A STUDY TO DETERMINE FACTORS INFLUENCING DOCUMENTATION IN NURSING AT MONZE HOSPITAL

BY

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A research study submitted to the Department of Post Basic Nursing, School of Medicine, University of Zambia in partial fulfillment of the requirements for the award OF the Bachelor of Science Degree in Nursing

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LIST OF ABBREVIATIONS

AIDS - Acquired Immuno-deficiency Syndrome

CBoH - Central Board of Health

CHAZ - Churches Health Association of Zambia

CSO - Central Statistical Office

GNC - General Nursing Council

HMIS - Health Management Information System

UTH - University Teaching Hospital

DECLARATION

I hereby declare that the work presented in this study, for the Bachelor of Science in Nursing Degree has not been presented either wholly or in part for any other Bachelor of Science Degree and is not being currently submitted for any other Degree.

Name: MUTINTA S. MALAMA

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(Supervising lecturer)

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various persons and sources to which I am indebted are clearly indicated in document.

Signed: Nal

Date: 01.04.04

(Candidate)

DEDICATION

This study is dedicated to my beloved husband, Kennedy Malama for the support and encouragement he gave me throughout my study.

ABSTRACT

The main purpose of this study was to determine factors influencing documentation in nursing practice. The ultimate goal was to help nursing leaders find means of uplifting nursing standards and make the nurses realize the benefits of documenting nursing practice.

A descriptive cross-section study was carried out to explore the factors influencing nursing documentation. Both quantitative and qualitative methods were used. The study was carried out at Monze Mission Hospital in Monze District. Monze District is situated about 200 km south of Lusaka.

Fifty respondents were selected using simple random sample method. Data was collected from the respondents through the use of self-administered questionnaire. Data collected was analysed manually using a data master sheet and a scientific calculator.

The study revealed that almost all (82%, 41) of the nurses documented nursing practice although it was found that most of the nursing care documented was inadequate and incomplete. (60%, 30) documented procedures, medication and inventory, (10%, 5) documented nursing care plan, (42%, 21) documented vital signs, blood pressure, fluid balancing, partogram, (18%, 9) documented admissions, history taking, (16%, 8) documented reports on critical clients and post-op clients, Glasgow coma scale. Majority of the nurses had an overwhelming positive attitude towards nursing documentation if constraints in the environment were removed. (56%, 28) reported that they like nursing documentation. Among the constraints cited leading to none documentation of nursing practice were: inadequate and poor staffing patterns on the wards. (92%, 46) respondents reported that staffing pattern was poor on the ward.

The study revealed that lack of in-service training on nursing documentation has contributed to inadequate knowledge on nursing documentation. (68%,

34) did not undergo in-serve training. If in-service training was conducted for all the nurses, it would certainly increase their knowledge of nursing documentation.

Recommendations of the study included, the hospital management to make amendments on the factors affecting nursing documentation and to plan in-service training on nursing documentation and Health Management Information System (HMIS).

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a landlocked country found in Southern Africa. It shares borders with Angola, Namibia, Botswana, Zimbabwe, Mozambique, Malawi, Tanzania and the Democratic Republic of Congo. It has 752, 612 square kilometers which is divided into nine provinces with 72 Districts. Lusaka is the capital city of Zambia. There are seventy three ethnic tribes with seven major languages. The population of the country is about 10.4 million as reported by 2000 census. The growth rate is 2.9 % (CSO, 2001).

The population of Zambia is concentrated along the line of rail because major towns are along this route hence the rural to urban drift in search of jobs. The rural area is mostly under developed with scarce social amenities.

The main health providers in Zambia are the Government Ministry of Health through the Central Board of Health (CBoH) and the church through church Health Association of Zambia (CHAZ). Other providers are the private sector such as the mine hospitals, the Zambian Flying Doctors' Services and the Traditional Healers and Practitioners.

The health services in Zambia are inadequate to meet the prevailing health needs of the country. Currently 1 in 6 children die before the age of 5. Under 5 mortality, which had shown a modest increase from 191 to 197 death per 1,000 births between 1992 and 1996 surveys, subsequently fell sharply to 168 in 2001 – 2002, (CSO and MoH, 2003). The maternal mortality ratio during the seven year period prior to the 2001-2002 is estimated as 729 maternal deaths per 100,000 live births (CSO and MoH, 2003).

The health care system in Zambia has undergone changes due to the National Health Reforms of the 1991. One of the areas of focus of the reforms has been improving the information system in health facilities in order to provide adequate information needed by policy makers, managers and care providers.

In 1998 the CBoH developed a concept of Health Management Information System (HMIS) to facilitate standard documentation of health care activities. The HMIS has been revised as part of the health reform process. The vision that guides the reform movement is to provide all Zambians with "equity of access to cost-effective quality health care as close to the family as possible" (CBoH, 1998).

The HMIS is a routine monitoring system. It relies on data that are regularly collected during operation of health system. "HMIS is intended that the standard of documentation in use or to be used in health facility must capture patient care data crucial for satisfying professional practice, quality assurance, costing and administrative requirements" (CBoH, 1998).

The HMIS concept has strengthened nursing care documentation in nursing practice. The General Nursing Council (GNC) of Zambia is a statutory body responsible for regulating nursing practice in the country. In order to monitor the quality of nursing care being rendered effectively in the country, the council incorporated the concept of nursing documentation through the adoption of the nursing process into the curriculum of the Registered and Enrolled Nursing in 1983. The council has emphasized that nurses must be able to document and account for the nursing care they offer to patients.

In Zambia the importance of improved documentation and implementation of nursing care guided by defined standards has been an agenda for many years especially in the last five years. In 1997 the Ministry of Health through CBoH facilitated the formation of Zambia Health Accreditation Council. This body has developed hospital Accreditation Survey tools with specific standards and

indicators assessing nursing care documentation and the quality of nursing being documented. These nursing care standards are similar to the ones the General Council of Zambia adopted. The General Nursing Council adopted the nursing care standards as its monitoring and its evaluation tools which were launched in 2001.

The CBoH in line with the health reforms has stressed the importance of improved information management. At the hospital level the information management system is being assessed through the nursing care standards contained in the performance assessment process guide of 2002.

The senior nursing personnel at Monze Hospital adopted the concept of nursing documentation as a central role in quality of care in 1992. Monze hospital is found in Monze District in the Southern Province. The District has a population of 173, 113 people (Monze Annual Report, 2002) Monze hospital has become a recognised General Hospital and was to focus on providing specialized patient care in the four major disciplines of Surgery, Obstetrics/Gynaecology, Paediatrics and Internal Medicine. The hospital receives patients from neighbouring districts for specialized care. Currently the hospital is offering secondary care to the public through early diagnosis and prompt treatment of disease and disabilities. Monze hospital has two schools, that is, Enrolled School of Nursing and Enrolled School of Midwifery.

In the recent past, nursing practice has undergone an evolutionary process. There is need for improved content of nursing care being documented. Nursing documentation promotes use of information to support evidence based nursing and quality of care. Today the public and regulatory bodies demand for quality of health care being rendered to the patients. Nurse managers need to establish an effective and efficient process of documenting the nursing activities which are especially sensitive and relevant.

In 1995 American Nurses Association (ANA) established the Development of Standards of Practice for Nursing Information Centre. The centre assess and analyses the information documented by nurses to see whether it is relevant to nursing practice. ANA has established this centre to evaluate health care information which support the documentation of nursing practice, (Milholland D. and Fellow, P. (1997). The need to evaluate the information system in nursing practice at international level indicates the importance of nursing documentation at all levels of health care delivery.

Despite the adoption of nursing documentation at Monze hospital, the nursing care being documented is usually imprecise, incomplete and below acceptable standards. The amount of documentation nurses are required to carry out is increasing. One of the main problems we are facing in nursing is lack of standardization of the documents and forms nurses are required to use. It is not unusual for differently designed forms that have similar functions to exist even within the same facility. The lack of uniformity creates confusion and increases chances of documentation error.

Nursing documentation has a central role in the quality of care. Well documented nursing practice is the foundation of the development of nursing professional. Around the 1960s came the concept of general management. This gave an opportunity for nursing to participate in general management. The nurse managers are challenged to identify, analyze and communicate the standards of nursing care appropriate at different levels of authorities. It is only through proper documentation that the quality of care can be appreciated. In addition to excellent clinical care, today's nurse must also meet responsibilities of regulatory and institutional management challenges.

It is therefore imperative that nurses be given efficient systems and tools to provide quality documentation without compromising care. Quality documentation facilitates correct representation of nursing by nurse practitioners and managers.

An efficient or inaccurate nursing documentation system can have significant impact on the quality of care given to the patients. Redundant information wastes valuable time for nurses and physicians. Missing or incomplete documentation can lead to frustration for care providers. Multiple versions of charts and forms for different units lead to confusion, inconsistence and ineffective communication among the professional staff.

In conclusion the findings from this study will help nursing personnel to find means of uplifting standards of nursing documentation and make the nurses realize the benefits of documentation in their daily practice. By so doing increase patient safety and enhance the quality of nursing.

1.2 STATEMENT OF THE PROBLEM

Documentation in nursing is very vital as it provides data to be used to evaluate the quality of nursing care. Sometimes it becomes very difficult to appreciate health services rendered by nurses because what they do may not be documented anywhere. Yocuum, F. (1992) states that, Employers group crave the data, accreditation organization require it, and every discipline in health care is trying to measure its own clinical outcomes. Yet no matter what the measurement tool, the results can only be as good as the information they are based on. If the nursing role in the health system is to be valued, nurses need to show how and what they are doing by adequate documentation of nursing activities they perform.

Evidence based nursing and accountability are important concepts in nursing practice which can only be achieved by appropriate nursing documentation. Nurses need to have evidence to support their actions as they provide nursing care. Saba V. K et al states that nurses need to be able to bring together the best available evidence about nursing diagnosis, interventions and outcomes documented at the point of care.

Nurses are obliged to document the nursing care on a particular patient to allow for easy continuation of nursing care thereby increasing patient's safety. The nursing care should be well documented in legible and complete words to enhance understanding in the nurse taking over the nursing duties. The General Nursing Council of Zambia's monitoring and evaluation tools of 2001 have one of its standards (standard 10) stating that Nursing care is documented in legible, complete client care management records in order to facilitate continuing of care and evaluation.

For the nursing professional to grow and function well, nursing administrators need to be given correct, complete and well documented information on which decisions could be based on. Proper documentation allows real representation of what is happening on the ground.

For many years now the term nursing process has been used. The nursing process can be used to evaluate the effectiveness of nursing care offered by the nurses. The process has a systematic series of steps. After collecting and analyzing data, problems are identified and a client care plan is written to display specific methods or proposed actions to resolve these problems. In Zambia, graduates from nursing schools from 1986 onwards have been taught how to use the nursing process.

Although nurses have been documenting nursing care activities for a number of years, what most nurses' document is incomplete, inaccurate, inadequate or may not be used easily. It is important that contents of the medical record contain information to meet regulatory, accreditation and professional organizational standards.

Common requirements specific to nursing documentation include; but are not limited to: the nursing assessment and care provided, informed consent for any/all procedures; teaching provided either to the client directly or to his

/her family; and response and reaction to teaching. Bent, N and Kopf, R (1997).

1.3 CONTRIBUTING FACTORS

Several factors may influence nursing documentation in Monze hospital. These will be discussed as follows:

ECONOMIC FACTORS

(a) Inadequate Stationery

Inadequate stationery may have made documentation impossible to implement at Monze hospital. It has been observed that important concepts in nursing practice have been summarized in order to try and economize on the paper. The nurses are told to improvise materials as they strive to provide quality health care to the patients. Nurses are forced to reduce the information to be documented thereby compromising the quality of nursing data being documented.

