UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

COURSE:

RN 510

SUPERVISING LECTURER:

Mrs. P. M. NDELE

TOPIC:

KNOWLEDGE, ATTITUDE AND PRACTICE OF NURSES TOWARDS DOCUMENTATION OF NURSING CARE PLAN.

INVESTIGATORS

1. **JONES KANYANGA (10111671)**
2. **KASAMWA CHILENGA (10036423)**
3. **MAHALE LUMPA S. (29074291)**

DECLARATION

We Chilenga Kasamwa,Lumpa Mahale and Kanyanga Jones declare that the work on which this research is based is original,except for where acknowledgement indicate otherwise and that the whole work or any part of it has not been, or is not being submitted for any other Degree at this or any other University.

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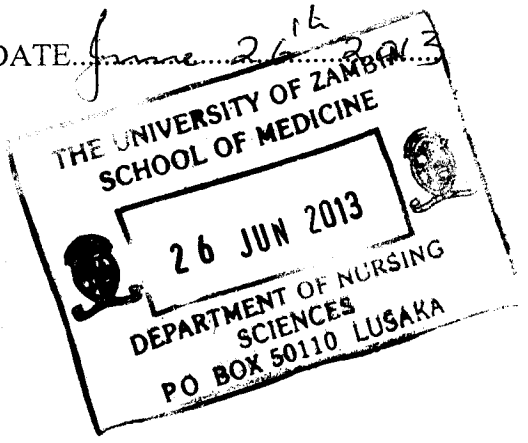
CANDIDATES

APPROVED BY..... DATE.....June 26th 2013.....

SUPERVISOR



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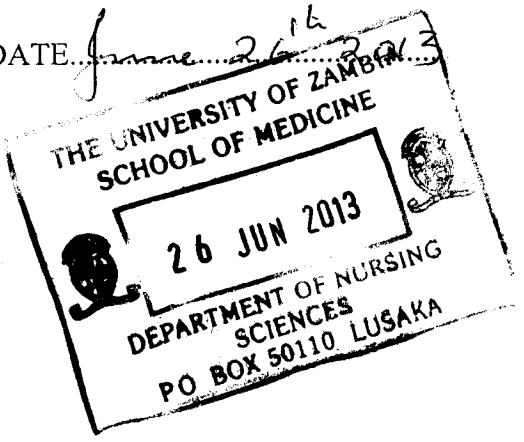

STATEMENT

We Chilenga Kasamwa,Lumpa Mahale and Kanyanga Jones hereby certify that this study is entirely the rest of our own independent investigations, the various sources to which we are indebted are clearly and gratefully acknowledged in the text and in the reference.

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CANDINDATES

DEDICATION

This study is dedicated to our beloved spouses and children for their unwavering support throughout our training.

ACKNOWLEDGEMENTS

We would like to thank the following for their support and guidance throughout the writing of this study: Our employer, the Ministry of Health, for sponsoring our training. Our supervising Lecturer, Mrs Patricia. M. Ndele for her persistent effort in guiding us through and being there for us whenever we needed her. The Library staff of the University of Zambia Medical Library. Our classmates who were always there for consultations whenever we needed help. Our spouses and children for their moral support, finally, the Almighty God for the strength he gave us to be able to move a step forward in our career.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
UNZA	University of Zambia
UTH	University Teaching Hospital
NHPS	National Health Policies and Strategies
HIMS	Health Information Management System
MOH	Ministry of Health
CBOH	Central Board of Health
SNCP	Standardized Nursing Care Plan

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ABSTRACT

The quality of nursing documentation is an important issue for nurses both nationally and internationally. Nursing documentation should, but often does not show the rational and critical thinking behind clinical decisions and interventions, while providing written evidence of the progress of the patient. Accurate nursing documentation leads to the evolution of knowledge and enhance professional autonomy.

The aim of this study was to assess knowledge, attitude and practice of nurses towards nursing documentation of nursing care plan. This is a descriptive cross section study which was carried out to examine knowledge, attitude and practice of nurses towards nursing documentation. Both quantitative and qualitative methods were used. The study was carried out at three different hospitals namely; Choma General Hospital, Southern province, Kitwe Central Hospital, Copper belt province and Senanga District Hospital in Western province.50 respondents were selected from each Hospital with a total of 150 respondents, a simple random sampling method was used. The research instrument which was used for data collection was a self administered questionnaire it consisted of five parts, namely section A had questions concerning demographic data, section B the nursing care performed, section C documentation performed in the wards, section D knowledge and section E staffing levels. The questionnaire was completed by nurses and analysed using the SPSS V.17 of the computer software. Findings showed that majority141 (94%) of nurses documented nursing care plan although it was found that most of the nursing care documented was incorrect and many did not know what to document.

Majority of respondents who have been practicing for more than 16 years 40 (26.7%) showed an overwhelming positive attitude towards nursing documentation. This proves the saying which says experience is the best teacher.87 (58%) of respondents reported that they like nursing documentation. The constraints cited leading to poor documentation of nursing care plan were among others (table 20) shortage of staff, lack of incentives and not knowing what to document. The study revealed that lack of in – service training in nursing documentation has contributed to inadequate knowledge on nursing documentation.133 (88.7%) of respondents did not undergo in – service training. If in – service training was an ongoing exercise for the nurses it would certainly increase their knowledge on nursing documentation.

The recommendations made are as follows;

The following recommendations were made in the light of findings of the study as follows:

Ministry of Health

The Ministry of Health should ensure that the following are done:

1. Improving on the supply of materials such as stationary

2. Employ more staff nurses of all categories in order to improve on the staff shortage.

3. The electronic computers should be provided in Hospitals in order to minimize use of paper for nursing documentation.

General Nursing Council

1. There is need to reorient and Introduce training courses on nursing documentation especially for the trainees trained from the private nursing schools in order for nurses to keep abreast.

Choma General Hospital, Senanga District Hospital and Kitwe Central Hospital

1. Improve nurses' attitude through motivating them and provision of necessary information with regards to nursing documentation.

2. The nurse managers that is the Nursing Officers and the Nursing Sisters to be monitoring the documentation on the wards.

3. The leaves such as occasional leave, vacation leave should be well planned by managers to avoid staff shortages.

4. The managers should put a deliberate policy of motivating those staff who are doing a commendable job.

5. Exchange visits with other hospitals should be encouraged to learn on how other hospitals are managing.

CHAPTER ONE

INTRODUCTION

Documentation in nursing is needed to support the continuous and efficient shared understanding of a patient's care history that at the same time aids sound intra and interdisciplinary communication and decision making about the patient's future care. Through documentation, nurses communicate their observations, decisions, actions and outcomes of these actions for clients. Documentation is vital to ensure the continuity, safety, and quality of care continues across the multiple handovers made by the many clinicians involved in a patient's care. In addition, the data is required for various purposes, including information for improving the provision of services to individual clients, statistics for planning and managing health services, and measurements for formulating and assessing health policy. The care should be well documented and readable to enhance understanding of care being provided. Sometimes it becomes very difficult to value the health services rendered by the nurses because what they do may not be documented anywhere. If the nursing roles in health system are to be valued the nurses need to show what they are really doing by documenting the nursing activities they perform (Yocuum, 2002).

It is usual to assume that written documentation is significant not only as a communication medium in nursing, but also in the fulfillment of a number of other professional and legal obligations by nurses. Nurses should be encouraged and supported to regard record keeping as a positive contribution to patient care, rather than as a chore to be endured. Evidence based nursing, accountability, accreditation and legal requirements are important concepts in nursing practice, and these can be achieved through proper nursing documentation. The multiple purposes of documentation which include the following; Documentation in the individual's record facilitates communication among professionals from different disciplines on different shifts. It provides information so that health care providers can deliver care in a coordinated manner. Information in the individual's record is a source of data for quality assurance and peer review programs. To promote good nursing care, documentation encourages nurses to assess client's progress and to determine which interventions are effective and which are not effective to and to identify and document change to the care of plan as needed.

The individual's record serves as a legal document that may be entered into courtroom proceedings as a record of care the person received. Therefore nurses need to have evidence to

support their actions as they provide nursing care. The nurses are obliged to document the nursing care on a particular client or patient to allow for easy continuation of nursing care thereby enhancing patient's recovery. The nursing care being documented should be legible, and there should be complete client care management of records in order to facilitate continuity of care and evaluation, this is according to General nursing council of Zambia monitoring and evaluation tools of 2001 standard 10.

The nursing administrators such as Nursing Officers need to be availed with proper, complete and well documented information for decision making as this information gives an accurate picture of what is happening on the ground. For many years now nurses have been documenting nursing care activities with not much improvement, as the information recorded is still inadequate, incomplete, fragmented and erroneous.

The Health care system in Zambia has undergone changes due to National Health reforms of 1991 in order to address the problem of poor health service delivery and improve the health status of Zambians. The health reform concept was articulated in the National Health Policies and strategies (NHPS) of 1992. One of the areas of focus of the Health reform has been improving information system in Health system in order to provide adequate information needed by policy makers, managers and care provider.

Zambia operationalised the Health Information Management System (HIMS) in 1996 and has since then been collecting routine information on disease epidemiology and delivery of health care services. This includes information on disease morbidity and mortality, maternal and child health services, staff workload, health facilities utilization, and availability of essential drugs (MOH, 2006).

In 1998 Central Board of Health (CBOH) developed a concept of HIMS to facilitate standard documentation of health care activities. HIMS has been revised as part of health reform process and the vision of the reforms has been, 'To provide all Zambians with equity of access to cost effective, quality health care as close to the family as possible'.

The importance of collecting routine information through the HIMS is crucial in the delivery of quality health care. This evidence based information provides guidance on the overall performance of the health sector, progress towards the attainment of the Millennium Development Goals (MDG), and programme design and resource allocation. HIMS has also strengthened the

nursing care documentation in nursing practice. Through HIMS planning guidelines and tools, performance assessment technical support tools and various protocols for treatment and prevention of various diseases have been developed.

The Health information Management system (HMIS) has demonstrated over the years that it is useful facility based information system designed for monitoring and evaluating the performance of the health sector in general, and the disease burden in particular. However, more work still needs to be done to ensure that the quality of HIMS data and its reliability are enhanced. Regular trainings among new and old staff on the use and management of HIMS data, supportive visits to health facilities and the ongoing performance assessment visits to Districts need to be encouraged by all parties as this plays an integral component in the improvement of the quality of HIMS data.

Knowing that HIMS data covers all the public health facilities in the country with a few privately owned ones, there is need therefore to incorporate private Health facilities so that there is a comprehensive picture of the utilization of health facilities in the country

The review of the current HIMS to be conducted by the Ministry of Health, is a step forward in the right direction as this would identify problem areas and needs of HIMS aimed at making evidence based decisions on health policy, program design and resource allocation, within the health sector. The use of and potential analysis of this data either at facility, provincial or National level is an important aid in resource allocation. If utilized appropriately, this analysis can have the potential to encourage greater efficiency in the allocation of resources as well as development of more appropriate responses to disease affecting our society (MOH, 2005).

Although MOH has institutionalized the HIMS, some components of these tools are not yet established or integrated. This has made information sharing retrieval, analysis and decision making very difficult. MOH will ensure that the HIMS is strengthened and integrated in order to improve decision making process in the institutions (MOH, 2005 - 9).

The main health care services in Zambia are, the public health facilities under the Ministry of Health, the Ministry of Defence, the Mine Hospitals and clinics, Mission Hospitals and clinics which are coordinated by the Churches Health Association of Zambia (CHAZ), Private Hospitals and clinics, and the Traditional healers (MOH, 2005).

In 1983 the General Nursing Council of Zambia incorporated the concept of nursing documentation through the adoption of the nursing process into the curriculum of Registered Nurses and Enrolled Nurses. The General Nursing Council's emphasis is that, the nurses must be able to document and account for the nursing care they offer to patients. Despite the adoption of the nursing care documentation in hospitals the nursing care being documented is usually not complete and mostly below acceptable standards.

