

## **Documentation: Historical Perspectives, Purposes, Benefits and Challenges as Faced by Nurses**

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### ***Introduction***

The authors of this article have examined the issues related to documentation under the following: Historical perspectives, Principles purposes, benefits and challenges being faced by the nurses in their endeavor to give quality care to patients/clients, especially in the developing countries. Documentation is communication regarding care of clients/patients and can be hand written or printed or stored in audiovisual systems. Nursing documentation is a permanent part of medical records.

### ***Historical Perspectives***

Since the time of Florence Nightingale, nurses have viewed documentation as a very important aspect of their professional practice. Nightingale described the need to document proper use of air, light, warmth, cleanliness and proper selection of diet with an aim of collecting and retrieving data to aid in proper patient management. Iyer, Levin & Shea, (2006) confirmed that whereas the aim of documentation in Nightingale's time was mainly to communicate implementation of Doctors orders, today's nursing documentation is applied in all the steps of the Nursing process from assessment to the evaluation. Virginia Henderson, a Nurse theorist, promoted the use of documentation when she introduced the idea of using the nursing care plans to communicate nursing care during the 1930's. However, the nursing documentation was discarded after the patient had been discharged. Since 1970's, nursing documentation has become more important reflecting the changes in nursing practice, regulatory agency requirements and legal guidelines. Nursing documentation has also evolved as an important mechanism in determining monetary reimbursement of the care provided to clients/patients (Iyer et al., 2006).

Documentation also stands in as a source of evidence of each health care provider's accountability in the delivery of care, therefore, professional nurses are expected to document the care given to patient/client in all settings (Crisp, Potter, Taylor, & Perry, 2005 (Online); American Nurses Association, 2005). In an endeavor to provide quality patient /client care, nurses and other health care providers aim at sharing accurate, concise, thorough, current, organized and confidential information about patients/clients. Documentation serves both as an educational tool and a method of monitoring patient's /client's status (American Nurses Associaion, 2005).

Patient/ client's record gives a lot of information about the care given and the response to that care. Examples of the documents used by health care providers are admission registers, referrals forms, cardexes, treatment sheets, mortality records, images (x-rays, ultrasound scans, and magnetic resonance imaging), observation charts, ward round records, matron's report, shift management reports and clinical anecdotal notes etc. (American Association of Nurses, 2005).

Documentation also acts as a formal legal document that gives details of a client's management. Throughout the world, it is well accepted that if a procedure is not documented, then it was not done, thus documentation should be complete and accurate (Wetter, 2005). However, most health care providers in many developing countries especially the Nursing staff have not been keen in this matter. A few scenarios could include, a nurse reporting for duty and attending to a patient for a period of 8 hours or more without recording the care given. Others include, signing of the treatment sheet before making sure the patient has taken their medication or administering an injection or, a mother may come in for maternity care and on discharge, there is no documentation regarding her admission, birthing process and the condition of the baby.

In an informal assessment undertaken regarding documentation in one of the leading health care facilities in Kenya (Clinical audit report, 2011), the following observations were made;

- Fragmented and incomplete information on patient care.
- Lack of standardized method of nursing documentation.
- Insufficient time for documentation due to acute shortage of staff.
- Insufficient training of nurses on the importance of nursing informatics.
- No audits undertaken to evaluate nursing documentation.

### ***Principles of Documentation***

Written communication should follow the guidelines of good communication and should be simple, clear, and pertinent and above all, it should be accurate. Every nurse/health care professional must be familiar with their organizational policies or procedures related to documentation so as to operate within what is acceptable and avoid getting into problems. The following are general principles that should be observed as regards documentation according to the American Nurses Association, 2005;

#### **I. Be objective**

Documentation on what is seen and heard should be made and not conclusions. A few examples of events documented could be, during an assessment, when one observes a client having some bleeding he/she should indicate how much blood has been lost/or is being lost, whether it is clear, gushing, oozing and the source of the bleeding. Another example is when a client/patient is found lying on the floor, one should not document "client fell" unless he/she was seen falling. Observation thus, client found on the floor should be documented.

After a nursing intervention, one should identify the patient's reaction, for example, after giving medications, one should record the patient's response as well as time, dosage, route and description of any side effects. After performing wound dressing, the date, time, the state of the wound and the solution used for the dressing should be indicated. If it is collection of a specimen, one should indicate the time it was obtained, the characteristics and where applicable where the specimen was taken and received. If a patient declines to take his treatment or any procedure, it is good to ensure that it is well documented.

