Jurnal Keperawatan Indonesia, 2022, 25 (1), 42–51
DOI: 10.7454/jki.v25i1.1139
Received December 2019; Accepted November 2021

pISSN 1410-4490; eISSN 2354-9203

Nursing Documentation in Accredited Hospital

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Abstract

Nursing documentation is assessed in hospital accreditation because it includes the actions taken and the quality of provided care. Hospital accreditation undergoes three phases consist of preparation, implementation, and post-accreditation. In the post-accreditation phase, there is reduced compliance of workers and nurses. This study determines the quality of nursing documentation at the fully accredited hospital by using descriptive and quantitative research with a retrospective approach. A simple random sampling method is used to attain 292 documents. Data are collected using the Evaluation of Nursing Care Instrument by the Ministry of Health Republic of Indonesia. Results show that nursing documentation has poor quality with an average achievement of 80.81%. In terms of components, the implementation is the most complete whereas the intervention and nursing care parts are the least filled out. Most of the factual indicators have good quality but other records have poor completion or compliance. Observation indicators for documentation quality need review to determine the factors that influence the decline in quality. Hospitals need to review and improve nursing documentation to prevent quality deterioration in the post-accreditation survey. Using information technology for documentation can help nurses because the standardized language and linked systems facilitate documentation of the entire care process, and thus enhance its completeness.

Keywords: accreditation, hospital, nursing care, nursing documentation

Abstrak

Dokumentasi Asuhan Keperawatan pada Rumah Sakit Terakreditasi*. Dokumentasi asuhan keperawatan dinilai dalam akreditasi rumah sakit karena berisi seluruh tindakan keperawatan dan mencerminkan kualitas asuhan keperawatan yang diberikan. Akreditasi rumah sakit terdiri atas tiga fase yaitu fase persiapan, implementasi, dan pasca akreditasi. Pada tahap pasca akreditasi, biasanya terjadi penurunan kualitas pelayanan. Penelitian ini menelusuri kualitas dokumentasi asuhan keperawatan di Rumah Sakit X yang terakreditasi paripurna dengan menggunakan desain deskriptif kuantitatif melalui pendekatan retrospektif. Sebanyak 292 sampel dokumen diperoleh dengan teknik* simple random sampling*. Data dikumpulkan dengan menggunakan Instrumen Evaluasi Asuhan Keperawatan oleh Departemen Kesehatan Republik Indonesia. Hasil penelitian menunjukkan kualitas dokumentasi keperawatan tidak baik, dengan pencapaian rata-rata 80,81%. Komponen implementasi merupakan yang paling banyak terisi, sedangkan intervensi dan catatan asuhan keperawatan paling sedikit terisi. Sebagian besar indikator faktual memiliki kualitas yang baik, tetapi catatan lain memiliki kelengkapan yang buruk. Indikator observasi kualitas dokumentasi perlu dikaji ulang untuk mengetahui faktor-faktor yang memengaruhi penurunan kualitas dokumentasi keperawatan. Rumah sakit perlu meninjau dan meningkatkan dokumentasi keperawatan untuk mencegah penurunan kualitas dalam survei pasca akreditasi. Penggunaan teknologi informasi untuk dokumentasi dapat membantu perawat karena adanya standarisasi bahasa dan sistem yang saling terkait memfasilitasi dokumentasi seluruh proses perawatan, dan dengan demikian meningkatkan kelengkapannya.*

Kata Kunci*: akreditasi, asuhan keperawatan, dokumentasi keperawatan, rumah sakit*

Introduction

As a form of recognition, hospital accreditation can determine the quality of services. Hospital accreditations are carried out regularly at least every four years by independent institutions, both local and abroad, based on applicable standards (Peraturan Menteri Kesehatan Republik Indonesia Nomor 12 Tahun 2020 Tentang Akreditasi Rumah Sakit, 2020). *Standar Nasional*

Akreditasi Rumah Sakit (SNARS) 2018 is a hospital accreditation assessment guideline carried out by *Komisi Akreditasi Rumah Sakit* (KARS) and represents a new form of KARS 2012 (KARS, 2012; SNARS 1 Edition 2018). SNARS has an assessment element equipped with regulations, documents, observations, simulations, and interviews. One of these documents is the patients' medical files and nursing actions or care documentation that are important for assessment. SNARS is revised to SNARS edition 1.1, effective on January 2020 (SNARS 1.1 Edition 2019).

