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Nursing documentation of inpatient care in eastern Ghana

James Avoka Asamani, Frank Delasi Amenorpe, Felicia Babanawo and Adelaide Maria Ansah Ofei

Abstract

Background: Despite the usefulness of a well-documented nursing care record, documentation still has its setbacks and receives varying levels of priority among nurses and other health professionals. However, since the quality and standard of patient care is often measured from retrospective records, it is imperative to examine the practice of nursing care documentation. **Aim:** The study described in this article examined current practices of nursing care documentation in Ghana. **Method:** By means of multiple sampling strategies, a retrospective approach was used to evaluate 100 patient care records in two hospitals between 1 November and 31 December 2012. **Findings:** Major findings are that 46% of care given to patients was not recorded in the nursing care records; that nurses' progress notes were not written for 63% of patients after the first day of admission; and that 57% of documentation was not signed by nurses. **Conclusion and recommendation:** The standard of nursing care documentation is not on a par with that in developed countries, partly owing to a lack of guidelines, as well as a persistent shortage of nurses and the limited use of nursing care records. It is recommended that nursing stakeholders use a multidisciplinary approach to develop policies/guidelines on nursing care documentation and provide training opportunities for nurses on effective documentation.

Key words: Documentation ■ Patient care records ■ Nursing care records ■ Nurse progress notes ■ Documentation guidelines

Globally, with the gradual rise in living standards and a better-educated population, knowledge about patient rights is becoming more predominant. As a result, nurses are constantly being reminded to work according to international standards (Donkor and Andrews, 2011).

In Ghana, recent developments in the health sector have seen a number of nurses being confronted with lawsuits and other forms of disciplinary proceedings. However, this

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is just the tip of the iceberg of patient care issues that could expose caregivers to medico-legal suits and other forms of disciplinary action. It is therefore appropriate for nurses to take a critical look at their documentation practices, which may be used as evidence to either incriminate or exonerate them in case of lawsuits. As noted by the UK's Nursing and Midwifery Council (NMC) (2010), accurate record-keeping and careful documentation is an essential part of nursing practice. The College of Registered Nurses of British Columbia (CRNBC) also cautions that, in a court of law, a client's health records serve as the only legal record of the care or service provided. In such situations, nursing care and the documentation of that care will be measured according to the standard of a reasonable and prudent nurse with similar education and experience in a similar situation within the specific jurisdiction (CRNBC, 2007).

The global trend of missed, inappropriate or incomplete documentation of nursing care is alarming (Cheevaksemsook et al, 2006) and as with most developing countries such as Ghana, grappling with inadequate nursing staff and yet burdened with an increasing workload, the tendency for documentation errors cannot be ignored. There is an urgent need to evaluate the documentation practices of nurses.

Aim and objectives of the study

The main aim of the study was to examine the current practice of nursing care documentation between 1 November and 31 December 2012. To meet this aim, the following main objectives were identified: to find out if nurses document every nursing care given to inpatients and to identify common errors of nursing care documentation. Other objectives were to determine the model or form of nursing care documentation frequently used by nurses in Ghana and to examine the extent to which that documentation is consistent with international practices.

Review of related literature

Nursing care documentation has been reported as a core component of nursing care. In fact, it is a prerequisite for quality care and facilitates efficient communication and cooperation among health professionals (Ammenwerth et al, 2003; Johnson, 2011) as well as effective coordination. Record-keeping or documentation is an important aspect of many professions, but particularly in the field of health—the only evidence of what was done right or wrong is the record of care. As a result, nurses tend to spend more time documenting the care and progress of patients (Keenan et al, 2006) than



Ghanian nurses who received training in nursing documentation as a result of the authors' research

actually caring for them, because documentation forms the bulk of evidence in nursing care. Korst and colleagues (2003) validated this in their study, which estimated that nurses spend at least 15.8% of their time on documentation alone.

The perceived or real usefulness of nursing care documentation has been widely proclaimed and documented (Cheevaksemsook, 2006; Keenam et al, 2006; NMC, 2010). These researchers, as reported by Johnson (2011), identified several areas of usefulness of nursing care documentation: compiling legal evidence of the process and outcome of care, and supporting the evaluation of the quality, efficiency and effectiveness of patient care. Other values worth mentioning are: providing evidence for research, finance, ethics and quality assurance purposes, and also providing a database infrastructure supporting the development of nursing knowledge. Moreover, documentation assists in establishing benchmarks for the development of nursing education and standards for clinical practice, ensuring appropriate reimbursement and providing a database for planning future health care. It is also useful in providing a database for other purposes such as risk management, learning experience for students and protection (in the form of evidence) in the event of lawsuits. The benefits of documentation are profound and nurses must endeavour to document all care given to patients.

