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FACTORS INFLUENCING DOCUMENTATION OF TREATMENT AMONG NURSES AT SOROTI REGIONAL REFERRAL HOSPITAL-SOROTI CITY. A CROSS-SECTIONAL STUDY.

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Abstract

Background

Nursing documentation reflects the entire process of providing direct nursing care to patients. Nursing documentation that is clear, accessible, and accurate is an essential element of quality, safe, and evidence-based nursing care. The study aimed to identify factors influencing the documentation of treatment among nurses at Soroti Regional Referral Hospital.

Methodology

The researcher used a descriptive cross-sectional study employing quantitative techniques of data collection and a total of 30 nurses working in different wards at SRRH were selected using the purposive sampling method. Data was analyzed by Microsoft Excel and presented in tables, pie charts, and tables.

Results

30 respondents participated in this study, 22 females and 8 males. The majority of the respondents were 25-29 years old, while those between 20-24 and 30-35 years old were the minority. The study found that 93.3% of nurses did not document patient care, 93.3% did not have the necessary documentation materials and, 60% of the nurses reported working alone in a shift.

Conclusion

Inadequate essential documentation materials and a low number of nurses working per shift were found as the major reasons for poor documentation of treatment among nurses in SRRH.

Recommendation

The hospital administration should provide adequate documentation materials and lobby for more nurses to boost the number of those currently employed at the facility.

***Keywords**; Documentation of Treatment, Nurses, Soroti Regional Referral Hospital, Soroti City.*
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Background of the study.

Nursing documentation can be described as a reflection of the entire process of providing direct nursing care to patients (De Groot et al., 2020). It serves as an important communication tool for the exchange of information between healthcare providers and it is stored in a printed or electronic medical record (Duclos-Miller,2016).

According to Wilbanks et al., (2016), good quality documentation has been defined as documentation that is correct and comprehensive, uses clear terminology, is legible and readable, timely, concise, and plausible. Clinical nursing documentation is essential in letting nurses continuously reflect on their choice of interventions for patients and the effects of their interventions. Therefore, it is vital to the quality and continuity of nursing care (McCarthy et al., 2019).

Globally, nursing documentation is very important in the healthcare system (Asamani et al., 2015). According to a study conducted by the World Health Organization (WHO), poor communication between healthcare workers is a contributing factor to many medical errors. In addition to this, there is evidence linking poor nursing documentation with patient mortality in healthcare institutions (Hailu et al., 2017). Another global evidence also shows that medical errors cause about $20 billion in losses each year (Saiva et al., 2022).

In Canada, nurses spend about 26% of their time on documentation (Roumeliotis et al., 2018), and in the USA percentages vary from 25% to as much as 41% (Schenk et al., 2017). In the Netherlands, nursing staff reported spending an average of

10.5 hours a week on documentation (De Veer et al., 2017), which means they spend about 40% of their time on documentation.

According to other evidence from the USA, documentation errors are a cause of at least one death and 1.3 million injuries annually (Krishna et al., 2017).

In Africa, health workers working in health care institutions experienced medical documentation record keeping as a major challenging practice facing several

challenges that include lack of time to complete the record, and shortage of recording materials (tools that the health care providers used to document the information about the patient) (Mutshatshi et al., 2018).

In Ghana, 46% of care is provided, and progress notes are not documented after the first day of patient admission (Avoka et al., 2014). In Nigeria, only 44% of health professionals had good documentation knowledge and practice (Oseni et al., 2014). In Ethiopia, documentation is poorly practiced and has been reported as being left undone (Kebede et al., 2017). Health professionals' documentation practice is 47.8% in Tigray (Tasew et al., 2019) and 37.4% (Kebede M et al., 2017) in Amhara regions. Surprisingly, 88% of the medication provided has been wrongly documented (Feleke et al., 2015). A study report in the Amhara region states that 87% of the medications had documentation errors (Feleke et al., 2015).