Whereas it is economical to reduce documentation of nursing care it is also very dangerous because what is summarized may not be the actual nursing care done and data may be unclear and misleading. Inadequate stationery may have led to most of the hospitals ignoring the use of nursing care plans as a central source of information about the client because it demands a lot of stationery.

(b) Poor Conditions of Service And Lack Of Incentives

Poor conditions of service and lack of incentives for the nurses may have made nurses to practice nursing with low motivation. For nurses to give quality care to the patients they need to be highly motivated by providing them with adequate resources such as materials and money. Kabombo, S. B. (1998), states that availability of resources is paramount to quality patient care. It has been observed that health workers especially nurses are leaving the country for what is termed as "greener pastures" in search of good

conditions of service leaving only a few nurses to practice nursing. This possess a threat to nursing practice because nurses who are already demotivated will be overworked and thus making nursing documentation difficulty to implement.

SERVICE FACTORS

(a) Negative Attitude and failure to see need to Document Nursing

Failure to see need for documenting nursing practice may have contributed to the poor documentation in nursing. Nurses have reported that it is a sheer waste of time to document nursing care because it is actually a repetition of what has already been done. Shea H. L (1986) argues that many nurses strive to administer high quality care. Inspite of the disuse of the nursing care plans, many patients do receive good care. In addition patients in Zambia are unaware of their rights to question nursing care offered to them and its future implications. The nurse has been left with freedom of not being bound to give evidence of her/his actions Central Board of Health, (1996) states that the health workers should give the patient/client clear information about their illness and condition and treatment plan for their recovery. Litigations against nursing practice are still insignificant. Nurses therefore see no reason why they should document their practice when there is no significant legal implications from the public.

(b) Lack of Ownership

Lack of ownership of information by nursing staff may have contributed to little documentation of nursing. For many years now, nurses have been documenting some nursing measures even when it is not informative enough. Nursing authorities have collected and used the information without giving the nurses a feedback which indicates whether data collected was relevant or irrelevant. World Health Organization (1997) states that most health care providers are obliged to deliver vast amounts of information on patients and diseases without receiving feedback. Information system tend to be data driven instead of action driven. If nurses where involved in collecting and

analyzing data they would feel part and parcel of the information system thereby getting motivated to document nursing activities.

(c) Lack of Skilled Nursing Staff

Lack of skilled nursing staff is another possible contributing factor to little documentation in nursing. Accurate documentation of nursing practice demands knowledge and skills. Nurses need to be taught from the nursing schools how to effectively document nursing activities in order to capture all the data required by nursing administration, nursing services department and for treatment continuation. According to World Health Organization (1997), requirements for recording or reporting data are frequently drawn up without reference to the technical skills of the personnel concerned. If nurses were equipped with the technical skills of documenting nursing actions, they will document nursing care effectively. Although graduates from nursing schools from 1986 have been taught how to document the nursing care plan, they do not gain adequate knowledge as a result they do not use the nursing care plan when they start practicing.

(d) Inadequate Knowledge

The HMIS may need to be incorporated in the nursing curriculum to facilitate teaching nursing care documentation. In service training on nursing documentation has been very low and if done it will only involve a few nursing staff, for example in 2001, CBoH managed to train 5 staff at Monze hospital in HMIS. Among the 5 health workers, 2 were nurses and were expected to orient the other nurses who did not get trained.

(e) Shortage of Staff

Shortage of staff and overcrowding in the wards may contribute to nurses not effectively documenting their practice. With the current levels of health needs in the country, it has been very difficulty for the nurses to provide quality care to the patients as well as documenting the care given. Monze hospital is a referral hospital serving a population of 173,113 and has a bed

capacity of 274 beds. The hospital has a total of 89 nurses. The nurse patient ratio is 1:30, Monze hospital Annual Report (2002). From this figure some nurses may not report for work due to one reason or another leaving only a handful of nurses to care and document the care rendered. The hospital management has not been able to employ adequate nurses due to lack of accommodation facilities.

According to international council for nurses, there is a standard nurse patient ratio which must be used. In general wards, nurse patient ratio for registered nurses is 1:6 and enrolled nurses 1:3, labour ward 1:2 and intensive care unit 1:1, Monze Hospital Annual Report (2002).

(f) System of Documentation

There may be need to device a system of documenting nursing practice which will reduce time spent on documenting and that which will reduce amount of data to be documented, without compromising the quality of data documented. According to Yocuum, F (1992), in order to justify the reduction of licenced staff and other skilled caregivers, nursing administration among other things sanction the practice of pre charting (charting care ahead of time). The assumption is that patient care needs are routine and predictable charting ahead of time reduce time spent on documenting because the nurse will only need to document the activities which are not routine.

(g) Institutional Management Teams

It has been observed that institutional management may have a general weakness on the management of information system. Institutional management teams has not taken information system as a priority such that little resources are allocated to stationery, staffing, research etc. There is need for the hospital management to allocate money and other resources towards management of information system. The management should look at allocating money to pay the nurses who are willing to relieve duties of nursing in the wards in order to facilitate nursing practice documentation.

Cook, C. (2003) confirmed that the nurse Reinvestment Act was signed into law in August 2001 which authorizes scholarships and loan payments for nursing students who agree to work in shortage areas after they graduate.

Improvements of staffing levels are important to ensure the success of adequate documentation of nursing.

(h) Nursing Research

Little research in nursing practice may contribute to the poor documentation of nursing care. The primary task of nursing research is to contribute to the scientific base of nursing practice. Studies are needed to determine the effectiveness of nursing interventions and nursing care. Through such research efforts, the science of nursing will grow and scientifically based rationale for making changing in nursing practice and patient care will be generated. The nurses directly involved in patient care are often in the best position to identify potential research problems and questions. This participation involves facilitating the data collection process, or it may include actual data collection process. If nurses are involved in data collection they would see and realize the gap and therefore work towards documenting complete, adequate and precise nursing care.

(i) Supervision

The nurses in-charge may lack proper supervision and enforcement of documentation in nursing. Furthermore, management may not even be conversant with importance of documentation in nursing practice. It has also been observed that although some good data are available, managers and care providers rely primarily on intuition when making decisions rather than using pertinent information. It is important that decisions made are based on the available data in order to achieve true representation in the nursing professional. If proper documentation of clinical nursing practice has to be enhanced, nursing managers need to take an upper hand to ensure that nurses document their practice.

SOCIAL - CULTURAL FACTORS

(a) Traditional Beliefs

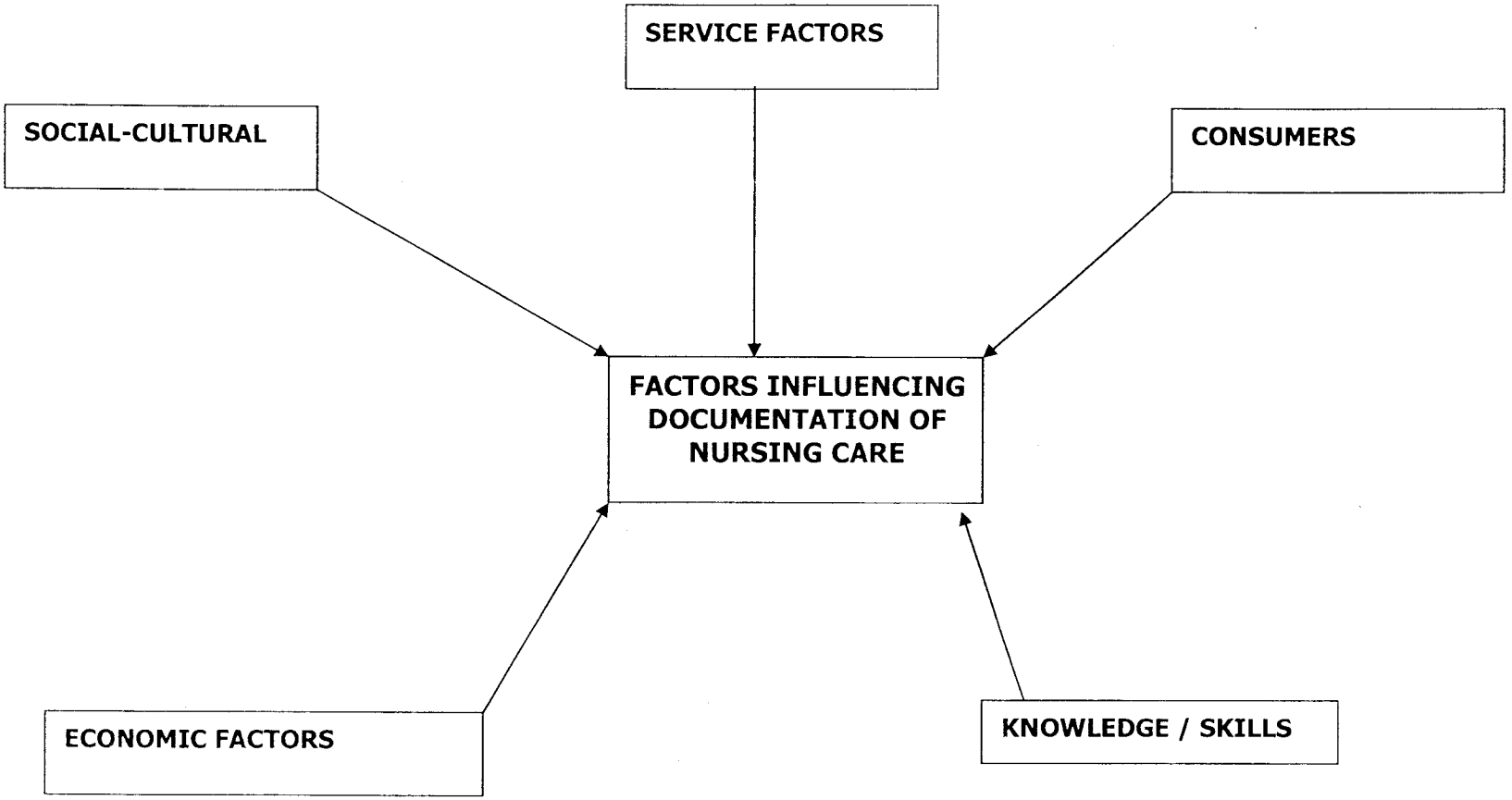
Nursing documentation may be inhibited by traditional beliefs fostered by tasks, procedures, rituals and other routines such as physician's advice and functional ward activities like 4 hourly observations. Such activities reduce the possibility of nursing practice documentation. According to Mulenga, G. (1997), "nurses should be responsible for prescribing nursing care and not only be concerned with carrying out the doctor's orders". Nurses have been socialized to document doctor's orders more efficiently than nursing care. This culture need to be reversed and emphasis be placed on nursing care documentation.

(b) Peer Pressure

Influence among nurses may contribute to the poor documentation of nursing practice. Long serving nurses who may be frustrated, demotivated and lacking interest, develop bad habits of not documenting nursing care activities as they say "you work as you earn". These long serving nurses are a source of discouragement to the newly qualified nurses who are eager to work and looking forward to encounter challenges of nursing profession. It may be necessary in the future to consider newly qualified nurses to be working in more sensitive and demanding wards or hospitals without the interference from the long serving nurses.

In conclusion, documentation in nursing practice may be greatly influenced by many factors in the environment within which it is used. Many of these factors will differ from country to country and from hospital to hospital. Nurses who therefore want to effect change must take into consideration factors such as supervision, availability of resources, peer pressure and many more as discussed earlier on. These factors will greatly affect the extent to which nursing practice will be documented and its contribution to the quality of nursing care.