#### **II. Be Specific**

Ambiguous statements and generalization in documentations should be avoided. It is common practice when handing over reports to hear statements such as "the patient had a fair night" or "the patient had an uncomfortable night". These do not give any specific information. If the nurse instead records that the patient was up 10 times because of diarrhea during the night, this would tell why that particular patient had an uncomfortable night.

When documenting what the patient said verbally, the health care provider should use direct quotes. One should not document hearsay or what someone else said about the patient. If one has to, then it has to be clearly quoted. For example Mrs. Collins told me that, "my husband does not like eating green vegetables". Documentation on this should be made immediately on receiving the information and never before. If there was an emergency that one had to attend to and did not document immediately, then it should be done as soon as possible as a "late entry" stating when the action was done and when it was entered.

**III. Be clear and consistent**

It is important to make sure that all hospital records are written in proper sentence structure, spelling and neatly written. Standard abbreviations should be used; one should not invent his/her own because this may bring about confusion and misinterpretations. It is paramount to append signatures for all procedures done on the patient/client.

**IV. Record all relevant information including communications with other members of the health team.**

A scenario that illustrates this is when for instance, a new patient arrives in the ward at 10.00p.m in the night and the doctor on duty is called at 10.30p.m to review the patient and does not turn up and a repeat call is made at 11.30p.m and the doctor says “I will be coming soon”, all of this conversation by phone should be documented stating the times, names and the responses obtained from the doctors called. One should also document all the other procedures that were being done while waiting for the doctor to come. Under many circumstances, disputes erupt when doctors deny being called or notified especially whenever a legal issue arises.

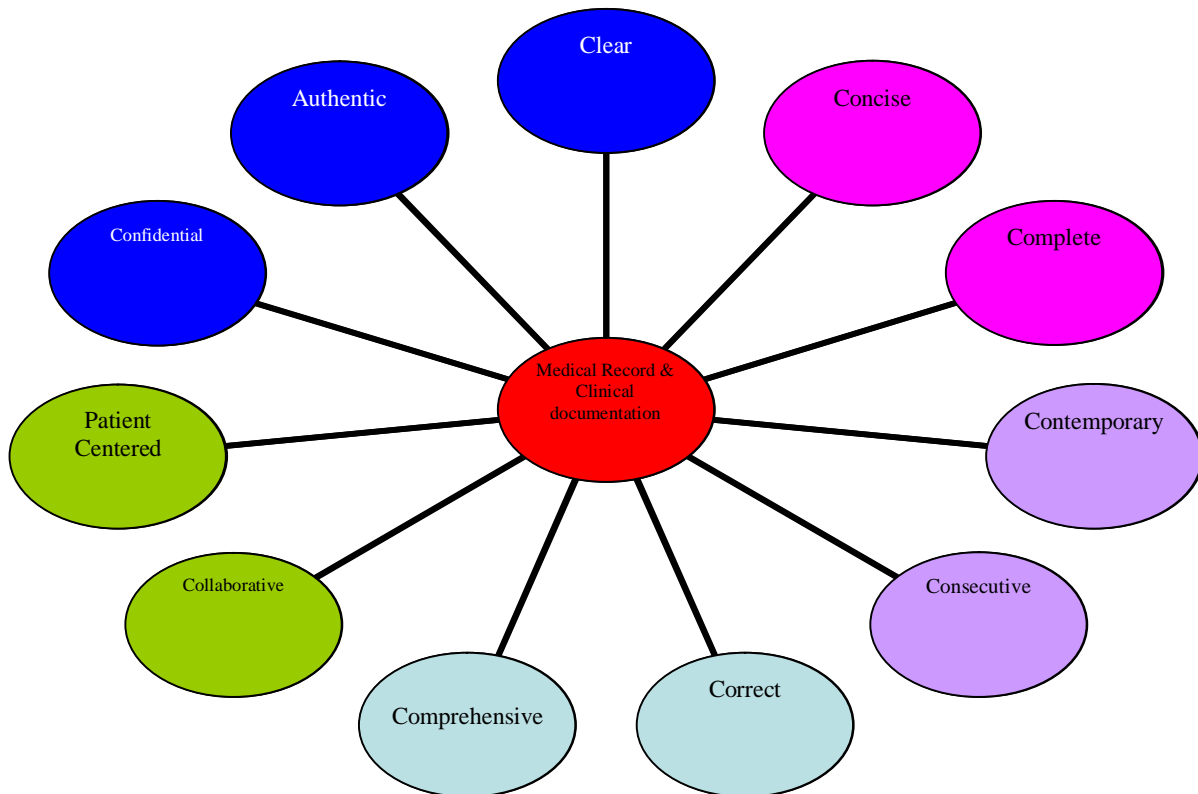
**V. Respect confidentiality**

Patient/client records should only be shared with the health care team participating in the management of that particular patient and not with any one else. It is unethical to discuss patients’ care/management over “tea or coffee time” for this amount to breach of confidentiality which is illegal.

