UNIVERSITY OF ALAWI

KAMUZU COLLEGE OF NURSING

RESEARCH PROPOSAL ON FACTORS AFFECTNG DOCUENTATION OF NURSING CARE PROVISION

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SUPERVISED BY

MR G MASACHE

DATE: JUNE 2009

Declaration

I here by declare that this proposal is the result of my work and effort.

Candidate:

Signature:..... Date: 12/06/09

Supervisor;

Signature: ..... Date:.....

DEDICATION

I dedicate this work to my parents, brothers and sisters for their encouragement support and prayers. May the Good Lord bless them.

ACKNOWLEDGEMENT

Firstly I thank the Almighty God for giving me life and wisdom up to date .

My heartfelt thanksgiving to my supervisor, Mr G Masache for the constructive comments and assistance throughout the writing of the proposal. I also acknowledge Mr Ngwale for the entire knowledge on research process and methodology and constructive critisisms during the development of the topic of study. I am not forgetting Mr Gondwe for his patience in his office.

ABSTRACT

Nursing documentation is a daily reality of nurses work .It is the evidence of nursing actions. However evidence in hospitals in Malawi has showed that nurses do not like to document their intervention or nursing actions done on the **patient**/client. This proposal is for a descriptive quantitative study aiming at finding factors that affect documentation of nursing care provision at Ntchisi District Hospital.

There is little literature of nursing documentation showing that .it is an area which has not been researched much both in Malawi and other countries. The study shall have a sample of twenty nurse midwife technicians and ten registered nurses drawn from Male, Female, Pediatric and Maternity wards at Ntchisi District Hospital. Convenience sampling will be used in getting nurse working in the mentioned wards.

A pilot study will be conducted to ensure validity and reliability of the questionnaire and the checklist developed by the researcher. The main study will be conducted between June and July 2009.A work plan will be formulated for the whole activity. Data for the study shall be collected from nurse who will be requested to answer and fill the structured questionnaire with open and close ended questions. Ethical consideration shall involve getting consent from those sampled before getting their views. Additional information on nursing documentation will be obtained from patients' files, utilizing the checklist.

Data analysis will be done manually and also using Epi Info 6. Results will be in frequency tables, percentages and ratios. Dissemination of results will be through report writing indicating findings of the study.

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CHAPTER ONE

INTRODUCTION

(The study will be on factors that affect documentation of nursing care provision.

Nursing is dedicated to the diagnosis and treatment of the client problem that may arise as a result of an illness (Hickey P. W. 1990). Access to high quality information is a prerequisite of good nursing care. The principal source of information for nursing care include nursing notes nursing care plans and nursing records system (Bjorvell et.al 2000, Ammewerth et. al 2003) cited in Journal of Advanced Nursing 2009 .

Documentation is any written or electronically generated information about a
Patient / client that describes care or service provided to the patient (
/ The common documentation styles that can be used in hospitals include the following;

- Narrative charting; this is the recording of relevant nursing interventions and response or lack of response to nursing or medical interventions.
- Problem oriented charting; this focuses on documenting all identified problems of the patient.
- Focus charting is when narrative notes are organized to include Data, Action and Response for each identified problem.
- And Charting by exception is the method of documenting finding that fall outside the standard of care and norms that have been developed at the institution.

For nursing care to be known or appreciated by other people (professionals), documentation plays a major role. However there are documentation challenges faced in provision of nursing care. Such challenges are:
increased rates of complications, ruptured uterus and deaths.
Patients/clients getting fragmented care
No continuity of patient or client care
Increased legal issues where nurses or institution is liable to pay for their misconduct.

Purposes of Documentation

Nursing documentation serves many purposes in nursing practice. Some of the purposes are listed below:

- Documentation facilitates the communication in nursing profession by increasing the likelihood that patient/client will receive consistent and informed care or services.
- Special occurrence like potential for miscommunication and errors are decreased through nursing documentation.
- Documentation is essential for promoting good nursing care by encouraging nurse Midwives to assess clients' progress and determine which interventions are effective and which are not and to identify changes to the plan of care as needed.
- Nursing documentation provides source of valuable data for making decisions about funding and resources management as well as facilitating nursing research,

all which have the potential to improve the quality of nursing care practice and client care.

- Documentation can be used as the legal record which can be used as evidence in legal proceedings such as lawsuits, disciplinary hearings through the regulatory bodies.
- Furthermore documentation serve the purpose of communicating necessary information regarding patient care provided resulting in continuity of care.
- In nursing documentation is vital in obtaining reimbursement from government and insurance companies following injury or disability which directly depends on what is recorded in the patient file.
- Individual nurses can use the outcome information from crucial incidents to reflect on their practice and make needed changes based on evidence.

1.1 BACKGROUND OF THE STUDY

Documentation is not a new concept in the nursing profession. According to (Camp & Iyer 1995) documentation started during the time of Florence Nightingale who is viewed as the founder and originator or nursing.

During Nightingale's Era

In Nightingales era, emphasis was on the need to document environment and nutritional needs for the patients. Documentation was vied as the core of the nursing profession with the aim of collecting, storing and retrieving data necessary to manage patients care intelligently.

During the Twentieth Century

Physicians taught nurses how to carry out medical orders and keep records. At that time documentation was viewed as a means of communication between the physicians and the nurses. In 1928 problems of ambiguity and incompleteness were common in the nurse's records and pattern of recording patient's information changed resulting in minimal recording. During 1930 another theorist Virginia Henderson promoted the idea of writing care plans to communicate patient/client care information.

Nursing intervention and observations done on the patient were included in the records in the 1940s.This was done in a simple manner to prevent liability in case of a lawsuit. Charting of the patient's response to actual nursing intervention was indicated in the records in 1950's.This time 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 files. Some of the tools that were used in recording the patient's information were flow sheets., checklists and care plans. Accountability of the nurses was emphasized much in the 1970s.Accurate and timely recording of both initial and continuous assessment was the focus of recording. In addition patient care plans and documentation of nurse's activities was done.