A well documented nursing practice has an important role in the quality care as it is the foundation of development of nursing profession. Quality documentation also facilitates correct representation of nursing by nurse practitioners and Managers.

Inaccurate nursing documentation system can have significant impact on the quality of care given to patients, and can also lead to frustrations to care givers.

The findings from this study are intended to assist the nursing profession by uplifting the standards of nursing documentation. This will make the nurses realize the importance of documentation in their daily practice. By so doing it will increase patient safety and enhance delivery of quality of nursing. Nursing uses documentation to assess patient conditions, to prepare a plan of care or specific interventions, to track outcomes and control quality in the given patient care. The patient care processes, communication, research, education and ward management can be delivered using the nursing care documentation.

1.2 STATEMENT OF THE PROBLEM

The literature reveals advantages and the importance of documentation of nursing care plan. The use of nursing care plan documentation systems in both private and Government Hospitals in Zambia has been initiated since the General Nursing Council of Zambia In 1983 incorporated the concept of nursing documentation through the adoption of the nursing process into the curriculum of Registered Nurses and Enrolled Nurses. It is a known fact that any new system takes time to be successfully implemented. Currently part of patient information is still being recorded, however there appears to be poor quality documentation of the care provided by nurses. The patients are either not receiving the correct treatment and management or there is no documentation by the nurses. In the light of the above it is postulated that the nurse as end-user of documentation will

experience problems with documentation of nursing care plan and resistance to change with reference to documentation.

1.3 ANALYSIS

1.3.1 THE FACTORS INFLUENCING DOCUMENTATION OF NURSING CARE PLAN

1.3.2 ECONOMIC FACTORS

1.3.2.1RESOURCES

Inadequate Stationary has made documentation difficult to implement. It has been observed that the important information which is expected to be documented on its own has been combined and summarized with other information in order to economize on stationary. This has affected documentation in nursing. Nurses have been instructed to improvise materials as they strive to provide quality health care to patients and clients. Nurses are therefore forced to reduce the information necessary for documentation thereby compromising the quality of nursing data being documented.

While it may be economical to reduce information being recorded the information summarized may not be the real nursing care performed and data may be misleading because it is incomplete. Inadequate stationary may have lead to hospitals ignoring the use of nursing care as a source of information of the client.

1.3.2.2 CONDITIONS OF SERVICE

Due to poor conditions of service nurses' performance has been compromised and nurses have been demotivated towards work and this has affected their work output.

The nurses need to be motivated for them to perform to the expected standards. Motivation is the psychological characteristic that contributes to a person's degree of commitment (stoner et al. 2009) therefore the nurses need to be highly motivated for them to give quality health care.

1.3.3 SERVICE RELATED FACTORS

1.3.3.1 STAFF ATTITUDE

A number of staff nurses have shown resistance to change to the new tool of Health information system because they feel it takes up a lot of time filling in the required documents. The nurses have resorted to summarizing most of the work which need to be documented. Some of the nurses may fear to be held accountable since documentation demands that the nurses document the activities that have been undertaken.

With the coming of the new tool of HIMS nurses who were trained long before the introduction of this tool need to be oriented through in-service training. The nurses who underwent the training need to influence others in the implementation of documentation.

1.3.3.2 SKILLED NURSING STAFF

It is assumed that since the introduction of Health Information Management System (HIMS) by the then Central Board of Health many nurses have not attended in-service training or been oriented to the importance of documentation in nursing.

Documentation of nursing is important as it reveals what exactly have been done on the patient therefore an orientation in the training of this tool is vital, this can be done through in – service training.

13.3.3 KNOWLEDGE

Many nurses have inadequate knowledge to the correct ways of documentation on the different types of forms as a result they tend to mix or summarise the data which is expected to be documented on a particular subject. The influence of knowledge, disposition toward critical thinking and reasoning skills, on the accuracy of nursing diagnoses can support nurses in deriving diagnoses and documentation of nurse's notes.

1.3.3.4 STAFF SHORTAGE

The proportion of nurse- patient ratio is overwhelming due to staff shortages hence in some institutions one nurse takes care of more than the recommended ratio. Provision of quality health care has been compromised in that the work which is expected to be done by a number of staff nurses is performed by one nurse and so concentrate much on the provision of nursing care, rather than stopping to document it.

1.3.3.4 SYSTEM OF DOCUMENTATION

The system of nursing documentation is not user friendly. When the health information system was introduced, too much information was started all at once, instead of implementing it steadly, so that all Health workers could get used to the big change. Any change takes a while before it can be accepted and learned for one to be proficient.

1.3.3.5 SUPERVISION OF STAFF

Lack of proper supervision of nurses by their superiors contributes to inadequate documentation of care given to patients. Some of the supervisors do not know the importance of documentation of nursing activities as such they do not see the necessity of supervising the subordinates. Some of the supervisors simply do not want to make follow ups to the Departments to inspect on what is happening on the ground. The staff nurses need guidance to ensure that what they are documenting meets the standard.

1.3.4 SOCIO CULTURAL FACTORS

1.3.4.1 PEER PRESSURE

The influence of other nursing staff can contribute to poor documentation of nursing care plans. At the work place there are nurses who have been in service for a long time, these may be frustrated and lacking interest in the work as a result they develop negative habits of not documenting the nursing care activities performed. These long serving nurses are a discouragement to newly qualified nurses who have the morale to work and are looking forward to encounter challenges in the nursing profession.

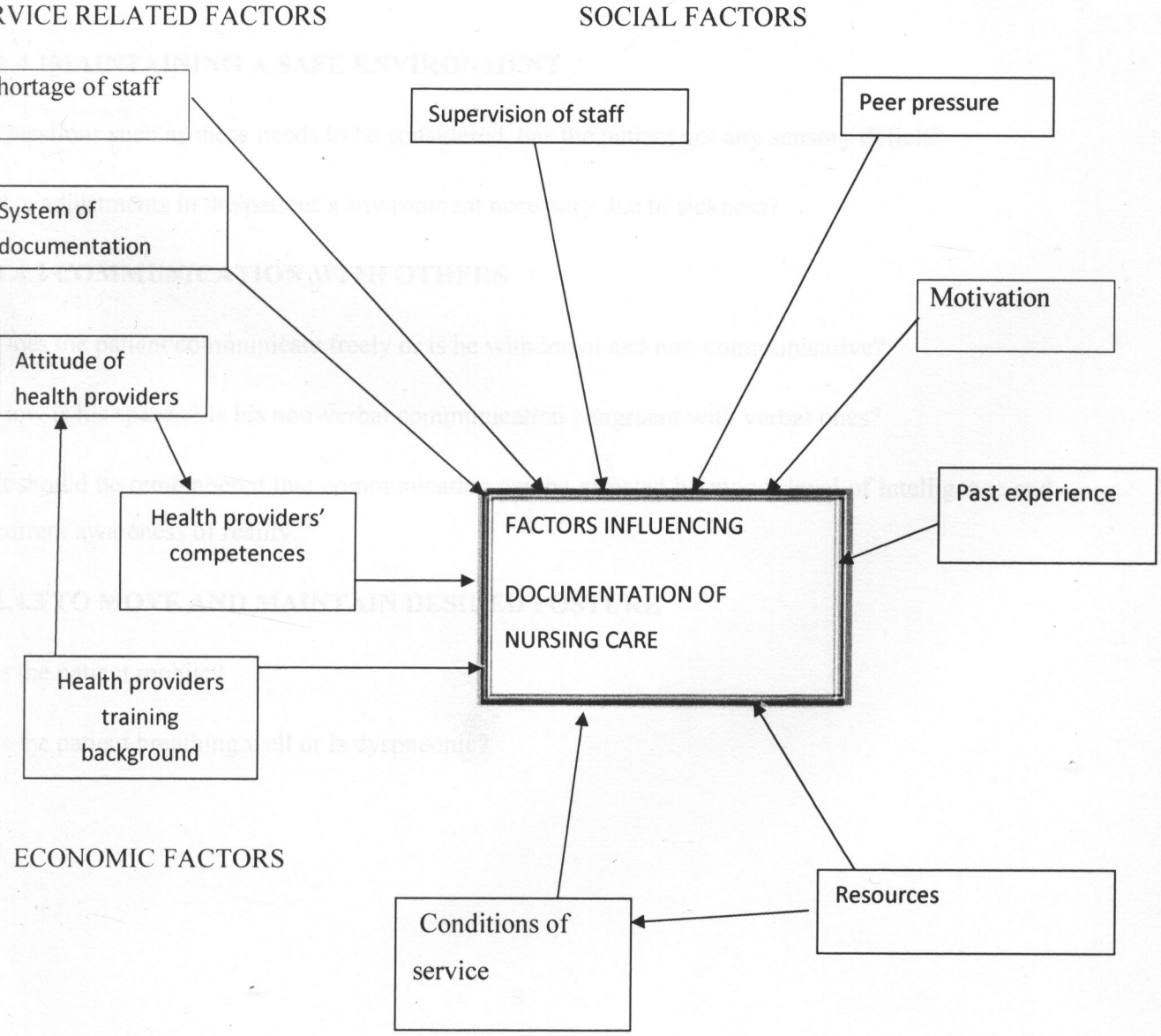
The newly qualified nurses need frequent in-service training including documentation in nursing.

1.3.4.2 TRADITION BELIEF

The nurses have the belief that their work is to carry out the Doctors orders; this leads to nurses to neglect their work hence affecting documentation. The nursing activities being carried out will not be reflected anywhere, this would indicate that the nurses do not carry out important activities on their patients

The nurses will need to be oriented that their work is dynamic and challenging, it is not just carrying out" Doctor's orders" as it is commonly called. The nurses need to document what nursing activities are performed during their tour of duty.

1.3.2 PROBLEM ANALYSIS DIAGRAM



1.4 THEORETICAL/CONCEPTUAL FRAMEWORK

In this study a model which has been considered is the Henderson Nursing model. The Henderson Theory of Nursing was created by Virginia Henderson (1897-1996), a nursing educator and prolific author, and was developed beginning in 1937. The theory contains 14 elements, each of which Henderson considered an essential function of a nurse. The foundation of Henderson's theory is that nurses should focus on the patients rather than the task. With this change of focus, nurses are able to perform their tasks of helping patients recover or pass away with peace and dignity (Jones, 1999).

1.4.0 THE 14 COMPONENTS OF HENDERSON'S THEORY INCLUDE THE FOLLOWING:

1.4.1MAINTAINING A SAFE ENVIRONMENT

Questions such as these needs to be considered, has the patient got any sensory deficit?

Are adjustments in the patient's environment necessary due to sickness?

1.4.2 COMMUNICATION WITH OTHERS

Does the patient communicate freely or is he withdrawn and non-communicative?

How is his speech? Is his non-verbal communication congruent with verbal ones?

It should be remembered that communication can be affected by mood, level of intelligence and current awareness of reality.

1.4.3 TO MOVE AND MAINTAIN DESIRED POSTURE

Is the patient mobile?

Is the patient breathing well or is dyspneonic?

1.4.4 WORKING

What is the patient's occupation?

Where does he work?

Are there any difficulties in the work situation?

1.4.5 TO PLAY AND PARTICIPATE TO RECREATION

What are his hobbies?

Are there difficulties in interpersonal and social relationships?

1.4.6 SLEEPING AND REST

Does the patient suffer from insomnia?

Does he feel refreshed or unrefreshed when he wakes up?

Does he suffer from early morning working?

At what time does he usually retire to bed?

What factors increase or decreases sleep?

1.4.7 EATING AND DRINKING

Does the patient take adequate diet?

Is the patient well nourished?

1.4.8 PERSONAL CLEANSING AND DRESSING

Is there any evidence of self neglect?

