the appropriate box)

(a) Yes

(b) No

(c) I do not know

(2.1.0) Are you familiar with the nursing standards as stipulated by the nurses and midwives council of Malawi pertaining to documentation of nursing interventions?

(a) Yes

(b) No

(2.1.1) Do you have written nursing care standards in your hospital or unit stipulated by the nurses and midwives council of Malawi to act as a guide in your profession?

(a) Yes

(b) No

(c) I do not know

If yes, are they followed? Explain briefly in two lines

(2.1.2) Do you have nursing care plans in your unit?

(Tick the appropriate box)

(a) Yes

(b) No

If yes do you use them?

(a) Yes

(b) No

If yes, how do you use them? Explain briefly in two lines.

____

____

If no, why do you not use them? Explain in two lines.

____

____.

(2.1.3) What do you think facilitates documentation of patients' information in your hospital or unit? List the factors in the space provided.

____

____

(2.1.4) What do you think hinders documentation of patient's information in your unit/hospital? List the factors in the space provided.

____

____

____

THANK YOU FOR TAKING YOUR TIME TO RESPOND TO THE QUESTIONS.

Appendix 2

CHECK LIST (Tally in the appropriate Column)

	Yes	**No**	**Not Applicable**	**Number of Days in the Hospital**	**Comments**
Appropriate Communication Skills indicated in the patient's file					
Name of the patient					
Date of admission					
Time of admission					
Age					
Address					
Religion					
Occupation					
Marital status					
Accurate diagnosis (relevant to the patients history)					

Hand writing readable					
Corrections made with one line and signed for					
Signed with (a) initials					
(b) full name					
(c) title					
(B) Nursing Process Skills Subjective data indicated					
Objective data (a) Blood pressure					
(b) Temperature					
(c) Pulse rate					

(d) Respirations (e) Laboratory tests (i) Haemoglobin					
(ii) Blood film					
(iii) Grouping and cross match					
(iv) Urinalysis					
Physical Assessment Findings					
Assessment data -time indicated					
Date of assessment indicated					
Correct medications given					
Correct nursing observations:					

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Other observations					
(C) Nursing Care Plan Available					
Implemented					
Updated					
Written in ink					
Individualized					
(D) Implementation of Nursing Care					
(E) Evaluation of Nursing Care					
(F) System of Documentation used in the Unit					
SOAP (IE) (					
Focus					

Narrative					
Charting By Exception					
Any other					
None (no documentation evident in the files)					
(G) Telephone Orders Timely written					
Date indicated					
Instructions given e.g results					
Caller name indicated					
To who information was given					
Information received documented					
Clarity of the information					
Signed for					
(H) Standards of Documentation					

(I) Storage Place of the Records In the office					
In the cardex					
Availability of stationery					

Appendix 3

University of Malawi,
Kamuzu College of Nursing,
Private Bag 1,
Lilongwe.

21st November 1999.

The Chairperson,
The Health Sciences Research Committee,
Ministry of Health and Population,
P.O Box, 30377,
Lilongwe 3.

Dear Sir or Madam,

RE: REQUEST FOR APPROVAL OF A RESEARCH PROPOSAL.

I am a second year mature entry student at the above-endorsed address. I am conducting this study for the partial fulfilment of a Bachelor of Science in Nursing at the above college. The study is on factors that contribute to poor documentation of nursing care in surgical units of Lilongwe Central Hospital, Malawi. The study proposed is to be conducted between 25 November to 18 December 1999 for the pilot and main study respectively. A request is put forth for review and approval of the research proposal. The study was conducted at Lilongwe Central Hospital, surgical wards of 1A and paediatric units. Thirty consenting nurse midwives will be the subjects. Fifteen Enrolled and five Registered nurses midwives will answer and fill the standardized questionnaire containing open and close ended questions. Observations will be done on the records from January to February 1999, utilizing the checklist.

You may contact me through the above college address or telephone number 721622 during school days and not holidays. The research proposal has been attached to this letter.

Thank you for your assistance. Looking forward to receiving your approval and undertaking the proposed research.

Yours Faithfully,

Maggie Mwangala-Phiri.
Dip. Nsg., UCM.

Kamuzu College of Nursing,
P/Bag, 1,
Lilongwe.
21st November 1999.