Currently (Twenty First Century)
Nowadays documentation is emphasized prevent complications which arise due to inadequate documentation since there is no continuity of nursing care. It is also emphasized because of increased lawsuits, which is making nurses liable due to malpractice.

1.2. STATEMENT OF THE PROBLEM

Lack of adequate documentation in provision of nursing care is contributing to poor clinical indicators such as high maternal and child morbidity and mortality. This is seen during maternal audits, where it is discovered that some women ended up rupturing uteruses, losing life and having fresh stillbirths due to inadequate monitoring, poor or no recording of labor progress and featal conditions.

1.3. SIGNIFICANCE OF THE STUDY

The findings of the study are of significance to the nurse practitioners, managers, educators and researchers. Documentation is a complex activity that is demanding, challenges beginners and experts in the nursing profession and it requires skilful writing habits, which contributed to accurate and complete recording. Clear, concise and consistent expression of ideas avoids chatting problems. Skilful writing habits enhance confidence and reduce stress that might be associated with documentation. The significance of the study to the:

(a) Nurse Practitioner
The findings will help her gain insight to factors that effect quality patient care through documentation.
The nurse practitioner will be in a position to identify their strengths and weaknesses and improve where necessary.

(b) Nurse Manager
The nurse manager will be able to identify the factors that affect patient care and make policies and standard guidelines of documentation for nurses to follow.

The nurse manager will be in a position to validate data about funding and resource management.

(c) Nurse Educator
The nurse educator will understand the need for emphasizing the component of documentation in the nursing curriculum for students.
Students in clinical areas will participate in several activities, therefore through documentation they will gain a comprehensive picture of patients conditions related to 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 evaluations of patient care.

(d) Nurse Researcher
Will use clients' records to gather data for study to determine the significant similarities to disease presentation, to identify contributing factors and to determine effectiveness of therapies.
In addition the information in the files will help the researchers to conduct research with the aim to design and plan effective preventing strategies and improve patient care.

1.4. PURPOSE OF THE STUDY

The purpose of the study is to examine factors that affect documentation of nursing care provision at Ntchisi District Hospital.

1.5. SPECIFIC OBJECTIVES OF THE STUDY

(a) To assess nurse midwives knowledge on the importance of documentation.

(b) To identify hindrances to documentation by nurse midwives.

(c) To identify ways of improving documentation of nursing care.

(d) To find out reasons for lack of adequate documentation in provision of nursing care.

CHAPTER TWO

LITERATURE REVIEW

Literature review is the summary of theoretical and empirical sources to generate a picture of what is known and not known about a particular problem (Burns & Grove 2003). It is done to know what other people have done already on the study to avoid repetition.

2.1. Documentation in Nursing

Most hospitals and other agencies have not seriously examined what actually is required to be documented. Many nurses have been taught to write as much as possible Carpenito, L. J. 1991).

Nurses operate under the philosophy, "If it was not charted it was not done" The result of this mindset was narrative charting which is related to all things the nurses had done on the patient. Green (2004) concurred with Carpenito (1991) stating that reservenursing procedures or treatment even if considered routine are assumed not done if they are undocumented.

Nurses need to document nursing care following standard skills. (Craven R. 2009) defined standard as a measure to which similar activities/items should conform. The standards are found in nursing practice act, nursing school hospitals and unit policies. This includes using approved abbreviations, signatures, method of error collection and writing of incidental reports.

Documenting refers to the ongoing communication of written information among all members of health care team with the aim of maintaining a continuous account of events over a period of time. It can also mean preparation and maintenance of account for sometime. Writing the patient assessment, findings, plan implementation and evaluation of response to care in the record is what is referred to as documentation.

The words documenting, charting, recording and record keeping are used interchangeably but they have different meanings.

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.

A record is an account in writing a temporary or permanent form, and serves as evidence of an action, statement of transaction or proceedings. It can give information regarding facts and events preserved and handed down.

Nurses' notes form part of the document; they are units of writing recorded by nurses in the patient record such as progress notes and the nurses' care plan. The notes vary in length and format. The nurses' notes include the patient medical history, nursing diagnosis care plans, nursing actions and patient care outcomes.

2.2. STUDIES DONE IN OTHER COUNTRIES

Time for Documentation

Lacks of ethical, legal, medical and institutional guidelines have influenced poor nursing records. Nursing documentation is varied, complex and time consuming (Carpenito L. J. 1991). However the nurses spend most time in repetitive, duplicative charting of routine care and observation as a result. Often specific significant observations are not recorded because of time constraints. The tradition of oral knowing has grown in value for nurses and other health professional, thus physicians rely on oral communication with nurses to acquire information about client satisfaction (Carpenito L.J. 1991) Dissatisfaction with documenting nursing care has encouraged nurses to value oral communication during handover and undervalue written words. Lack of power which has an effect on the operation of social relationships between groups and individuals has contributed to poor documentation. Power is something that is exercised rather than possessed and produces pleasure and form of knowledge. Poor documentation of all nursing observations and actions done on a patient contributed to fragmented care (Potter & Perry).That is the record does not easily show how information from various care disciplines is related or how care is coordinated to meet all the clients' needs. Resistance to change has also contributed to poor quality of documented information (Camp & Iyer 1995) .For example changing of documentation form should complement the existing expectation of care, reduce duplication of information. Camp and Iyer (1995) on their book indicated that increased demand of quality patients care and nurses shortage have decreased the amount of time available for documentation.

Carpenito (1991) indicated that nurses spend 35 to 140 minutes per shift documenting activities done to patients, nurses feel tired and frustrated at the end of the shift. The writer commented that despite the work done by nurses, the profession exposes total commitment to the welfare of the patient and family by requesting nurses to continue despite the problems faced. This frustrates nurses. Camp & Iyer concurred with Carpenito that currently nurses spend 15 percent of their time documenting nursing care activities. Camp and Iyer (1995) indicated that what is documented reflects the character, competence and caring of the nurse. Although documentation is a primary and essential professional responsibility in nursing not all nurses value it and adhere to documentation standards. In other words the nurses see reward for documenting well or consequences of documenting poorly.