A qualitative study done in Uganda found that documentation practice is limited by constraints and poor support from the health facility administration (Nakate et al., 2015).

The quality and consistency of documentation among nurses in Uganda are concerning, potentially impacting patient outcomes and the educational experience (Wanyama et al., 2020). Therefore, the study aimed to find out factors influencing documentation of treatment among nurses at Soroti Regional Referral Hospital.

Methodology

Study design and rationale

A descriptive cross-sectional study was used employing quantitative techniques of data collection. This study design was preferred because it was time-saving and cheap, given the short time allocated for research.

Study setting and rationale

The study was conducted at Soroti Regional Referral Hospital, which is in the city of Soroti, in Eastern Uganda. It is located 320 kilometers North-East of Kampala and is the referral hospital for the districts of Amuria, Bukedea, Kaberamaido, Kalaki, Kapelebyong, Katakwi, Kumi, Ngora, Serere and. Soroti. The hospital has the following departments medical, surgical, pediatrics, maternity, gynecology, outpatient department (OPD), Antenatal Unit, Family Planning Unit, Mental Unit, Palliative care Unit, ART clinic, Young children's clinic (YCC) and Therapeutic feeding Centre (TFC) unit among others. It has a bed capacity of over 500 beds. It employs Consultant doctors, medical doctors, clinical officers, and nurses among others. It is also a training setting for interns (doctors, and nurses, among others). The

study area was chosen because it has a wide catchment area hence a big population of nurses for the research study. Also, the hospital is easily accessible by the researcher, hence minimizing the costs of transport during data collection.

Study Population

The study population consisted of nurses at SRRH.

Sample size determination

The study targeted 30 nursing staff at SRRH. Slovin's formula was used to determine the sample size.

n = N / (1 + $Ne2$)

where: n = sample size

N = population size =30 nursing staff at SRRH

e = level of precision (maximum allowed error at 95%confidenceinterval in estimating the population size) =5%=0.05.

Substituting the formula:

n = 30 / (1+30×0.052)

n = 27.9

n = 30

The sample size was 30 nurses working at SRRH. The sample size was selected because it was adequate to generate the needed information for the study and it was relatively cheap for the researcher in terms of time and finances.

Sampling procedure

The researcher used a purposive sampling method to get the respondents. A population with a particular characteristic that the researcher is interested in was sampled.

Inclusion criteria

Nurses working at SRRH.

Exclusion criteria

Nurses absent from shift at the time of data collection and nurses who did not consent.

Definition of variables

Variables are characteristics of interest that a researcher likes to handle, observe, and manipulate in research and they were majorly divided into dependent and independent variables.

Independent variables

Factors influencing documentation of treatment.

Dependent variable

Documentation of treatment among nurses working at SRRH.

Research instruments

The study employed self-administered questionnaires, comprising both open and closed-ended questions in which all questions and answers are specific with minimal respondent comments so that it would be easy to analyze. As part of the quality control requirement, the questionnaire was pre-tested at Princess Diana HC IV so that errors could be detected to make sure it was simple

with straightforward instructions to obtain valid and reliable data.

Data collection procedure

An introductory letter was issued upon approval of the research proposal by the research committee of Soroti School of Comprehensive Nursing to collect data which then was presented to the Hospital director of Soroti Regional Referral Hospital for permission to collect data. The researcher was then introduced to the in-charges of different wards by the hospital director to collect data. The in charge in turn introduced the researcher to the respondents.

The respondents that met the criteria were identified, the purpose of the study was explained, consent was obtained and time was given to them to seek and ask questions in regards to understanding the study, and a questionnaire was administered to the respondents.

Data Management

Data collected was processed by sorting, editing, coding, and tabulating. The researcher used frequency tables, pie charts, bar graphs, and narratives for data presentation.

Data Security

The study materials were stored in an area only accessible to the researcher to avoid loss and the data were recorded in a computer with a powerful anti-virus and a strong password. Backups like flash and external hard disc drives were used to store data.