Does the patient take interest in appearance?

1.4.9 BREATHING

Does the patient smoke?

Does the patient complain of difficulty in breathing?

Does the patient have pain or discomfort associated with breathing?

1.4.10 ELIMINATION OF BODY WASTE

Does the patient experience frequency of micturition?

Does the patient have constipation associated with low food and fluid intake?

Do the patient express delusional beliefs about bowel function?

1.4.11 MOBILIZATION

Is the patient physically active?

1.4.12 CONTROLLING BODY TEMPERATURE

Is there any evidence of flushing, excessive perspiration, goose flesh or shivering?

Is there any evidence of pyrexia or hypothermia?

1.4.13 TO LEARN, DISCOVER AND SATISFY CURIOSITY

Difficulties in learning and understanding the treatment regimen due to possible lack of education.

1.4.14 TO WORSHIP ACCORDING TO ONES FAITH

Inability to worship according to ones faith can be due to lack of privacy and being far away from familiar places.

1.4 15 SELECT SUITABLE CLOTHING

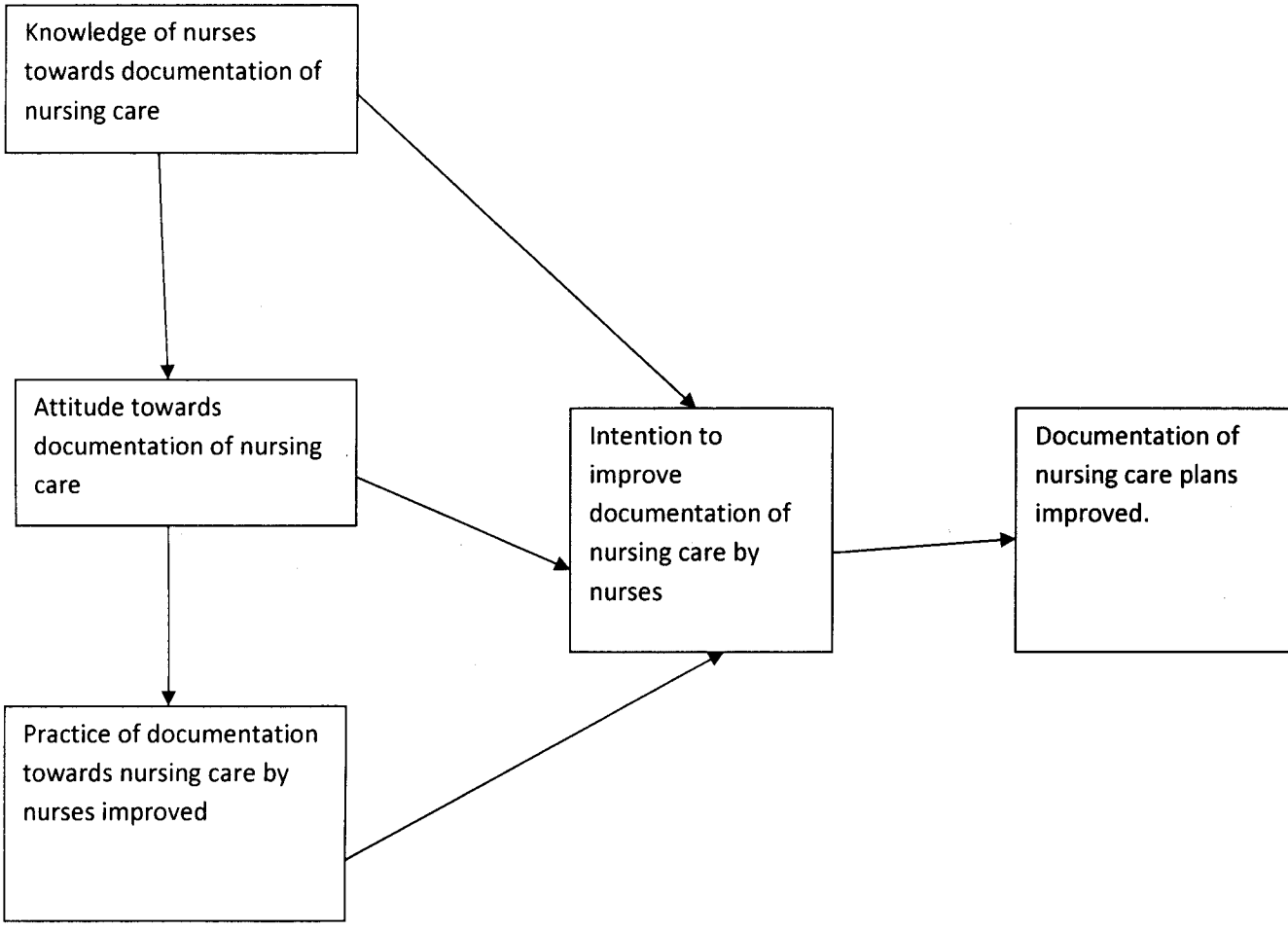
Failure to dress appropriately due to hospitalization

1.4.1 THE PREDICTED RELATIONSHIP

This model can be used to make an assessment of the patient's needs as well as for care provision. The fourteen elements contained in the theory are related to the study in that the

nursing care provided by nurses to patients need to be documented, this can only be achieved if the nurses are aware and know how to apply the 14 elements by focusing on the patients individual needs.

1.4.2 DIAGRAM OF THE FRAMEWORK



1.5 JUSTIFICATION

All nurses are aware of the importance of recording their plans of action and the actual implementation of care. To improve efficiency and quality of patient care, hospitals worldwide are increasingly relying on nursing documentation to improve not only efficiency but also accuracy in various fields of health care. It is generally believed that improved accuracy and quality of documentation, efficiency in communications and better accessibility to and retrieval of data are benefits of clinical information systems. Decisions made at the end-point of care provide the most current patient information and contribute to high quality of care. There are different views pertaining to the attitude of nurses towards the use of documentation, which cannot be generalized as being positive or negative. Many of the users expressed concerns that the new nursing documentation system method of charting would be more time consuming and would detract from patient care. Nursing care is legally equivalent to medical care hence documentation of nursing care is a legal issue and serves as professional standards. For the purpose of supporting documentation, clinical decisions and evaluation of care, patient care records system was introduced into primary health care through the then Central Board of Health(CBOH). This study was done during the implementation of nursing documentation after the General Nursing Council of Zambia incorporated it into the nursing curriculum in 1983. The implementation of nursing documentation of patient record involved new knowledge of the nursing process documentation and practice. Be it electronically or manually the fact remains that documentation of nursing care has to be meaningful, clear, tangible and unambiguous. As a communication strategy documentation has to have the ability to send a clear message to the next person reading what is written. A nurse has to always bear in mind that it is the same documentation of nursing care that will be referred to months or years later, should there be a need to testify and review the same documentation that she or he has written. However nurses' documentation serves not only to communicate information to others, but also has a political function as a presentation of what is important and ethically "right" to report . Faced with a chronic communication problem, hospital managers have implemented corrective measures to resolve it, but with limited success. Breakdown of communication is of particular concern to nursing management since much of the duty for clinical communication is assured by nursing staff and because the nurses are the only professional group that maintain continuous service for patients over the 24 hour period. Further they assume responsibility for a large amount of

documentation or charting as they attend to all aspects of patient care. Indeed nurses spend 38% of their day in activities that involve transmitting information through nursing care plans and nursing notes. Therefore, critical information must be written down and permanently stored. It is imperative then, that there be commitment and compliance among nurses if effective communication is to occur. Charting is often seen as taking priority over "hands-on care" that nurses regard as purposeful use of their time and while most nurses will acknowledge the merits of documentation, few will see the task as rewarding or completely performed. Nursing is not complete until the care has been properly documented and the old saying "if it was not documented, it was not done" applies with strong force today. However, redundancy of forms, repetitive data records and imprecise language contributed to a lack of accurate documentation. Therefore the purpose of this study is to determine the gaps in the knowledge base of Nurses regarding documentation of nursing care plan.

1.6 RESEARCH STUDY OBJECTIVES

1.6.1 GENERAL OBJECTIVE

To determine the knowledge, attitude and practice of nurses towards documentation of the Nursing Care Plan

1.6.2 SPECIFIC OBJECTIVES

- To describe the documentation knowledge among nurses towards nursing care plans.
- To find out the attitude related to documentation of nursing care plan amongst the nurses at the Hospitals under the study.
- To determine if nurses in Hospitals practice documentation of the nursing care plan.

1.7 THE STUDY HYPOTHESIS

The following hypothesis will specify the expected relationship among the variables.

- There is an association between knowledge of staff nurses and documentation in nursing practice.
- There is an association between Nurses who have received training in health information management system and documentation of the nursing care plan.

1.8 OPERATIONAL DEFINITIONS

For the purpose of this study, the following terms conceptually defined as:

Attitude: The physical expression of an emotion, intention, belief, opinions and feelings.

Knowledge: The belief which is in agreement with the fact.

Nursing: A profession focusing on the holistic person receiving health care services and providing a unique contribution to the prevention of illness and maintenance of health.

Nursing Practice: The application of knowledge and the performance of psychomotor skills that assist in improving or maintaining health.

Nursing care: Any action performed by a Nurse(s) to assist clients to meet health goals, promote wellness, prevent disease/illness, restore health and facilitate coping with altered functioning.

Nursing care plan: It is the written guide to direct the efforts of nursing team as they work with clients to meet health goals, specifies priority Nursing diagnosis, client goals and Nursing orders.

Patient/client: A person requiring health.

Quality care: The extent to which health service provided to individuals and patients in order to improve the desired heath outcome.

1.9 CONCEPTUAL DEFINITION OF TERMS

Attitude: Involves a person's feelings or emotions, the way we behave or act and the person's belief.

Knowledge: The condition of being learned through reasoning.

Nursing Practice: This is the provision of nursing care or advise to a patient/client and the nurse must follow the accepted standards of care which would provided by a competent, knowledgeable and skillful nurse.

Nursing: This is the treatment and diagnosis of human responses to health and illness.

Nurse: A person who qualified from a program of basic Nursing Education and is authorized by the Government to provide nursing care.

Nursing care: Is the service given by Nurses to individuals or clients.

Nursing care plan: A prescribed method on the stages of nursing process.

Patient/client: A term used to describe those who are the beneficiaries of nursing care.

Quality care: These are quantified services carried out by Nurses that comprise activities like pain relief, nutrition, observations and many more.

1.10 VARIABLES AND CUT OFF POINTS

Dependent variable

- Knowledge

Independent variable

- Attitude
- Practice

TABLE 1: RESEARCH VARIABLES, INDICATORS AND CUT OFF POINTS

RIABLES	INDICATOR	CUT OFF POINTS	QUESTIONS
lependent riable Knowledge	• High • Moderate • Low	• Able to answer more than 8-12 questions on knowledge. • Able to answer 6 to 10 questions on knowledge. • Able to answer 5 or less on questions on knowledge.	21,23,24
pendent variables Practice	• Very good • Good • Poor	• Able to answer 7-11 questions on practices. • Able to answer 5-9 questions on practices. • Able to answer 4 or less questions on practices.	8,15,16,27
pendent variables Attitude	• Very good • Good • Poor	• Able to answer 2 questions on attitude which appear under knowledge. • Able to answer 1 questions on attitude • Not able to answer any question on attitude	15,23

Knowledge is when one is able to:

- Define nursing documentation.
- Mention at least 4 components of nursing care plan.
- Tell whether in – service training improves nursing documentation.

Practice is when one is able to:

- Be Supervised or monitored by supervisor on nursing documentation.
- Document nursing care plan on the area of practice.
- Know and understand the type of nursing care practiced.
- Give appropriate care even when staffing pattern is affected.