**VI. Recording errors**

Whenever an error is made during documentation, white out should not be used on the patient’s chart. This is illegal and may be considered as a cover-up. This should be crossed out in a single line and an “error” written on it followed by a signature and the correct statement written.

The diagram below describes the guidelines that should be followed during clinical documentation (Clinical Audit & Nursing Research, MTRH 2011)



**Fig 1: Guidelines for documentation**

### **Rationale for Documentation**

1. It provides a means of communication between the members of the health care team and facilitates coordinated planning and continuity of care. This is because it is often the major and occasionally the only medium for data exchange between the health care team (American Nurses Association, 2005).
2. Clear, complete, accurate and factual documentation provides a reliable, permanent record of patient care.
3. It acts as a means of professional responsibility and accountability. Documentation is a part of nurses overall responsibility for patient care that helps in coordinating and evaluation of care (Iyer, et al., 2006).
4. It provides proof of practice or malpractice. Nursing documentation may provide valuable evidence about the patients' condition and treatment. It may be critical in determining whether the standards of care were met.
5. Documentation is a legal document. Iyer et al., (2006), asserts that, timely, accurate and complete charting helps the patient secure better care and protects the nurses, hospital and other health care providers from litigation. Care not documented, is care not done in a court of law. Nurse's notes and plans of care often will be the only proof in future years that clients/patients were monitored and cared for (Crisp et al., 2005).
6. It serves as a basis for evaluating the quality and appropriateness of health care provided. This is because data derived from patients records are prime sources of information on patient's characteristics and responses to interventions and is essential in assessing the quality of care (American Nurses Association, 2005).
7. It provides data useful in research education be it retrospective, longitudinal or prospective. Students of Nursing and other health related disciplines use these records as educational resources. A client's record contains a variety of information including diagnosis, signs and symptoms of disease, successful and unsuccessful therapies plus behaviors. Analysis of such information provides evidence-based nursing practice (Crisp et al., 2005).
8. Helps in planning and budgeting. If a hospital has to offer quality care for its patients and clients, proper planning and budgeting has to be put in place. This is only possible if proper documentation has been done so as to know the number of patients/clients expected to receive particular services. This in turn will aid in establishing the number of staff required and the amount of materials and equipment required (Grisp et al., 2005).
9. Documentation aids health care facilities in getting re-imburement of services provided to clients / patients. Most health care facilities have charge sheets for documenting the supplies used for every procedure done to the clients /patients. Sufficient and accurate data will therefore disclose all the care rendered to a patient or a client and this will help in proper billing for those services (Grisp et al., 2005).

### **Challenges of Documentation**

Nurses face a number of challenges as far as documentation is concerned and this continue to draw a lot of criticism from professional community and the regulatory organization because of incomplete and sub-standard charting practices (Howse & Bailey, 1992; Parker & Gardner, 1992; Renfroe, O'Sullivan, & McGee, 1990; Tapp, 1990). These challenges include;

a) Shortage of staff.

Compared to the developed countries, most of the hospitals especially in the developing countries Kenya included are experiencing a grave shortage of nursing staff. Coupled with lots of duties to undertake, they are therefore left with very limited time dedicated to documentation.

b) Inadequate knowledge concerning the importance of documentation.

Most nurses do not realize the importance or have limited knowledge regarding documentation and therefore do not pay much attention to it.

c) Shortage of materials for documentation.

Nurses working in some of the hospitals occasionally experience shortages of materials for documentation.

d) Numerous types of documentation requirements.

Some health care facilities /hospitals ask for too much paper work that the nurses have reported taking more time in documentation than in providing care to the patient.

### ***Conclusion and Recommendations***

The authors of this article having been in the nursing profession for many years and have served in various positions within the Health Care Delivery settings in Kenya therefore recommend the following;

1. Nurses spent a lot of time with patients, 24 hours a day. They should therefore ensure that all their encounters with patients /clients are documented accurately and on time.
2. Documentation should be done only after the procedure is complete and not before.
3. There is need for ongoing sensitization/training of nurses on the importance of documentation
4. Time spent on documentation is time well spent in the prevention of a lawsuit on patient care

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