The Influence of In-House Training Towards The Accuracy of Nursing Care Documentation

Sr. Felisitas A. Sri S., Emy Sutiyarsih*
Panti Waluya Malang School of Health Sciences
**emymlg23@yahoo.com*

ABSTRACT

Nursing documentation can be used as legal evidence if there are lawsuits. Therefore, nursing documentation must be done systematically and continuously. If nursing interventions are well documented, accurate, objective, complete, and in accordance with nursing care standards, it can be used as evidence that nursing interventions have been carried out correctly. The aim of this study was to analyze the effect of in-house training about nursing care documentation to the accuracy of documenting nursing care at X hospital. This study was a quasi-experimental study with one group post-test design. The population of nurses at X hospital, where the study was carried out, were 254 nurses. The sample size is determined by using the Solvin Formula with the final results of the sample were 156 respondents. The respondents were nurses that were randomly selected from all wards at X hospital. The ANOVA test was used for data analysis. The results of this study stated that there was a significant influence of in-house training on the accuracy of documentation of nursing care, with p-value = 0.000 < 0.05. In conclusion, the findings highlight that continuous training in nursing care process will be able to improve the quality of nursing care documentation. However, it is recommended to conduct an ongoing evaluation because there are several factors that can influence the accuracy of nursing care documentation.

Keywords: In-House Training, Documentation, Nursing Care, Nurses

BACKGROUND

Nursing care documentation is an integral part of nursing care quality component. Nursing care documentation is a sophisticated communication tool that can be used by nurses and other health professionals. Evidence from nursing care documentation can be used as an evaluation by nurse managers to monitor nursing care by nurses in a professionally, competently, and in accordance with standard operating Procedures (Munyisia, Yu, & Hailey, 2010).

Proper and complete nursing care documentation can improve the quality of nursing care felt by patients and their families. Nursing care documentation must be completed and in accordance with standards because it is a liaison to monitor the patient health condition. Therefore, it is very necessary to have complete nursing care documentation which is a mandatory duty of a nurse. This is also regulated in Republic of Indonesia Regulation Number. HK.02.02 / Menkes / 148 / I / 2010 about permission and implementation of nursing practice. Wang, Hailey, and Yu (2011) stated that the quality of nursing care documentation showed the provision of good care through effective communication between nurses and other care providers such as the patient's family.

Nursing documentation can also be used as legal evidence if there are lawsuits. Therefore, nursing care documentation must be done systematically and continuously (Munyisia, Yu, & Hailey, 2010). Nursing documentation does not only reflects the quality of care but also proves the accountability of each nursing team (Potter & Perry, 2005). If nursing activities are well documented, accurate, objective, complete and in accordance with the standards of nursing care, it can be proven that nursing intervention has been done correctly (Gillies, 2012). Based on the explanation above, this study was conducted to analyze the influence of in-house training to the accuracy of nursing care documentation at X hospital.

METHODS

This study was a quasi-experimental study using a one group post-test design, which is a design that evaluates cause and effect relationship by involving a group of subjects that are not randomized (Afiyanti, 2014). In this study, respondents with initial conditions were collected for data before in- house training. Then, those respondents were included in the in-house training activities, after two weeks observations were done.

This study was carried out for 6 months starting from September 2019 until February 2020 at X Hospital in Malang. The target population in this study were nurses in X Hospital Malang as many as 254 people. The sample size is determined by using the Solvin Formula with the final results of the sample were 156 respondents. The sampling technique used cluster random sampling by calculating the proportion of respondents in each ward.

RESULTS
Table 1. Data before in-house training

Variable	df	P-value
Working periods	4	0.000
Clinical nurse level	5	0.000

Table 1 showed that the significance value of both variables were 0.000 < 0.05. It could be

concluded that the working period and the clinical nurse level could influence the data before the intervention.

Table 2. Data after in-house training

	df	P-value	R square
Intercept	1	0,000	
Working periods	4	0,004	0.227
Clinical nurse level	5	1,000	

Table 2 showed that the assumptions for the ANOVA test have been fulfilled. The intercept value (0.000 < 0.05) indicated that without an independent variable, the value of dependent variable could change. It means that the independent variable, which were working period and clinical nurse level, gave meaning to the accuracy of nursing care documentation. The R Squared (0.227) showed that there was an influence between the working periods with the clinical nurse level on the accuracy of nursing care documentation.

Table 3. Characteristics of evaluation results of in-house training implementation

Characteristic	Frequency	Percentage
Passed	135	86.5
Didn't pass	21	13.5
Total	156	100

Table 3 showed that most of the respondents passed the evaluation after in-house training implementation, with total of 135 respondents (86.5%). Those who did not pass the evaluation had to take remidial.

Table 4. Characteristics of accuracy in nursing care documentation

Characteristic	Frequency	Percentage
Precise	142	91
Imprecise	14	9
Total	156	100

The observations of nursing care documentation were conducted after the respondents took part in the in-house training. Table 4 showed that most of respondents did nursing care documentation appropriately, with total of 142 respondents (91%).

Table 5. Influence of in house training on nursing care documentation

Variable	df	Sig	Exp (B)
In house training	142	0.000	0.034

The results of the data analysis were shown in table 5, with the significance value was (0.000) < 0.05. It can be concluded if there was a significant influence of in-house training activities on the accuracy of nursing care documentation. These results also proved that respondents who passed the in-house training had a 3.4% chance of being able to do the nursing care documentation properly, with an Exp (B) value of 0.034.