Attitude is when one has

- Emotions or feelings one has towards a subject
- What one actually does

CHAPTER 2

2.0 LITERATURE REVIEW

Literature review is an organized written presentation of what has been published on a topic by scholars and includes a presentation of research conducted in a selected field of study (Burns and Groove, 2009). Literature review is conducted to generate an understanding of what is known about a particular situation or phenomenon and the knowledge gaps. Reviewing literature helps one clarify which problems have been investigated, which ones require further investigation or replication and which have not been investigated. It also helps the researcher find out what others have learned and reported on the problem to be investigated. It helps to be familiar with the various types of methodology that may be adopted in the study. Literature can be sourced from published journals, books, medical records, articles, abstracts and research studies. In this review, literature was obtained from medical journals.

Since the days of Florence Nightingale, nurses have viewed documentation of patient care as an integral part of nursing practice. Florence Nightingale is most remembered as a pioneer of nursing and a reformer of hospital sanitation methods. Nightingale pushed for reform of the British military health care system and with that the profession of nursing started to gain the respect it deserved. During the spread for her opinions on reforms, she published two books, notes on Hospital (1859) and notes on nursing (1859).With the support of her wealthy friends she was able to improve the quality of nursing. Nightingale became involved in the Education of nurses as a result of her experiences in training nurses to care for British soldiers. Some of her new beliefs about nursing education were: A holistic framework inclusive of illness and health. The need for a theoretical basis for nursing practice. A liberal education as a foundation for nursing practice. The importance of creating an environment that promotes healing. The need for a body of nursing knowledge that was distinct from medical knowledge (Nightingale, 1969).

During her time at Scutari, she collected data and systematized record-keeping practices. Nightingale was able to use the data as a tool for improving city and military hospitals (Cohen 31). When her sanitary reform was implemented, the mortality rate declined. The statistics provided an organized way of learning and lead to improvements in medical and surgical practices as Nightingale demonstrated. She also developed a Model Hospital Statistical Form for

hospitals to collect and generate consistent data and statistics. She became a Fellow of the Royal Statistical Society in 1858 and an honorary member of the American Statistical Association in 1874. Karl Pearson acknowledged Nightingale as a "Prophetess" in the development of applied statistics. Throughout the development of modern nursing, a variety of documentation systems have emerged in response to changes intrinsic in health care delivery. Systems of recording and reporting data relevant to the care of clients have evolved in response to the demand for Health care practitioners to be held accountable to societal norms, professional standards of practice, legal and regulatory standards, and institutional policies and standards (Brent, 1997).

2.1 OVERVIEW OF DOCUMENTATION OF NURSES TOWARDS NURSING CARE PLAN

Documentation is anything written or printed that is relied on as a record or proof for authorized persons (Perry and Potter 2005). Nurses rely on documentation tools that support the implementation of the nursing process. All the tools used by nurses should form a system. Systematic documentation is critical because it provides the care administered by nurses in a logical fashion (DeLaune and Ladner, 2006). This approach is as follows:

Assessment of data, this data is obtained through interviewing, observing and inspecting; this information provides the foundation for nursing care plan. The risk factors and the identified alteration in the functional health pattern, it directs the formulation of nursing process.Identifying the nursing diagnosis promotes the development of the client' s short term goals, long term goals, and expected outcomes and triggers the nursing intervention. The plan of care identifies the actions necessary to resolve the nursing diagnosis. Implementation is evidenced by actions the nurse performs to assist the client in achieving the expected outcomes (Daniels et al, 2010).

Documentation will differ depending on the health care facility which can be either the Hospital or the nursing homes, and the setting within the facility and with specific client population such as obstetrics. Regardless of what client care is administered the documentation of that care must reflect the nursing process.

2.2 KNOWLEDGE

Accurate nursing documentation leads to the evolution of knowledge and enhance professional autonomy. It can also be a useful source in educating students and for nursing researches. Therefore, the first step in improving the quality of training is to understand the client's perspective. Thus the study under reviewed was conducted to assess knowledge, attitude and performance of nursing students towards nursing documentation. This is a descriptive study which examines knowledge and performance of Tabriz University of Medical Sciences nursing students. 120 students out of 130 were selected using census sampling method.

Findings showed that most students' knowledge of recording nursing reports was moderate, the attitudes of majority of them were "good", too. In order to promote nursing students' knowledge and attitude towards recorded reports as well as improving their performance taking training course on nursing documentation is recommended. The implementation of these programs should be integrated with clinical and theoretical training by authorities of nursing schools. Survey of Knowledge, Attitude and Performance of Nursing Students towards Nursing Documentation.

Today, there is a lack of knowledge about how to successfully implement standardized nursing care plans (SNCPs) in various settings in general and hospital wards in particular. There are few previous studies of SNCPs, and those identified focused on effect and utilization as opposed to implementation. Dahm and Wildenstein [1] found that nurses perceived that SNCPs increased their ability to provide the same quality of care to all patients and reduced the time spent on documentation as well as unnecessary documentation.

Lee and Chang [2] also revealed that SNCPs enhanced the quality of care, as the nurses were reminded of care procedures and time was saved, as they did not need to write everything themselves. However, the SNCP could sometimes be time consuming due to the need to fill in many forms. Another problem was that the SNCP can be inflexible and difficult to apply. The aim of this study was to explore important factors and conditions at hospital wards that had implemented SNCPs. Our study demonstrates that in order for SNCPs to be implemented in clinical practice, they need to be easy for the nurses to assimilate, thus enabling their use as a tool in clinical practice. It is also important for internal facilitators to be supported by the nurse leaders in order to ensure time and resources for the implementation work. It takes time and knowledge to develop an SNCP, but it increases the quality of the operations. Therefore such

work should be prioritized and co-ordinate to avoid every hospital or unit carrying out duplicate work. Resources should be devoted to knowledgeable care developers and internal facilitators working jointly to develop SNCPs that can be used within different types of operations. More research is required to explore the reason why patient experience is not considered and how this situation can be improved.

2.3 **ATTITUDE**

The study of nurses' attitudes towards the documentation of nursing care plan and the factors affecting these attitudes has not been widely studied. According to Helsinki University Central Hospital it was seen that in general, nurses' attitudes toward nursing documentation of nursing care plan was positive. Those over 40 years of age who had clinical experience from 10 to 19 years, Post Basic Nursing education and previous knowledge of nursing diagnoses were most positive in their attitudes. However, the use of nursing diagnoses in preoperative practice was not seen as either necessary or accurate in describing patients' problems. Furthermore, the documentation of perioperative routines was seen as time-consuming and frustrate

2.4 **PRACTICE**

There are several literature reviews of nursing documentation systems. Urquhart and Currell24 completed the most systematic and comprehensive review, examining the literature through 2004. They focus on nursing record systems as variations in the systems effect nursing practice and patient outcomes. Currell and Urquhart conclude that nurses experience tensions between patient care needs and hospital management-promoted documentation rules. They also found that the studies show both mixed responses to new systems and inconclusive links between the nursing documentation system used and its impact on patient care. Also noted was the lack of standardization among systems.

Study 2: conducted by Aaron Mtsha of Stellenbosch University Saudi Arabia N=45 (56. 3%) of the respondents complained that there are lots of paper to write on and it is time consuming. According to Langowski (2005) manual documentation is time consuming. One may miss important documentation requirements, may not be aware of what someone else is documenting or has documented. It is therefore recommended that the use of paper be minimized by shifting

some of the nursing documentation procedures from paperwork to an electronic version especially given the dynamic nature of technology.

2.5 RELATIONSHIP AMONG KNOWLEDGE, ATTITUDE AND PRACTICE.

The focus of the study is on the knowledge, attitudes and practice of nurses and exploring the relationship between these attributes and the nurses' documentation behaviors. The direction of the relationship seems to be lack of standardization of documentation of Nursing care plan causing a negative response among nurses. Taken as a whole, it appears that exposing these practices and attitudes of nurses will increase Nursing documentation in Hospitals.

Generally it is expected that knowledge affects behaviour and by increasing knowledge healthy behaviours should also become better, therefore there is a significant relationship between nurse's attitude and practice on nursing documentation and with promoting their attitude, their practice become well. Attitude can impress all aspects of one's behaviour and even determine his or her whole behaviour (Habashneh et al, 2005).

2.6 THEORETICAL / CONCEPTUAL FRAMEWORK REVIEW

According to Virginia Henderson (1897-1996) Nursing Theory, the intent of this Nursing model is to provide a structure that depicts the parts, subparts and their interrelationship for a holistic view of the patient, as a complete system (Neuman & Fawcett, 2002). Henderson's theory of nursing includes the following concepts: Maintaining a safe environment, Communication with others, to move and maintain desired posture, Working, to Play and participates to recreation, Sleeping and rest, eating and drinking, Personal cleansing and dressing and Breathing.

Patients are viewed as wholes whose parts are in dynamic interactions. The patients are open systems that have a continuous interaction with the environment, other people, and within themselves. The main components of the model are organized by the nursing metaparadigm concepts which include the person, the environment, the person's health and nursing (Neuman & Fawcett, 2002). These interactions between the components can cause stress to the patient. The goal of nursing care, in this model, is the promotion of optimal wellness of the individual through maintenance, or attainment, of system stability by strengthening the lines of resistance. This goal is accomplished through intervention at the three levels of prevention (Sohier, 1997), these are the Primary, secondary and tertiary prevention.

In a Zambian set up not much research has been carried out on nursing documentation. The literature reviewed shows only one study which was conducted by a post basic student on nursing documentation at Monze Hospital with the study unit of 50 nurses. The results showed that most nurses did not have factual knowledge on nursing documentation and although almost all documented nursing care, they did not complete the documentation and that there was lack of guidance.

2.7 **CONCLUSION**

The reviewed literature on nursing documentation is supporting that there is still a gap which needs to be addressed in the knowledge, attitude and practice of documentation of nursing care plan among nurses. We hope that findings of the current study will assist nurses in the field of the documentation of nursing care plan. Therefore it is recommended to provide facilities to present services and teaching courses before and after nurses complete their training. Conducting studies on knowledge, attitude and practice may be helpful in this regard.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

A research design is a blue print for conducting a research study. It maximizes control over factors that could interfere with the study's desired outcome. The type of design directs the selection of a population, sampling procedure, methods of measurement and a plan for data collection (Burns and Grove, 2001).

The purpose of this study is to determine the knowledge, attitude and practice of nurses towards documentation of nursing care plan. A descriptive cross section design with a quantitative approach will be used since it involves a systematic collection and presentation of data to give a clear picture of a particular situation. The cross section design aims at quantifying the distribution of certain variables in a study population at one point of time.

They cover a sample of the population and may also cover the following:Physical characteristics of people, material, environment Socio-economic characteristics such as age and income.Behavior of people and knowledge, attitudes, beliefs and opinions that help explain behavior.Questionnaires were distributed to the participants and answered anonymously with no identities written on the questionnaires. The information obtained from the questionnaires was used for both qualitative and quantitative study

3.2. RESEARCH SETTING

A research setting is the environment in which the research study takes place and can be a natural or controlled environment. Natural setting is real life study environments without any changes made for the purpose of the study (Burns and Grove, 2001). The study was conducted in the various Hospitals randomly selected. These Hospitals are homogenous as they are in urban areas except one of these Hospitals which render male and female in patient services, Maternal and Child Health services, and paediatrics services.

The study was carried out in a natural setting since no changes were made to the Hospital situation or any special treatment was given to the respondents, which can affect the results. The data for the study was collected during the normal hospital working days.

The study was carried out at three Hospitals from different Provinces of Zambia namely; Kitwe Central Hospital, Senenga District Hospital and Choma General Hospital. These Hospitals are located in the urban areas of the country except Senenga which is located in rural area of Western Province. These different Hospitals have been selected because of their proximity, cost effectiveness and, convenience in terms of the languages used by the local people .

