Community Service

OPTIMIZATION OF NURSING CARE DOCUMENTATION COMPLETENESS TO IMPROVE THE QUALITY OF CARE AND DEFENSE AGAINST POTENTIAL MALPRACTICE LAWSUITS

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ABSTRACT

Nursing Care Documentation is an essential aspect that requires attention because the documentation results can assist in the nursing care process for patients (Grano et al., 2021). The poor quality of nursing care documentation in hospitals is primarily due to nurses' lack of knowledge and understanding, who often prioritize direct care over documentation, as well as a shortage of nursing staff (Oktavianti, 2019). Incomplete nursing care documentation can impact the significance of the documentation itself, affecting legal aspects, service quality, communication, finances, education, and accreditation (Ayu & Pasaribu, 2019). Observations at Suaka Insan Hospital revealed incomplete documentation in several sections of the nursing care documentation for patient status and the absence of a Standard Operating Procedure (SOP) for Nursing Care Documentation. Of 10 patient statuses, 60% had unclear statements in the barriers section, incomplete physical examination entries, empty psychological sections, unfilled treatment assessments, unrecorded nutritional evaluations in the initial nursing assessment, unfilled vital signs evaluations, and incomplete general patient data.

In contrast, 40% of patient statuses were fully documented. Interviews with 7 nurses revealed that 3 expressed insufficient study of applying reasonable and proper documentation standards. The challenges identified included a lack of time due to high patient numbers and limited teamwork. The outcome of this activity is an increase in nurse's knowledge regarding the importance of complete nursing documentation, which impacts the quality of nursing care and helps prevent potential malpractice lawsuits.

Keywords: Nursing Care Documentation, Nurses

INTRODUCTION

The World Health Organization (WHO) has revealed through surveys that nursing care documentation is linked to patient mortality rates due to medication errors, which can occur if there is inadequate communication between healthcare providers and patients. Studies have shown that non-compliance with nursing documentation is a global issue, characterized by incomplete documentation and low accuracy and quality (Tasew et al., 2019).

Documentation in nursing is crucial for the continuity of patient care, determining clinical replacements, avoiding malpractice, and facilitating communication among rotating providers. Documentation is an organized national record of facts and observations made by nurses to provide ongoing care (Ministry of Health, 2019).

Nursing care documentation is an important aspect that requires attention because the documentation results can assist in the nursing care process for patients (Grano et al., 2021). Poor quality in nursing care documentation in hospitals is often due to a lack of knowledge and understanding among nurses, who tend to prioritize direct actions, and a shortage of nursing staff (Oktavianti, 2019). Furthermore, this can lead to a decline in the quality of nursing services, as it hampers the ability to assess the effectiveness

of the nursing care provided (Sodik & Widyastika, 2020). Incomplete nursing care documentation can significantly affect its importance from various aspects, including legal, service quality, communication, finance, education, and accreditation (Ayu & Pasaribu, 2019).

Several studies indicate that the lack of nursing documentation compliance occurs worldwide, including incomplete, inaccurate, and low-quality documentation (Basid & Negara, 2022). Research conducted at Gondar Teaching Hospital in Ethiopia found that more than one-third of respondents (74 or 36%) reported not documenting nursing care due to time constraints (19%), a high patient load (22%), a combination of limited time and a large number of patients (62%), lack of format (2.2%), and lack of space (4.3%). A study at Felege Hiwot Referral Hospital in Northwestern Ethiopia revealed that nearly 87% of healthcare services experienced documentation errors. In Indonesia, interviews with 4 out of 13 nurses (30%) from the Teratai Inpatient Ward at RS Amelia Pare Kediri indicated that sometimes they did not have time to write in the provided format due to the numerous actions required for patients (Sholihin et al., 2020).

Several factors can influence the completeness of nursing documentation, including limited time, a high number of patients, absence of documentation formats, lack of space for documentation, insufficient nursing staff, inadequate knowledge about the importance of documentation, lack of training, and absence of support from head nurses (Manurung & Udani, 2020). From a legal perspective, without documentation, the legal guarantee for all professions involved in the nursing process cannot be substantial (Adawiah, 2021).