Despite the widespread acknowledgements of the usefulness of well-documented nursing care records, some setbacks still exist and have received (or are receiving) different levels of priority among nurses and other healthcare team members. Hardey et al (2000) assert that nurses give documentation

lower status and priority than direct patient care. However, since the quality and standard of care that is given to patients is often measured from records after the patients are discharged or have died, it is imperative that nurses understand that documentation is neither an added responsibility nor a task to be done to please employers or supervisors—but part and parcel of every nursing care activity (NMC, 2010).

With an estimated 20% shortage of nurses in developed countries (Cherry and Jacob, 2008), the tendency to devote less time to documentation is expected to increase, especially in developing countries where nurses shortages are endemic (Dovlo, 2005). Despite the shortages, nurses in Ghana are being called to do more to contain the rising health needs of society, but are also constantly reminded to do their work by international standards (Donkor and Andrews, 2011).

Nursing documentation standards

Nursing care documentation is being implemented by different healthcare facilities in varying standards and models (Chevakasemsook et al, 2006). Currell and Urquhart (2003) lament the lack of standardisation of nursing care documentation systems. Even within one hospital, it is common to see that there is no uniform or standardised method of documentation. Some wards may use a narrative form of documentation (describing what happened in a form of 'story writing'), whereas others may resort to a focused charting method or a problem-orientated medical record method (Keenam et al, 2006). The nursing process is described as the first standard for comparison (Karkkaninen



Ghanian nurses documenting their care

and Eriksson, 2003; Johnson, 2011), but this does not seem to work. Jefferies et al (2010) also identified seven themes that form the core of quality nursing care documentation. These include the principle of patient centeredness (one), so that the documentation records the nurse's actual work and is written to reflect the nurse's objective clinical judgment (two). It should be presented in a logical manner (three), a sequential manner (four), written as events occur (five), record variances in care (six), and fulfil legal requirements (seven).

Some nursing regulatory bodies, particularly in developed countries, periodically issue best practice guidelines on nursing documentation. However, it appears there are limited or no guidelines on nursing documentation in some developing countries (Chevakasemsook et al, 2006), especially Ghana (Johnson, 2011). The other point is that the availability of these standards/guidelines may be one thing—but the actual use of them by nurses, quite another.

Johnson (2011) argues that initial stages of nursing care and intervention are adequately recorded, but that nursing diagnosis, planning, evaluation of care and discharge summaries are given less attention. Others fault nurses for writing copies of the physician notes (Ehnfore and Smedby, 1993) and claim that nursing care documentation usually does not give a true picture of patient care (Karkkaninen and Eriksson, 2003; Johnson, 2011). Some maintain that nurses give preference to the recording of medical treatments, admission assessments and nursing interventions (tasks) over the care provided to the patient (Kirrane, 2001). To this extent, nursing care documentation does not always constitute complete information on actual care (Hale et al, 1997). Accordingly, Johnson (2011) concludes that adequate nursing care documentation may not necessarily guarantee that all the patient's needs were met.

Methodology

Design

A retrospective approach was used to evaluate the patient care records of patients who were discharged or who had died. This design was adopted because it reflects actual practices and provides a non-obtrusive, non-reactive means of examining what nurses actually documented as their nursing

care (Polit and Beck, 2009). The study was done between the period of 1 November and 31 December 2012.

Research setting

Two district hospitals in the eastern region of Ghana were used for the study. Hospital 'A' is a 150-bed government hospital that has about 12 wards. Hospital 'B' is a 105-bed mission hospital with 6 wards.

Population

The study used the patient care records of inpatients who were discharged or died in the preceding month from the wards of the selected hospitals. Records of patients who died in less than 24 hours were excluded.

Sampling

A sample size of 100 patient care records was used for the study. According to Polit and Beck (2009), the issue of sampling in research is a 'search for typicality' of the population. To obtain a truly typical sample, multiple sampling techniques were used. A quota sampling was used to obtain 50 patient care records from each hospital. The quota of each hospital was proportionately divided among the wards in that hospital according to the ratio of their admissions. In each ward, patient care record (folder) numbers were systematically selected from the admission and discharge (A&D) register of those discharged/deceased in the preceding month. The total number of admissions in the ward for the preceding month was divided by the required sample from that ward to get the sample interval (Babbie, 2005). A random start was then made to get the first, and the rest were followed using the sample interval until the required sample size was obtained.