3.3 STUDY POPULATION

Population has been defined by Brink (2006) as the entire group of persons or objects that is of interest to the researcher, in other words, that meets the criteria which the researcher is interested in studying. The total population of nurses both Registered and Enrolled Nurses working in different Hospitals under study was included and a sample of 50 Nurses was selected from each Hospital.

3.3.1 INCLUSION CRITERIA

Inclusion criteria are characteristics that the respondents must have in order to be included in the study (Burns and Grove, 2001). In this study the respondents included were all nurses who were found practicing on the wards and willing to participate in the study.

3.3.2 EXCLUSION CRITERIA

Exclusion criteria are the characteristics that the respondents lack in order not to be included in the study (Burns and Grove, 2001). In this study the respondents not willing to participate in the study were excluded.

3.4 SAMPLE SELECTION

Sampling is a process of selecting a portion of the population to represent the total population and the findings from the sample represent the rest of the group. The selected samples should

have similar characteristics to the population under study to allow generalisability of the results to represent the population (Polit and Beck, 2006).

In the study Random sampling method was used were every nurse in the hospital had an equal chance of being selected as a participant. Participants sampled included both Registered and Enrolled nurses working in different wards.

3.5 SAMPLE SIZE

There are no hard or fast rules about the sample size but a sample should have at least 30 respondents, this is according to Burns and Grove (2001). Polit and Beck 2006 state that quantitative research design require large samples to increase representativeness and reducing sampling error. Because of the limited scope of this study a sample of 150 respondents from three hospitals under study were used.

3.6 DATA COLLECTION TOOL

Data collection is a systematic process in which the researcher collects relevant information to achieve the research purpose and objectives. The instrument or tool used to collect the data depends on the design (Burns & Groove, 2001). The target population were Registered Nurses and Enrolled nurses working in Hospitals under study using a questionnaire. Burns and Grove (2001) defined a questionnaire as a printed self-report form designed to elicit information that can be obtained through the written response of the subject. The respondents were requested to complete the questionnaires and the completed questionnaires were collected by the researcher. A questionnaire was used because it is rapid and efficient, the respondents remain anonymous, it is flexible, all respondents answer the same questions and it has the ability to gather data from a wider population.

3.7 VALIDITY

Validity is the extent of accuracy of an instrument to measure the construct it is supposed to measure in the contexts of the concepts or variables being studied (Polit and Beck,2006). The questions was closely examined to ensure that they measure the desired variable. The structured

questionnaire was developed after review of relevant literature to incorporate and measure important variables in the study.

3.7.1 INTERNAL VALIDITY

Internal validity is the extent to which the results of the study reflect reality rather than extraneous variables. The threats to internal validity are factors that may give false positives or false negatives in measurement of variables. Lack of internal validity may be observed when other variables rather than those under study are responsible for part or the entire observed outcome of the variable. Therefore, other variables that may affect the results had to be observed. (Burns and Groove, 2001).

3.7.2 EXTERNAL VALIDITY

This validity deals with the ability to generalise the findings of the study to other members of the population rather than sample. The study will have limited generalisability due to small sample size. However, the use of the three Hospitals under study will improve the possibility of the study to be generalised.

3.8 RELIABITY

Reliability is the degree of consistency with which the data collection instrument produces the same results every time it is implemented in the same situation or used by different investigators. The data collection instrument should be accurate and stable to reflect true scores of the attributes under investigations and minimise error (Polit and Beck, 2006). The reliability was supported by a pilot study. The pre-tested questionnaire was checked for inaccuracies and ambiguity to ensure that it measures exactly what it is expected to measure.

3.9 DATA COLLECTION TECHNIQUE

A structured questionnaire will be used with information about the research study. It will be simple, clear and will have instructions on how to go about completing it. The nature of the questions in the questionnaire will ensure rapid computation and statistical analysis of the data The questionnaire has five sections, namely section A, section B, section C, section D and section E. Section A contains demographic data, section B the nursing care performed, section c documentation performed in the wards, section D knowledge and section E basically staffing levels.

3.10 PILOT STUDY

A pilot study is defined as a smaller version of a proposed study conducted to refine the methodology. It is developed like the proposed study, using similar subjects, the same setting, the same treatment and the same data collection and analysis (Burns and Grove, 2001).

The pilot study was done prior to the collection of data itself under the same circumstances as the actual study. This was done at the University Teaching Hospital Wards. The questionnaire was tested for inaccuracies and ambiguity. 10 registered nurses and enrolled nurses were used in the pilot study. The nurses who participated in the pilot study did not take part in the actual study.Some adjustments were made to the questionnaire such as the number of children one has.

3.11 ETHICAL AND CULTURAL CONSIDERATION

According to Basson and Uys (1991) nursing research must not only be able to guarantee or refine knowledge, but the development and implementation of such research should also be ethically acceptable. The ethical acceptability of the research should apply first of all to the people directly involved in it, but also to the people involved in carrying out the research.

For the purpose of this study the permission was apply for from the University of Zambia School of medicine, from the Provincial Directors, The District Directors from the different Hospitals under study and verbal permission was sought from the respondents before the written

questionnaires were given for completion. Informed written consent was obtained from each participant. Participation was voluntarily and without any coercion. The aim and the reason for the study were explained to the participants. Anonymity and confidentiality was ensured by use of serial numbers.

CHAPTER 4

4.0 DATA ANALYSIS AND INTERPRETATION

INTRODUCTION

In this chapter the data analysis and the findings of the collected data from the research is presented. All the data from completed questionnaires were transferred to the computer by the researchers. The data are presented, analyzed and interpreted in this chapter. All the respondents were nurses in different categories being the registered midwives, Registered nurses, the Enrolled midwives and the Enrolled nurses. There were 150 questionnaires distributed and non was spoilt, they were returned completed. No complaints of inability to understand the questionnaire or difficulty experienced in answering questions were reported.

4.1 DATA ANALYSIS AND INTERPRETATION

The data was analyzed using SPSS version 17.0 software computer program by the researchers. Descriptive and inferential statistics such as frequency tables, percentages and correlation tests were used. In the data analysis and summaries, simple tests of associations were also used to identify relationships between variables, including frequencies, chi square test to compare relationships between variables.

4.2 PRESENTATION OF FINDINGS

The research results were presented in the form of bar graphs, pie charts and frequency tables to summarize results of the study in a way that enables readers to understand findings easily. Cross tabulations of variables were used to clearly show the relationship between variables and for the researcher to be able to draw meaningful inferences. The tables and charts have been clearly numbered and carefully labeled with self explanatory headings.

4.2.1 SECTION A: DEMOGRAPHIC DATA

This section presents the demographic characteristics of the participants in terms of gender, age, marital status, religion, job title, duration of practice as a nurse.

Question 1: Gender (n= 150) Table 1

Gender	Frequency	Percent
Male	28	18.7
Female	122	81.3
Total	150	100.0

Majority 122 (81.3%) of the respondents were females while 28 (18.7%) were males.

Question 2: Ages of Respondents (n= 150) Table 2

Age	Frequency	Percent
18 - 20 yrs	1	.7
21 - 30 yrs	45	30.0
31 - 40 yrs	52	34.7
41 - 50yrs	32	21.3
50 and above	20	13.3
Total	150	100.0

Majority 52 (34.7%) of the respondents were aged 31 – 40 years followed by those aged 21 – 30 years 45 (30%). The Mean age of respondents is 30 years. The Mode is 31-40 years with the frequency (52), and the Median is 41-50 years (32)

Question 3: Marital status (n = 150) Table 3

Marital status	Frequency	Percent
Single	55	36.7
Married	80	53.3
Widowed	8	5.3
Separated	7	4.7
Total	150	100.0

Majority 80 (53.3%) of the respondents were married followed by 55 (36.7%) who were single.

Question 4: What is your religion? (n= 150) Table 4

Religion	Frequency	Percent
Christian	150	100.0

All the respondents were Christians 150 (100%).All respondents were Christians.

Question 5: What is your job title? (n = 150) Table 5

Job title	Frequency	Percent
RN	44	29.3
RM	25	16.7
EN	46	30.7
EM	35	23.3
Total	150	100.0

Majority 46 (30.7%) respondents were Zambia Enrolled nurses followed by Registered nurses 44 (29.3%).

Question 6: How long have you been practicing as a nurse? (n = 150) Table 6

Period of practice	Frequency	Percent
6months - 2 yrs	15	10.0
3 - 5 yrs	34	22.7
6 - 10 yrs	33	22.0
11 - 15 yrs	28	18.7
16 yrs above	40	26.7
Total	150	100.0

Majority 40 (26.7%) of the respondents have been practicing as nurses for more than sixteen years while 33 (22%) about 6 – 10 years.

Question 7: How long have you been working on your present ward? (n= 150) Table 7

Period of working at current ward	Frequency	Percent
Less than 6 months	29	19.3
1 - 2 yrs	74	49.3
3 - 5 yrs	24	16.0
6 - 10 yrs	19	12.7
11 yrs above	4	2.7
Total	150	100.0

Majority 74 (49.3%) respondents have worked for 1 – 2 years on their present wards while few 4 (2.7%) for 11 years and above.

4.2.2 SECTION B: NURSING CARE

This section presents the nursing care plan with characteristics which include the type of nursing care practiced, the individual preference of nursing care and the rating of nursing care in the ward of practice. The tables below will indicate the responses of the respondents.

Question 8: What type of nursing care was practiced in your hospital where you trained? (n = 150). Table 8

Nursing care practiced	Frequency	Percent
Patient allocation	62	41.3
Task allocation	82	54.7
Other(specify)	6	4
Total	150	100.0

Majority 82 (54.7%) respondents practiced task allocation nursing care at the hospitals of their practice while 62(41.3%) of respondents practiced patient allocation.

Question 9: Which type of nursing care in question 10 would you favor if you were given an option? (n = 150) Table 9

Preferred nursing care	Frequency	Percent
Patient allocation	93	62.0
Task allocation	57	38
Total	150	100.0

Majority 93 (62%) of respondents preferred practicing patient allocation while 57 (38%) preferred task allocation nursing. The reason could be that most respondents prefer patient allocation nursing care because it is viewed that it provides a holistic care to individual patients.

Question 10: state the reasons for your answer in question 11 (N= 150) Table 10

Reasons	Frequency	Percent
Appropriate	104	69.3
not appropriate	45	30.0
not applicable	1	0.7
Total	150	100.0

Majority 104 (69.3%) of respondents said they prefer patient allocation because it encourages individualized care while 45 (30%) were not sure.

Question 11: In your opinion how is the present delivery of nursing care on your ward?

Table 11

Delivery of nursing care	Frequency	Percent
Very good	19	12.7
Good	61	40.7
Average	58	38.7
Poor	12	8.0
Total	150	100.0

Majority 61 (40.7%) of respondents stated the nursing care delivered in their ward was good followed by 58 (38.7%) respondents who said the nursing care was average.

Question 12: Give reasons for your answer in question 11 (N=150) Table 12

Reasons	Frequency	Percent
Appropriate	98	65.3
"not appropriate"	50	33.3
"not applicable"	2	1.3
Total	150	100.0

Majority 98 (65.3%) of respondents stated the present delivery of nursing care on their ward is good because they use the available materials on the ward while 50 (33.3%) of respondents said the nursing care being delivered on their current wards was not very good.

4.2.3 SECTION C: DOCUMENTATION

This section presents the data about the knowledge of nurses on nursing documentation.

The tables below show the characteristics of the participant's responses.

Question 13: Was nursing documentation taught in the school where you trained? (n = 15

Table 13

Documentation taught	Frequency	Percent
Yes	142	94.7
No	8	5.3
Total	150	100.0

Majority 142 (94.7%) of respondents stated the nursing documentation was taught in the school where they trained whereas 8 (5.3%) of respondents did not agree.