Quality of Documentation

Journalists, Buresh and Gordon (2006) stated that most nurses undervalue themselves due to the fact that they do not like to take credit for the important role they play cited in Nursing for Women Health Journal of 2008.Traditionally nurses allow their work to remain in the backgrounds of quality supporting the medical records of patient care. Consequences of downplaying the contribution of nursing to patient care means that nurses' work is not noticed as a distinct role of nursing is underestimated, undervalued and at risk due to lack of adequate documentation.

Saranto K and Kinnunem U. M (2009) conducted a survey on evaluation of nursing documentation at Kuipio University Finland. The findings were that the quality of nursing documentation was rather poor and the poor recordings were reflected in the nursing outcomes. They further underlined the importance of evaluating the comprehensiveness of documentation and of using the results of evaluation to provide effectiveness of quality and cost of the nursing care and resources allocation. Saranto and Kinnunem further stated that evaluation inform change and generate management recommendations which improve both the validity patient records data, to promote better patient care decisions.

Mbabazi P. C. (2006) conducted a related study at Kigali Hospital in Rwanda. The purpose of the study was to evaluate the quality of nursing care documentation of hospitalized patients and its effectiveness. The researcher indicated that nurses focused ore on medical prescription charts than on nursing care plans. He also indicated that large percentage of patients' vital signs, pupil reaction, skin color and mental status were not taken on admission. As one reason of documentation is for recording purposes it was found that under half of the records were kept in permanent form. In the study documentation was viewed as a daily reality of nurses' work. Mbabazi (2006) further indicated that despite large numbers of emergency cases admitted in the hospital, nurses were able to document basic needs within 24 hours of admission to the hospital. The data showed that there was no effectiveness of patient document since they were neither properly documented nor completely utilized (http://www.sabnet,co,29).

Completeness of Charting

Patient information system is a highly efficient system for creating, publishing, managing and auditing locally produced patient information. It is designed to serve time and money. Douglas G. P.et. al stated that patient management information system utilizes the computer for data entry to enhance patient care. Before using (PMIS) at Lilongwe Central Hospital review on patients charts revealed problems in ordering medication and laboratory investigation. Substantive numbers of dosage calculation errors were present when nurses were transcribing orders from chart of the patient to treatment sheet. Additionally incomplete and illegible documentation accompany specimen to laboratory often resulting in delay in results and unnecessary repeating of orders. Computer Based (PMIS) deployed in wards at Kamuzu Central Hospital wards facilitate admission process, placing orders whereby the hospital formulary and pediatric dose rules based on weight are integrated in the patient management information system soft ware. This has re reduced errors in medication calculations made by clinicians and eliminate request for nurses to transcribe orders. In laboratory has significantly improved the completeness and legibility of documentation accompanying specimen to laboratory.

Charting in advance nursing actions to serve time was also identified as a problem (Guido G. W. 2006). Her study revealed that charting should be done soon after the procedure. She also indicated the problem of early charting, like patient not tolerating the procedure as indicated, or another patient ay require urgent attention and the already charted procedure remains incomplete.

Documentation and Legal Issues

Literature revealed that nursing and medical records play an important role in the outcome of legal proceedings such as personal-injury actions, wrongful death. Failure to record essential information occasionally can have catastrophic consequences. BERNZWEIG E. P. (1998) explained a case of a patient who underwent uncomplicated hysterectomy (surgical removal of the uterus). The patient was placed on Bed B in a room of two patients and the other was on Bed A. The following morning the patient on Bed A was moved to another location but the nurse failed to write in the file. Later on an orderly seeking Bed A patient came to the room and informed the patient on Bed B of his intention to take her to ultrasound laboratory testing. Despite her repeated protests that she has just come from surgery, was told not to move without directions and knew no scheduled test, the orderly persisted, without checking the patient's identity with the nursing staff. She was placed on a wheelchair and taken in excruciating pain to laboratory where after continued remonstrations the laboratory personnel determined the true identity. Even then the laboratory personnel failed to notify the patient's attending nurse of the errors made. Shortly after discharge from the hospital the patient suffered incision dehiscence and hernia necessitating further surgery .A malpractice suit was filed against the hospital and the nurse. The jury awarded the patient 100 000 dollars in actual (compensatory) damage and 10 million dollars in punitive damage based on callous indifferences of hospital employees, lackadaisical attitudes toward patient identification and the described reckless and wanton disregard of patient's rights. Apart from showing simple humanity towards a patient in obvious emotional and physical distress, prompt and accurate charting could have provided a main value of defense to the nurse and hospital and the patient would have been prevented from the entire incidence of injury.

In addition Fiesta J.J .D. (1994) identified problems related to documentation such as failure of nurses to document significant information provided to physicians and omission of significant information. He further indicated that failure to document expose nurses to liability as nurses notes are important documents, they literally and figuratively stand out like a red flag.

A publication in the Legal Eagle Eye Newsletter for the Nursing Profession (2007) stated that extravasations: hospital pays settlement for poor nursing documentation. A one month old preterm infant was in the hospital's neonatal unit. She has fluid infusion through an intravenous set on her right calf. The nurse came on duty at midnight. Her first progress notes mentioned that all was well with the intravenous set. The nurse wrote another progress note at 1.00 am which mentioned nothing about the IV site. At 2.30 am the nurse found the IV site swollen and discolored from infiltration of fluid into the surrounding tissue. The nurse stopped the IV, but not before a permanent residual cosmetic deformity was created on the baby's right lower leg .The hospital lawyer offered a 650 000 pounds settlement right before the case was to go for trial in the New York court of Claims, and the parents accepted. The parent's lawyers were prepared to point a finger of blame at the fact that there was no nursing notes to prove that the IV site was checked every thirty minutes per hospital policy or at least every hour as the experts were going to testify is the national standard of care, notwithstanding the fact that nurses

initials were marked for the IV every 30 minutes on the ICU nursing flow chart. There was a two and half hours gap in the nursing progress notes while the patient's IV fluids extravagated. The site should have been checked perhaps actually was checked every 30 minutes, but the proof, it was checked was spotty at best.