Data collection tool

A structured questionnaire was designed by the researchers for data collection. The researchers used best practice guidelines from NMC (2010), CRNBC (2007) and textbooks to guide the construction of the questionnaire, which was divided into five parts. Part 1 contained five items to collect demographic data, such as type of ward, age of patient, diagnosis, length of stay and patient outcome. Part 2 contained three questions

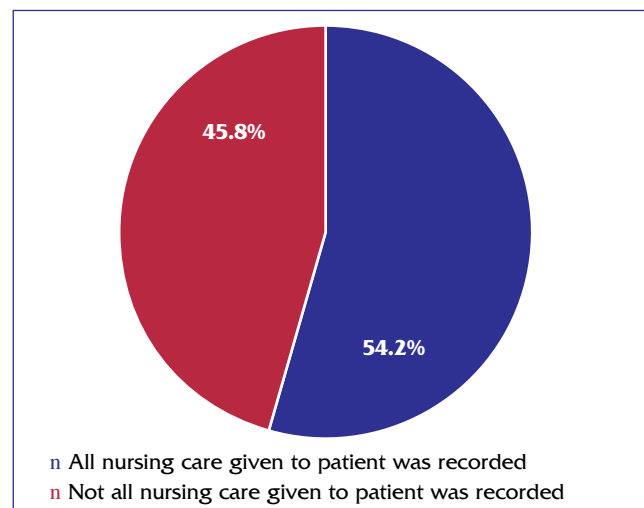


Figure 1. Documentation of nursing care in patient care records

on the completeness of documentation. It also contained a table summarising nursing procedures carried out on patients and whether documentation was complete on those procedures. Part 3 evaluated documentation standards and contained a checklist of 14 standard requirements of nursing documentation adopted from NMC (2010) guidelines. Part 4 contained a checklist of eight common errors of documentation adopted from the NMC (2010) and CRNBC (2007). Part 5 contained three items identifying the type of nursing documentation model(s) used. As noted by Enarson et al (2001), a questionnaire remains the most widely used instrument for recording data. A well-designed questionnaire should collect accurate and reliable data (Awases, 2006).

Data collection procedure

The researchers visited each of the hospitals for collection of data. In each hospital, the nurse managers of the wards made available their admission and discharge registers. The researchers then used a systematic random sampling procedure to select patient care record (folder) numbers and retrieved them from the biostatistics department. Each patient care record was then evaluated by the researchers using the research questionnaire as a guide.

Data analysis

Data analysis was carried out using the Statistical Package for Social Sciences (SPSS v.16) and the results were presented in percentages and figures.

Validity and reliability

Validity refers to the soundness of the study evidence and reliability of the accuracy and consistency of information obtained in a study (Polit and Beck, 2009). To make the study instrument valid and reliable, all the key concepts relevant to the topic were included. A pre-test of 10 patient-care records was carried out and amendments were made to the instrument based on the findings of the pre-test.

Ethical issues

Ethics is associated with morality and deals with issues of right and wrong among society or communities (Polit and Beck, 2009). Researchers need to take ethical concerns seriously (Babbie, 2005). The purpose of the study, assurance of confidentiality, and the right of withdrawal were explained to the authorities of the participating hospitals. In addition, official permission and ethical approval were obtained from each of the hospitals before the study started. The researchers made an application for permission from the hospitals and sent a research proposal. This was vetted by the research and ethics committees of the participating hospitals, after which official permission was granted for the study to start.

Results and discussions

Documentation of care given

The study found that 54.2% of patient care records captured all the nursing care given to the patients (Figure 1). However, 45.8% of patient care records did not capture all of the nursing care given to the patients on the nurses' progress notes. For instance, on two patient care records, blood transfusion