Question 14: State what was taught in nursing documentation (N= 150) Table 14

What was taught	Frequency	Percent
Nursing care plans and nursing notes	90	60.0
Not appropriate	60	40.0
Total	150	100.0

Majority 90 (60%) of respondents stated they were taught on how to document all nursing notes whereas 60 (40%) did not know what was taught.

Question 15: Did you document your nursing care in the clinical area during your training? (n= 150) Table 15

Did you document	Frequency	Percent
Yes	141	94.0
No	9	6.0
Total	150	100.0

Majority 141 (94%) of respondents documented the nursing care plan on the clinical area during training while 9 (6%) did not document.

Question 16: Is nursing practice being documented on your present ward?

(n= 150) Table 16

Is nursing care being documented on ward	Frequency	Percent
Yes	110	73.3
No	40	26.7
Total	150	100.0

Majority 110 (73.3%) of respondents are documenting nursing care on their present ward while 40 (26.7%) is not documenting.

Question 17: What nursing care is being documented in your ward? (n = 150) Table 17

Care being documented	Frequency	Percent
Appropriate	134	89.3
Not appropriate	16	10.7
Total	150	100.0

Majority 134 (89.3%) of respondents are documenting every procedure done on a patient and reports, followed by 16 (10.7%) of respondents who are not sure whether nursing care is being documented.

Question 18: What are the reasons for not documenting? (n = 150) Table 18

Reasons	Frequency	Percent
Appropriate	93	62.0
Not appropriate	55	36.7
N/A	2	1.3
Total	150	100.0

Majority 93 (62%) of respondents are not documenting because of poor staffing and negative staff attitude, while 55 (36.7%) of respondents are not sure and 2 (1.3%) did not write down anything.

Question 19: If nursing care is being documented in your ward who monitors the documented work (n= 150) Table 19

Monitoring	Frequency	Percent
SNO	14	9.3
NO	13	8.7
Nursing sister	94	62.7
Others (specify)	29	19.3
Total	150	100.0

Majority 94 (62.7%) of respondents who document nursing care are monitored by the Nursing sisters followed by 29 (19.3%) of respondents who are monitored by both the Nursing officer and the nursing sister.

Question 20: What are the constraints of documenting nursing care plan? (n= 150)

Table 20

Constraints	Frequency	Percent
Lack of incentives	15	10.0
Don't know what to document	6	4.0
Shortage of staff	120	80.0
others (specify)	9	6.0
Total	150	100.0

Majority 120 (80%) of respondents stated shortage of staff is one of the constraints of documentation followed by 15 (10%) of respondents who said it is due to lack of incentives.

4.2.4 SECTION D: KNOWLEDGE

This section presents the knowledge of nurses about nursing documentation, it has characteristics such as the definition of nursing documentation, the feel of nurses about documentation, and the components of nursing care plan.

Question 21: State in your own words what nursing documentation involves? (n = 150)

Table 21

Definition of nursing documentation	Frequency	Percent
Appropriate	73	48.7
Not appropriate	55	36.7
N/A	22	14.7
Total	150	100.0

Majority 73 (48.7%) of respondents defined nursing documentation as involving writing all procedures done on a patient, incident and report writing followed by 55 (36.7%) of respondents who did not know the meaning of nursing documentation.

Question 22: How do you feel about documenting nursing care plan? (n=150) Table 22

Feel about documentation	Frequency	Percent
I like it	87	58.0
Its time consuming	31	20.7
Nobody appreciates it	8	5.3
others(specify)	24	16.0
Total	150	100.0

Majority 87 (58%) of respondents like documenting nursing care plan followed by 31 (20.7%) who stated it is time consuming.

Question 23: List the components of nursing care plan (n = 150) Table 23

Components of nursing care plan	Frequency	Percent
Appropriate	103	68.7
Not appropriate	39	26.0
N/A	8	5.3
Total	150	100.0

Majority 103 (68.7%) of respondents know the components of nursing care plan followed by 39(26%) of respondents who do not know the components of nursing care plan.

Question 24: Did you attend in- service training (n = 150) Table 24

In – service training	Frequency	Percent
Yes	17	11.3
No	133	88.7
Total	150	100.0

Majority 133 (88.7%) of respondents did not attend in-service training on nursing documentation while 17(11.3%) did attend the in – service training.

Question 25: How long ago did you attend the training? (n = 150) Table 25

Period of training	Frequency	Percent
3months - 1 year	7	4.7
2 - 3 yrs	10	6.7
4 - 6 yrs	1	.7
10 yrs ago	4	2.7
others (specify)	128	85.3
Total	150	100.0

Majority 6 (4%) of respondents did the in – service training between 3 months – 1 year followed by 5(3%) who trained between 2 – 3 years ago.

Question 26: After training did the supervisor follow up. (n = 150) Table 26

Follow up	Frequency	Percent
Yes	14	9.3
No	136	90.7
Total	150	100.0

Majority 136 (90.7%) respondents did not attend in-service training. The respondents who attended in-service training were few 14 (9.3%) and they were all followed up.

4.2.5 SECTION E: STAFFING PATTERNS

This section presents the views of nurses on staffing levels.

Question 27: How would you rate the staffing pattern on the ward you are working? (n=150) Table 27

Staffing pattern	Frequency	Percent
Adequate	7	4.7
Moderate	67	44.7
Poor	74	49.3
Others	2	1.3
Total	150	100.0

Majority 74 (49%) respondents rated the staffing level on their present wards as poor, followed by 67 (44.7%) who stated that the staffing level was moderate.

Question 28: Which nurses are the most affected? (n = 150) Table 28

Cadre	Frequency	Percent
Registered midwives	3	2.0
Registered nurses	12	8.0
Enrolled midwives	5	3.3
Enrolled nurses	23	15.3
All are affected	107	71.3
Total	150	100.0

Majority 107 (71.3%) respondents stated that all categories of nurses were affected by the shortage followed by 23 (15.3%) who stated that the Enrolled nurses were affected.

CHI SQUARE TEST

Chi-square test examines the relationship between two variables at nominal and discrete level in quantitative or qualitative research. The test compares the actual frequencies with the expected outcomes or how close they match or differ from the expected distribution and whether two variables are independent or not. In this study, most of the questions were nominal and discrete hence the use of this test and frequent tables in interpretation of data (Burns &Grove 2001: Munro 1997). Chi square was done on question 5 and 8 respectively, and it is represented as chi 198.800, 27.387: P-0.000, 0.061 .In the study since the p-value is less than 0.05($p<0.05$) significance level will be rejecting the null hypothesis that is actually true.

CROSS TABULATION OF KNOWLEDGE AND PRACTICE VARIABLES WITH DEMOGRAPHIC DATA; RELATION BETWEEN KNOWLEDGE OF NURSING DOCUMENTATION AND GENDER

KNOWLEDGE ON DOCUMENTATION	**GENDER**		**TOTALS**
	MALE	**FEMALE**	
Appropriate	14(50%)	59 (48.4%)	73(48.7%)
Not appropriate	13(46.4%)	42(34.4%)	55(36.7%)
Not applicable	1(3.5%)	21(17.2%)	22(14.7%)
TOTALS	**28(18.7%)**	**122(81.3%)**	**150(100%)**

Only I (3.5%) male respondent did not have knowledge on nursing documentation.

Test statistics	**Gender of staff**	**State what documentation is in your own words**
Chi – square	58.907	26.760
Asymp.sig(p value)	.000	.000

KNOWLEDGE ON IN-SERVICE TRAINING IN RELATION TO PERIOD OF COMMENCING NURSING PRACTICE

KNOWLEDGE ON IN SERVICE TRAINING	PERIOD OF IN-SERVICE TRAINING					
	6mths – 2	**3 – 5**	**6 - 10**	**11 – 15**	**16 above**	**TOTAL**
Yes	1(6.5%)	3(8.8%)	4(12.1%)	3(10.7%)	6(15%)	**17(11.3%)**
No	14(93.3%)	31(92%)	29(87.9%)	25(89.3%)	34(85%)	**133(88.7%)**
TOTAL	**15(10%)**	**34(23%)**	**33(22%)**	**28(19%)**	**40(27%)**	**150(100%)**

34(85%) of respondents attended in-service training some 16 years ago

CROSS TABULATION OF NURSING PRACTICE WITH GENDER

RELATION OF JOB TITLE AND THE TYPE OF NURSING CARE PRACTICED AT TRAINING SCHOOL.

PRACTICE OF NURSING CARE PLAN	TYPE OF NURSING CARE PRACTICED AT TRAINING SCHOOL			TOTAL
	PATIENT ALLOCATION	TASK ALLOCATION	OTHER (SPECIFY)	
Registered midwife	8(32%)	17(68%)	0	**25(16.7%)**
Registered nurse	21(47.7%)	23(52.2%)	0	**44(29.3%)**
Enrolled midwife	11(31.4)	23(65.7%)	1(2.9%)	**35(23.3%)**
Enrolled nurse	22(47.8%)	22(47.8%)	2(4.3%)	**46(30.7%)**
TOTALS	**61(40.7%)**	**82(54.7%)**	**3(2%)**	**150(100%)**

23(65.7%) Enrolled Midwives practiced task allocation nursing care at their training school.

Test statistics	Job title	Type of nursing care practiced at training school
Chi square	27.387	198.800
Asymp.sig.(p value)	.061	.000

RELATION OF PRACTICE ON PRESENT WARD AND THE PRESENT DELIVERY OF NURSING CARE PLAN ON PRESENT WARD

PRACTICE ON PRESENT WARD IN YRS	PRESENT DELIVERY OF NURSING CARE PLAN				TOTAL
	VERY GOOD	GOOD	AVERAGE	POOR	
1 - 2	7(9.5%)	32(43.2%)	28(37.8)	7(9.5)	**74 (49.3%)**
3 - 5	3(12.5%)	8(33.3%)	11(45.8%)	2(8.3%)	**24(16%)**
6 – 10	2(10.5%)	9(47.4%)	6(31.6)	0(0)	**4 (2.7%)**
11 above	1(25%)	0(0%)	3(75%)	0(0%)	**4(2.7%)**
TOTALS	**19(12.7%)**	**61(40.7%)**	**58(38.7%)**	**12(8%)**	**150 (100%)**

32(43.2%) of respondents who had worked on their present wards for 1 – 2 years are practicing good nursing care plan.

CHAPTER 5

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

INTRODUCTION

This chapter presents a discussion of the research findings based on the analysis of responses from a sample of one hundred and fifty (150) nurses who are currently practicing using a questionnaire. These were drawn from Choma General Hospital, Kitwe Central Hospital and Senanga Hospital respectively.

5.1 DEMOGRAPHIC DATA

The demographic characteristics of the respondents which were relevant to this study included age, gender, marital status, religion, job title and years of experience. The information on demographic characteristics was essential for interpretation of study findings.

The results of the current study showed that Out of 150 respondents questioned using a questionnaire 122 (81.3%) were females and 28 (18.7%) were males (Table 1). In the current study, an observed increase in females could be attributed to that ,Traditionally we recognize nursing as female dominated profession, this dates back to the time of Florence Nightingale commonly called as "The lady with the lamp "this epitomized the caring profession that 180 years after her birth we still think of her as the nursing icon. This long-skirted Victorian gave birth to a stereotype, which still prevails, that to be a nurse you must be female. But Florence Nightingale was no shrinking violet, famed for tending the sick and dying in the Crimean war, she was a formidable woman and the qualities she possessed commonly to many nurses today were not those regarded as strictly female. Although this is the case observed, the General Nursing Council and the Ministry of Health have included in the strategic plan that when enrolling nurses in schools of nursing the ratio should be Female 3: Male 1.Thus in future it is expected that male nurses in the profession will improve.

Majority 52 (34.7%) of the respondents were aged 31 – 40 years followed by those aged 21 – 30 years 45 (30%). The Mean age of respondents is 30 years. The Mode is 31-40 years with the frequency (52), and the Median is 41-50 years (32)

The reason why majority of respondents are within the ages between 31 and 40 could be attributed to the time that the respondents spend in colleges, denoting that mainly people attend college around 25 – 30 years respectively and spend at least about three (3) or more years before graduating to start working.