Nursing documentation comprises written and printed forms that must be completed accurately, comprehensively, and flexibly to obtain important data, legal aspect, track patient care outcomes, and quality control (Nilasari & Hariyati, 2021; Sulistyawati & Susmiati, 2020). Documentation of nursing care is a tool for communication and providing information on patient status, medical care, ways of nursing care, and raising standards (Subekti et al., 2012). Nursing documentation can also indicate responsibility in carrying out care duties, good quality service, and improving patient satisfaction (Nursalam, 2014). Nursing documentation describes a complete process starting from assessment, nursing diagnoses, interventions, implementation and evaluation of nursing care, and patient responses and outcomes (Kamil et al., 2018).

Documentation of nursing care is part of the medical record that is assessed during the accreditation. Professional care providers work in teams to provide integrated patient care. Each person performs an assessment based on gathered information, conducting analysis to create a care plan, and evaluating the actions taken as stated in the integrated patient progress record or *catatan perkembangan pasien terintegrasi* (CPPT) (SNARS 1.1 Edition 2019). Nursing documentation is a form of professionalism and communication tool to healthcare professionals on the patient's condition (Alkouri et al., 2016). It provides an accurate overview of clients, what happened and when it happened. The completeness in documentation is legal aspect proof of a nursing activity (Hariyati et al., 2015). Documentation of nursing care that is incomplete, inaccurate, and irrelevant may cause difficulties in carrying out proof of actions that have been carried out (Muryani et al., 2019).

Muryani et al. (2019) assessed the quality of nursing documentation in the Central Kalimantan Hospital from 222 medical records and found that 55.9% of those records were in good quality and 44.1% in poor quality. The results of each nursing process showed not in accordance in assessment, the appropriate diagnosis was 59%, suitability of planning was 54%, proper implementation was 90%, and conformity evaluation was 64%. Another study at X Hospital in Jakarta, stated that most nursing documentation is still incomplete (71.6%) and the complete ones are few (28.4%) (Siswanto et al., 2013).

Empirical studies also evaluate whether hospitals maintain compliance with quality and safety during the accreditation by improving and maintaining the quality of health services prior to such assessment. A previous study found an increase in the completeness of patient records at RS Dr. Moewardi from 64.33% in the pre-accreditation phase to 94.75% in the accreditation phase (Widyaningrum, 2013). The accreditation consisted of the incision, pre-survey, post-accreditation deterioration, and the stagnation phases as a reduction in compliance in an Abu Dhabi hospital (Devkaran & O'Farrell, 2014). One element assessed in hospital accreditation is nursing care, which can be determined from the documentation. As such, this study aims to determine the quality of nursing care documentation in a fully accredited hospital based on previous data on its changes during the accreditation.

Methods

This study is carried out in the fully accredited X Hospital to observe inpatient nursing care documentation. A quantitative and descriptive design is applied with a retrospective approach.

The data comprises 1,075 documentation files in the medical record room between April 1 – June 30, 2016 (post-accreditation deterioration phase). The sample is determined using the calculation of Slovin's formula (Sugiyono, 2017) and simple random sampling with 292 results. The study uses the Instrument A Quality Evaluation Nursing Care by the Department of Health Republic of Indonesia, as modified and tested for validity by Aini (2018), which states that files with +1 results indicate validity. A univariate (descriptive) analysis is applied by describing and summarizing data that are presented in frequency distribution tables and percentages. The ethical test is fulfilled in the *Komisi Etik Penelitian Kesehatan (KEPK)* of the Faculty of Dentistry, University of Jember, with ethical certificate number 316/UN25.8/KEPK/DL/2019. The ethical principles include autonomy, confidentiality, justice, and expediency.

Results

The 292 files are interpreted to have good quality if the completeness is ≥ 85% and interpreted to have poor quality if the completeness is < 85%. This interpretation is according to the Department of Health Republic of Indonesia standard in 2005 modified by Aini in 2018 (Aini, 2018).

Table 1 shows the results of the average quality of nursing documentation at the X Hospital. The overall result is 80.81% that is categorized as poor because less than the standard of 85% (Aini, 2018). The assessment of nursing documentation showed several files that do not follow applicable standards. Documentation of nursing care at X Hospital uses a predetermined format, assessment with checklist and filling out sheets, and a table of contents for diagnosis, intervention, implementation, and evaluation. However, several documentations are neither completely filled out nor following the existing format. The results lead to the assumption that nursing care documentation cannot be guaranteed to have good quality despite the full accreditation of hospitals or other health services.

