Review Article

Documentation in Nursing

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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 data with an aim of collecting and retrieving information to aid in proper patient management. Previous study, 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 [(1)] Over the last few decades, more efforts have been made to advance nursing documentation to increase its usability. One of these initiatives was the development and use of researchbased standardized nursing terminologies such as the International Classification of Nursing Practice (ICNP) and the International Nursing Diagnoses Classification (NANDA International) Standardized nursing languages provide common definitions of nursing concepts and allow for theory based and comparable nursing data to emerge there for they promote shared understanding and continuity of care and make it possible to use records for research and management purposes

The introduction of electronic documentation systems into care practice has led to the transformation of nursing record-keeping. Electronic documentation systems can improve health professionals access to more complete, accurate, legible and up-to-date patient data[(2)]

Background: Documentation is sometimes viewed as burdensome and even as a distraction from patient care.[(3)]

Documentation and record keeping is a vital part of registered nursing practice. The quality and coordination of client care depends on the communication between different health-care providers.[(4)]

Nursing documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic[(5)]

Documentation of nurses' work is critical as well as for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care[(3)]

Documentation is a nursing action that produces a written and/or electronic account of pertinent client data, nursing clinical decisions and interventions, and the client's responses in a health record .Documentation is an integral part of professional nursing and safe practice[6]. **Documentation is not optional**. [5] Documentation in the health record begins with date and time and ends with the recorder's signature and designation. Signatures and initials need to be identifiable and follow specific agency policy. Personal initials can only be used if a master list matching the caregiver's initials with a signature and designation is maintained in the health record. [5]

Why is Documentation Important?

Nurses document their work and outcomes for a number of reasons: the most important is for **Communicating within the health care team**: Documentation is fundamentally communication that reflects the client's perspective on his/her health, the care provided, the effect of care and the continuity of care.[6]

Nurses and other health care providers aim to share information about patients and organizational functions that is accurate, timely, contemporaneous, concise, thorough, organized, and confidential. Information is communicated verbally and in written and electronic formats across all settings. Written and electronic documentation are formats that provide durable and retrievable records. Foremost of such electronic documentation is the electronic health record (EHR), provides an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care. assessments, clinical problems, communications with other health care professionals regarding the patient, communication with and education of the patient, family, and the patient's designated support person and other third parties, medication administration records (MAR), order acknowledgement, implementation, and management, patient clinical parameters, patient responses and outcomes, including changes in the patient's status, plans of care that reflect the social and cultural framework of the patient[6]

Credentialing: is a voluntary, self-regulatory process by which governmental, nongovernmental, or voluntary associations or other statutory bodies grant formal recognition to programs or institutions that meet stated quality criteria[5]

Documentation is served to monitor performance of health care practitioners' and the health care facility's compliance with standards governing the profession and provision of health care. Such documentation is used to determine what credentials will be granted to health care practitioners within the organization. [5]

Medico Legal inference: The client record is a legal document and can be used as evidence in a court of law or in a professional conducts proceeding.

• Courts rely on documentation as evidence of what was done or not done. Generally speaking, if it was not documented, it was not done.

• Courts may use the client record to reconstruct events, establish time and dates, refresh an registered nurses memory and verify and/or resolve conflicts in testimony.

• Failure to meet the standards set out by your regulatory body can result in disciplinary action against you. Poor documentation can also undermine or destroy your defense in a law suit. [4].

Documentation that is incomplete, inaccurate, untimely, illegible or inaccessible, or that is false and misleading can lead to a number of undesirable

outcomes, including: Impeding legal fact finding jeopardizing the legal rights, claims, and defenses of both patients and health care providers Putting health care organizations and providers at risk of liability[3]

Regulatory and legislative: Audits of reports and clinical documentation provide a method to evaluate and improve the quality of patient care, maintain current standards of care, or provide evaluative evidence when standards require modification in order to achieve the goals, legislative mandates, or address quality initiatives.