Majority 80 (53.3%) of the respondents were married followed by 55 (36.7%) who were single. The majority of the respondents are married, this may be attributed to the fact that majority of them have had time to go to college and now they are settled wanting to have their own families.

All the respondents were Christians 150 (100%).All respondents were Christians; this could be due to the declaration of Zambia as a Christian nation in 1991 by the late President Dr.F.T.J.Chiluba.

Majority 46 (30.7%) respondents were Zambia Enrolled nurses followed by Registered nurses 44 (29.3%).The ENs were the majority of respondents in the Hospitals under study, this is because nearly all Health institutions are manned by Enrolled nurses. Way back a good number of nursing schools were training Enrolled nurses than Registered nurses, but currently a good number of EN schools have been converted to training of Registered Nurses. In addition there are a lot of private nursing schools which have been opened to train registered nurses. This is the reason why RNs 47 (31%) is following the ENs on the respondents

Majority 40 (26.7%) of the respondents have been practicing as nurses for more than sixteen years while 33 (22%) about 6 – 10 years. The respondents who have been practicing nursing for more than 16 years revealed to have a good attitude towards nursing documentation in comparison with those who have been working for 2 years or less 15 (10%).

Majority 74 (49.3%) respondents have worked for 1 – 2 years on their present wards while few 4 (2.7%) for 11 years and above. The reason could be attributed to the ward rotations which take place after every 1 – 2 years in most hospitals. Those who have been on the same ward for a long period of time have done specialties in those particular Departments such as management of malnutrition in children, thus if rotated to other wards they may be rendered ineffective.

5.2 NURSING CARE

Several approaches of nursing care were being used in delivery of nursing care to patients. The study shows that the most popular approach is task allocation used by 82 (54.7%) of respondents, this is because majority of Health institutions practice task allocation because it is convenient. The patient received fragmented care in which the emphasis is on the tasks rather than the patient, this is followed by patient allocation as stated by 62(41.3%) of respondents. It is interesting to note that although respondents practice all these approaches Majority 93 (62%) of respondent's recognized patient allocation as a better method of delivering nursing care. This could be attributed to the fact that it provides individualized care and it improves nurse-patient relationship and it is easy to evaluate.

5.3 ATTITUDE

In accordance to Booyens 1998, completion and accurate documentation of all nursing tasks is a professional and ethical requirement. In the study job title does not influence the level of nursing documentation as it is taught in all nursing schools whether Registered Nursing or Enrolled Nursing schools. The incomplete and variations in nursing documentation could be attributed to the negative attitude of respondents or probably being forgetful of what was taught in training school. The study has also indicated that majority 40 (26.7%) of the respondents have been practicing as nurses for more than sixteen years while 33 (22%) about 6 – 10 years. The respondents who have been practicing nursing for more than 16 years revealed to have a positive attitude towards nursing documentation in comparison with those who have been working for 2 years or less 15 (10%).In a similar study at Helsinki University Central Hospital it was seen that in general, nurses' attitudes toward nursing documentation of nursing care plan was positive. Those over 40 years of age who had clinical experience from 10 to 19 years, post basic nursing education and previous knowledge of nursing diagnoses were most positive in their attitudes.

5.4 KNOWLEDGE

In accordance with the Zambia Demographic and Health Survey conducted between April and October 2007 established that knowledge is a pre condition of proper or high utilization of any given service (C.S.O, 2007).The findings in the study indicated that 73 (48.7%) of respondents have general knowledge on nursing documentation while 55 (36.7%) of respondents had low knowledge. similar studies conducted at Tabriz University of Medical Sciences by Mohajjel et al 2012,suggest the nurses educational need to learn more about nursing documentation which is consistence with the results of the present study(table 24).It is unfortunate that although nurses like nursing documentation87(58%), there are many constraints(table 20) that hinder them to document. Among the constraints are staff shortage, inadequate materials and equipment, lack of training on nursing documentation.

Table 24 shows that 133 (88.7%) of respondents have not received in-service training on nursing documentation, therefore proves the hypothesis which states that nurses who had in-service training on HIMS are likely to document than those who did not attend the training.

5.5 PRACTICE

In any health institution man power should correspond with the needs of their organisation. The study reveals that 74 (49.3%) of respondents were of the opinion that staff pattern was poor (table 27). The poor staffing pattern will mean nurses are overstretched and tension rises in the way they practice, this will lead to provision of poor nursing care. A similar study was conducted by Currell and Urquhart 2004 who concluded that nurses experience tensions between patient care needs and hospital management. They also found that the studies show both mixed responses to new systems and inconclusive links between the nursing documentation system used and its impact on patient care. It was also noted that there was lack of standardization among systems. The reduction in staffing levels can be attributed to transfers, nurses seeking for greener pastures and absenteeism due to ill health and stress among practicing nurse.

5.7 IMPLICATIONS FOR THE HEALTH CARE SYSTEM

In the past few decades the nursing profession has witnessed a change toward a more independent practice with open knowledge of nursing care. With the change has come the obligation to document not only the performed interventions that are medical and nursing but also the decision process, explaining why a specific nursing action has been prompted.

The increase in staffing level on the clinical area will ensure that nurses' offer individualized patient care without overworking themselves. Complete documentation depends on the ability and competence of nurses. On the other hand poor nursing care coupled with shortage of staff and inadequate materials results in poor quality nursing services to the public.

The study indicated that majority of nurses had a positive attitude towards nursing documentation; this attitude should be promoted through getting rid of the constraints such as staff shortage and inadequate supply of materials in the working environment.

5.8 SIGNIFICANCE TO NURSING

Based on the results of this study, the following are significances made with reference to Knowledge, Attitudes and Practice in nursing documentation.

5.8.1Nursing practice

Nursing practice is a direct service provided to a variety of patient/client populations throughout the life cycle as well as groups and communities (Parker, 2010).

The study results show that respondents have low knowledge. The results imply that Majority 73 (48.7%) of respondents did not know the meaning of nursing documentation.

1. Nurses are less knowledgeable about the benefits obtained from the use of documentation and skeptical regarding the role of information system in improving the quality of Healthcare.
2. Majority of respondents have not received in-service training on nursing documentation, this proves that nurses who had in – service training on HIMS are likely to document than those who did not attend the training.

5.8.2 Nursing research

Nursing research is defined as a scientific process that validates and refines existing knowledge and generates new knowledge that directly and indirectly influences the delivery of evidence – based nursing practice (Burns, 2009). Research is relevant because:

1. Few researches have been carried out on knowledge, Attitude and practices of documentation in nursing to improve care based on scientific evidence knowledge.
2. It can also help show why nurses have low knowledge and practices in documentation of nursing care plan thereby not giving quality information to policy makers and managers on what to do.

It is therefore necessary that nurses take interest in researching on various aspects of nursing documentation and conduct research on a large scale to improve knowledge and practices of nurses on documentation.

5.8.3 Nursing administration

Nursing administration is a process which is related to decisions in which planning, organizing, staffing, directing coordinating, registering, budgeting and evaluation are placed (Basavanthappa, 2007). The results show that majority of nurses were affected by staff shortage The following can be done by nurse administrators:

1. To alleviate shortage of staff, administrators should ensure that there is adequate number of nurses on the wards through motivating the nurses by doing of part-time jobs so that they have time to give adequate nursing care plan to patients.
2. Nurse administrators need to intensify on lobbying for more nurses from the Ministry of Health so that nursing knowledge and practices of documentation can be enhanced.

5.8.4 Nursing education

The respondent's low knowledge can be attributed to lack of in – service training. It is important that nurses receive adequate training on nursing documentation during their pre service training so that they share their knowledge with those nurses who have been in service before the incorporation of documentation in the curriculum of nurses. Nurses who are already in-service can have continued education on documentation by having weekly presentations on Health Information Management System (HIMS). This is very important because a knowledgeable nurse will feel confident to teach others what they have learnt.

CONCLUSION

In regard to results obtained in the study, it seems that most respondents did not have factual knowledge on nursing documentation, although all the respondents documented nursing care, some did not complete, some did not know what to document, and this can be attributed to negative attitude of staff and other constraints. In order to address this problem training courses should be promoted especially to capable respondents who have the ability to present comprehensive and general care reporting, these will in turn train or teach others.

5.9 RECOMMENDATIONS

The following recommendations were made in the light of findings of the study as follows:

5.9.1 Ministry of Health

The Ministry of Health should ensure that the following are done,

1. improving on the supply of materials such as stationary

2. Employ more staff nurses of all categories.

5.9.2 General Nursing Council

1. There is need to reorient and Introduce training courses on nursing documentation especially for the trainees trained from the private nursing schools.

5.9.3 Choma General Hospital, Senanga District Hospital and Kitwe Central Hospital

1. Improve nurses' attitude through motivating them and provision of necessary information with regards to nursing documentation.

2. The nurse managers that is the Nursing Officers and the Nursing Sisters to be monitoring the documentation on the wards.

3. The leaves such as occasional leave, vacation leave should be well planned by managers to avoid staff shortages.

4. The managers should put a deliberate policy of motivating those staff who are doing a commendable job.

5. Exchange visits with other hospitals should be encouraged to learn on how other hospitals are managing.

5.10 DISSEMINATION OF FINDINGS

The study findings will be disseminated by submitting copies of the report to the following:

1. Department of Nursing Sciences, UNZA.
2. The Medical Library, UNZA
3. Ministry of Health Headquarters.

Summary of findings will be submitted to the following:

1. Choma General Hospital
2. Kitwe Central Hospital
3. Senanga District Hospital
4. Workshops/meetings will be held at the three Health institutions.

5.11 LIMITATIONS OF THE STUDY

Some of the limitations to the study were as follows:

1. There was an inadequate study done in Zambia to compare the findings on knowledge, practices and attitude of nurses towards nursing documentation on nursing care plans as well as in other countries. Hence there was inadequate material for literature review.

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APPENDIX 1

THE UNIVERSITY OF ZAMBIA **SN.**

SCHOOL OF MEDICINE

DEPATMENT OF NURSING SCIENCES

STRUCTURED INTERVIEW SCHEDULE

TOPIC: KNOWLEDGE, ATTITUDE AND PRACTICEOF NURSES TOWARDS DOCUMENTATION OF NURSING CARE PLAN

DATE OF QUESTIONNAIRE DISTRIBUTION.....

PLACE/LOCATION.....

NAME OF INTERVIEWER.....

INSTRUCTIONS TO RESPONDENTS

1. Introduce yourself to the respondent before giving instructions.
2. Explain the purpose of the questionnaire
3. Get written consent from the respondent and do not force them to answer the questionnaire
4. Assure the respondent that the names and/or addresses will not be written on the questionnaire and that all responses will be held in strict confidence to ensure privacy and anonymity
5. Encourage respondents to answer all questions
6. Indicate response by ticking in the appropriate space for closed ended questions
7. Indicate response by filling in the spaces provided for open ended questions
8. Collect the questionnaire and store them safely

SECTION A

DEMOGRAPHIC DATA **Official use only.**

1. Sex of staff

a) Male ( )

b) Female ( )

2. How old were you on your last birthday?

a) 18 – 20 years ( )

b) 21 -30 years ( )

c) 31 – 40 years ( )

d) 41 -50 years ( )

e) 50 years and above ( )

3. What is your current marital status?

a) Single ( )

b) Married ( )

c) Widowed ( )

d) Separated ( )

4. What is your religion?

a) Christian ( )

b) Hindu ( )

c) Moslem ( )

d) Other (specify) ( )

5. What is your job title?

a) Registered Nurse ( )

b) Registered Midwife ( )

c) Enrolled Nurse ( )

d) Enrolled Nurse ( )

6. When did you start practicing as a Nurse?

a) 6Months – 2 years ( )

b) 3 – 5 years ( )

c) 6 – 10 years ( )

d) 11 – 15 years ( )

e) 16 years and above ( )

7. How long have you been working on your present ward?

a) Less than 6 months ( )

b) 1 – 2 years ( )

c) 3 – 5 years ( )

d) 6 – 10 years ( )

e) 11 years and above ( )

SECTION B NURSING CARE

8. What type of nursing care was practiced in your Hospital where you trained?

a) Patient allocation ( )

b) Team Nursing ( )

c) Other (specify) ( )

9. Which type of nursing care in question 10 would you favour if you were given an option to choose?

a) Patient allocation ( )

b) Team nursing ( )

c) Other (specify) ( )

10. State the reasons for your answer in question 11.....

.....