Data analysis

Data was then analyzed using the application, statistical package for Social Sciences (SPSS) version 25 and Excel. This process automatically converts the Excel file into the SPSS file then different statistical tests run, for example, mean, mode, medium, and standard deviation.

Ethical consideration

The research committee of Soroti School of Comprehensive Nursing approved the research topic and proposal. A letter of introduction was given by the school to the researcher who presented it to the research and ethics committee of the hospital. The research and ethics committee then in writing, granted permission to the researcher to conduct a study in the hospital. Maximum confidentiality and privacy of respondents were observed particularly by anonymity. The respondents were reassured of their voluntary participation in the study.

Results

Individual factors influencing documentation of treatment among nurses at SRRH

Table 1: Age of respondents in years (n=30)

Variable	Frequency (f)	Percentages (%)
20-24	2	6.7
25-29	16	53.3
30-34	10	33.3
35-39	2	6.7
Total	**30**	**100**

N = 30, Primary data (2024).

The majority of the respondents were 25-29 years old while those between 20-24 and 30-35 years old were the minority.

Table 2: Gender of respondents

variable	Frequency (f)	Percentages (%)
Female	22	73.3
Male	8	26.7
Total	**30**	**100**

N = 30, Primary data (2024).

More females were involved in the study than males.

Table 3: Level of education of respondents (n=30)

variable	Frequency (f)	Percentages (%)
Certificate nurse	12	60
Diploma nurse	18	40
Total	**30**	**100**

N = 30, Primary data (2024).

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60% of the respondents were certificate holders while 40% were diploma respondents.

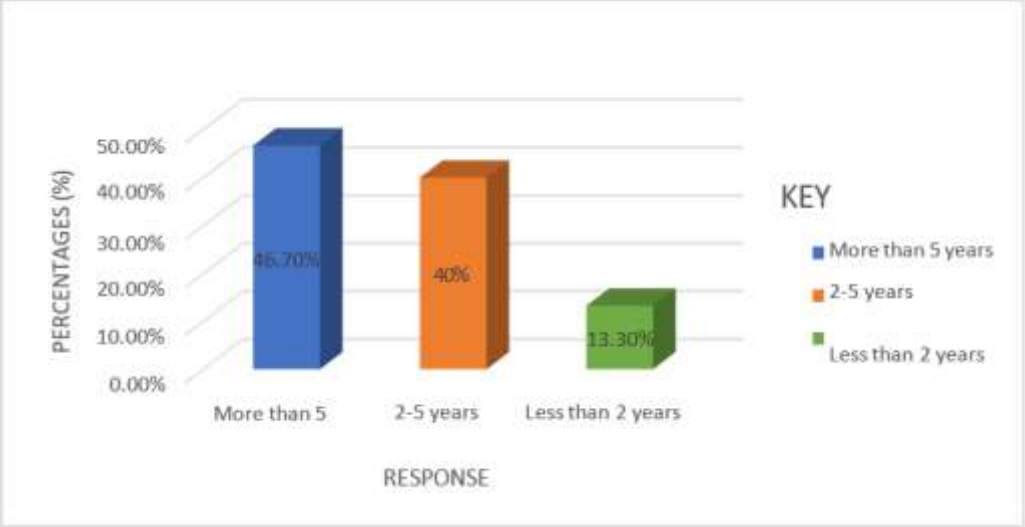
Table 4: Designation of respondents (n=30)

variable	Frequency (f)	Percentages (%)
Assistant nursing officer	3	10
Nursing staff	27	90
Total	**30**	**100**

N = 30, Primary data (2024).

Only 10% of the respondents were assistant nursing officers while 90% were nurses.

Figure 1: Distribution of respondents according to working experience (n=30)



The majority of the respondents have a working experience of more than 5 years while the minority reported having a working experience of less than 2 years.