Table 2 shows that among the 292 nursing care documentation files, 166 have good quality and 126 are poorly prepared. Siswanto et al (2013) found similar findings that the quality of 68 inpatient nursing care documentation (71.6%)

Table 1. The Average Quality of Nursing Care Documentation

Rated aspect	Number of questions	Total score	Average
Assessment	4	1030	88.18%
Diagnosis	3	618	70.55%
Intervention	6	1345	76.77%
Implementation	3	861	98.29%
Evaluation	4	931	79.71%
Nursing Care Notes	6	1250	71.35%

$$\text{Average} = \frac{\Sigma\text{average}}{\Sigma\text{rate aspect}} = 80.81\% \text{ (poor)}$$

Table 2. Quality of Documentation: Component "A"

Variable	Frequency (f)	Percentage (%)
Quality of documentation		
Good	126	43.2
Poor	166	56.8

Table 3. Documentation Component: Assessment, Diagnosis, Intervention, Implementation, Implementation, and Nursing Care Note

Variable	Frequency (f)	Percentage (%)
Assessment		
Good	167	57.2
Poor	125	42.8
Diagnosis		
Good	54	18.5
Poor	238	81.5
Intervention		
Good	6	2.1
Poor	286	97.9
Implementation		
Good	277	94.9
Poor	15	5.1
Evaluation		
Good	226	77.4
Poor	66	22.6
Nursing care record		
Good	6	2.1
Poor	286	97.9

Table 4. Quality of Documentation: Factual, Accurate, Complete, New, Organized

Variable	Frequency (f)	Percentage (%)
Factual		
Good	252	86.3
Poor	40	13.7
Accurate		
Good	6	2.1
Poor	286	97.9
Complete		
Good	42	14.4
Poor	250	85.6
New		
Well	6	2.1
Poor	286	97.9
Organized		
Well	216	74.0
Poor	76	26.0

have poor quality while 27 files (27%) are good.

Table 3 shows that the implementation of nursing care documentation has the highest good score (94.9%), meanwhile the intervention and nursing care records have the lowest good score (2.1%). This result is similar to the previous study that the suitability of planning was 54%, documentation. This result is different than the findings in Ariani's research (2018) that illus-

meanwhile, the proper implementation was 90% (Muryani et al., 2019).

Table 4 shows that the factuality of nursing documentation has the highest good score (86.3%). Meanwhile the accurateness and novelty have the lowest good score (2.1%). This condition shows that nurses do not write new things in the trated the documentation accuracy is 59.5% accurate.

Discussion

The assessment component has good quality, with 167 files (57.2%) scoring above the Department of Health Republic of Indonesia standard of 85% (Aini, 2018). The assessment component includes four questions (1 – 4), of which the most filled out is number 1 (recording the results of the study data following the guideline of each room) and the least completed is number 3 (data assessed from the patient arrival and departure). A previous study showed that nursing assessments were incomplete at 97.8% (Supratti & Ashriady, 2018). Documentation carried out by nurses follows the format or guideline for each examined room, are incomplete in terms of assessment from the patient arrival to departure, and especially the spiritual portion. Effective assessment results in decisions on immediate and ongoing action and planned care. Patient assessment is a continuous, dynamic process in all units ranging from emergency, in-patient, out-patient, and other service units. Assessment is important to identify patient needs before starting care and must be carried out by professional personnel (SNARS 1.1 Edition 2019). Assessments with poor or incomplete quality can affect the nursing diagnoses.

Poor nursing diagnoses are found in 54 files (81.5%). The diagnosis component includes three questions (5 – 7), of which the most filled out is number 7 (actual nursing/risk/potential nursing diagnoses have been formulated) and the least completed is number 6 (actual nursing diagnoses formulated based on Problem, Etiology, Symptom (PES), risk diagnoses based on Problem, Etiology (PE), and potential diagnoses based on Problem, Symptom (PS). The results at the *Rumah Sehat Terpadu Dompet Dhuafa* (RST DD) Hospital showed that the assessment, nursing diagnosis, and intervention are the most often unfilled. Compared with other components, diagnostics has the lowest average (Purwandari et al., 2013). Nursing diagnoses must be documented according to the problem statement, reflecting PE/PES and the actual and potential findings (Persatuan Perawat Nasional Indonesia (PPNI), 2016; Wilkinson, 2015). However, numerous nursing documentations are still not standardized, with diagnoses missing the etiology and symptoms. In addition, several nursing care diagnoses are only made once upon the arrival of the patient at the ward.