2.3. STUDIES DONE IN MALAWI RELATED TO DOCUMENTATION

Hiwa .L.C. (2001) conducted a study on the perceptions of student Nurse Midwives Technicians on the factors that contributed to poor use of problem oriented documentation of nursing care at Mulanje College of Nursing, where ten nurse midwife technicians were sampled. The findings indicated that the students had inadequate knowledge on SOAPIER format as the method of documentation and how it is related to the nursing process. They had no knowledge at all on other styles of documentation. This could be a reason why they seem not to be aware that SOAPIER is seen to be superior to other styles. Te students lack role models and the situation is made worse by shortage of staff.

Chitsulo, C. (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 records. The most reported type of records was the nursing observations and patient complaints, which was reported by 41.1%. Forty one of the respondents recorded intake and output, vital signs and doctor's prescriptions.

2.4. DOCUMENTATION STYLES IN PRACTICE

There are many methods of recording nursing care, which have evolved over the years (Camp & Iyer 1995). The choice of documentation styles in practice depend on time availability, patient condition and availability of re sources like nurses and stationery and also institutional setting. The most familiar and commonly preferred method is Narrative Charting. Craven .R. (2009) defined it as the method of recording relevant nursing interventions and the response or lack of response to nursing or medical care. Furthermore this style, most nurse midwives learn it from, therefore it is the second nature to charting narratively. On the other hand problem oriented charting focus all documentation on the patient identified problems. Nurse midwives use subjective data, objective data, assessment, planning, interventions and evaluation (SOAPIE) .Subjective data is the information given by the patient, guardian, or family members to the nurse about what the patient expresses. Objective data is what the nurse finds out from observations, physical examination and laboratory investigations. Assessment is when the nurse analyses the data from subjective and objective portions and make a nursing diagnosis.

Planning includes what the nurse intends to do. Interventions are the specified actions taken on specified diagnosis. And lastly evaluation includes patient responses to nursing midwifery interventions.

In focus charting the narrative notes are organized to include Data Action and Response for each identified problems (Craven, R. 2009). Data stands for subjective and objective data relating to the patients problem. Actions are nursing interventions and responses or outcomes of nursing interventions related to the patient's response to care.

Furthermore charting by exception (CBE) is a method in which the nurses document only findings that fall outside the standard of care and norms that have been developed at the institution (Craven. 2009).The system aim at developing clinical standards that describe acceptable norms. For example, the nurses' assessment of the patient respiratory status provides information on the rate, bilateral breath sounds and breathing pattern. The information from this assessment falls within the acceptable norms; therefore all that will normally be necessary for charting by exception entry is a check mark and the nurse's signature or initials.

The other style of documentation is PIE charting (Problem Intervention and Evaluation). This method incorporates the plan of care into progress notes (Craven. R. 2009). During each shift, each nursing diagnosis is documented and entered by using PIE charting. This method increases efficiency and flexibility.

2.5. DOCUMENTATION GUIDELINES FOR QUALITY ASSURANCE

Kozier & Erbs (2008) defined quality assurance as an ongoing, systematic process designed to evaluate and promote excellence in health care provided to patient/clients. Craven .R. (2009) also stated that all entries should be legible and easy to read to prevent interpretation errors. Furthermore all entries on the patient record to be in ink for permanence and identification of changes. Documentation should be done as soon as possible after assessment or intervention. No recording before providing nursing care. This helps to avoid forgetting, omitting or entering inaccurate data leaving important data out. Refer to institutional policies about frequency of documentation and adhere to that as client condition indicates. For example a client whose blood pressure is changing requires more frequent documentation than a client. Document the date and time of each recording. This is essential not only for legal reasons but also for client safety. If possible record the events in order in which they occur (sequence) i.e. according to assessment. This provides support to demonstrate that appropriate responses were identified and reported. Each recording on the nursing notes should bear a signature of a nurse making it, this include the name and the title. Basing on the above stated points, accurate, complete documentation provide proof of the quality of care given to the patient.

2.6. THE NURSING PROCESS AND DOCUMENTATION

Kozier & Erbs (2008) pg 167 defined nursing process as a systematic, rational method of planning and providing individualized nursing care. Hall originated the nursing process in 1955 and Johnson (1959), Orlando (1961) and Wiedenbach (1963) were among the first people to use the nursing process and to refer to the series of phases describing the practice of nursing. The main purpose of nursing process to identify a client's health status, actual and potential health care problems and needs, to establish plans to meet the

identified needs to deliver specific nursing interventions to meet those needs. The client may be an individualized family or a group (Kozier & Erbs 2008).

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 revealed over a period of time that the patient and the nurse have a professional relationship.

The process comprises of; Assessment, the systemic and continuous collection and organization, validation and documentation of data. Diagnosis, this is the interpretation of assessment data and identifying client strength and problems. It is a pivotal step in nursing process. Planning is a deliberate systematic phase which involves decision making and problem solving, formulating client goals and designing nursing interventions required to prevent, reduce or eliminate clients' health problems. Implementation is the performance of all nursing interventions for a specific problem. Lastly evaluation is to judge or to appraise. This is a planned ongoing purposeful activity in which clients and the health care professionals determine the client progress towards achievement of goals.

Documentation of nursing care follow the indicated 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 nursing process nurses will have nothing to document, as such care of patients will not be revealed to other healthcare 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. Lastly nursing care is related to documentation and the nursing process because what nurses document in the file is what he or she has done to the patient /client.