Table 5: Relevance of documentation (n=30)

variable	Frequency (f)
Good patient outcome	4
Easy follow-up	15
Continuum of care	25
All the above	15

All respondents knew at least 1 relevance of documentation that is to say good patient outcome, Easy follow-up, or continuum of care.

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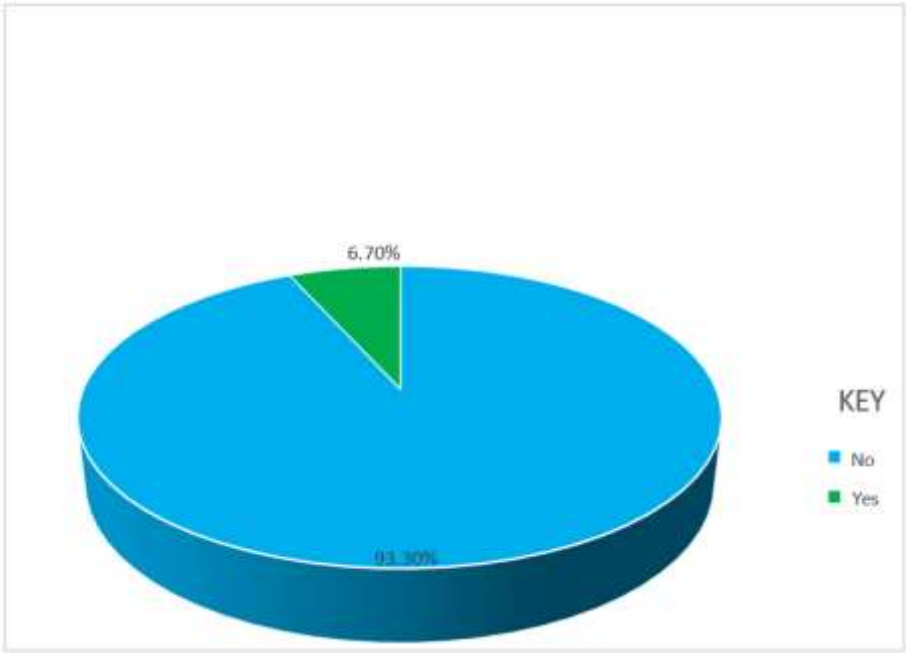
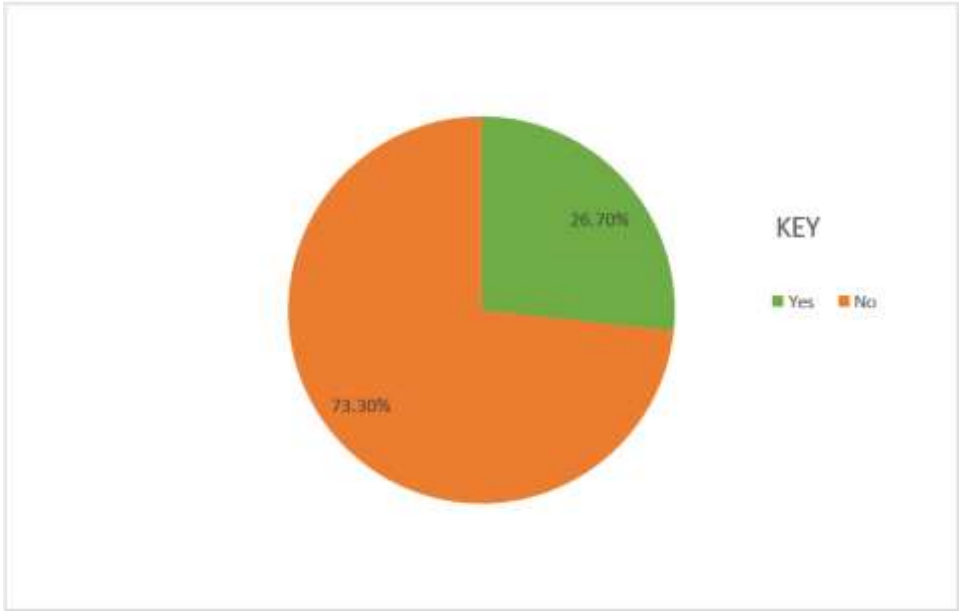
Figure 2: Distribution of respondents according to whether they document patient's care (n=30)