Documentation of nursing care interventions still shows numerous categories in 286 files (97.9%) with poor quality. The intervention component includes six questions (8–13), of which the most filled out is number 8 (action plan based on nursing diagnoses) and the least completed is number 10 (goal formula containing patient components, behavior changes, patient conditions, and/or SMART time criteria). The previous study revealed considerable poor nursing planning writing, as much as 98.75%, and those involving patients and families are only 63.75% (Widjayanti, 2012). Nursing intervention writing in the documentation must be prepared as follows: according to the diagnoses; arranged in order of priority problems; contain patient components, behavior changes, conditions, and time criteria based on SMART; refer to the results criteria with command sentences; detailed and clear; describe patient involvement and family; describe the cooperation with other health teams, education and independent nurse actions (Ackley et al., 2017).

Documentation of the implementation of nursing care shows good quality on 277 files (94.4%). Component implementation includes three questions (14–16), of which the most filled out is number 15 (response appropriate to the patient nursing action) and the least completed is number 16 (writing nursing actions using verbs). Results of the documented implementation show good quality. However, the writing still uses command words, which should be verbs, while others do not include the name and initial for each action taken. The documentation should meet applicable standards and be written accurately, using correct grammar, spelling, and complete sentences. Nurse who performed which action should also be clearly distinguished, and

thus nurses must also record their own actions (DeLaune & Ladner, 2011; Wang et al., 2011). Implementation is selected based on the needs and/or wishes of the patient in accordance with the patient's current condition. It requires the ability to analyze patient needs so that implementation does not just act as a routine. The primary team assignment system makes it easier for the nurse in charge to control the patients for whom she is responsible because the patients being managed are followed from the patient entering until the patient leaves (Suyanti et al., 2021).

Documentation of evaluation of nursing care are mainly of good quality on 226 files (77.4%). The evaluation component includes four questions (17–20), of which the most filled out are numbers 17 (evaluation refers to goals) and 18 (evaluation results are recorded and formulated using SOAP/SOAPIE) and the least completed is number 20 (revised actions based on evaluation results). The previous study showed a complete nursing evaluation of 63.4% (Supratti & Ashriady, 2018). The assessment shows no revisions of action, indicating that the nurses always perform tasks that have been planned at the beginning, in the absence of appropriate action revision of patient response. Documenting the nursing care evaluations using the SOAP format is easier for nurses. Evaluation is important for determining the next steps in inpatient care. SNARS 1.1 (2019) conveys that reassessment by professional care providers is essential for evaluating correct and effective care decisions. Reassessment is carried out and recorded in the information, analysis, and plan-based CPPT using the SOAP method (Ryandini, 2018).

Numerous nursing care records show poor quality on 286 files (97,7%). Notes in Nursing includes six questions (21–26), of which the most filled out is number 23 (recording of clearly written, concise, standardized terms, and right) and the least completed is number 26 (using zigzag accompanied by a name or initial on an empty page). The results are the same in the study of Hartati (2010) that the lowest compliance is for inclusion of the initial/clear name, response, and time taken at only 63 files (21.21%) with good quality. The PPA assessment must be correctly recorded and documented while the CPPT must contain the name, initials, date, and time (SNARS, 1.1, 2019). Numerous nurses still do not write down the name and initials for each action taken and do not use the zigzag on the blank sheet. Thus, several aspects of recording nursing care are not carried out according to standards.

The results of the study carried out at Hospital X show that the quality of nursing care documentation have good quality with 252 files (86.3%). According to another study, documentation must be factual (Wang et al., 2011). Descriptive data are necessary and the objectives observed by nurses are to be recorded using clear terms, avoiding the use of "looks" or "seems". The documentation written by nurses in X Hospital are grouped according to bio-psy-cho-social-spiritual and based on facts and continuity. Suppose that the documentation does not pay attention to the quality of factual indicators, then discontinuity and mixing of data can occur, leading to difficult analysis of patient data.