1.4 PROBLEM ANALYSIS



1.5 JUSTIFICATION

The purpose of the study is to determine the factors influencing nursing practice documentation. Studies have been done about how to document nursing care using nursing care plan without reflecting on the factors that contribute to nursing documentation. The study intends to bring forth the factors which contribute to inadequate, incomplete, imprecise nursing documentation and those which facilitate effective nursing documentation. The study seeks to determine the importance of documenting nursing care being provided in health institutions. The information provided will be used by the Ministry of Health, Central Board of Health, General Nursing Council of Zambia, Monze hospital and Non-Government Organizations that seek to improve the quality of nursing care being provided.

1.6 RESEARCH OBJECTIVES

1.6.1 General Objective

1.6.1.1 To determine factors influencing documentation in nursing practice.

1.6.2 Specific Objectives

1.6.2.1 To determine the quality of nursing care being practiced on the wards;

1.6.2.2 To determine the level of knowledge on nursing documentation;

1.6.2.3 To determine whether nurses document their nursing practice;

1.6.2.4 To determine the staffing levels on the wards;

1.7 HYPOTHESIS

The following hypotheses specify the expected relationship among variables:

1.7.1 Staffing levels influence documentation in nursing practice;

1.7.2 Nurses who have had in-service training on health management information system are more likely to document nursing care than nurses who have had no in-service training;

1.8 OPERATIONAL DEFINITIONS OF TERMS

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

1.8.1 **Nursing Care/Practice:** Care given by nurses to individuals;

1.8.2 **Nursing Care Plan:** Prescribed format on the stages of nursing process.

1.8.3 **Nursing Process:** systematic scientific problem solving method used by the nurse and clients to identify problems, plan solutions, implement care and evaluate its outcome;

1.8.4 **Nurse:** Person who completed a programme of basic nursing education and is qualified and authorized by the government to provide nursing care;

1.8.5 **Patient/Client:** Used to describe those who are recipients of nursing care;

1.8.6 **Nursing:** The diagnosis and treatment of human responses to health and illness;

1.8.7 **Skill:** Physical ability to document nursing care;

1.8.8 **Quality Care:** These are measures carried out by the nurse and they compromise of such activities as pain relief, hygiene, nutrition, observation, and many others;

1.8.9 **Overcrowding:** This is when there is 100% utilization of the beds in the ward and there are floor beds sometimes or most of the time;

1.8.10 Data: Pieces of information obtained after recording nursing activities;

1.8.11 Staffing levels: The number of nurses delivering nursing care per shift.

1.8.12 Nurse Motivation: Factors that cause and sustain nurses' behaviour towards delivering quality care;

1.8.13 Registered Nurse: An individual who has undergone three years of nurse training at a recognised School of Nursing and is registered with the General Nursing Council of Zambia;

1.8.14 Enrolled Nurse: Individual who has undergone two years of nurse training at a recognised School of Nursing and is registered with the General Nursing Council of Zambia.

1.8.2 VARIABLES AND CUT OFF POINTS

VARIABLE	CATEGORY	CUT OFF POINTS
Care	Patient allocation	Adequate
	Team nursing	Moderate
	Task allocation	Poor
Documentation	Nursing assessment, care provided, patient teachings, treatment responses and discharge plan.	Adequate
	Doctor's orders, treatment, vital signs.	Moderate
	Doctor's orders and vital signs.	Poor
Knowledge	• Definition • Importance • Guidelines • When and who does documentation	High
	• Definition • Importance	Moderate
	• General knowledge	Poor
Staffing levels	Number of nurses per shift	
	5 -6 nurses	Adequate
	3 – 4 nurses	Moderate
	1 -2 nurses	Poor

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Since the days of Florence Nightingale, nurses have viewed documentation of patient care as an integral part of nursing practice. As action –oriented professionals, nurses often experience conflict between time spent caring for patients and time needed to accurately record what care was provided. When time is limited and many tasks need to be done, nursing care may seem to take priority. However, documentation is one of the most critical skills nurses perform. Although one may approach documentation as a chore, one's entire nursing career could depend on the accuracy and completeness of one's charting.

According to the New International Webster's Dictionary, a document is a written or printed matter conveying authoritative information, records or evidence. The Nurses' Legal Handbook (1987) defines documentation as preparing and assembling records to authenticate the care we gave our patient, as well as the reasons for giving that care. Thus, documentation is the creation of an authentic record of patient care.

Various authorities have stressed the importance of keeping records of nursing practice. In 1948, Brown, E. in her report alluded to the importance of provision of quality nursing care services and this marked the beginning of the need to give proof of nursing practice by documenting and record keeping. In 1961, the Surgeon General of the States Public Health Service appointed a consultant group to give advice about nursing needs and nursing problems. The consultant group among other things advised strongly the importance of practicing nursing in a systematic way. It was for this reason that nurses were required to express their knowledge, art and skill of documenting nursing practice in a systematic way. Effective documentation is

systematic, timely, accurate, well-written account of nursing care provided to individual patients.

GENERAL DOCUMENTATION GUIDELINES

General guidelines for documenting nursing practice according to Brent and Kopf, R. (1997) are as follows:

- *Contents of the medical record must meet all regulatory, accrediting and professional organization standards.*

  What you chart may be examined by many reviewers, including accrediting, certifying, and licensing organizations. Nursing documentation comprises a critical part of the complete medical report.

- *Use black permanent ink for entries*

- *Date, time and sign all entries. Use first initial, last name and title. Full signature and title must be on file in agency.*

- *Entries are to be legible with no blank spaces left on a line or in any area of the documentation. If a space is left on a line, draw a line through the space to the end of the line. For large areas not used on a form or page, use diagonal lines to mark through the area;*

- *If an error is made, draw a line through the error, write error, initial and date the line. Do not attempt to erase, obliterate or "white out" the error.*

- *Entries are to be factual, complete, accurate, contain observations, clinical signs and symptoms, client quotes when applicable, nursing interventions, and patient reactions. Do not give opinions, make assumptions, or enter vague, meaningless statements (e.g "Is a good parent"). Be specific.*

- *Use correct grammar, spelling and punctuations.*

- *Write client's name and other identifying information on each medical record page;*

- *Be sure to use only those abbreviations approved by your agency/facility;*
- *Always record a client's non-cooperative/non-compliant behaviour;*

- *Never document for someone else or sign another nurse's name in any portion of the medical record;*

- *Documentation should occur as soon after the care given as possible. Note problems as they occur, resolutions used and changes in client's status;*

- *When leaving messages, document time, name and title of person taking message, and telephone number you called;*

- *Record client assessment before and after you administer medications or other treatments;*

- *Document any discussion of questionable medical orders, and the directions the doctor gave. Include the time and date of discussion and your actions as a result of the discussion and consequent directions given;*

- *Chart an omission as a new entry. Do not backdate or add to previously written entries;*

- *When an unusual incidence occurs, document the incident on a special incident or occurrence report form. Do not write "incident report" filed in the medical record. Do write what happened to the client and actions taken to assure the client's well-being in the medical record;*

- *Record only your own observations, actions. If you receive information from another caregiver, state the source of the information;*

- *Record the date, time and content of all telephone client –related communications;*

- *Remember if you did not document it, it did not occur.*

THE IMPORTANCE OF DOCUMENTATION

According to Nurses' Legal Handbook (1987), the importance of documentation is to verify quality of care, to assist in the coordination of care, to ensure continuity of care, to seek confirmation of hospitalization, to comply with regulations of the government and accrediting organizations, to provide in the court of law, and to generate data for research.

WHEN IS DOCUMENTATION DONE OR NECESSARY?

Nurses are required to document all patient care interventions from the moment we enter a professional relationship with a patient and his or her family. Documentation ends with or termination of such relationship. In between this initiation and termination of a professional relationship with a patient, how often we are supposed to document is governed by our workplace policies and procedures, our professionalism in implementing the nursing process, and the condition of the patient. One has to be familiar and comply with the standard frequencies of documentation of initial assessments, as well as in the complex situations stipulated in those policies and procedures.

"Remember that institution's policy is not the law", Nurses' Legal Handbook, (1987). While the later statement is true, it is important to acknowledge that, institutional policies are supported in the court of law. These policies are considered by the court of law because they are developed taking into consideration the regulations and standards of care by the government and the professional nursing organization.

Invariably each facility has its own forms and flow sheets developed for the purpose of documentation. These forms are designed to suit the type of documentation facility decided to have. Types of documentation may be SOAPIE (subjective, objective, assessment, plan, implementation and evaluation), PIE (problem, intervention and evaluation), or DAR (data, action and response).

WHO CARRIES OUT THE DOCUMENTATION?

Nurses and non-nursing staff coordinate care hence their documentation reflects coordination. Each piece of documentation by nursing staff or non-nursing staff has equal status. Hence, one should not document any patient care intervention thinking that one's particular intervention may not be important compared to some other intervention by some other care providers.

The facility's policies and procedures stipulate which staff can document various aspects of nursing practice depending on the competence and knowledge attached to that aspect of nursing. For example, at a certain facility the policy may state that Registered Nurses can document, perform all assessments and develop plans of care, Enrolled Nurses can document and may perform initial assessment only if their competence has been demonstrated and documented, ward attendants (nursing aides) can document intake and output, vital signs, activities of daily living and specific tasks assigned to them. In addition a facility's policy and procedure may allow patients to self document patient care activities. Patients can self document in areas of chronic pain, blood glucose monitoring and blood pressure (Charting Tips, 1997).

2.2 GLOBAL SITUATION ON NURSING DOCUMENTATION

In the last few years, some significant trends in documenting patient care have become reality. These trends include changes in traditional care planning and efforts to meet the need for increased documentation and improved communication while making charting less time consuming.

Since the early 1990s, handwritten plans of care have been replaced by computer charting system. Computerized charting systems improve legibility, decrease recording time and costs, result in fewer errors, improve communication among health care team members and provide great access to medical data for patient care, education, research, and quality improvement. Computer charting system is an especially effective communication tool in home health care.

Data from records will increasingly be used for care planning, quality assessment, research and health planning and allocation of resources. Hence, data collected from the various nursing documents need to be accurate and complete to allow full representation. Ehrenberg A., (2001) in her study aimed at analyzing the concordance between the nursing documentation in nursing homes and descriptions of some specific problems of nurses and patients, her study demonstrated that there are major limitations in using records as data source for the evaluation, planning and development of care. The study revealed considerable deficiencies in accuracy of the patient's records when the records were compared with the reports from nurses and residents. From her work the overall agreement between interview data from nurses and from the patient records was low.

Nursing documentation may be accurate and complete if the nurses can be educated on nursing documentation. It takes a nurse who knows the benefits of documenting to effectively document nursing practice. Bjorvell, C. (2002) in her study aimed at "evaluating the longitudinal effects of nursing – documentation intervention on the quality and quantity of the nursing documentation in a sample of patient records saw that organizational changes and education regarding nursing documentation significantly increased scores in quantity as well as quality of nursing documentation". From her findings it clearly indicates that organizational support is the key success to adequate nursing documentation. The organizational authorities need to give nurses guidelines and principles of nursing documentation. Educating nurses about

the principles of documentation and the importance of implementing risk reduction practices will help guard against liability and ultimately improve patient care, Frank Stomborg, Marilyn (2001).

It is important that authorities in nursing focus on nursing documentation and expanding technology that offer different ways to document, deliver and receive patient records and avoid nursing liability for inadequate or inaccurate documentation. Whatever technology used by each facility, should look at its efficiency and effectiveness.

On the other hand Frank-Stromborg Marilyn (2001) in her study aimed at focusing nursing documentation and how it can lead to a malpractice lawsuit, she observed that new technology is altering how health care documentation should be done and raises new confidentiality issues. While nurses are looking for new technology for documenting nursing, ethical issues of nursing should be considered. Each individual in her health care environment has the right to be protected and obligations to fulfill. The client's rights must be considered when delivering and documenting nursing care.