93.3% of the respondents did not document their patient's care while only 6.7% documented their patient's care

Health facility factors influencing documentation of treatment among nurses at SRRH

Figure 3: Availability of the necessary documentation materials (n=30)



The majority of the respondents reported not having the necessary documentation materials while the minority reported having the necessary materials like patient forms, outpatient forms, etc.

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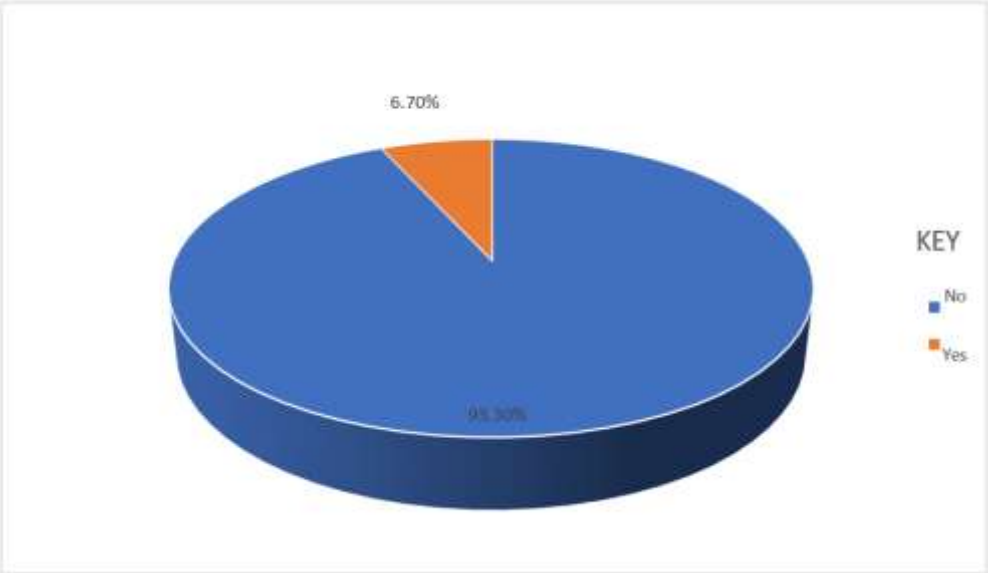
Figure 4: Distribution of respondents according to whether the hospital avails the necessary documentation materials (n=30)



93.3% of the respondents reported the hospital did not provide them with the necessary documentation materials while 6.7% reported the hospital availed the necessary materials like inpatient forms, outpatient forms, etc.

Table 6: Frequency of supervision on documentation (n=30)

Variable	Frequency (f)	Percentage (%)
Daily	14	46.7
Weekly	6	20
Monthly	6	20
Quarterly	4	13.3
Total	**30**	**100**

N = 30, Primary data (2024).

46.7% of the respondents were supervised daily, while 13.3% were supervised quarterly. Regarding whether the respondents had continuous medical education on documentation, the study results revealed that 86.7% did not have continuous medical education on documentation while 13.3% had.

Table 7: Ward of respondents (n=30)

Variable	Frequency (f)	Percentage (%)
Medical	6	20
Surgical	10	33.3
Maternity, Pediatrics	14	46.7
Total	**30**	**100**

N = 30, Primary data (2024).

46.7% of respondents worked in maternity and pediatric wards while 20% worked in medical wards.

Table 8: Shift type of respondents (n=30)

Variable	Frequency (f)	Percentage (%)
Day	16	53.3
Night	6	20
Shift	8	26.7
Total	**30**	**100**

N = 30, Primary data (2024).