Reimbursement: Documentation is utilized to determine the severity of illness, the intensity of services, and the quality of care provided upon which

payment or reimbursement of health care services is based.

Research: documentation data are essential for attaining the goals of evidence based

practice in nursing and quality health care. Nurse researchers should examine variables related to use of electronic documentation for nurses in administrator, educator, and direct care role which are includes :benefits to patient care variables , data use in clinical decision-making that support interventions and the continuity of care , ergonomics and other usability factors , environmental factors and variable , ethical considerations , legal considerations , nursing-sensitive indicators and patient care outcomes , time needed to attain proficiency in documentation , time required by nurses in various settings—including the related environmental factors and variables—to create documentation as delineated in this publication and time savings to nursing and/or the health care team related to interdisciplinary and inter professional documentation[5].

Quality activities: Documentation is the primary source of evidence used to continuously measure performance outcomes against predetermined standards, of

individual nurses, health care team members, groups of health care providers (such as units or code teams), and organizations. This information can be used to analyze variance from established guidelines and measure and improve processes and performance related to patient care. [2] Clear, complete and accurate nursing documentation facilitates quality improvement initiatives and risk management analysis for clients, staff and organizations.

Documentation is used to evaluate quality of services and appropriateness of care through chart audits and performance reviews.

Professional Principles of Documentation

Principle 1. Documentation Characteristics: High quality documentation is

Accessible, accurate, relevant, and consistent auditable clear avoid using abbreviations. abbreviations may not be understood or may be misinterpreted.[3], concise, and complete documentation on admission, transfer, transport and discharge provides baseline data for planning subsequent care and follow up[4]. Legible/readable thoughtful timely entries are essential to the client's ongoing care in order to reflect a clear record of what has happened.[4], Documentation should occur as close as possible to the time of care to enhance credibility and accuracy of health care records [3]. Contemporaneous, and sequential [3]

Principle 2. Education and Training Nurses, in all settings and at all levels of service, must be provided comprehensive education and training in the technical elements of

Documentation [3] accurate documentation of this education is essential to enable effective communication and continuity of what has been taught. The following aspects of client education should be documented in the health record:

both formal (planned) and informal (unplanned) teaching, materials used to educate
method of teaching (written, visual, verbal, auditory and instructional aides) , involvement of client and /or family ,evaluation of teaching objectives with validation of client comprehension and learning any follow up required[3]each nurse should be ensure to be capable in Functional and skillful use of the global documentation system , Competence in the use of the computer and its supporting hardware , Proficiency in the use of the software systems in which , documentation or other relevant patient, nursing and health care reports, documents, and data are captured[3]

Principle 3. Policies and Procedures the nurse must be familiar with all organizational policies and procedures related to documentation and apply these as part of nursing
practice

Principle 4. Protection Systems Protection systems must be designed and built into documentation systems, paper-based or electronic, in order to provide the following as
prescribed by industry standards, governmental mandates, accrediting
agencies, and organizational policies and procedures: Security of data, Protection of patient identification, Confidentiality of patient information, Confidentiality of clinical professionals' information and confidentiality of organizational information

Principle 5. Documentation entries into organization documents or the health record (including but not limited to provider orders) must be: Accurate, valid, and complete; Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted; Dated and time-stamped by the persons who created the entry; Legible/readable; and Made using standardized terminology, including acronyms and symbols.