The most important legal issue associated with computerized charting is the need to preserve patient privacy and confidentiality. With a computerized system, access to patient information can be retrieved by anyone who has the proper entry code; mastering documentation (1999). Fax machines are also being used more in patient care. As convenient as fax machines are, they may not protect the confidentiality of patient information. For example if the fax (information) went to the wrong number, Mastering Documentation (1999).

The new technology of charting nursing practice may not adequately consider the law. Hognes (2002) in her study aimed at:

1. Exploring the changes in structure and content of nursing care documentation in patient records when implementing electronic charting.

2. Assessing the nursing care documentation in context to the new health care law and regulations.

The findings of the study revealed that comprehensiveness in the documentation of identified nursing problem improved, but looking at the electronic charting from legal requirements showed that most of the current charting did not meet the demand of laws and regulations in the health care system in Norway.

Medical records are legal documents in court and provide proof of the care received by the patient and the standards by which the care was provided. For the best legal protection, make sure that nursing documentation not only adheres to professional standards of nursing care, but also follows nurse employer's policies and procedures, especially in high risk situations, Mastering Documentation (1999).

Increasing documentation efficiency is another trend, particularly given the amount of time that nurses spend documenting care. Some newer nursing information system (electronic) can suggest nursing diagnosis based on predefined assessment data that nurses enter. These systems are interactive, prompting nurses with questions and suggestions about the information nurses enter. The questions and diagnostic suggestions make documentation quick and thorough, Mastering Documentation (1999).

Some trends are aimed at improving communication. Trends aimed at improving communication through documentation include an increased use of nursing diagnoses and shift from narrative and problem oriented documentation system to focus on summarized complete charting. The use of fax machines is expected to increase as a means of communicating patient care needs, and computers will replace paper and pen charting as the primary means of documenting care in the 21st century.

2.3 REGIONAL SITUATION ON NURSING DOCUMENTATION

In most developing countries there is a prevailing critical shortage of health care professionals. It has been observed that other health care professionals have experienced more shortages than nurses have such that the health service is largely depending on the nursing services. This situation has adversely affected many countries in Southern Africa for example, Zimbabwe, Botswana, Zambia and Namibia. Nurses are therefore utilized effectively in maintaining health services and at the same time compromising nursing services. It has become difficult for nurses to render nursing care services and to document their practice due to overwhelming duties.

The inadequate training facilities and resources has led to the nursing authorities to insist on the unrealistic standards and policies of nursing documentation without considering the prevailing problems in developing countries. Principles and procedures of nursing practice are incompatible to the western countries, Mulenga G. (1997).

The result of training student nurses on nursing documentation around western countries situation is that, the graduates become out of touch with prevailing problems in developing countries when they start practicing.

In Africa research in nursing has not taken a priority. The reviewed literature shows that not much has been published on nursing documentation.

2.4 ZAMBIAN SITUATION ON NURSING DOCUMENTATION

Zambia is one of the developing countries in the world and it is apparently having a critical shortage of nurses in most health facilities. The health information system in Zambia has not been given a lot of support which it needs both at the national or local levels. However there has been an increasing support in the last 5 years. The regulatory bodies (CBoH, MoH, GNC) are requesting good quality of information from the health professionals. HMIS was introduced in 1998 to strengthen among other

things Nursing Documentation. In July (2001), the Hospital Reform Steering Committee for HMIS, presented an unpublished report on the status of the hospital information system. The report reviewed that there was need for the management of health facilities to be committed to the use of HMIS for their planning function. Management will help to reduce the confusion nurses may face in using different versions of documentation within and across health care facilities.

This would help reduce chances of poor documentation and interpretation. The report also reviewed that nurses preoccupied with rendering of nursing care may not document on time or not do it correctly. If nurses do not document in time, there is a high possibility of recording vague information as an occupied nurse forgets easily. In the same report, it was reviewed that different case definitions used in different health institution/facilities has led to the altering of information when aggregated. For example, the committee data analysis from hospitals showed that at some districts AIDS patients were about seven percent (7%) of the totals, but in many districts they were less than one percent (1%). For Nursing Documentation to be accurate, there is need for health authorities to define cases (diseases) clearly so that data documented can yield similar results across the nation.

2.5 CONCLUSION

The reviewed literature on nursing documentation is disapproving but we can not go back to the traditional system of focusing only on documenting doctor's orders. We need to achieve an effective nursing documentation in a systematic and accurate method. With the review of various aspects of nursing documentation including its purposes and principles, there is need to determine factors influencing nursing documentation.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

"Research design is defined as the researcher's overall plan for obtaining answers to the research hypothesis", Polit, F. D and Hungler, P. B (1996). The purpose of this study was to determine factors that influence nursing documentation. A descriptive cross section type of study was carried out. This involves a systematic collection and presentation of data to give a clear picture of a particular situation understudy. A descriptive cross section study is more effective in finding out the nature of the problem more accurately and the possible influencing factors.

The information was collected by means of a questionnaire. A questionnaire schedule was used because the research was dealing with a literate group therefore the self reports given reflected the view of the nurses on nursing documentation. This method gave respondents freedom to express themselves. Both qualitative and quantitative data was obtained.

3.2 RESEARCH SETTING

Research setting as described in Polit, F. D and Hungler, P. B (1996) is the physical location and conditions in which data collection takes place in a study. The study was conducted at Monze Mission Hospital. The hospital has low cost wards comprising of male ward (Medical and Surgical), female ward (medical and surgical), tuberculosis ward, (male and female), gynaecological ward, maternity delivery ward, antenatal ward, postnatal ward, children's ward and outpatient department. The fee paying sidewards compromise of 3 female ward sidewards, 4 male ward sidewards and 1 maternity delivery sideward. There is an average of 12 nurses per ward including those on leave, Monze Hospital Annual Report (2002). The average number of patients in the ward ranges from 50 to 55 with an average of 2 nurses per shift, excluding student nurses. Monze District shares borders with Mazabuka to

the North, Gwembe to the East, Choma to the south and Namwala district to the west, Monze District has a total population of 173,113, Hospital Annual Report (2002). The study was conducted at Monze Hospital for easy access by the researcher.

3.3 STUDY POPUALTION

The study population is "the entire number of units understudy", Treece E. W and Treece, J. W (1986). These were Registered Nurses, Registered Midwives, Enrolled Nurses and Enrolled Midwives.

3.4 SAMPLE SELECTION

Sample selection is "a process of selecting a portion of the population to represent the entire population", Treece E. W. and Treece, J. W. (1986). In this study, a random sampling of nurses was performed to ensure that each element has an equal chance of being included in the sample.

3.5 SAMPLE SIZE

A sample is a subset of population (Seaman, C. H and Verhonick, J. P., 1982). The study population were all nurses from Monze Hospital. From these a total of 50 (fifty) respondents were sampled. The sample size was decided upon taking into consideration the time within which the research was to be completed and submitted. It also took into consideration the availability of funds.

3.6 DATA COLLECTION TOOL (VALIDITY AND RELIABILITY)

Data collection tool refers to equipment used to collect data (Treece, E. W. and Treece, J. W, 1986). A self-administered questionnaire was used to collect data. "A questionnaire is a written question and answer sheet which provides data about a subject's attitude, beliefs, habits and socioeconomic background (Treece, E. W. and Treece, J. W., 1986). The questionnaire contained both open and closed ended questions. The advantages of a questionnaire are that it is less expensive in terms of time and money, it is a

quick way of obtaining data from a large group of people, anonymity of respondents is maintained and are more likely to provide more honest answers, it avoids biases since the format is standard for all subjects. . A questionnaire also has disadvantages and these include; It can not be used with an illiterate population; It yields a low response rate; Questions may be misunderstood. Questionnaires were administered and data collected over a period of two weeks. The questionnaire was checked for completeness accuracy and uniformity before and after collecting data.

3.6.1 VALIDITY

Validity refers to "an instrument's ability to actually test what it is supposed to test" (Treece, E.W. and Treece, J. W.,1986). Validity constitutes external and internal validity. External validity is the extent to which the findings of the research can be generalized to a larger population or to a different social, economical political setting. The implication is to have a representative sample. A random sampling method was used in order to give each one a change to participate. This was in an attempt to determine if the studied variables are actually the influencing factors to nursing documentation.

Internal validity refers to interpretation of findings within the study or data collected. It is the degree to which the researcher is able to accomplish the study. Validity was upheld by the tool used which reflected the factors under study. During administration of the questionnaire, observations were made to respondents engaged to see if they exhibit the measured variables.

3.6.2 RELIABILITY

Reliability refers to "the accuracy of measuring instrument to obtain consistent results" Treece E.W. and Treece, J.W.1986).

Two basic sources of inaccuracy are present and these are:

- Deficiency in the instrument
- Inconsistency in taking readings form the instrument

These problems were overcome by a good understanding of the instrument and how it was to be used. The respondents were literate enough to understand the instrument and were allowed to answer the instrument after working hours when they were relaxed and at ease to avoid inaccuracies in data collection.

3.7 DATA COLLECTION TECHNIQUE

Data collection is "gathering of information needed to address a research problem", Polit, D. F and Hungler B. P., (1997). It allows for systematic collection of information about our objectives of study. Data collection constitutes primary and secondary data collection techniques. The primary method was used in this study. This is the technique used when the researcher is involved in the collection of data on his/her own. She/he may use:

- Observation
- Interviews
- Administering written questionnaires
- Focus group discussion (FGD)

A written questionnaire was used. Questions were read carefully to avoid cross examining respondents. Questions not understood were merely repeated not to indicate the direction to the answer. Probing was done to those questions not fully answered by respondents

3.8 PILOT STUDY

A pilot study is "a small scale version or trial of the major study" (Polit, F. D and Hunglar, B. P, 1996). A pilot study was done at Mazabuka District Hospital.

A pilot study was done to obtain information for improving the questionnaire or for assessing its feasibility. It was also done for the purpose of determining reactions of the respondents to the research procedure, validity and reliability of the data collection tool and procedure for data processing and analysis.

The pilot study involved 5 respondents comprising 10% of the sample which is 50 respondents. Amendment to the questions were made to enable all responds to understand the questions and avoid ambiguity.

3.9 ETHICAL AND CULTURAL CONSIDERATIONS

Ethics can be defined as "a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants", (Polit, F. D. and Hungler, B. P. 1997).

A letter was written to the Executive Director of Mazabuka District Hospital asking for permission to conduct the pilot study. Another letter was written to Monze Hospital Director for permission to carry out the actual study in the wards. Verbal permission from the respondents to participate in the study was sought and the respondents were not forced to participate in the study. The purpose of the study was explained to the respondents so as to win maximum support and cooperation. Privacy and anonymity was maintained by using serial numbers.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 DATA ANALYSIS

"Data analysis is the process of categorizing, scrutinizing and cross-checking the research data," (Treece E., W., and Treece J., W., 1986). The purpose of the study was to assess factors influencing nursing documentation at Monze hospital. (The data presented was analysed into frequency tables, cross tabulations and numerical descriptions for each table). The data was analysed manually with the aid of the pocket calculator. This was done in order that the data collected may be easily understood.

4.2 PRESENTATION OF FINDINGS

The findings are presented according to the sequence of the questions in the questionnaire and some of them are grouped together to give an overall picture.