2.7. SUMMARY OF LITERATURE REVIEW

Time for documentation:
Literature review shows that nurses spent much time on repetitive documentation of activities done on patients. This results in not documenting significant observations due to time constraints.

Quality of documentation
Quality of documentation remained poor such that it was reflected in nursing outcomes, for example increased complications. In addition it also showed that nurses' work was not recognized or noticed because nurses' support medical records of patient care.
Completeness of charting:

Literature also revealed that documentation to be done soon after completing the procedure not before. Early charting leads to incomplete procedures if there is another patient requiring urgent attention.

Documentation and legal issues:
Literature shows that inadequate documentation makes the nurse liable as well as the institution due to consequences which arise.

CHAPTER THREE

CONCEPTUAL MODEL

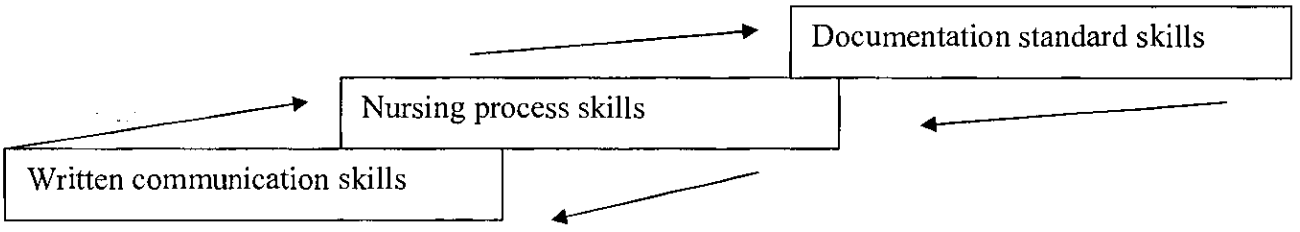
Conceptual model provides a coherent, unified and orderly way of envisioning related events relevant to the discipline, Fawcett, (2005) http/w.w.w.Pubmed central, h gov./. The conceptual model utilized in this study will be that of Fischbach (1991). It is called FISCHBACH'S CONCEPTUAL MODEL FOR DOCUMENTATION (1991)–The model was developed from three major concepts which are:

(a) Written communication skills
(b) Nursing process communication skills
(c)Documentation standard skills

The concept was chosen because the key concepts utilized will match fully with this study on factors that affect documentation of nursing care provision.at Ntchisi District Hospital.....

Communication is the process of exchanging information, feelings between two or more people and is a basic component in human relationships including nursing (Kozier &Erbs 2008). Communication is essential in nursing care and can be verbal, non verbal or written. The model will explain how best the nurse can communicate through writing in the patient's file. In addition the nursing process, documentation skills will explain how nurses can communicate in a written form, utilizing steps of the nursing process. Furthermore documentation standard skills will focus on the quality and quantity of documentation that is considered adequate for a particular situation. Through literature review, this is the only model identified for documentation. Fischbach (1991) stated that the concept 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 processes where by nurses send and receive information necessary for patient management. The nurses require 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 records convey clear and understood information. It indicates what has been done to the patients and the gaps to be filled by others. Furthermore written documents indicate riles the nurses can perform on their own and in collaboration with others thus independent and interdependent roles respectively. For example wound dressing and administration of drugs. The roles will be evident in the interventions done and recorded in the file. Accurate data from patients' assessment as indicated in the records signifies good communication skills. The nurses' creativity is reflected in the written records through the development and implementation of care plans. The good written records with the nurses' skills will reflect patient past health problems, 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 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 steps of assessment, nursing diagnosis, planning, implementation and evaluation (Kozier & Erbs 200). Skills in recording the nursing process require the nurse to follow the stated five steps when documenting the interventions done on the patient. The process helps to make appropriate judgments in the delivery of patient care. Data are collected and recorded in the patient's file following the five steps. Recording of the patient's information is done on specific time periods, but the nurse is not restricted to document at certain interval when need arises (Cravvn.R.2009).

The nurses make the diagnosis 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 patient 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 identified when the data are collected and written in the file in a systematic way.

(c) Documentation Standard Skills

A standard is a measure to which a similar activities/items should conform (Craven. 2009).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 the institutional policies, that is approved abbreviations, signatures, methods of error collection and writing of incidental reports. 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 patient on time.