The Director,
Lilongwe Central Hospital,
P. O Box 149,
Lilongwe.

Att: The Principal Nursing Officer

Dear Sir or Madam,

RE: REQUEST FOR UTILIZATION OF LILONGWE CENTRAL HOSPITAL AS A SITE FOR A PILOT AND MAIN STUDIES.

I am a student pursuing a Bachelor of Science in Nursing course at the above-endorsed address.

I am planning to conduct a research study for my Degree in Nursing Education in your premises. The study is on factors that contribute to poor documentation of nursing care in surgical wards of Lilongwe central hospital. The hospital has been chosen for convenience in terms of affordability. I intend to carry out the pilot study on 25th to 28th November and main study between 6th to 18th December, 1999 in ward 1 A and paediatric wards utilizing the bays where surgical patients are kept.

The pilot study will be conducted in ward 1Awhere three Enrolled nurses and two state registered nurses will be asked to answer and fill the structured questionnaire. Observations will be made on the records for the month of January 1999 utilizing the checklist.

In the main study twenty nurses will be involved of two cadres. Fifteen Enrolled and five Registered nurse midwives will be requested to answer and fill a structured questionnaire after getting consent from them .No risk is attached to the study. The results of the study will be bound and copies will be put at Kamuzu College of Nursing library and Nkhatabay District Hospitals.

A letter and my proposal were posted to Ministry of Health and Population through my research supervisor. You may contact me through the stated address.
Thank you for your assistance in the issue.

Yours faithfully,
Maggie Mwangala-Phiri.
MRN/MRM.

Our Ref. No.:
Telephone No.: (265) 721 555
Telefax: (265) 721 018

Correspondence to be addressed to:
Senior Medical Superintendent

E-mail: lch@unima.wn.apc.org
Healthnet: me-kch@miw.healthnet.org

MINISTRY OF HEALTH AND POPULATION
LILONGWE CENTRAL HOSPITAL
P.O. BOX 149
LILONGWE
MALAWI

3rd December, 1999

Maggie Mwangala - Phiri
Kamuzu College of Nursing
Private Bag 1
LILONGWE

Dear Madam,

Re: LILONGWE CENTRAL HOSPITAL AS SITE FOR STUDY

Thank you for your application in which you requested to use Lilongwe Central Hospital as a site for your study. Permission has been granted.

Yours faithfully,

Fannie Kachale (Mrs.)
for: HOSPITAL DIRECTOR

Kamuzu College of Nursing,
P/Bag 1,
Lilongwe.

26th October 1999.

Through the Research Supervisor,
Mrs Patricia- Taulo,
Kamuzu College of Nursing,
P/ Bag 1,
Lilongwe.

To: Mr Mike Zulu,
Head of Basic Studies,
Kamuzu College of Nursing,
P/Bag 1,
Lilongwe.

Dear Sir,

REQUEST TO ADOPT PART OF YOUR QUESTIONNAIRE INFORMATION USED IN STUDY ON INFECTION PREVENTION AND CONTROL IN NURSING PRACTICE IN WARDS OF MALAWIAN HOSPITALS IN MY STUDY

I am a second year mature entry student in preparation to conduct a research study. The study is on Factors that contribute to poor documentation of nursing care in surgical units of Lilongwe Central Hospital. Part of page one information that was used to collect data in your study has been chosen to be used in my study. This is so because the information gathered tallies fully to what the researcher intends to find out. The study will start on 29th November 1999.

Looking forward to your considerable acceptance.

Yours Faithfully,

Maggie Mwangala-Phiri.
Dip Nsg, UCM.

To: Mrs Maggie Mwangala- Phiri.

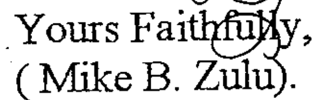
From: Head of Basic studies.

Date: 28th October, 1999.

Through: Mrs Patricia Taulo,
Research supervisor.

REQUEST TO USE PART OF THE QUESTIONNAIRE INFORMATION ON PAGE 1.

I would like to inform you that I have no reservations regarding the use of my questionnaire in your study.
I look forward to the outcome of your research project
I will give you all the support.



Yours Faithfully,
(Mike B. Zulu).