TABLE 1

DEMOGRAPHIC DATA

VARIABLE	FREQUENCY	PERCENTAGE
SEX		
Female	42	84
Male	8	16
Total	50	100
AGE GROUP		
23 -26	3	6
27 – 30	11	22
31 – 34	19	38
35 – 38	4	8
39 – 42	5	10
43 – 46	6	12
47 – 50	2	4
TOTAL	**50**	**100**
MARITAL STATUS		
Single	16	32
Married	25	50
Divorced	4	8
Widowed	5	10
Separated	0	0
TOTAL	**50**	**100**
RELIGION		
Christian	49	98
Hindu	0	0
Moslem	0	0
Non	0	0
Buddhism	1	2
TOTAL	**50**	**100**

JOB TITLE		
Registered Midwife	3	6
Registered Nurse	10	20
Enrolled Midwife	17	34
Enrolled Nurse	20	40
TOTAL	**50**	**100**
LENGTH		
1 -2 years	4	8
3 – 5 years	10	20
6 – 10 years	19	38
11 – 15 years	4	8
20 years and above	3	6
TOTAL	50	100
NUMBER OF CHILDREN		
None	11	22
One child	8	16
Two children	14	10
Three children	5	10
Four children	6	12
Five and above children	6	12
TOTAL	**50**	**100**

The table shows that (84%, 42) of respondents were female. The majority of respondents (38%, 19) were aged between 31 and 34 years while (4%, 2) belong to 47 -50 years age group. (32%, 16) of the respondents were single, while (50%, 25) were married. (8%, 4) are divorced and (10%, 5) were widowed. Almost all respondents were Christians (98%, 49) and only (2%, 1)

was non-Christian. (38%, 19) respondents have worked for 6 -10 years while (20%, 10) respondents had worked for 3 – 5 years. Eight percent (4) respondents had worked for 11 – 15 years and (6%, 3) respondents had worked for 20 years and above. The table also shows that 28% (14) of the respondents had two children each while (22%, 11) had no children. Only (12%, 6) of the nurses had five children and above.

SECTION B: CARE

TABLE 2: TYPE OF NURSING CARE RENDERED

	FREQUENCY	**PERCENTAGE**
Task allocation	24	48
Patient allocation	13	26
Team nursing	13	26
Primary nursing	0	0
Others	0	0
TOTAL	**50**	**100**

Majority (48%, 24) of the respondents used task allocation during their training while (26%, 13) used patient allocation and another (26%, 13) used team nursing.

TABLE 3: TYPE OF NURSING CARE MODEL PREFERRED

	FREQUENCY	PECERNTAGE
Task allocation	16	32
Patient allocation	25	50
Team nursing	9	18
Primary nursing	0	0
Others	0	0
TOTAL	**50**	**100**

The table shows that (50%, 25) respondents preferred using patient allocation as a model of nursing care. None of the respondents preferred to use primary nursing.

TABLE 4: REASONS GIVEN FOR THE PREFERRED NURSING CARE MODEL

	NURSING CARE MODEL				FREQUENCY	PERCENTAGE
Reasons given for preferred nursing model	Task allocation	Patient allocation	Team nursing	Primary nursing	Frequency	Percentage
Easy work evaluation	4	2	2	0	8	16
Total nursing care rendered	8	19	2	0	29	58
Patient needs are met	9	6	6		21	42

The table shows that 19% respondents preferred patient allocation because total nursing care would be offered if the model was used.

TABLE 5: THE QUALITY OF NURSING CARE RENDERED

	FREQUENCY	**PECERNTAGE**
Adequate	2	4
Moderate	41	82
Poor	7	14
TOTAL	**50**	**100**

Majority (82%, 41) of the respondents were of the opinion that the quality of nursing care being rendered in the wards was of moderate quality.

TABLE 6: REASONS GIVEN FOR THE LEVEL OF NURSING CARE RENDERED

	ADEQUATE	MODERATE	POOR	FREQUENCY	PERCENTAGE
Death rate reduced	2	2	0	4	8
Staff and stationery shortage	0	35	7	42	84
Not all nursing care is given	0	5	0	5	10
No motivation	0	4	2	6	12
Congestion	0	1	2	3	6

Majority (84%, 42) respondents alluded to the fact that shortage of staff and stationery contributed to the level of nursing care rendered on the wards.

SECTION C: DOCUMENTATION

TABLE 7: WHETHER NURSING DOCUMENTATION WAS TAUGHT DURING TRAINING

	FREQUENCY	PECERNTAGE
Yes	45	90
No	5	10
TOTAL	**50**	**100**

The table shows that (90%, 45) of the respondents were taught nursing documentation during training while (10%, 5) were not taught.

TABLE 8: WHAT WAS TAUGHT IN NURSING DOCUMENTATION DURING TRAINING

	FREQUENCY	PECERNTAGE
Reports Glasgow Coma scale, doctors, orders	6	12
Nursing care plan	12	24
Procedures, medication, opening bowels	31	62
Vital signs, blood pressure, fluid balancing	21	42
Registration of patients	18	36

Majority, (62%, 31) respondents were taught how to sign for the procedures done, medication offered, and opening of bowels for post operative patients while (24%, 12) were taught how to document patient reports, Glasgow coma scale and doctors orders.

TABLE 9: WHETHER DOCUMENTATION WAS CARRIED OUT IN THE SERVICE AREA DURING TRAINING

	FREQUENCY	PECERNTAGE
Yes	45	90
No	5	10
TOTAL	**50**	**100**

This table shows that (90%, 45) of the respondents were documenting nursing care in the service area during there basic training.

TABLE 10: WHAT NURSING DOCUMENTATION WAS CARRIED OUT IN THE SERVICE AREA DURING TRAINING

	FREQUENCY	PECERNTAGE
Report, Glasgow coma scale	9	18
Nursing care plans	17	34
Procedures, medication, consent form, lab form	29	58
Vital signs Blood pressure, fluid balancing	16	32
Registration of patients	7	14

Majority (58%, 29) of the respondents were documenting procedures done, medication given, consent and lab forms on the ward during their training. Only (18%, 9) respondents were documenting patients reports and Glasgow coma scale.

TABLE 11: DURATION OF RESPONDENTS IN PRESENT WARD

	FREQUENCY	PECERNTAGE
0 -5 months	6	12
6 – 11 months	9	18
12 – 17 months	14	28
18 – 23 months	5	10
24 and above	16	32
TOTAL	**50**	**100**

Majority, (32%, 16) of the respondents worked in their present ward for 24 years and above while (28%, 14) of the respondents worked between 12 and 17 months. Only (12%, 6) of the respondents had worked in their ward for less than five (5) months.

TABLE 12: WHETHER DOCUMENTATION WAS CARRIED OUT IN THE PRESENT WARD

	FREQUENCY	PECERNTAGE
Yes	41	82
No	9	18
TOTAL	**50**	**100**

The table shows that (82%, 41) of the respondents document nursing in their ward while (18%, 9) did not.

TABLE 13: REASONS GIVEN FOR NOT DOCUMENTING NURSING CARE IN PRESENT WARD

	FREQUENCY	PECERNTAGE
Shortage of staff	7	14
Inadequate hospital policy	1	2
Not stated	1	2

Majority, (14%, 7) of the respondents did not document nursing because the wards were understaffed.

TABLE 14: TYPE OF NURSING DOCUMENTATION CARRIED OUT IN PRESENT WARD

	FREQUENCY	PECERNTAGE
Procedures, medication inventory	30	60
Nursing care plan	5	10
Vital sign, blood pressure fluid balancing, partogram	21	42
Ward incidents	1	2
Doctors' orders, lab forms	4	8
Admission, history taking	9	18
Reports on critical clients, post op clients Glasgow coma scale	8	16

Majority (60%, 30) of the respondents documented procedures, medication, and inventory. While (42%, 21) documented vital signs, fluid balancing and partograms. Only (2 %, 1) respondents documented ward incidents.

TABLE 15: WHO MONITORS NURSING DOCUMENTATION

	FREQUENCY	PECERNTAGE
Senior Nursing Officer	3	6
Sister in Charge	34	68
Hospital management team	1	2
Central Board of Health	1	2
None	3	6

Majority (68%, 34) respondents reported that nursing documentation was monitored by the sister in charge of the ward while (20%, 10) reported that nursing documentation was monitored by the nursing officer.

SECTION D: KNOWLEDGE

TABLE 16: DEFINITION OF NURSING DOCUMENTATION

	FREQUENCY	percentage
Knew	29	58
Did not know	19	38
No response	2	4
Total	50	100

Majority (58%, 29) of the respondents knew what nursing documentation involves while (38%, 19) did not know.

TABLE 17: ADVANTAGES OF NURSING DOCUMENTATION

	FREQUENCY	PERCENTAGE
Facilitates quality nursing care and setting of nursing standards	16	32
Facilitates easy continuity of work	29	58
Evaluation and monitoring nursing care	23	46
Promotes interaction and communication between nurse and patient	6	12
Promotes record keeping and gives evidence of nursing care	28	56
Promote completion of task promote accountability	3	9
Prevents duplication of task	8	16

Majority (58%, 29) of the respondents revealed that nursing documentation facilitates easy continuity of nursing care. (56%, 28) of the respondents reported that nursing documentation provides record and evidence of nursing care rendered.

TABLE 18: HOW RESPONDENTS FEEL ABOUT NURSING DOCUMENTATION

	FREQUENCY	PERCENTAGE
I like it	28	56
I find it time consuming	18	36
Nobody appreciates it	1	2
It is important	1	2
Not possible	1	2
It is informative	1	2
TOTAL	**50**	**100**

Majority (56%, 28) of respondents liked nursing documentation while (36%, 18) found it time consuming.

TABLE 19: CONSTRAINTS THAT HINDER NURSING DOCUMENTATION

	FREQUENCY	percentage
Staff and stationery shortage	44	88
Knowledge and skills lacking	6	12
Lack of supervision	2	4
Negative attitude and laziness	7	14
No motivation	8	16
Did not know	5	10

Majority, (88%, 44) of the respondents reported that staff and stationery shortages prevent adequate nursing documentation.

TABLE 20: WHETHER RESPONDENTS HAD INSERVICE TRAINING

	FREQUENCY	percentage
Yes	16	32
No	34	68
TOTAL	**50**	**100**

The table shows that (68%, 34) had no in-service training while only (32%, 16) had in –service training on nursing documentation.

TABLE 21: WHEN INSERVICE TRAINING WAS UNDETAKEN

TRAINING DONE	FREQUENCY	percentage
1 year ago	7	14
2 – 3 years	7	14
4 – 5 years	2	4
6 – 10 years	0	0
10 years and above	0	0

The table shows that (14%, 7) of the respondents had their in-service 2-3 years prior to this study while another (14%, 7) had their in-service training 1 year ago.

TABLE 22: WHETHER RESPONDENTS WHO HAD INSERVICE TRAINING WERE FOLLOWED UP

	FREQUENCY	percentage
Yes	13	26
No	3	6

The table illustrates that, out of the (32%, 16) who had in-service training. (6%, 3) did not have a follow up.

SECTION E: STAFFING PATTERN

TABLE 23

OPINION ON STAFFING PATTERN ON PRESENT WARD

	FREQUENCY	percentage
Adequate	0	0
Moderate	4	8
Poor	46	92
TOTAL	**50**	**100**

Majority (92%, 46) of the respondents were of the opinion that the staffing pattern was poor on the wards.

TABLE 24: AGE IN RELATION TO LEVEL OF CARE

.	**LEVEL OF CARE**			**total**
	Adequate	**Moderate**	**Poor**	
23-26 years			3 (6%)	3 (6%)
27 – 30 years		1 (2%)	10 (20%)	11 (22%)
31 – 34 years			19 (38%)	19 (38%)
35 -38 years		1 (2%)	3 (6%)	4 (8%)
39 – 42 years			5 (10%)	5 (10%)
43 – 46 years			6 (12%)	6 (12%)
47 – 50 years			2 (4%)	2 (4%)
TOTAL		**2 (4%)**	**48 (96%)**	**50 (100%)**

Majority (48, 96%) of the respondents offered poor nursing care out of which 38% were aged 31 to 34 years of age.

