

# **Assessment of Nurses' Documentation Skills in Neonatal Intensive Care Units**

*Thesis*

*Submitted for Partial Fulfillment of Master Degree in Pediatric Nursing*

*By*

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# **Assessment of Nurses' Documentation Skills in Neonatal Intensive Care Units**

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## *List of Abbreviations*

| Abb.       | Full term                            |
|------------|--------------------------------------|
| AEs .....  | Accidents and Adverse Events         |
| CBC.....   | Complete Blood Count                 |
| CNS.....   | Central Nervous System               |
| DAR .....  | Data, Action and Response            |
| DRG .....  | Diagnosis Related Group              |
| GA.....    | Gestational Age                      |
| GI .....   | Gastrointestinal                     |
| Hb .....   | Hemoglobin                           |
| HCT .....  | Hematocrit                           |
| IDM.....   | Infants of Diabetic Mothers          |
| MAD.....   | Medication Administration documented |
| MEs.....   | Medical Errors                       |
| NCP .....  | Nursing Care Plan                    |
| PIE.....   | Problem Intervention, Evaluation     |
| PPS .....  | Prospective Payment System           |
| PROs ..... | Peer Review Organizations            |
| TFI .....  | Total Fluid Intake                   |
| TSB .....  | Total Serum Bilirubin                |

## Abstract

**Background:** Documentation is a fundamental nursing responsibility with professional, legal and financial ramification. **Aim:** This study aimed to assess the nurses' documentation skills in neonatal intensive care unit and assess the nurses' knowledge about the documentation skills and its importance in neonatal intensive care units. **Research design:** descriptive study. **Setting:** The study was conducted at Neonatal Intensive Care Units at Maternity and Gynecological Hospital and Children's Hospital affiliated to Ain Shams University Hospitals and Said Galal Hospital affiliated to Al-Azhar University hospitals, Egypt. **Subjects:** A purposive sample the subject of the study included of nurses (60) and purposive sample of neonates (60) who admitted in Neonatal Intensive Care Units (NICU) in the previously mentioned settings. **Tools:** four tools were used: *First tool*, Structured questionnaire format: to assess nurses' knowledge as regard to documentation skills. *Second tool*, neonates' assessment sheet. *Third tool*, Standardized frame for documentation skills for neonatal problems regarding common neonates problems. Fourth tools, nurses' attitude regarding documentation skills in NICU. **Results:** The mean age of the studied nurses was  $26.5 \pm 5.91$  years. Regarding educational qualification, 53.3% of studied nurses had nursing technical institute education. In relation to mean years of experience in neonatal intensive care for newborns, the mean was  $6.62 \pm 2.87$  years. Three quarters of nurses had no attendance of previous training courses in nursing documentation. There is a statistically significant relation between total knowledge of the studied nurses and their socio-demographic characteristics (age, educational qualification and years of experience). There is a statistically significant relation between total practice of the studied nurses and their socio-demographic characteristics (age, educational qualification and years of experience). There is a statistically significant relation between total attitude of the studied nurses and their educational qualification. **Conclusion:** More than half of nurses had satisfactory knowledge regarding documentation skills. The majority of nurses had positive attitude regarding documentation skills. More than half of nurses had competent practice regarding documentation skills. There is a highly statistically significant positive correlation between total nurses' knowledge, attitude and practice. **Recommendations:** Further research studies are needed for ongoing assessment of nurses including large sample for generalization of results.

**Key words:** Documentation Skills, Neonatal Intensive Care Units.

## INTRODUCTION

Throughout the development of modern nursing, a variety of documentation systems has emerged in response to changes inherent in health care delivery. Changes in consumer and legal expectations, accreditation standards, and research findings direct provider accountability for the documentation of services. Systems to recording and reporting data pertinent to the care of neonates have evolved primarily in response to the demand for neonatal nurses to be held accountable to societal norms, professional standards of practice, legal and regulatory standards and institutional policies and standards (*Safey El-Din, 2014*).

Documentation is a nursing action that produces a written or electronic account of pertinent neonate's data, nursing clinical decisions and interventions, and the neonate's responses in a health record. Documentation is an integral part of professional nursing and safe practice. 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 (*Potter et al., 2017*).

Clear, accurate, and accessible documentation is an essential element for safe, quality and evidence-based nursing practice. Nurses practice across settings at position levels from the bedside to the administrative nurses are responsible and accountable for the nursing documentation that is used throughout

an organization (*American Nurses Association, 2014*). Also, it provides a basis for demonstrating and understanding nursing contributions both to neonates' outcomes and to the viability and effectiveness of the organizations that provide and support quality neonates care (*O'Daniel & Rosenstein, 2018*).

Effective nursing documentation reduces inefficiencies and decreases the probability of medical errors. It helps in clinical-decision making for improved neonates care, thereby helping to reduce health care costs. In addition, it affects financial reimbursement as third party payers evaluate documentation in neonates documented to determine whether payment is appropriate (*Okaisu et al., 2014*).

High quality nursing documentation is a necessary and integral aspect of the work of neonatal nurses. It requires sufficient time and resources to support documentation activities. When accessing, generating, and sharing information in health care is rapidly changing, it is particularly important to articulate and reinforce principles that are basic to effective documentation of nursing services (*American Nurses Association, 2014*).

Neonatal Intensive care unit (NICU) as one of the important units needs the fast and accurate performance and care of nurses (*Moyen et al., 2014*). NICU nurses must have the ability to document the best nursing documented which

indicates a complete and accurate care, and all standard and acceptable nursing intervention (*Cartwright-Vanzant, 2014*).

### **Significance of the study**

The Egyptian nurse is a victim of nursing service problem, shortage of human and material resources in addition to high workload. Information from the health documented is often used to evaluate professional practice during quality improvement processes, such as performance reviews, chart audits, accreditation, legislated inspections and board reviews. Individual nurses can use outcome information or information from a critical incident to reflect on their practice and make needed changes based on the evidence. In Egypt incompetent nurse fails to give quality care as well as fails to be a caring employee skills and its importance in neonatal intensive care units (*Safey El- Din, 2014*).

Neonates admitted to Neonates intensive care unit (NICU) are a variable for many health problems, they require for special kind of cases. Confirmation for this received care requires complete nursing documentation which is mainly the role of the nurses in NICU. Therefore this study will be conducted to assess the nurses' documentation skills in neonatal intensive care unit.

## **AIM OF THE STUDY**

### **This study aimed to:**

- To assess the nurses' knowledge about the documentation skills and its importance in neonatal intensive care units.
- To assess the nurses' documentation skills in neonatal intensive care unit.

### **Research questions:**

1. Are the nurses document their nursing skills routinely in Neonatal Intensive Care Unit?
2. Are the nurses having satisfactory knowledge regarding documentation skills in Neonatal Intensive Care Unit?
3. To what extent are the nurses complying with the practice regarding documentation skills in Neonatal Intensive Care Unit?

## Operational Definition

Documentation is any printed or written documented of activities in health care. It should include: changes in the neonate's condition, the administration of tests, treatments, procedures, and the results of neonate's response to them, the neonate's response to an intervention and the evaluation of expected outcomes and complaints from family (*Duncan, 2013*).

Documentation as a nursing intervention is defined as "recording relevant neonates data in a clinical record". Health records may be paper documents or electronic documents, such as electronic medical records, faxes, e-mails, audio or video tapes and images through documentation (*Kockrow, 2011*).