Documentation of nursing care by nurses still has poor quality in terms of accuracy, with 286 files (97.9%). Previous study stated that 22 files (59.5%) of nursing care documentation at Dr. Rasidin Padang in 2012 are accurate (Ariani, 2018). However, various files are still not equipped with names and initials in each action. Similar to the previous study that many nursing care documentation in RST Dompet Duafa Bogor do not include the name and initials (Purwandari et al., 2013). This omission can result in unusable documents for evidence in the case of lawsuits, which require the name, initials, or signature in the documentation. According to another study, accurate documentation uses correct grammar and spelling, complete sentences, and signature (Wang et al., 2011). Signature indicates that nurses are responsible for the posted information. This suggests that nurses' comprehension of writing good documentation is necessary.

Documentation of nursing care has poor quality overall on 250 files (85.6%). Records are incomplete given that only the patient's arrival at the inpatient ward is included, and the diagnosis only contains the problem and not equipped with PE or PES. Moreover, interventions have no goals and criteria for results. Previous researchers mentioned that completeness documentation in RST Dompet Duafa Bogor remains low given the incomplete common assessment, diagnosis, and interventions (Purwandari et al., 2013). Other documentation reflects the routine and not the action plan.

Documentation completeness is necessary to ensure the quality of the provided nursing care, and its continuity that affects patient safety (Bjerkan et al., 2021). Nursing comprises activities that organize, manage, and direct various sources, including clients and nurses, effectively and efficiently to provide quality care. Nursing care can be used to measure the quality as outlined in the documentation, providing an accurate overview of patients, what happened, and when it happened (College of Registered Nurses of British Columbia, 2012). Documentation is a form of nursing professionalism and communication tool for healthcare professionals regarding the patient's condition.

The quality of nursing care documentation in terms of novelty remains poor in 286 files (97.9%). Documentation is considered 'new' if the obtained data is immediately recorded. Several aspects need to be recorded timely, one of which is the treatment for a sudden change in patient status (Muhlisin, 2011). The unwritten portions are immediately apparent from the brief and incomplete documentation. In addition, numerous intervention writings still exclude the objectives and outcome criteria and evaluations that are not accompanied by revised actions. This omission can result in the documentation not meeting the novelty criteria because of the lack of updates according to patient needs.

The nursing documentation shows good quality in terms of organization. Files that have good quality are 216 (74.0%). Documentation of organized nursing care is structured or arranged in one unit. The recorded information must use logical data. In line with the previous author, organized documentation describes all the patient needs, assessment, and corresponding interventions (Muhlisin, 2011). Documentation in the proper format allows for easier updating by nurses (Bunting & de Klerk, 2022; De Groot et al., 2022). Moreover, collaborative actions with other health teams must be included as implementation of patient-centered care, and in order to improve patients' satisfaction (Purwandari et al., 2019). Thus, the documentation follows organization indicators and facilitate nursing care according to the necessary steps. Guidance and renewal of nursing care documentation are required, and the use of standardized language also needs to be applied using information technology (IT) (Siokal, 2021). The role of a leader is very important in the completeness of nursing documentation. The previous study also concluded that there is a relationship between the supervision frequencies to the quality of nursing documentation (Siswanto et al., 2013). Supervision is the most dominant variable related to nursing care documentation so that the suggestion for the hospital is to include the head nurse for supervising and implementing nurses in seminars or training on documentation of care nursing services. This suggestion aims to improve the quality of nursing services in accordance with standards. Also, nursing management can make an audit of nursing care documentation to evaluate the completeness of nursing care documentation in accordance with standards (Togubu et al., 2019).

Conclusion

This study concludes that the nursing care documentation at the fully accredited X Hospital has overall poor quality. Many components do not meet or observe the indicators of quality of nursing care documentation, which, when deviating from standards and rules, cannot be used as strong evidence of legal responsibility and accountability. The documentation still needs

improvement, and the hospital needs to review and improve this aspect by providing training, guidance, and motivation to the staff to prevent deterioration during the stagnation phase after hospital accreditation. The limitation of this study is that only the completeness of the document is considered, but neglects the relationship between the components of nursing care. Optimizing the role of leaders in supervising and motivating nurses is needed. Using information technology for documentation assists nurses because the standardized language and linked systems facilitate the updating of the whole care process, and thereby the completion of documentation.

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