TABLE 25: JOB TITLE IN RELATION TO LEVEL OF CARE

	ADEQUATE	MODERATE	POOR	TOTAL
Registered Midwife	0	0	3 (6%)	3 (6%)
Registered Nurse	0	1 (2%)	9 (18%)	10 (20%)
Enrolled Midwife	0	1 (2%)	16 (32%)	17 (34%)
Enrolled Nurse	0	0	20 (40%)	20 (40%)
Others	0	0	0	0
Total	0	2 (4%)	48 (96%)	50 (100%)

The table shows that the majority of respondents (20, 40%) who reported that there was poor nursing care were Enrolled Nurses. (18%, 9) of registered nurses reported that poor nursing care was rendered.

TABLE 26: LENGTH OF SERVICE IN RELATION TO LEVEL OF CARE

	level of care			total
	ADEQUATE	MODERATE	POOR	
1 – 2 years			3 (8%)	4 (8%)
3 – 5 years		1 (2%)	9 (18%)	10 (20%)
6 – 10 years			19 (38%)	19 (38%)
11 – 15 years		1 (2%)	9 (18%)	10 (20%)
16 – 19 years			4 (8%)	4 (8%)
20 years and above			3 (6%)	3 (6%)
Total		2 (4%)	48 (96%)	50 (100%)

Majority (96%, 48) of the respondents reported that there was delivery of poor nursing care out of which (38%, 19) of the respondents who reported that there was poor nursing care had practiced for 11-15 years.

TABLE 27: AGE OF RESPONDENTS IN RELATION TO LEVEL OF NURSING DOCUMENTATION

	DOCUMENTATION			TOTAL
	ADEQUATE	MODERATE	POOR	
23 – 26 years		1 (2%)	2 (4%)	3 (6%)
27 – 30 years		2 (4%)	9 (18%)	11 (22%)
31 – 34 years		1 (2%)	18 (36%)	19 (38%)
35 – 38 years			4 (8%)	4 (8%)
39 – 42 years			5 (10%)	5 (10%)
43 – 46 years			6 (12%)	6 (12%)
47 – 50 years			2 (4%)	2 (4%)
Total		4 (8%)	46 (92%)	50 (100%0

Majority (92%, 46) of respondents documented nursing poorly, out of which 18 (36%) of respondents who reported that they did not document nursing care were aged 31-34 years.

TABLE 28: JOB TITLE IN RELATION TO LEVEL OF DOCUMENTATION

	DOCUMENTATION			TOTAL
	ADEQUATE	MODERATE	POOR	
Registered Midwife		1 (2%)	2 (4%)	3 (6%)
Registered Nurse			10 (20%)	10 (20%)
Enrolled Midwife			17 (34%)	17 (34%)
Enrolled Nurse		3 (6%)	17 (34%)	20 (40%)
Total		4 (8%)	46 (92%)	50 (100%)

Majority (92%, 46) of respondents documented nursing poorly, out of which (34%, 17) of the respondents who said that their documentation was poor were Enrolled Nurses.

TABLE 29: LENGTH OF SERVICE IN RELATION TO LEVEL OF DOCUMENTATION

	DOCUMENTATION			TOTAL
	ADEQUATE	MODERATE	POOR	
1 – 2 years		1 (2%)	3 (6%)	4 (8%)
3 – 5 years		1 (2%)	9 (18%)	10 (20%)
6 – 10 years		2 (4%)	17 (34%)	19 (38%)
11 – 15 years			10 (20%)	10 (20%)
16 – 19 years			4 (8%)	4 (8%)
20 years and above			3 (6%)	3 (6%)
Total		4 (8%)	46 (92%)	50 (100%)

Majority (92%, 46) of the respondents documented nursing poorly, out of which (34%, 17) of the respondents who reported documenting nursing care poorly had served 6 to 10 years.

TABLE 30: AGE IN RELATION TO KNOWLEDGE ON DOCUMENTATION

	KNOWLEDGE			TOTAL
	High	Average	Low	
23 – 26 years			3 (6%)	3 (6%)
27 – 30 years		1 (2%)	10 (20%)	11 (22%)
31 – 34 years		2 (4%)	17 (34%)	19 (38%)
35 – 38 years			4 (8%)	4 (8%)
39 – 42 years		1 (2%)	4 (8%)	5 (10%)
43 – 46 years			6 (12%)	6 (12%)
47 – 50 years			2 (4%)	2 (4%)
Total		4 (8%)	46 (92%)	50 (100%)

Majority (92%, 46) of respondents had low level of knowledge about nursing documentation, out of which (34%, 17) of the respondents with low level of knowledge on documentation were aged 31 and 34 years.

TABLE 31: JOB TITLE IN RELATION TO KNOWLEDGE ABOUT DOCUMENTATION

	KNOWLEDGE			TOTAL
	ADEQUATE	**MODERATE**	**POOR**	
Registered Midwife		1 (2%)	2 (4%)	3 (6%)
Registered Nurse		1 (2%)	9 (18%)	10 (20%)
Enrolled Midwife		1 (2%)	16 (32%)	17 (34%)
Enrolled Nurse		1 (2%)	19 (38%)	20 (40%)
Total		**4 (8%)**	**46 (92%)**	**50 (100%)**

Majority (92%, 46) of respondents had low knowledge about nursing documentation, out of which (38%, 19) of respondents with poor level of knowledge on documentation were Enrolled Nurses while (18%, 9) were Registered Nurses.

TABLE 32: LENGTH OF SERVICE IN RELATION TO KNOWLEDGE ABOUT NURISNG DOCUMENTATION

	KNOWLEDGE			TOTAL
	High	**Average**	**Low**	
1 – 2 years			4 (8%)	4 (8%)
3 – 5 years		2 (4%)	8 (16%)	10 (20%)
6 – 10 years		1 (2%)	18 (36%)	19 (38%)
11 – 15 years		1 (2%)	9 (18%)	10 (20%)
16 – 19 years			4 (8%)	4 (8%)
20 years and above			3 (6%)	3 (6%)
Total		**4 (8%)**	**46 (92%)**	**50 (100%)**

Majority (92%, 46) of respondents had low knowledge about nursing documentation, out of which (36%, 18) of the respondents who had low level of knowledge had practiced for 6-10 years while 18% had practiced for 11-15 years.

TABLE 33: KNOWLEDGE ABOUT DOCUMENTATION IN RELATION TO LEVEL OF NURSING DOCUMENTATION

	DOCUMENTATION			total
	Adequate	**Moderate**	**Poor**	
High			4 (8%)	4 (8%)
Average		1 (2%)	3 (6%)	4 (8%
Low		3 (6%)	43 (86%)	46 (92%)
Total		**4 (8%)**	**46 (92%)**	**50 (100%)**

Majority (86%, 43) of the respondents with low knowledge about nursing documentation also reported poor level of documentation.

TABLE 34: STAFFING PATTERN IN RELATION TO LEVEL OF NURSING CARE

	LEVEL OF CARE			total
	Adequate	**Moderate**	**Poor**	
Adequate	0	0	0	0
Moderate	0	0	4 (8%)	4 (8%)
Poor	0	2 (4%)	44 (88%)	46 (92%)
Total		**2 (4%)**	**48 (96%)**	**50 (100%)**

Majority 46 (92%) of the respondents who stated that the staffing pattern was poor on the wards also rendered poor nursing care.

TABLE 35: STAFFING PATTERN IN RELATION TO NURSING DOCUMENTATION

	DOCUMENTATION			TOTAL
	Inadequate	**Moderate**	**Poor**	
Adequate	0	0	0	0
Moderate	0	1 (2%)	3 (6%)	4 (8%)
Poor	0	3 (6%)	43 (86%)	46 (92%)
Total		**4 (8%)**	**46 (92%)**	**50 (100%)**

Majority (92%, 46) of respondents who stated that the staffing pattern on the wards was poor also rendered poor nursing documentation.

TABLE 36: LEVEL OF CARE IN RELATION TO NURISNG DOCUMENTATION

	DOCUMENTATION			total
	Adequate	**Moderate**	**Poor**	
Adequate	0	0	0	0
Moderate	0	0	2 (4%)	2 (4%)
Poor	0	4 (8%)	44 (88%)	48 (96%)
Total		**4 (8%)**	**46 (92%)**	**50 (100%)**

Majority, (96%, 48) of respondents that rendered poor nursing care also reported poor nursing documentation.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1 CHARACTERISTICS OF THE SAMPLE

Out of fifty respondents questioned using a structured interview schedule, (84%, 42) were females and (16%, 8) were males. The age ranged between 23 to 50 years and highest frequency (38%, 19) of respondents were found to be between 31 to 34 years. The sample had a mean age of 34.

Half of the respondents (50%, 25) were married. Majority of the respondents (98%, 49) were Christians. The population sample constituted of Registered Midwives 3 (6%), Registered Nurses (20%, 10), Enrolled Midwives (34%, 17) and Enrolled Nurses (40%, 20). (38%, 19) of the respondents had been practicing nursing between 6 to 10 years. (28%, 14) of the respondents had two children each while (22%, 11) did not have any children.

5.2 NURSING CARE

Several approaches of nursing care are being used in delivering of nursing care to the patients. The study shows that the most popular approach is task allocation used by (48%, 24) of the respondents followed by patient allocation and team nursing approaches which is used by (26%, 13) and (26%, 13) of the respondents respectively (table 2). It is interesting to note that although respondents practice all these approaches half of the respondents 10 (50%, 10) recognize patient allocation as a better method of delivering nursing care (table 3). This could be attributed to the fact that, it provides individualized care, improves nurse-patent relationship and it is easy to evaluate. From the study it has been shown that nursing care rendered in the wards is inadequate. (96%, 48) reported that the nursing care rendered on the wards was inadequate (table 5). The study also found that (84%, 42)

of the respondents reported that shortage of staff and stationery contributed to the inadequate nursing care rendered on the wards (table 6).

The study shows that the level of nursing care rendered to the patient is related to the age of the nurse providing the nursing care. Out of the (96%, 48) respondents who rendered poor nursing care, (38%, 19) were aged between 31 and 34 years of age (table 24). This could be attributed to the fact that this age group could have served for about 10 years such that they have no more continuous motivation to drive them to work hard. On the other hand the study shows that there is no relationship between the level of care rendered by the nurse and their job title. The study (table 25) has shown that all the Registered Midwives (6%, 3) and all the Enrolled Nurses (40%, 20) rendered poor nursing care.

It is surprising to note that as individual nurses get more experienced in their work, their input reduces. The study revealed that the length of service one has worked is directly related to the level of nursing care he/she renders. (96%, 48) of the respondents rendered poor nursing care, out of which (38%, 19) had served between 6 and 10 years (table 26). These findings could be attributed to the lacking and poor conditions of service for the nurses. Kabombo, S. B. (1998), states that the present situation with regard to the conditions of work and life of nursing personnel is serious as it warrants the quality of care.

It is important to note that documentation of nursing care is greatly influenced by the level of nursing care being rendered. Nurses are supposed to document what they practice so that their records reflect their actual performance. The study shows that the majority of the respondents who rendered poor nursing care also reported poor nursing documentation. (96%, 48) of the respondents rendered poor nursing care while (92%, 46) reported poor nursing documentation (table 36). For nurses to document adequately there is need for them to render adequate nursing care.