Interviews with the Head Nurse at Suaka Insan Hospital revealed that there has not yet been an audit on nursing care documentation. That documentation in the hospital still uses the North American Nursing Diagnosis Classification (NANDA), Nursing Intervention Classification (NIC), and Nursing Outcome Classification (NOC). Observations showed gaps in several sections of the patient status documentation, and there was no Standard Operating Procedure (SOP) for nursing care documentation in the hospital. Out of 10 patient statuses, 60% had unclear statements in the barriers section, some physical examinations were incomplete, psychological assessments were left blank, treatment assessments were unfilled, initial nursing assessments (e.g., nutrition) were incomplete, vital signs assessments were left blank, and general patient data was not recorded, with only 40% of statuses fully documented. Interviews with 7 nurses revealed that 3 expressed a lack of study regarding applying proper documentation standards. Challenges identified included insufficient time due to high patient loads and a lack of teamwork.

Objective

This activity aims to increase a nurse's knowledge regarding the importance of complete nursing documentation, which impacts the quality of nursing care and helps prevent potential malpractice lawsuits.

Time and place

The community service activity was held on October 15, 2024, from 08:00 to 13:00 WITA in the auditorium of STIKES Suaka Insan Banjarmasin.

Target

15 nurses from Suaka Insan Hospital Banjarmasin and 35 nursing students from STIKES Suaka Insan Banjarmasin participated.

METHOD

1. Optimization of Documentation Completeness According to Nursing Care Documentation Standards
2. Optimization of Nursing Care Documentation Implementation at Suaka Insan Hospital Banjarmasin, which still utilizes the North American Nursing Diagnosis Classification (NANDA), Nursing Intervention Classification (NIC), and Nursing Outcome Classification (NOC) by nurses.

RESULTS AND DISCUSSION

The service team developed strategies for implementation based on the analysis of each identified problem. The goal of the community service activity for nurses is to enhance their knowledge. Experience and research have shown that behaviours grounded in knowledge are more sustainable than those not (Nandang and Ijun, 2009).

The method for community service to the nursing staff at Suaka Insan Hospital involves optimizing the completeness of nursing care documentation to improve care quality and provide a defence against potential malpractice lawsuits. The educational technique to be used is audiovisual methods, as research by Ira Rahmawati et al. (2007) indicated that knowledge improvement in respondents through audiovisual methods is significantly more significant than that achieved through module-based methods. This is because audiovisual methods engage most of the respondents' senses, leading to better outcomes.

The results of this activity include an increase in nurse's knowledge regarding the importance of complete nursing documentation, which positively impacts the quality of nursing care and helps prevent potential malpractice lawsuits. The optimization of nursing documentation was conducted following standardized references such as NANDA, NIC, NOC, SDKI, SLKI, and SIKI. The nurses appeared very enthusiastic in asking questions about documentation completeness, particularly concerning legal aspects.

CONCLUSION

The community service activity was held on October 15, 2024, from 08:00 to 13:00 WITA in the auditorium of STIKES Suaka Insan Banjarmasin. The team implementing this community service activity consists of 4 members, with 1 serving as the Team Leader and 3 lecturers as members. The Team Leader is a staff member actively involved in community engagement. The team has a firm grasp of teaching public health topics and issues related to families and communities.

The target outcomes that the service team aims to achieve are an increase in the percentage of completeness and application of nursing care documentation at Suaka Insan Hospital Banjarmasin, utilizing the North American Nursing Diagnosis Classification (NANDA), Nursing Intervention Classification (NIC), and Nursing Outcome Classification (NOC).

SUGGESTION

We expect that all nurses at Suaka Insan Hospital in Banjarmasin and nursing students from STIKES Suaka Insan Banjarmasin will be able to understand and apply nursing documentation according to standards such as NANDA, NIC, and NOC, as well as SDKI,

SLKI, and SIKI. Furthermore, nurses are encouraged to complete nursing documentation essential for improving the quality of nursing care and protecting them from potential malpractice lawsuits.

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