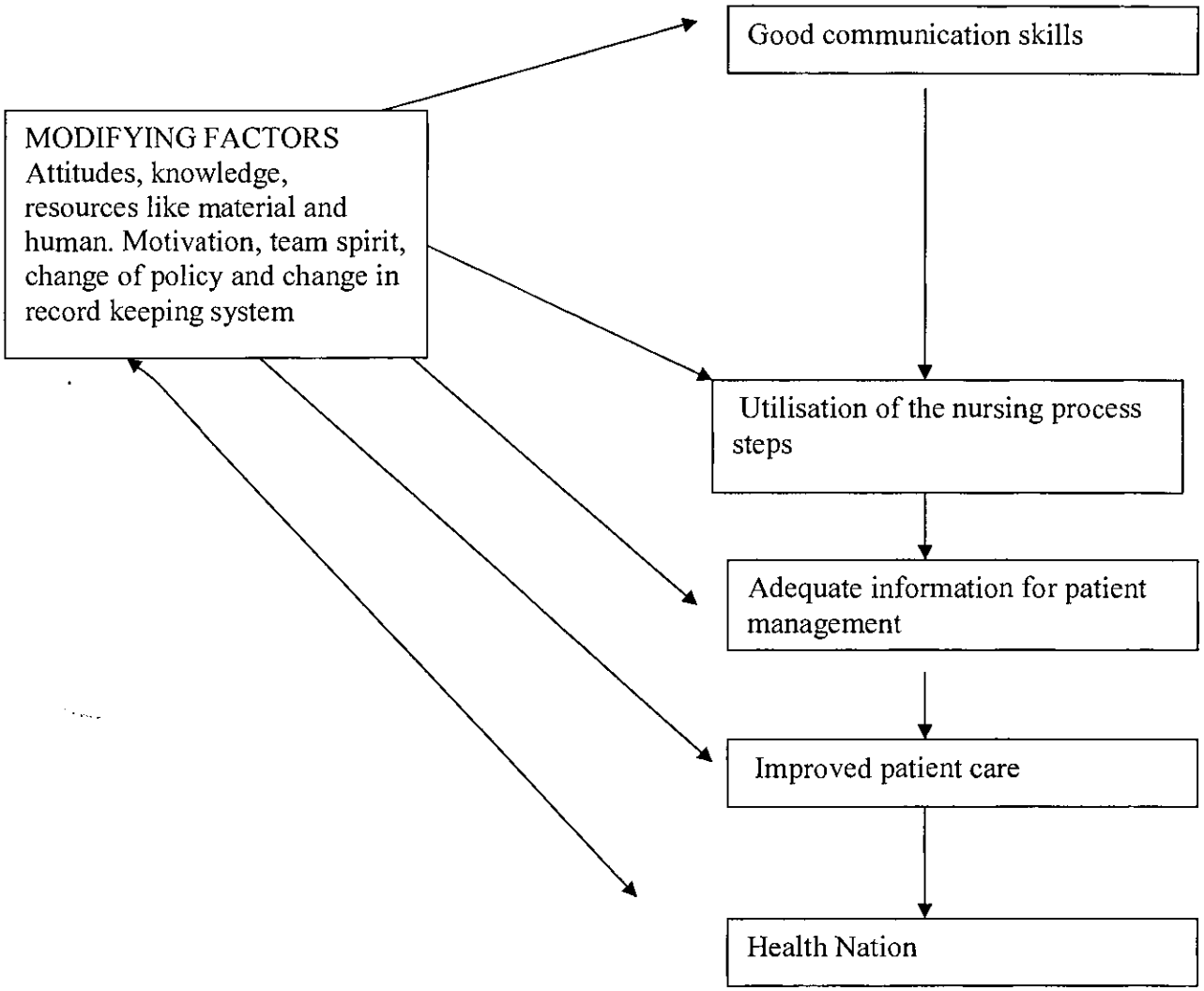
3.2. SUMMARY OF FISCHBACH CONCEPTUAL MODEL OF DOCUMENTATION

Fischbach (1991) explains that through written communication, nurses get information from patients and 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 nursing profession provides 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 Malawian setting. A conceptual map is a diagram that graphically shows the interrelationship of the concepts understudy (Burns &Grove 2003).The major purpose of the conceptual map is to organize all information the researcher had about the study topic to a clear statement of the relationship among variables.

FIGURE 2.CONCEPTUAL MAP OF DOCUMENTATION



CHAPTER FOUR

METHODOLOGY

4.1 STUDY DESIGN

The study will be descriptive in nature. Quantitative research methods will be utilized. Burns & Grove (2003) defined quantitative research as a formal, objective, systematic process in which numerical data are utilized to obtain information about the world. The major purpose of using this design will be 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 Beck 2006).

4.2 SAMPLE AND SETTING

Polit and Beck (2006) defined a sample as a subset of a population, selected to participate in the study. The population understudy will be Nurse Midwives technicians and Registered Nurses because they are the ones in close contact with the patient/clients and responsible for providing nursing care. The convenience sample technique has been chosen because the researcher will use the most readily available persons as participants in the study. The subjects will be twenty nurse midwife technicians (NMT) and ten registered nurse midwives (SRNM).These will be a representative of the population understudy. The study will be conducted at Ntchisi District Hospital, in maternity, pediatric, male and female wards. Eight nurse midwives will be drawn from maternity and pediatric wards respectively seven from male and female ward respectively. The hospital has been chosen for the study because of the researcher's convenience and affordability.

4.3 INSTRUMENATTION AND DATA COLLECTION

Through literature review the researcher identified concepts in the conceptual model which will be used in the development of the structured questionnaire and checklist (see appendix 2 and 3). The tool will be used to rectify or elaborate any difficulties encountered by the subjects in answering or filling the questionnaire.

Furthermore a checklist developed by the researcher containing areas of communication skills, nursing process skills styles of documentation in nursing and record keeping will be utilized to collect data from thirty patients' records of February and March 2009.The checklist will be used by the researcher to assess the documentation practices used by Ntchisi District Hospital. Knowledge skills and attitudes of the nurses toward the concept of documentation in nursing practice will be assessed utilizing the questionnaire and the checklist.

4.4. VALIDITY AND RELIABILITY

Polit and Beck (2006) defined reliability as the consistency with which an instrument measures the attribute and validity as the degree to which an instrument measures what it is supposed to be measuring. To ensure reliability of the questionnaire a pilot study will be conducted before the main study from late June to early July 2009. Burns and Grove (2003) defined pilot study as a smaller version of the proposed study conducted to refine the methodology. Problems with the study design and data collection instruments will be identified and resolved before the main study. On data collection days, consent will be provided to individual nurses and will be requested to sign the consent form and the read and fill the structure questionnaire after explanations from the researcher to collect data from the patient/clients files.

4.5. DATA ANALYSIS

Data analysis is a systemic technique of organizing and synthesizing research data (Polit & Beck 2006). Data analysis will be conducted to address the research purpose or objective.

The other purpose is to reduce, organize and give meaning to data. Data will be analyzed manually and using Epi Info 6.

Content analysis will be performed and categorized into common themes. Content analysis is the process of organizing and integrating narrative, qualitative information according to emerging themes and concepts, with a goal of quantitatively measuring variables (Polit and Beck 2006).

4.6. ETHICAL CONSIDERATION

A letter will be written and forwarded to the Chairperson of research committee at Kamuzu College of Nursing seeking consent to carry out the study. Permission will also be sought from the District Health Officer of Ntchisi District Hospital to conduct a pilot and the main study at the hospital. The DHO will have to accept the use of nurses as subjects to be included in the study.