5.3 DOCUMENTATION

In accordance to Booyens S. W. 1998, completion and accurate documentation of all nursing tasks is a professional and ethical requirement. The study shows that the majority of respondents documented nursing tasks but did not complete their documentation. It also showed that what nurses documented on the ward varied considerably. The study shows that (82%, 41) of all the respondents documented nursing tasks (Table 12), (60%, 30) documented nursing procedures, medication and inventory while (10%, 5) documented nursing care plans, (42%, 21) documented vital signs, blood pressure, fluid balancing and partogram. (18%, 9) documented admissions and history taken, (16%, 8) documented reports on critical clients, postoperative clients and Glasgow coma scales, and lastly (8%, 4) documented doctor's orders and laboratory forms (Table 14).

Incomplete and variations in nursing documentation could be attributed to the background of the nurses. The study shows that during the basic nursing school education, the students were not oriented to a complete accurate documentation practice. It also shows that respondents had variations in documenting nursing care when they went to the service area. (90%, 45) of the respondents were taught some nursing documentation during their basic nursing training (table 7).

The study shows that as student nurses, 9 (18%) documented reports on clients and Glasgow coma scale, (34%, 17) documented nursing care plans, (58%, 19) documented procedures, medication, consent forms and lab forms, (32%, 16) documented vital signs, blood pressure, fluid balancing, and lastly (14%, 7) documented registration of clients (table 10).

When a strong foundation is built it follows that the outcome is also strong. The nursing profession has a poor foundation in nursing documentation and this could be attributed to the inadequate coverage of nursing documentation in the nursing school curriculum. The study reveals that the inadequacy

nursing documentation is due to shortage of staff and inadequate hospital policy for guidance. (14%, 7) of respondents reported that they could not document nursing care because of shortage of staff on the ward while (2%, 1) reported that inadequate documentation is due to lack of guidance (table 13). From the study it has been shown that the age of a nurse plays an importance role in nursing documentation. It has been revealed that younger nurses document more nursing care than the older nurses. The study reveals that (92%, 46) of respondents rendered poor documentation, out of which (36%, 18) were of the age between 31 and 34 years (table 27). As nurses grow older they tend to ignore the importance of documentation especially if no one reminds them. Younger nurses document more because they want to experience the practice of nursing and still remember the importance of documenting as they have just completed their basic nursing school.

The study shows that job title of individual does not influence the level of nursing documentation. From the study it has been observed that the majority of the respondents reported poor nursing documentation and this included both Registered Nurses and Enrolled nurses. (92%, 46) reported poor nursing documentation out of which 10 (20%, 10) are Registered nurses and (34%, 17) are Enrolled nurses (table 28). These findings could be attributed to the inadequate coverage of nursing documentation in both Registered Nurses and Enrolled Nurses curriculums. The school curriculum plays an important role in shaping the nursing professional because what students learn is more likely to be practiced when they qualify as nurses.

As age of nurses influence the quality of documentation, it also followed that the length of nursing practice influence the quality of documentation. As nurses increase their length of practice their age also increases. From the study it has been observed that the longer the nurses serve the less the level of performance. The study reveals that (92%, 46) of respondents rendered poor documentation, out of which (34%, 17) had served between 6 and 10 years, and (20%, 10) had served between 11 and 15 years (table 29). This

could be attributed to the fact that as nurses increase their experience they tend to deviate from the normal working system of the professional and try to replace the system with other practices to suit their experience while ignoring the importance of following the normal working system. Despite the older age or longer length of service of an individual nurse, nurses are required to document adequately in order to reflect a true picture of their practice. Full representation of practice facilitates monitoring and evaluation of nursing care rendered to the clients.

5.4 KNOWLEDGE

In accordance with the Zambian Health and Demographic Survey conducted between 2001 and 2002, it was established that, knowledge is a precondition of proper or higher utilization of any given service (CSO and MoH, 2003).

The study revealed that (58%, 29) of the respondents have general knowledge on nursing documentation (table 16). The study also shows that (58%, 29) alluded that nursing documentation facilitates easy continuity of data while (56%, 28) alluded that it promotes record keeping and gives evidence of nursing care (table 17). In addition the study also shows that on average (56%, 28) respondents like nursing documentation.

It is unfortunate that although nurses like nursing documentation, there are many constraints (Table 19) that hinder them to document. Among the many constraints, lack of knowledge and skills was one of the main constraints. From the study (Table 20), it is shown that (68%, 34) of the respondents have not received in-service training on nursing documentation. This shows that most of the respondents had no actual guidelines on documentation as a result had no capacity to document accurately or adequately and therefore proves the hypothesis which states that nurses who had in-service training on Hospital management information system are likely to document nursing care than those without in-service training. It is important to note that out of (32%, 16) of respondents who had in-service training, (14%, 7) of them only

had the training a year ago (Table 21). This finding clearly indicates that the actual knowledge on principles, guidelines and importance of nursing documentation is low among the nurses.

From the study it has been shown that age of the nurses contributed to the level of actual knowledge the respondents had. The study shows that (92%, 46) of the respondents had low level of knowledge on nursing documentation, out of which (34%, 17) were aged 31 and 34 years (table 30). This could be attributed to the inadequate in-service training activities that are offered on nursing documentation. In addition, it could be that as nurses grow, they forget what they learnt some years back as a result fail to do the right thing. It is therefore important that periodic in-service training on documentation are provided among all nurses especially the elderly ones – so that they can keep up with the knowledge and skill they need to document accurately.

On the other hand the study shows that the job title of individual nurses did not influence the level of knowledge the respondents had on nursing documentation. The study shows that (92%, 46) of respondents had low knowledge on nursing documentation, out of which (38%, 19) of Enrolled Nurses had low knowledge and (18%, 9) of Registered Nurses had low knowledge (table 31). This could be attributed to the fact that all these respondents trained in basic nursing when the curriculum did not have adequate coverage on nursing documentation.

The study reveals that (92%, 46) of respondents had low level of knowledge, out of which (36%, 18) had served between 6 and 10 years while (18%, 9) had served between 11 and 15 years (table 32). This clearly indicated that as years pass some practicing nurses fail to keep abreast with information pertaining to their work. Nurses need to be well informed about documentation for them to document accurately. The study has also shown that there is a strong relationship between knowledge and the ability to document. From the study (table 33), it is shown that (92%, 46) of the

respondents rendered poor documentation. Another (92%, 46) of respondents had low knowledge on nursing documentation.

5.5 STAFFING PATTERN

In any health institution manpower should match the needs of their organization. The study reveals that (92%, 46) of the respondents were of the opinion that the staffing pattern on the wards was poor (table 23). The reduction in staffing levels could be attributed to transfers. When a nurse is transferred, a replacement had to be made as soon as possible if staffing levels have to be maintained. When staffing levels are adequate, nursing care is expected to be adequate too if the resources are available. The study shows that the staffing pattern influences the quality of nursing care rendered on the ward. From the study (table 34), (92%, 46) of the respondents reported that the staffing pattern on the ward was poor and (96%, 48) of the respondents rendered poor nursing care.

Inadequate staffing pattern means that nurses are over-stretched and as a result provide poor nursing care. A tired nurse cannot be expected to give the best. The nurse literally pulls him/herself through the ward and will use short cuts in order for her to care for more clients, meanwhile she will have no time at all to document adequately her care. Her documentation will be incomplete and inaccurate. The study reveals that staffing pattern strongly influences the level of nursing documentation. From the study (table 35) it is shown that (92%, 46) of the respondents were of the opinion that staffing pattern was poor on the wards, it also shows that (92%, 46) of the respondents reported poor nursing documentation. From the study findings it is in order to accept the hypothesis that states that adequate staffing influences documentation in nursing practice. Nursing documentation is a necessity in the nursing profession but for it to be done, there should be adequate staffing patterns on the ward.

5.6 IMPLICATIONS TO THE HEALTH CARE SYSTEM

The nursing professional plays a vital role in the delivery of health care. The nurses form the majority of employees in the Ministry of Health. Through the introduction of nursing documentation, nursing is striving to gain professional autonomy and an identity independent of medicine. Nurses should be responsible for prescribing nursing and documenting it accurately. Although the study revealed that a large number of nurses had a high level of general knowledge on nursing documentation, those who had factual knowledge were only a few. Therefore, there is need for in-service workshops on nursing documentation, so that the nurses can understand the concept fully.

It was also discovered that increased staffing levels of nurses on the clinical area will also ensure that nurses offer individualized patient care without overworking themselves, thereby carrying out a complete and accurate documentation of their activities.

The complete documentation of nursing care depends on the ability and competence of nurses. However, poor nursing care coupled with shortage of staff and stationery results in poor and incomplete nursing care documentation. This results in poor quality nursing services to the public. This implies that it is difficult to document nursing care when there is poor nursing care, shortage of staff, and shortage of stationery.

Finally, this study revealed that majority of the nurses had a positive attitude towards nursing documentation if constraints in work environment were removed such as, low staffing levels and an erratic and inadequate supply of stationery.

5.7 CONCLUSION

The results of this study show that most respondents did not have the factual knowledge on nursing documentation and although almost all the respondents documented nursing, they did not complete the documentation.

Incomplete and inaccurate documentation could be due to negative attitude erratic and inadequate supply of stationery, high nurse-patient ratio, and poor nursing care.

In order to achieve complete and accurate nursing documentation, there is need to change staff patterns, to have knowledgeable and competent nurses and to provide quality nursing care. There is also need for total commitment of bedside nurses and management in any given health facility in documenting nursing care.

5.8 RECOMMENDATIONS

1. There is need for the authorities to emphasize on the Health Management Information System (HMIS) in the Nurses and Midwives Curriculum (2002-2003 Draft) to facilitate nursing documentation. Plan in-service training on nursing documentation and Health Management Information System (HMIS).

2. There is need to improve the staffing levels and relieve nurses of most orthodox duties by:

   (a) Involving maids in damp dusting and bed making
   (b) Ward attendants should take care of some ward basic procedures such as bathing patients.

3. Make amendments on the factors affecting nursing documentation.

4. Ward Managers should teach nurses on nursing documentation.

5. A study to be done on a larger scale to determine why nurses do not document nursing activities.

5.9 DISSEMINATION OF FINDINGS

The results of the study will be disseminated by sending an executive summary to the research site which is Monze Mission Hospital for

implementation of recommendations to all the staff in different departments of the hospital. Findings of the study will also be disseminated to interested parties such as General Nursing Council of Zambia and the Central Board of Health.

5.10 LIMITATIONS OF THE STUDY

The sample size used was 50, this was too small and therefore may not be representative of the population. This was done due to limited resources in terms of finances and time.

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7.0 LIST OF APPENDICES

7.1 STRUCTURED WORK SCHEDULE

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

STRUCTURED INTERVIEW SCHEDULE ON FACTORS INFLUENCING NURSING DOCUMENTATION AT MONZE HOSPITAL

INSTRUCTIONS

1. Do not write your name on the questionnaire

2. Answer 4 questions accordingly as arranged

3. For questions provided with alternatives, indicate the letter bearing the response by ticking in the appropriate box against it;

4. For questions without alternatives, write down the response on the space provided.

5. All the information will be held in confidence.

SECTION A: DEMOGRAPHIC DATA

For official use only

1. Sex of staff

(a) Male ☐

(b) Female ☐

☐

2. How old were you on your last birthday?_____

3. What is your marital status?

(a) Single ☐

(b) Married ☐

(c) Divorced ☐

(d) Widowed ☐

(e) Separated ☐

☐

4. What is your religion?

(a) Christian ☐

(b) Hindu ☐

(c) Moslem ☐

(d) Non ☐

(e) Any other (specify).....