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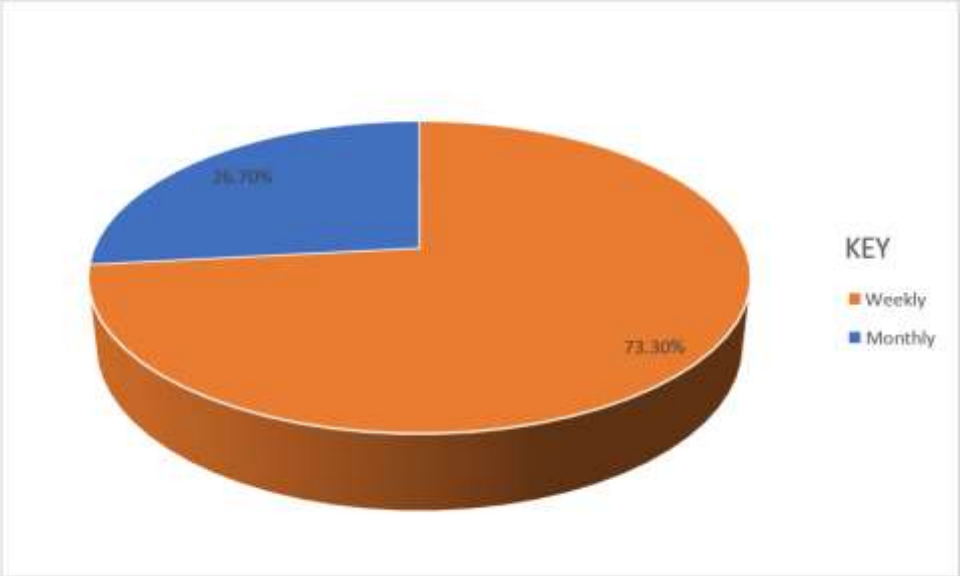
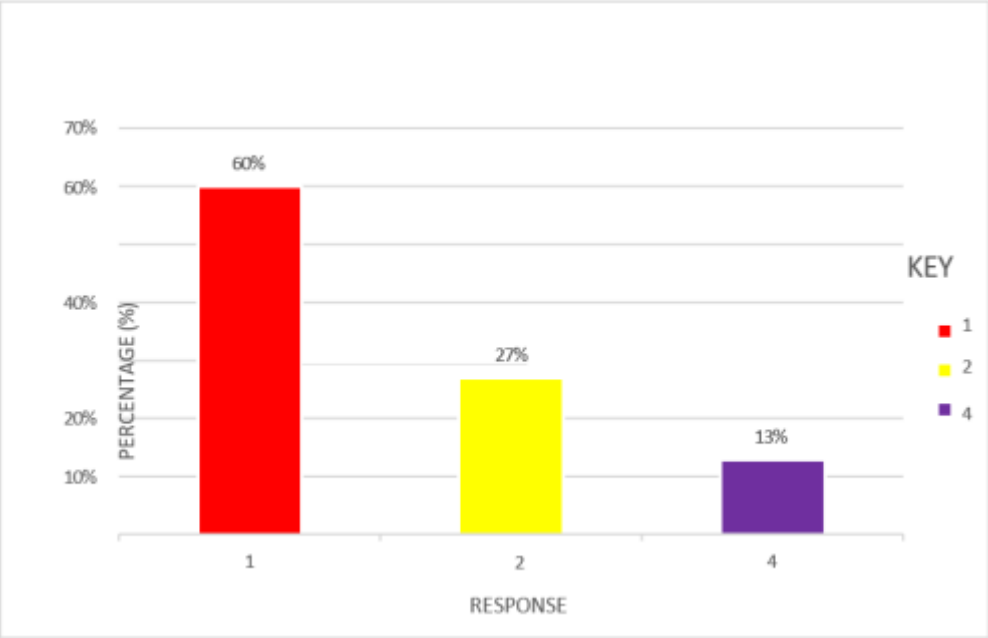
The majority worked the day shift while a minority of the respondents worked the night shift. According to shift duration, 80% reported working for 8 hours while 20% reported working for 12 hours.