.....

11. In your opinion, how is the present delivery of nursing care on your ward?

a) Very good ( )

b) Good ( )

c) Average ( )

d) Poor ( )

12. Give reasons for your answer in question 13.

.....

.....

SECTION C DOCUMENTATION

13. Was nursing documentation taught in the school where you trained?

a) Yes ( )

b) No ( )

14. If yes to question 15, state what was taught in nursing documentation

.....

.....

15. Did you document your nursing care in the clinical area during your training?

a) Yes ( )

b) No ( )

16. If the answer to question 17 is 'yes' state in your own words what you documented during your training in the clinical area.

.....

.....

.....

17. Is nursing practice being documented on your present ward?

a) Yes ( )

b) No ( )

18. If the answer to question 19 is 'yes', what nursing care is being documented in your ward?

.....

.....

19. If the answer to question 19 is' No 'what are the reasons for not documenting?

.....

.....

20. If nursing care is being documented in your ward who monitors the documented work?

a) Senior Nursing Officer ( )

b) Nursing Officer ( )

c) Nursing sister ( )

d) Other (specify).....

21. What are the constraints of documenting nursing care plan?

a) Lack of incentive ( )

b) I don't know what to document ( )

c) Shortage of staff ( )

d) Others (specify).....

SECTION D KNOWLEDGE

22. State in your words what nursing documentation involves

.....

.....

23. How do you feel about documenting nursing care plan?

a) I like it ( )

b) I find it time consuming ( )

c) Nobody appreciates it ( )

d) Others (specify).....

24. List the components of nursing care plan.

.....

.....

.....

.....

25. Did you attend in-service training on documentation of nursing care plan?

a) Yes ( )

b) No ( )

26. If the answer to question 27 is 'Yes 'how long ago did you attend the training?

a) 3 months - 1 year ago ( )

b) 2 – 3 years ago ( )

c) 4 – 6years ago ( )

d) 10years ago ( )

Others (specify) ( )

27. After attending the in – service training on nursing documentation did the supervisor follow up to ensure that nursing care was being documented on the ward?

a) Yes ( )

b) No ( )

SECTION E STAFFING PATTERNS

28. How would you rate the staffing pattern on the ward you are working?

a) Adequate ( )

b) Moderate ( )

c) Poor ( )

29. Which nurses are the most affected?

a) Registered Midwives ( )

b) Registered Nurses ( )

c) Enrolled Midwives ( )

d) Enrolled Nurses ( )

e) All are affected ( )

30. What would you recommend to improve the nursing care plan documentation among nurses?

.....

.....

.....

THANK YOU FOR YOUR PARTICIPATION

APPENDIX IV

WORK SCHEDULE

TASK TO BE PERFORMED	RESPONSIBLE PERSON	WEEKS	DATES	PERSON DAYS REQUIRED
Finalize research proposal	Principal Investigator	1-14 weeks	22/04/07 to 30/07/07	100 days
Clearance from Ethics committee	Researcher Supervisor	Week 15-16	31/07/07 to 13/08/07	14days
Training of research assistants	Principal Investigator	Week 17-18	14/08/07 to 27/08/07	14 days
Field testing the tool	Principal Investigator	Week 19	28/08/07 to 03/09/07	7 days
Data collection	Principal Investigator	Week 20-24	04/09/07 to 30/09/07	27 days
Data analysis	Principal Investigator	Week 25-30	01/10/07 to 10/12/07	71 days
Report writing and submission	Principal Investigator	Week 31-33	11/12/07 to 31/12/07	21 days
Dissemination	Principal	Week 34-38	01/01/08 to	25 days

of findings	Investigator		25/01/08	
Monitoring and evaluation	Continuous by the Principal Investigator			

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SK TO BE RFORMED	ESPONSIBLE PERSON	APRIL	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DE
lizing earch proposal	Principal Investigator									
rance for ling from istry of Health	Principal Investigator									
rance and nt local orities	Principal Investigator and district health director									
ning research tants and st	Principal Investigator									
ection of data	Principal Investigator and research assistants									

liminary data lection	Principal Investigator									
al data analysis	Principal Investigator									
ort writing	Principal Investigator									
mitting report	Principal Investigator									
semination of ings	Principal Investigator									
nitor and uation	Principal Investigator									

APPENDIX V

BUDGET FOR THE RESEARCH STUDY

	ITEM	UNIT COST K N	TOTAL K N
1	**Field work and travel expenses**		
	(a) Lunch allowance for the Researcher and research assistants	30 000 per day x 10 days	300 000 00
	(b) Transport allowance for the Researcher and assistants	20 000 per day x 10 days	200 000 00
	Subtotal		**500 000 00**
2	**Secretarial Services**		
	(a) Typing and editing of the study	3 000.00 per page x 100 pages	300 000 00
	(b) Photocopying of report	200.00 per page x 100 pages	20 000 00
	(c) Stationary	30 000 per ream of paper x 3 reams	90 000 00
	(d) Binding final report	50 000 per copy x 3 copies	150 000 00
	(e) Pens	500.00 per pen x 5	2 500 00
	(f) Pencils	500.00 per pencil x 5	2 500 00
	(g) Eraser	1 box of eraser at 5 000	5 000 00
	Subtotal		**570 000 00**

3	Dissemination workshop	2 000 000. 00	2 000 000. 00
	Subtotal		**2 000 000. 00**
	Contingent fund 10% of the total Budget	307 000.00	**307 000. 00**
	GRAND TOTAL		**3 377 000. 00**

BUDGET JUSTIFICATION

STATIONARY

During the study the investigators needed stationary in order to collect data. The notebooks are required for taking notes of all important points during data collection and analysis. The research bags were used for storing the questionnaires during and after the study.

TRANSPORT AND MEAL ALLOWANCES

The study sites which are the Hospitals are all located away from the usual residence of the investigator meaning he /she was away from home for a minimum of 20 working days collecting data. Transport expenses and meals had to be provided. This included expenses for the Research Assistants.

SECRETARIAL SERVICES

Secretarial services were engaged to prepare the document. The data was analyzed and will be disseminated. The document was professionally prepared and well bound copies made to keep the information secure. Funds were required for preparation of copies.

APPENDIX III

University of Zambia,

School of Medicine,

Department of Nursing Sciences,

Box 50110,

Lusaka.

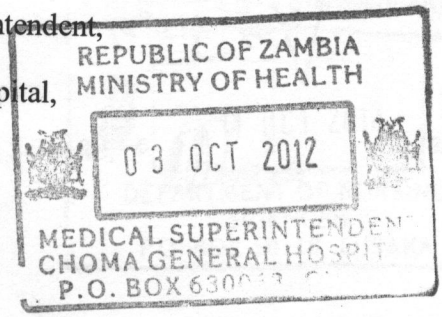
1st October, 2012

The Medical Superintendent,

Choma General Hospital,

Box 630063,

Choma.



UFS

The Head of Department,

Department of Nursing Services,

Box 50110,

Lusaka.

Dear Sir,

Re: Research study at Choma General Hospital

Am a 5th year final student at the University of Zambia, Department of Nursing Sciences currently pursuing a Bachelors degree course in Nursing. In partial fulfillment of this programme, am requested to conduct a research study my topic being "Knowledge, Attitude and Practice of nurses towards Documentation of Nursing care plan".

Am hereby requesting for permission to conduct the study.

Thanking you in advance.

Yours Faithfully,

Chilenga Kasamwa

University of Zambia,

School of Medicine,

P.O. Box 50110,

Lusaka.

27TH September, 2012.

The Medical Superintendent,

University Teaching Hospital,

Private bag 1x RW,

Lusaka.

U.F.S Head of Department,

Department of Nursing Sciences,

School of Medicine,

P.O. Box 50110,

Lusaka.

Dear Sir,

RE: REQUEST FOR PERMISSION TO CARRY OUT A PILOT STUDY

We are 5th year undergraduate students at the Department of Nursing Sciences, School of Medicine, University Of Zambia. In partial fulfillment of the Bachelor of Science Nursing degree programme, we are required to conduct a research study. The title of our study is **Knowledge, attitude and practice of nurses towards documentation of the nursing care plan**. We will particularly conduct this study among nurses at UTH.

We are therefore requesting for permission to conduct a pilot study at your institution prior to the main study. We wish to conduct the pilot study on 28th September, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Mahale Lumpa. S, (29074291)

Kanyanga Jones (10111671)

Chilenga Kasamwa (10036423)

cc Supervisor Mrs P. M. Ndele

The University OF Zambia,

School of Medicine,

Department of Nursing Sciences,

P.O.Box 50110,

Lusaka.

01ST October, 2012.

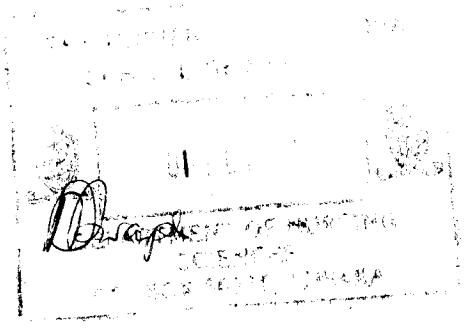
No objection
Dr. TSHIBWEF

The Medical Superintendent,

Senanga District Hospital,

Box 920060,

Senanga.



UFS

Head of Department,

Department of Nursing Sciences,

Box 50110,

Lusaka.

Dear sir,

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT YOUR HOSPITAL.

I am a 5th year final student at the University of Zambia, Department of Nursing Sciences in the School of Medicine, currently pursing a Bachelor degree course in Nursing. In partial fulfilment of this programme, I am required to conduct a research study on the topic "**knowledge, attitude and practice of nurses towards documentation of Nursing care plan" .**

I am hereby requesting for permissionto conduct the research study at your institution. I with to conduct the study from 01st October to 26th October, 2012.

Your consideration will be highly appreciated.

Yours faithfully

Mahale Lumpa. S

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
KITWE CENTRAL HOSPITAL

Kuomboka Drive
P O Box 20969
Kitwe
Zambia

Telefax: 224365/228604
EM-kchmb@zamtel.zm

All correspondence to be addressed to the Senior Medical Superintendent

Our Ref :MH/KCH/

Your ref:

23rd October, 2012

Mr. Jones Kanyanga
University of Zambia
School of Medicine
Department of Nursing Services
P.O. BOX 50110
LUSAKA

Dear Mr. Kanyanga

RE: APPLICATION TO UNDERTAKE A STUDY AT KITWE CENTRAL HOSPITAL - YOURSELF

Reference is made to your application dated 1st October, 2012 regarding the above subject.

I am pleased to inform you that authority has been granted to conduct a research on **"knowledge, attitude and practice of Nurses towards documentation of Nursing Care Plan".**

Kindly note that this research is purely for academic purposes and a copy of the report should be submitted to Kitwe Central Management for record purposes.

We wish you success in your studies.

Yours faithfully
KITWE CENTRAL HOSPITAL

Phales Phiri Shantima (Mrs)
Ag/Senior Human Resource Management Officer
FOR/SENIOR MEDICAL SUPERINTENDENT

PPS/mmh