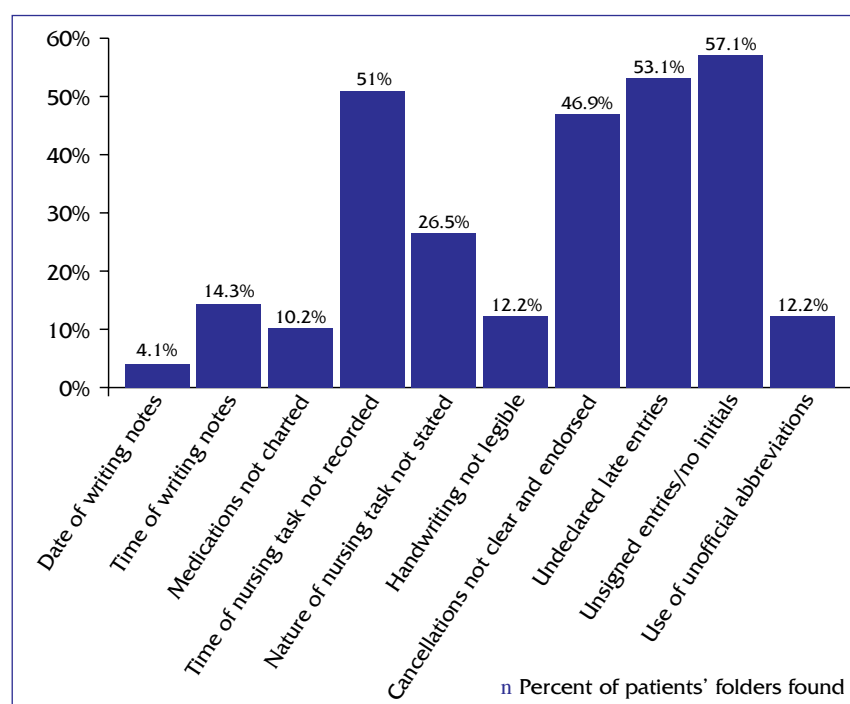


Figure 2. Common documentation errors identified

ordered by the medical officer was given and noted in the physician's notes, but was not captured in the nurses' progress notes except for a red ink mark on the temperature chart.

Furthermore, 63% of patient care records did not have nurses' progress notes written after the first day of admission. This finding corroborates the assertion by some researchers that nurses place less importance on nursing documentation than on direct patient care (Hardey et al, 2000; Chevakasemsook, 2006). Tornvall et al (2004) supported this assertion in their study, which concluded that nursing documentation is limited and inadequate for evaluating the actual care given. However, as Donkor and Andrews (2009) argue, nurses are simply asked to do more than they (in their numbers) can. Even though this study did not examine the number of

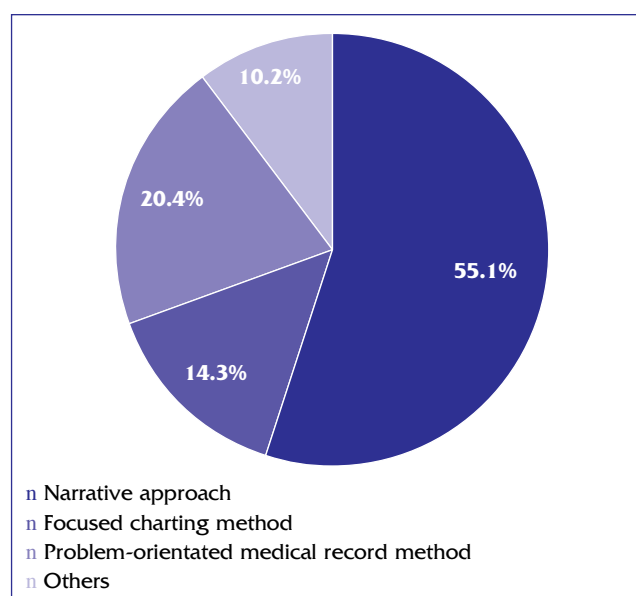


Figure 3. Frequently used methods of nursing documentation

KEY POINTS

- A retrospective approach was used to audit 100 patient care records in two Ghanaian hospitals after discharge
- As much as 45.8% of care given to patients was not recorded in nurses' notes. Alarming documentation errors were common to all patients' folders
- Nursing care documentation practices in Ghana are below expectations owing in large part to a lack of national/local guidelines and policies
- Development of local documentation guidelines, training of nurses and further research are recommended to attain a high standard of documentation practice

nurses who were on duty during the period in which the patients were admitted, it is acknowledged that nurses in developing countries like Ghana are overburdened with work and hence likely to pay more attention to direct patient care than writing records that the patients themselves might not care about. These findings are consistent with the claim by Ehnfore and Smedby (1993) that the initial stages of nursing care are usually adequately recorded but subsequent ones are given less attention. This is evident in the fact that nurses' progress notes were not written in as many as 63% of the patient care records beyond the first day of admission. This study was done in resource-constrained settings where nurses will be tempted to prioritise attending to the influx of new cases than writing 'what is usually being done' for all patients.

The duplication that exists in nursing care documentation might be a disincentive for recording all care given to patients, which Chevakasemsook et al (2006) identified as one of its setbacks. Yet no excuse could exonerate a nurse in any malpractice suit. Nurses must be reminded that documentation of care is part of their remit, not an optional or added responsibility (NMC, 2010).