Figure 5: Distribution of respondents according to how they change shift (n=30)



73.3% of the respondents reported they changed their shift weekly while 26.7% of the respondents reported they changed their shift monthly.

Figure 6: Number of respondents per shift (n=30)



60% of the respondents were alone in their shift with 13% reporting they were 4 per shift.

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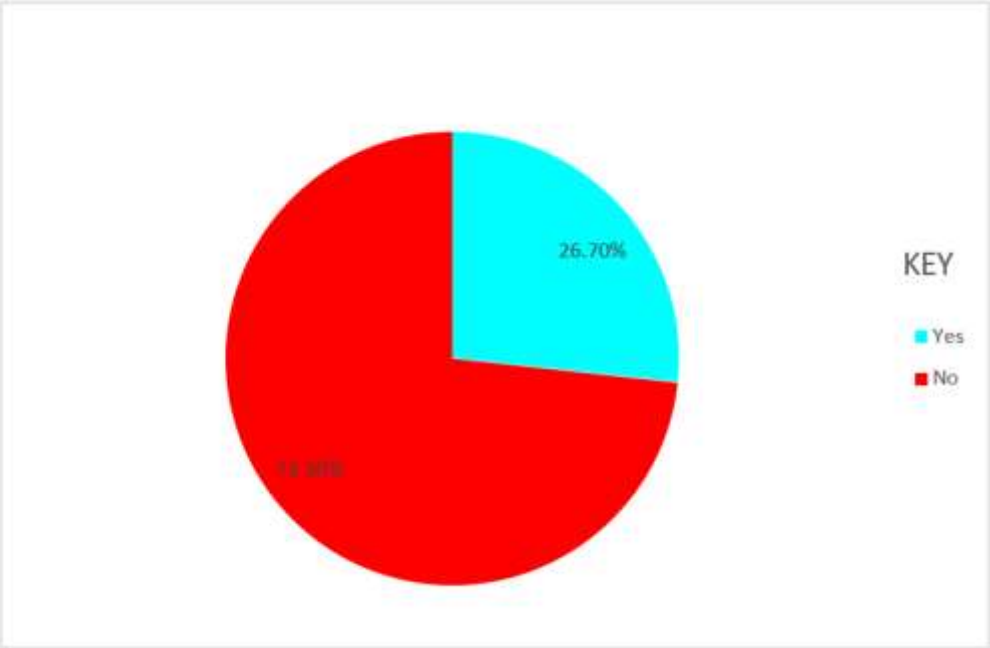
Figure 7: Whether nurses were enough for the shift (n=30)



73.3% of the respondents reported they were not enough for the shift while only 26.7% reported being enough for the shift.

Discussion

Age and experience gained from exposure leads to proficiency. This study revealed that the majority of the nurses were aged between 25-30 years and had worked for more than 5 years with the minority having less than 2 years. The possible reason for the majority of documentation was exposure to medical legal issues and knowing the benefits and relevance of documentation of nursing care. As well repetitive performance of the same task brings about mastery. The study findings were in line with Tamir (2021), which revealed that older health workers (age above 30 years) had a positive association with medical documentation practice.

Availability of documentation materials means familiarization with documentation sheets and accessibility of integrated routine health forms for recording and reporting. This study found that for 73.3% of nurses, necessary documentation materials were unavailable while only 26.7% had the necessary documentation materials. The findings were consistent with a study by Gilson, (2014) where findings revealed that the unavailability of recording documents also posed a challenge to nurses making recording difficult.

One of the significant factors influencing documentation practices among nurses was their level of knowledge and education regarding proper documentation protocols. The study found that the majority of nurses were employed as enrolled nurses. Beshir et al., (2023) argued that Nurses in charge, Senior nursing officers, and Principal nursing officers are administrative positions held in wards and hospitals and come along with responsibilities. He further revealed that nurses with titles above nurse in charge were more likely to document care compared to those with professional titles below senior nursing officer.