☐

5. What is your job title?

(a) Registered Nurse ☐

(b) Registered Midwife ☐

(c) Enrolled Nurse ☐

(d) Enrolled Midwife ☐

☐

For official use only

6. When did you start practicing as a nurse?

(a) 1 -2 years ago
(b) 3 – 5 years ago
(c) 6 – 10 years ago
(d) 11 – 15
(e) 16 – 20
(f) 20 years ago and above

7. Do you have children?

(a) Yes
(b) No

8. If your answer to question 7 is 'Yes', how many?

(a) 1
(b) 2
(c) 3
(d) 4
(e) 5 and above

SECTION B: CARE

9. What type of nursing care was practiced in your hospital where you trained?

(a) Task allocation
(b) Patient allocation
(c) Team nursing
(d) Primary nursing
(e) Others, please specify_____

10. Which type in question 9 would you favour if you were given the option to choose?

_____

_____

11. Please state reasons for your answer.

_____

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12. In your opinion, how is the present delivery of nursing care in your ward?

(a) of high quality

(b) of average quality

(c) of low quality

13. Give reasons for your answer in question 12.

_____

_____

SECTION C: DOCUMENTATION

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

(a) Yes

(b) No

15. If the answer is "Yes", to question 14, state what was taught in nursing documentation.

_____

16. Did you document your nursing care in the service area during your training?

(a) Yes

(b) No

17. If then answer to question 16 is "Yes", state in your own words what you documented during your training in the service area.

_____

_____

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

_____

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19. Is nursing practice being documented in your present ward?

a. Yes ☐

b. No ☐

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

_____

_____

21. If the answer to question 19 is "Yes", what nursing practice is being documented in the ward?

_____

22. If nursing is documented in your ward, who monitors the documented work?

(a) Senior Nursing Officer ☐

(b) Nursing Officer ☐

(c) Sister in Charge ☐

(d) None ☐

(e) Other (specify)_____

SECTION D: KNOWLEDGE

23. State in your own words what nursing documentation involves.

_____

_____

24. What are some of the advantages of documenting nursing activities?

(a) _____

(b) _____

(c) _____

(d) _____

(e) _____

25. What are your feelings about documenting nursing care? For official use only

(a) I like it

(b) I find it time consuming

(c) Nobody appreciates it

(d) Other (specify) _____

26. What are the constraints of documenting nursing care?

(a) _____

(b) _____

(c) _____

(d) _____

(e) _____

27. Did you attend in-service training on the documentation of nursing practice or health management information system?

(a) Yes

(b) No

28. If your answer to question 27 is "Yes", how long did you attend this training?

(a) 1 year ago

(b) 2 -3 years ago

(c) 4 -5 years ago

(d) 6 – 10 years ago

(e) Over 10 years ago

29. After attending in-service training on the documentation of nursing or health management information system, did the coordinator follow up to ensure that nursing practice was being documented in the ward?

(a) Yes

(b) No

SECTION E: STAFFING PATTERN

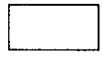
For official use only

30. How would you rate the staffing pattern on the ward?

(a) Adequate

(b) Moderate

(c) Poor



THANK YOU FOR YOUR PARTICIPATION

7.2 RESEARCH WORK SCHEDULE

TASK TO BE PERFORMED	DATA	PERSONNEL	DAYS REQUIRED
Literature	Continuous	Researcher and supervisor	Continuous
Finalize research proposal	21st April to 8th August, 2003	Researcher	16 weeks
Clearance from school and funding authority	21st April to 29th August, 2003	Researcher	19 weeks
Data collection tool	1st September to 5th September, 2003	Researcher	5 days
Data collection	8th September to 19th September, 2003	Researcher/Research Assistant	10 days
Data Analysis	22nd September to 3rd October, 2003	Researcher	14 days
Report writing	6th October to 17th October, 2003	Researcher	14 days
Draft reporting to PBN	20th October to 26th October, 2003	Researcher	7 days
Finalization of report	1st November to 14th November, 2003	Researcher	14 days
Monitoring and evaluation	Continuous	Researcher	Continuous

7.3 THE GANNT CHART SHOWING VARIOUS TASKS TO BE UNDERTAKEN AND THE TIME REQUIRED FOR EACH TASK TO BE PERFORMED FROM APRIL TO DECEMBER 2003.

MONTHS		APRIL				MAY				JUNE				JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DEC.	
Number of weeks per month		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2
Task performed	Person responsible																																		
Finalize research proposal	Researcher																																		
Clearance	Researcher																																		
Data collection tool (pilot study)	Researcher																																		
Data collection	Researcher and Assistant																																		
Data analysis	Researcher																																		
Report writing	Researcher																																		
Draft report to PBN	Researcher																																		
Finalization of report	Researcher																																		
Monitoring and evaluation	Researcher																																		

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P. O. Box 50110
LUSAKA

18th August, 2003

The Director
Mazabuka District Hospital
MAZABUKA

UNIVERSITY OF ZAMBIA
22 AUG 2003
POST BASIC NURSING
SCHOOL OF MEDICINE

RFS: The Head of Department
Department of Post Basic Nursing
LUSAKA

Dear Sir,

Re: PILOT STUDY AT MAZABUKA DISTRICT HOSPITAL

I am fourth year (final year) student at UNZA, Department of Post Basic Nursing. I am currently pursuing a degree course in nursing.

In partial fulfillment of this programme, I am requested to conduct a research study. My topic is "to assess factors influencing documentation in nursing:.

I am hereby requesting for permission to conduct a pilot study at Mazabuka District Hospital from 1st to 5th September, 2003.

Thanking you in anticipation.

Yours faithfully,

Mutunta Siatwinda Malama (Mrs.)
4TH YEAR B.Sc. NURSING STUDENT

All communications should be addressed to

In reply please quote:
No.....

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

OFFICE OF THE MEDICAL SUPERINTENDENT
MAZABUKA DISTRICT HOSPITAL
P.O. BOX 670060
TEL: 032 – 30188, 30205
MAZABUKA

Mrs Mutinta Satwiinda Mazama
Post Basic Nursing
Lusaka

Dear Madam,

RESEARCH AT MAZABUKA DISTRICT HOSPITAL

Thank you for your letter requesting to do your research at our hospital. We have no objection to this and hope you will find the required information.

Wishing you well in your studies.

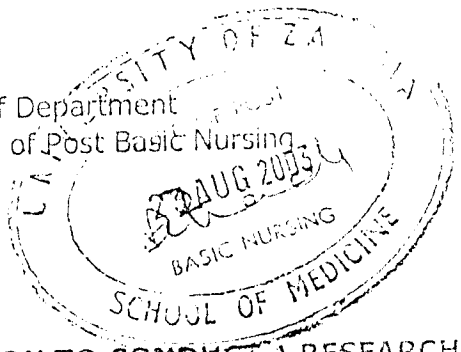
Mwendabai P. Nyambe
N.O
For Medical Supt

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P. O. Box 50110
LUSAKA

18th August, 2003

The Director
Monze Mission Hospital
MONZE

UFS: The Head of Department
Department of Post Basic Nursing
LUSAKA



Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH

I am a fourth year (final year) student pursuing a B.Sc. degree in nursing at the University of Zambia, School of Medicine. As part of the fulfillment for a degree programme, I am required to carry out a research study. The topic of my study is "a study to assess the factors that influence documentation in nursing".

I would like therefore to ask for permission to conduct a research study at Monze Mission hospital. Collection of data will be done from 8th to 19th September, 2003.

I will be very grateful if my request is considered.

Yours faithfully,

Mutinta Siatwinda Malama (Mrs.)
4th YEAR B.Sc. NURSING STUDENT

Monze Mission Hospital Management Board

Phone Monze 50171/50143
Fax: 50593

P O Box 660029
Monze
Zambia

Our Ref:

Your Ref:

1st September, 2003

Mutinta Siatwinda Malama
University of Zambia
School of Medicine
Department of Post Basic Nursing
P O Box 50110
LUSAKA

Dear Madam,

RE: PERMISSION TO CONDUCT A RESEARCH

I write on behalf of Management to let you know that your request to conduct a research at our Institution has been accepted.

Wishing you all the best in your research study.

Yours faithfully,

D. MUKOLOBA
SENIOR NURSING OFFICER

7.6 RESEARCH BUDGET

BUDGET CATEGORY	UNIT COST (K)	QUANTITY (K)	TOTAL (K)
1. PERSONAL			
(a) Lunch allowance			
Researcher	50,000	10 days	500,000
Research Assistant	50,000	10 days	500,000
(b) Training			
Training of research assistants	50,000	1 day	50,000
SUBTOTAL			**1,050,000**
2. STATIONERY			
(a) Typing or bond paper	25,000	2 reams	50,000
(b) Pens	500	10	5,000
(c) Pencils	400	4	1,600
(d) Note books	500	4	2,000
(e) Tipex	800	1	8,000
(f) Scientific calculator	50,000	1	50,000
(g) Stapler	25,000	1	25,000
(h) Staples	5,000	1 box	5,000
(i) File	15,000	1	15,000
SUBTOTAL			**161,600**
3. SECRETARIAL SERVICES			
(a) Diskette	3,000	2	6,000
(b) Bag for questionnaires	50,000	2	100,00
(c) Typing services	2,000	100 pages	200,000
(d) Photocopying questionnaire	1,000	60 questionnaires	60,000
(e) Binding report	50,000	5 copies	250,000
SUBTOTAL			**616,000**
TOTAL			**1,827,600**
CONTINGENCY 10%			**182,760**
GRAND TOTAL			**2,010,360**

BUDGET JUSTIFICATION

The resources required for the study were described as follows:

- **STATIONERY**

Stationery was required to carry out research. Paper was needed for writing. The notebook was needed for taking note of all important points during data collection and analysis and for writing down the results following data analysis. Stapler and staples were needed to put papers together and properly arranged. Tipex was used to correct any errors; a scientific calculator was used for calculations. Files were used for filing all documents for safe keeping.

- **PERSONNEL**

A trained assistant were trained for one day to help with administering of questionnaires. Lunch allowance was needed throughout data collection.

- **SECRETARIAL SERVICES**

Monetary resources were required to pay for all typing services. A diskette for saving information and bags for carrying the questionnaires was needed. Binding of the report was also done at the end.

- **CONTINGENCY**

Contingency is the ten percent (10%) of the total amount for the budget. It was to be added to the total amount of the budget for unforeseen expenses during the research.

MARK SHEET

VARIABLE	QUESTION NUMBER	WRONG	CORRECT	TOTAL MARKS
Care	9	a	b,c,d,e	1
	10	a	b,c,d,e	1
	11	-	a,b,c	3
	12	c	a,b	1
	13		a,b,c,d,e	5
	Total			**11**

75% - 100%	Adequate nursing care
50 – 74%	Moderate nursing care
0 – 49%	Poor nursing care

VARIABLE	QUESTION NUMBER	WRONG	CORRECT	TOTAL MARKS
Documentation	13	B	A	1
	14	F	a,b,c,d,e	5
	15	B	A	1
	16	F	a,b,c,d,e	5
	17		a,b,c,d,e	1
	18	B	A	1
	19	C	A,b	2
	20	H	A,b,c,d,e,f,g	7
	21	D	A,b,c,e,f	5
	Total			28

PERCENTAGE

75 -100%	Nursing documentation – adequate
50 – 75%	Nursing documentation – moderate
0 -49%	Nursing documentation – poor

KNOWLEDGE

VARIABLE	QUESTION NUMBER	WRONG	CORRECT	TOTAL MARKS
Knowledge	22	b,c	a	1
	23	a	a,b,c,d,e,f.g	7
	24	b,c,e	a,d,f	3
	25	f	a,b,c,d,e	5
	26	b	a	1
	27	f	a,b,c,d,e	1
	28	b	a	1
	Total			**19**

PERCENTAGES

75 -100% Knew nursing documentation

50 – 74% Knew some nursing documentation

0 – 49% Did not know nursing documentation

VARIABLE	QUESTION NUMBER		
Staffing pattern	29	Adequate	5 – 6 nurses
		Moderate	3 -4 nurses
		Poor	1 -2 nurses