The nurses to be involved in the study will be informed of the purpose of the study by giving the letter of consent to read through. Thereafter they will be requested to sign a letter of consent. Anonymity of the subjects will be maintained by using standardized structured questionnaire having code numbers. The subjects will be informed not to use their names when filling the questionnaires. Confidentiality will be maintained throughout the data collection period by not allowing the subjects to confer when answering and filling the questionnaires. After data collection, questionnaires will be kept in big envelopes and will only be accessible to the researcher and the supervisor during data analysis.

4.7. DISSEMINATION OF THE RESULTS

After data analysis, a final report will be written to indicate the findings of the study. The report will be submitted to Kamuzu College of Nursing for assessment of partial fulfillment of my Bachelor Science in Nursing Degree. The other copies of the report will be in Kamuzu College of Nursing Library for student use.

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APPENDIX1

WORKPLAN

ACTIVITY	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Problem identification											
Pre-literature search											
Proposal writing											
Proposal submission											
Obtaining clearance & pilot											
Data collection											
Data analysis											
Report writing											
Submission of dissertation											

Appendix 2

QUESTIONAIRE

SECTION ONE:
IDENTIFICATION AND BACKGROUND
(Fill in the blank space);

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 ward on data collection day.....

1.0.7. Age of respondent.....

1.0.8. Position in the unit.....

1.0.9. EDUCATIONAL QUALIFICATIONS
(Tick appropriate box)

(a) Junior certificate ☐

(b) MSCE ☐

(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 INSTUTIONS
(Tick the appropriate box)

(a) Government ☐

(b) University ☐

(c) CHAM ☐

(d) Others ☐

1.1.2 YEAR OF QUALIFICATION
(i) NURSING

(a) Before 1980 ☐

(b) 1981-1990 ☐

(c) 1991-2000 ☐

(d) 2001-2008 ☐

(ii) MIDWISERY

(a) Before 1980 ☐

(b) 1981-1990 ☐

(c) 1991-2000 ☐

(d) 2001-2008 ☐

1.1.3 YEARS IN NURSING PRACTICE
(Tick appropriate space provided)

(a) 1-4years..... ☐

(b) 5years – 8 years..... ☐

(c) 9yrs – 12 years..... ☐

(d) 12 years and above..... ☐

1.1.4 LENGTH OF STAY ON THE WARD

(Tick appropriate space provided)

(a) Less than one month..... ☐

(b) 1 month – 6 months..... ☐

(c) 6 months – 1 year..... ☐

(d) Over 1 year..... ☐

SECTION TWO

DOCUMENTATION IN NURSING AND MIDWIFERY PRACTICE

2.0.0. Do you know what documentation or charting means?

Yes ☐ No ☐

(a) If Yes

What is it? Explain in the space provided below.

.....

.....

.....

(b) If No! go to question 2.0.1

2.0.1. The patient medical record is a communication tool in nursing care
(Tick the appropriate answer)

(a) Yes ☐ (b) No ☐

(c) I don't know ☐

2.0.2 Is it necessary to record all the information in the patients file after assessment?

(a) Yes ☐ (b) No ☐

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

.....
.....
.....

If no, go to 2.0.3

2.0.3 Were you taught how to document in the patients file at the nursing or midwifery college?
(Tick one)

(a) Yes ☐

(b) No ☐

(c) I have forgotten ☐

If yes, how do you do it? Explain in space provided
.....
.....
.....

2.0.4 When do you document/record in the patients file?
(Tick the appropriate answer)
(a) Before the procedure
(b) During the Procedure
(c) Soon after the procedure (5min-30min)
(d) After the procedure (a day or more)
(e) I don't know

2.0.5 What documentation style(s) do know?

2.0.6 What documentation styles are you using in the ward?
(Tick the appropriate space provided)

(a) Narrative ☐ (b) Focus charting ☐

(c) SOAPIE ☐ (d) Others ☐

(e) I don't know ☐

2.0.7 Why did you choose the documentation style you are using?
(a) Told by supervisors
(b) Routinely used.

(c) Less time involved
(d) I don't know
(e) Other reasons (Indicate in space provided below)
.....
.....

2.0.8 Do you know what the nursing process is? Tick appropriate box)
2.0.9

(a)Yes ☐ (b) No ☐

If yes: Explain briefly in space provided.
.....
.....
.....
.....

2.0.10 Do you follow the nursing process steps in the management of patients in your ward? (Tick appropriate box)

(a) Yes ☐

(b) No ☐

2.1.0 Do you have a written policy in your hospital or ward regarding documentation of nursing care?

(a) Yes ☐

(b) No ☐

(c) I don't know ☐

2.1.1 Are you familiar with the nursing standards in your hospital/ward stipulated by Nurses and Midwives Council of Malawi act as your profession?

If yes are they followed? Explain briefly in the space provided.
.....
.....
.....

Do you have Nursing care plans in your ward?
(Tick the appropriate space provided.)

(i If yes do us them? (a) Yes ☐ No ☐

(iii) If yes do you use them? Explain in the space provided.

.....
.....
.....
.....

(iv) If no, why don't you use them? Explain in the space provided.

.....
.....
.....
.....

2.1.2 What do you think motivates nurses to document patients information in your Hospital/Ward? List factors in the space provided blow:

.....
.....
.....
.....
.....

2.1.3 What do you think hinders documentation of patients information in your hospital/ward. List factors in the space provided below.

(i) .....
(ii) .....
(iii) .....
(iv) .....
(v) .....

Thank you for taking time to respond to the questions.

Appendix 3.

The checklist will be used by the researcher to collect information from thirty patient files.