Time is a significant barrier to effective documentation among nurses. With high patient-to-nurse ratios and competing demands, nurses often struggle to find time for thorough documentation. The study found that there was inadequate staff in almost all units and departments of the hospital which led to increased workload. A study by Aseratia et al., (2014) found that nurses frequently viewed documentation as a burden, leading to abbreviated notes and incomplete records. The study further revealed that placing extra workload on the nurses predisposes them to decreased morale and inadequate work practices including poor documentation.

The introduction of electronic health records has transformed documentation practices in nursing. While electronic health records (EHRs) offer advantages such as improved accessibility and streamlined data entry. They also present challenges. EHR systems are frequently difficult for nurses to use, which can lead to frustrations and potentially lower the quality of documentation. The study found that 80% of nurses used paper-based methods of documentation with only 6.7% using

electronic methods. This is consistent with a study by Tubaistat et al., (2016), who argued that health workers with high e-health literacy are more likely to have good medical documentation practice than those who have no e-health literacy.

Gilson (2014) argued that the lack of recording materials poses a significant challenge to documentation among nurses. His findings were in line with the study results that revealed that for 93.3%, the hospital did not provide necessary documentation materials such as patient files and vital observation charts.

Increased workload leads to multitasking among nurses. According to Aseratie (2024), results revealed that nurses were not recording because of work overload owing to mismatches between staffing resources and workload. This study found out 60% of the nurses worked alone in their shifts, as a result, failure to document nursing care was evident.

The study found that 46.7% of nurses were supervised daily while 13.3% were supervised quarterly. Monitoring and supervision both influence documentation where nurses who were continuously supervised had better documentation practice compared to their counterparts who were rarely supervised. The study is in line with a study by Bijani et al., (2016), which revealed that the absence of supervision and continuous monitoring were the greatest contributors to poor documentation of patient care.

Conclusion

In conclusion, the study found that inadequate documentation materials and a low number of nurses working in a shift influenced documentation of treatment among nurses.

Recommendations

The hospital should lobby enough necessary documentation materials in time in the right quantities from the mini.

The hospital administrations should lobby for more nurses to add on those employed already.

All nurses should be encouraged to document regardless of age, working experience, ward allocation, and presence of supervision among other reasons.

Training should be done for all nurses to use the electronic-based method of documentation. Also organizing in-service training particularly to emphasize the relevance of documentation.

Implications to Nursing Practice

To help SRRH administration come up with strategies to fill up the gaps they have on factors influencing documentation of treatment.

The findings from this study will be used to ensure the safety and well-being of all patients. The comprehensive records will help nurses to make informed decisions and provide continuity of care to patients.

Nursing documentation serves as a legal defense for healthcare providers in case of malpractice allegations or lawsuits. This will be through providing evidence that the care provided was consistent with the established protocols.

Identification of risks and management in healthcare systems, accurate records help identify risks and prevent adverse events.

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List of Abbreviations

CMEs: Continuous medical education services
eHealth: Electronic Health
GoU: Government of Uganda
SPSS: Statistical package for social sciences
SRRH: Soroti Regional Referral Hospital
USA: United States of America
WHO: World Health Organization
NICU: Neonatal Intensive Care Unit
EHRS: Electronic Health Record System

Source of funding,

This study was not funded.

Conflict of interest

The author declares no conflict of interest.

Author contributions.

Rose Mary Awino, research principal investigator.
Charles Ayen Owiny supervised the research.
Gabriel Abongo did the data entry.
Patricia Pita, data collector.
Derick Modi, data cleaning, analysis, and manuscript development

Data availability
Data is available upon request

Informed consent
All the study respondents consented to this study.

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Derick Modi holds a bachelor's degree of science in Public Health, from Lira University School of Public Health.

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