Principle 6. Standardized terminologies because standardized terminologies permit data to be aggregated and analyzed, these terminologies should include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of the
patient or client in diverse settings [3]

Verbal Orders and Telephone Orders

Authorized prescribers are expected to write orders whenever possible. Verbal orders should only be accepted in emergent or urgent situations where the prescriber cannot document their medication orders. Telephone orders should be limited to situations when the prescriber is not present. The prescriber may be accountable to review and co-sign their verbal or telephone orders as soon as reasonably possible or within the timeframe indicated in an agency's policy. [5]

Serious Reportable Events (SREs)

A serious reportable event (SRE) or occurrence is an event which is not consistent with the routine, expected care of a client or the standard procedures in place in a practice setting. Examples include patient falls, medication errors, needle stick injuries, or any circumstance that places clients or staff at risk of injury. Serious reportable events which involve clients are generally recorded in two places: in the client's medical record and in a SRE report, which is separate from the chart [5]

Use of Technology and Documentation

Increasing numbers of health care professionals are using mobile devices to communicate prescriber orders by text message or email. This type of communication is discouraged due to the risk of violation of confidential health information and incomplete communication of client status. [5]
Unauthorized disclosure of client's personal health information (PHI) is a risk because mobile devices

can store and retain data on the device itself. Also, mobile devices are vulnerable to loss and theft because of their small size and portability .Encryption and the use of strong passwords are the most effective way to safeguard a client's PHI. Without encryption, any emails, voicemails, pictures or text could be inappropriately accessed or disclosed if the mobile device is lost, stolen or inadvertently viewed by another person.(5)

What if you make a mistake or forget to chart something?

How do you make a correction?

Mistakes can happen when documenting. What should you do if you realize you made an error in a client record? Fix it as soon as you can. When making a correction, follow these rules:

• Always keep the original;

• Draw a single line through the entry and write "error" along with your initials;

• Document the corrected information;

• Record the date and time the correction was entered;

• Do not use white out or eliminate an entry entirely;

• Do not remove pages from a paper record; and

• If you have already distributed the record, write your correction and resend the updated version in an addendum. (3)

• Identify the new entry as a "late entry";

• Ensure the date and time of your additional note is clearly indicated;

• Clearly identify the event or previous note to which the new note is concerned;

• Sign all new entries and include your designation; and

• Never leave blank lines. (4)

Challenges of Documentation: Nurses face a number of challenges , these challenges include; a) Shortage of staff. Compared to the developed countries, Coupled with lots of duties to undertake, they are therefore left with very limited time dedicated to documentation. 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. Nurses working in some of the hospitals occasionally experience shortages of materials for documentation. 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.(1)

Conclusion

Nurses should recognize that the documentation of their nursing decisions and actions is equally as valuable, professionally and legally, as the direct care provided to clients. Quality documentation is an important element of nursing practice, essential to positive client outcomes and a key component of meeting their Standards of Practice.

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References:

1. Islamic University of Gaza Faculty of Nursing. Trends and Issues Documentation.site.iugaza.edu.ps/ajedi/files /2014/02/Seventh-Lecture-Documentation.ppt (accessed 9 may 2019).
2. Wang, Ning ,Hailey, David Yu, Ping Quality of nursing documentation and approaches to its evaluation: A mixed method systematic review Article , Journal of Advanced Nursing · April 2011 DOI: 10.1111/j.1365-2648.2011.05634.x · 1858-75
3. College of registered nurses of Manitoba. Documentation Guidelines for

RegisteredNurses.https://www.crnm.mb.ca/uploads/ck/files/Documentation%20Guidelines%20for%20Nurses%20-%20web%20version.pdf (accessed 8 may 2019).

4. College of Licensed Practical Nurses of Nova Scotia. Documentation Guidelines forNurses.https://crnns.ca/wp-content/uploads/2017/12/Documentation-Guidelines-for-Nurses-Final.pdf (accessed 3 February2019).
5. American Nurses Association. Principles for Nursing Documentation. http://www.nursingworld.org/4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf (accessed5February2019).

ChelagatD, SumT, obelM, CheborA, KiptooR, Bundotich P. Documentation: Historical Perspectives, Purposes, Benefits and Challenges as Faced by Nurses. *International Journal of Humanities and Social Science* 2013; 3(16): . http://www.ijhssnet.com/journals/Vol_3_No_16_Special_Issue_August_2013/28.pdf (accessed 3May 2019)

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