Common errors of nursing documentation

This study also found that the most frequent documentation errors included unsigned entries (57.1%), undeclared late entries (53.1%), no time of procedure/intervention/event in nurses notes (51%) and cancellations not being clear and endorsed (46.9%). While there is no local literature on these variables for comparison, these errors are alarming and unacceptable. Chevakasemsook et al (2006) describe these errors as 'incompleteness' of documentation. It suggests that many nurses are ignorant of what should be included in their documentation, while others might be taking things for granted (Castledine, 1998). In the work of Irwin (2001), lack of knowledge on the part of nurses was also found to be the cause of most documentation inaccuracies. A number of documentation errors have been widely reported by diverse researchers, depicting it as a global problem (Castledine, 1998; Smith and Crawford, 2003; Cowden and Johnson, 2004; Keenan et al, 2006). Allen (1998) makes similar claims, citing the competence and attitude of the nurses as a setback to quality documentation.

This study, however, did not assess nurses' attitudes or competence regarding patient care documentation. In Ghana, inadequate documentation is largely attributable to too few nurses with an increasing workload, and the lack of

national and/or local guidelines on nursing documentation. Many involved in nursing in Ghana believe it is a matter of urgency to put in place national guidelines and standards of documentation to safeguard the interests of the patient, healthcare institutions and the practice of nursing itself.

Preferred documentation method

This study has brought to light the fact that 55.1% of nursing care records were written in a narrative manner, while 20.4% and 14.3% were written by means of focused-charting and problem-orientated medical recording methods, respectively (Figure 3). There is no doubt that, in a setting where nursing documentation is not standardised according to national or local guidelines, nurses will experiment with what they have learned or seen elsewhere (Chevakasemsook et al, 2006; Keenan et al, 2006). The CRNBC (2007) notes that the narrative method is the oldest of all nursing documentation methods and tends to be widely used. Some believe that the problem-orientated medical records approach is the most comprehensive and captures all aspects of patient data, care and evaluation (Keenan et al, 2006; Johnson, 2011). Others highlight the easy-to-use nature of the focused charting approach, which has been the gold standard in some places (Johnson, 2011).

While this study did not examine the impact of each documentation method on the quality of patient care or the patient's satisfaction with nursing care, what we need in Ghana is a 'paradigm shift' away from writing nurse notes in an unsorted 'personal experience manner' to a more organised approach, whereby information gathered, interventions carried out and evaluation of the patient at any time, is well documented in the nursing care records.

Consistency with international standards

To what extent, then, is nursing documentation in Ghana consistent with international practice? In the words of Johnson (2011): 'nursing documentation in Ghana is neuralgic [...] and inconsistent'. Some of the findings of this study—such as the 45.8% rate of incompletely entered nursing care in the records, the 63% failure rate to write nurses' notes after the first day of admission, and alarming levels of documentation errors—certainly do not meet most international guidelines for documentation (Chevakasemsook et al, 2006; CRNBC, 2007; Jefferies et al, 2010; NMC, 2010).

However, this study also found that 85.4% of patients had their vital signs checked and recorded, which exceeds the average currently emerging from developing countries (Castledine, 1998; Smith and Crawford, 2003). So although the standard of nursing care documentation in Ghana is below the standard in developed countries, it is on par with, and in some cases better than, the standard in many developing countries.

Manfredi (1993), Potikosoom (1999), Pearson (2003) and Johnson (2011) attribute the lower standard of nursing care documentation in developing countries to several factors: lack of policy and guidelines; shortage of nurses; lack of knowledge; and nurses' perceived irrelevance of care records to nursing practice itself, as well as that of other healthcare team members across developing countries.

Conclusion

This study used a retrospective approach to evaluate care records of discharged patients or those who died for nursing care documentation. The authors found that 45.8% of nursing care given to patients was not recorded in its entirety in the nursing care records and that nurses' progress notes were not written for 63% of patients after the first day of admission. The study also acknowledged alarming errors in documentation, including unsigned entries of nurses' progress notes (57.1%), among others. In addition, the study showed that nurses often use the narrative method of charting to document nursing care.

Overall, we conclude that the standard of nursing care documentation in Ghana is below expectation, partly owing to lack of national policy/guidelines on care documentation compared with developed countries. Shortages of nurses and perceived irrelevance of nursing care records, among other factors, have also had an influence. The authors recommend that nursing regulatory bodies and other stakeholders use a multidisciplinary approach to develop policies/guidelines on nursing care documentation and provide training for nurses.

Further research is needed to examine nurses' knowledge of documentation, their attitude towards it, the perceived relevance of nursing documentation among healthcare team members and factors influencing documentation in nursing.

Feedback

The findings of this study have been discussed with the authorities of the two hospitals in the study. They have made quick interventions by organising in-service training programmes on effective documentation for all their nurses. The impact of these interventions has yet to be evaluated. BJN

Conflict of interest: none

All photos supplied by the authors

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