DISCUSSIONS

The influence of respondent characteristics on the accuracy of nursing care documentation

The working periods and clinical nurse level simultaneously influence the accuracy of nursing care documentation as indicated by the significance value of 0.000. The working periods and clinical nurse level describe the work experience of the respondents, therefore they also explain the experience of nurses in terms of documenting nursing care. The results of this study are supported by previous studies by Amalia, Herawati, and Nofriadi with the title The Thorough Factors of the Documentation of Nursing Care at the Inpatient Installation of Lubuk Sikaping Hospital. The statistical test results of that study showed that there was a correlation between motivation, work periods, age, education, workload and nursing care documentation completeness.

Intercept values, $(0,000) < 0.05$, means that in-house training had an influence on the accuracy of nursing care documentation. Respondents who took part in in-house training will get additional insights. This was in accordance with the concept of the in-house training objective, which is to improve the quality of human resources in an institution, so that it can support the effort to achieve the goals and also to explore problems encountered at work so that human resources can share solution to solve their problems (Smile Group Yogyakarta, 2015).

The influence of in-house training to the accuracy of documenting nursing care at X hospital

Based on the results of the study, there was a significant influence of in-house training as dependent variable on the nursing care documentation as independent variable. Respondents who passed in-house training indicated that they had the opportunity to be able to properly documenting the nursing care. Respondents who attended in-house training will get new insight and experience in documenting nursing care. Passing the in house training can also provide an overview of the level of respondents understanding as participant. The results of the in-house training are expected to be applied when documenting nursing care. Accuracy in documenting nursing care can be influenced not only by attending the in-house training, but also can be influenced by each nurse awareness of the importance in nursing care documentation accuracy.

Another supporting study by Asmirajanti et al. (2019) revealed that nursing interventions in hospital are very important and must solve the patients' problem. Every nursing intervention must be documented with critical thinking. If nursing care documentation is unclear and not accurate, communication between health professionals and evaluation of nursing care will not be optimal. Nursing interventions and documentation must be directed, controlled, and evaluated continuously by the nurse manager.

In-house training can add the insights of documenting nursing care for nurses, but there are other factors that can influence the accuracy of nursing care documentation. As revealed by Amalia, Herawati, Nofriadi about the results of the study, it showed that there was a correlation between motivation, work periods, age, education, workload and nursing care documentation.

CONCLUSIONS

The results of the study obtained that there was a significant influence of in-house training activities on the accuracy of nursing care documentation. Continuous training in nursing

care process will be able to improve the quality of nursing care documentation. Good nursing care documentation will reflect the quality of nurses in carrying out nursing interventions to patients.

REFERENCES

Afiyanti, Y., Rachmawati, I. N. (2014). Qualitative Research Methodology in Nursing Research. Jakarta: PT. RajaGrafindo Persada.

Akemat K. B. A. Psychiatric Professional Nursing Practice Model. Jakarta: EGC. 2012

Gillies, DA. (2012) Nursing Management: A. System Aproach, Philadelphia: Sannders Company.

Gomez at all, Basic nursing Care Manual.Ned Foundation

Kasim, M., & Abdurouf, M. (2016). Improving the quality of services and documenting nursing care by team methods. Nurseline Journal, 1 (1), 62–72

Made Indra Ayu Astarini. (2018). Literature Review: Effectiveness of Modification of Nursing Documentation. Lantern Nurse Journal. Volume 6, Issue 1, pp 42-48 issue date 12-12-2018.

Mira Asmirajanti, Achir Yani S. Hamid, Rr. Tutik Sri Haryati (2019), Nursing care activities based on documentation, BMC Nursing 18, Article number 32, cite this article 3760, 1 almetric

Munyisia, E.N., Yu, P., & Hailey, D. (2010). The changes in care groups' perceptions about the quality of information and benefits of nursing documentation associated with the introduction of an electronic documentation system in a nursing home. International Journal of Medical Informatics, 80 (2), 116–126. https://doi.org/10.1016/j.ijmedinf.2010.10. 011

Noorkasiani, N., Gustina, G., & Maryam, R.S. (2015). Factors related to the completeness of nursing documentation. Indonesian Journal of Nursing, 18 (1), 1–8. https://doi.org/10.7454/jki.v18i1. 391

Nurseto, I.D., Sukesi, N., & Wulandari. (2014). The effect of nurse satisfaction on the completeness of nursing care documentation in the Inpatient Room at Ambarawa Regional Hospital. Journal of Nursing and Midwifery. Retrieved from http: // ejournal. stikestelogorejo.ac.id/index.php/ilmukeper awatan / article / view / 219

Owen, K. (2005). Documentation in nursing practice. Nursing standard, 19 (32), 48–49.

Potter, P.A., & Perry, A.G. (2005). Nursing fundamentals: Nursing fundamentals: Concepts, processes & practices. Process & practice. (Interpreting: Yasmin Asih, et al.,) (Issue 4). Jakarta: EGC Publisher.

Rum Ramadhani. (2019). Factors affecting Nurse Compliance in Documenting Nursing Care. Scientific Journal of Health. Vol. 18 Number 1, 2019

Wang, N., Hailey, D., & Yu, P. (2011). Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review. Journal of Advanced Nursing, 67 (9), 1858–1875. doi: 10.1111 / j.1365-2648.2011.05634.x