CHECKLIST (Tally in the appropriate column)

	YES	NO	Not Applicable	Number of Days in the hospital	Comments
(A) Appropriate communication skills indicated in the patients file					
Name of the patient					
Date of admission					
Age					
Address					
Religion					
Occupation					
Marital Status					
Accurate diagnosis relevant to the patients					
Handwriting					
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) Pulserate					
(d) Respirations					
(e) Laboratory Tests (i) Hemoglobin					
(ii) Blood film					
(iii) Grouping and cross match					
(iv) Urinalysis					
Physical Assessment findings					
Date of assessment indicated					
Correct medications given					

Correct nursing observations					
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					
SOAPIE					
Focus					
Narrative					
Charting by Exception					
Any other					
None (no documentation in the files)					
(G) Telephone orders timely written					
Date indicated					
Instructions given e.g. results					
Caller none indicated					
To who information was given					
Information received documented					
Clarify of the information					
Signed for					
(H) Standards of Documentation					
(I) Storage place of the records in office					
In the cardex					
Availability of stationery					

Appendix 4

University of Malawi
Kamuzu College of Nursing
Private Bag 1
Lilongwe

27th April, 2009

The Chairperson,
Research Committee,
Kamuzu College of Nursing,
Private Bag 1
Lilongwe.

Dear Sir/Madam,

RE: REQUEST FOR APPROVAL OF A RESEARCH PROSAL

I am a second year mature entry student at the above mentioned address. I am conducting this study in the partial fulfillment of a Bachelor of Science in Nursing at the above collage. The study is on factors that contribute to poor documentation of nursing care at Ntchisi District Hospital, Malawi. The study proposed is to be conducted between 22nd June and 12th July 2009, for the pilot and main study respectively. The request is put forth for review and approval of the research proposal. The study will be conducted at Ntchisi District Hospital. Thirty consenting nurse midwives will be subjects. The nurse midwives will answer and fill the standardized questionnaire containing open and close ended questions. Observations will be done on the records from February to March 2009, utilizing the checklist.

You may contact me through this number 099 9637548. The research proposal has been attached to this letter.

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

Yours faithfully,

Felistas Bunu
Dip NSg, UCM

Appendix 5

Kamuzu College of Nursing
Private Bag 1
Lilongwe

27th April, 2009.

The District Health Officer
Ntchisi District Hospital
P.O. Box 44
Ntchisi.

Dear Sir/Madam,

RE: **REQUEST FOR PERMMISION TO CONDUCT A RESEARCH AT NTCHISI DISTRIC HOSPITAL**

I am a student pursuing a Bachelor of Science in Nursing course at the above mentioned college. In partial fulfillment of this award, I am expected to conduct a research study hence the request.

The study is on factors that contribute to poor documentation of nursing and midwifery care at Ntchisi District Hospital. The hospital has been chosen for convenience to the researcher. I intend to carry out the pilot study and main study in June 2009, in male, female, pediatric and maternity wards.

The pilot study will be conducted in pediatric wards where three nurse midwife technicians 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 February and March, 2009 utilizing the checklist. In the main study twenty five nurses will be involved of two cadres. Twenty Nurse Mid wife Technicians/Enrolled Nurse wives and five state registered nurses will be requested to answer and fill a structure questionnaire after getting consent from them. No risk is attached to the study. The results of the study will be bound and copies well be put at Kamuzu College of Nursing Library and Ntchisi District Hospital.

A letter of my proposal was posted to Ministry of Health through my research supervisor. You may contact me through the state address.

Thank you for your assistance in the issue.

Yours faithfully,

Felista Bunu
Dip Nsg UCM

Appendix 6:

CONSENT FORM:

Kamuzu College of Nursing
Private Bag 1
Lilongwe

27th April, 2009.

Dear Respondent,

I am a mature entry Year II Bachelor of Science in Nursing student at the above college. You are requested to participate in a study on factors that contribute to poor documentation of nursing care in male, female, paediatric and maternity wards at Ntchisi District Hospital. The place is chosen for convenience in terms of affordability to the researcher. Participation in the study depends on your feelings towards the subject at hand. The information you give will be handled with respect and confidentially, because the information gained will be accessible to my supervisor and I only.

You are requested to answer and fill the code questionnaire basing on your understanding and knowledge of the subject at hand.

The are no risks attached to the study. The results will be accessible from Kamuzu College of Nursing Library for students and public use. The results may be presented at in-service training at your hospital. No incentives are attached to the participation in the study.

I the undersigned, have read the information, I fully understand that all information will be confidential and anonymous and that no risks are attached to the study. I have agreed to participate the study.

Signature of the participant :..... Date:.....

Signature of the researcher :..... Date.....

Appendix 7:

BUDGET

STATIONERY	
4 reams of printing papers at 900mk	= 3600.00
1 staple machine at 1200mk	= 1200.00
Staple pins 1 box 500mk	= 500.00
10 big envelopes at 150 each	= 1500.00
4 shorthand note books at 250mk each	= 1000.00
Ball pen 1 unit at 600mk	= 600.00
Pencils 4 at 40mk	= 160.00
1 Ruler at 80mk	= 80.00

SUB TOTAL MK 9,640.00

SECRETERIAL SERVICES

Typing of proposal	= 4000.00
Typing of Questionnaires	= 6000.00
Typing of checklists	= 6000.00
Typing and printing of consent forms	= 3500.00
Typing of letters	= 1000.00
Typing and printing of 4 documents	= 12000.00
Typing and photocopying of report	= 2500.00

SUB TOTAL MK 35,000.00

Transport 700mk for 5 days	3500.00
Meal allowance 600mk for 5 days	3000.00
Incidentals	3000.00

SUB TOTAL MK 9,500.00

TOTAL	K54140.00
10% contingency	5414.00

GRAND TOTAL MK59,554.00

BUDGET JUSTIFICATION

A budget is very important in research proposal because money will be require for things like stationery, secretarial services, transport and meals. Stationery include papers, pens and pencils, ruler, required during proposal development, actual data collection exercise and finally during data analysis and report writing.

Secretarial services will be required throughout the study for typing printing and photocopying of research proposal, questionnaire letters and dissertations.