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The Influence of Checklist Model Documentation on the Completeness of Nursing Care Documentation at Arosuka Hospitals 2017

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ABSTRACT

Background: The nursing care documentation technique that applied at Arosuka Hospital was narrative recording technique. Based on documentation evaluation of nursing care, nursing documentation at Arosuka Hospital was still not equal to documentation of nursing care.
Methods: This research intends to analyze the effect of checklist documenting model to the documentation of nursing care in Arosuka Hospital. This research had been conducted since January to June 2017 and the data were collected from May to June 2017. The method of this research was quasi-experiment, pre-test and post-test group research. There were forty-five nurses taken as the samples with total sampling techniques applied. The instruments that used in this research were the forms of checklist documenting model and nursing care evaluation sheet.
Result: The result of the research has shown that there is difference of the completeness of nursing care documentation before and after using the checklist model documenting format. The average number of nursing care documentation is higher with the checklist model compared to narrative model *mean (40,533)*. This checklist documenting model is recommended to be applied in Arosuka Distric Hospital to improve the completeness of nursing care documentation in Arosuka Distric Hospital.

Keywords: *Checklist model, documentation, nursing care*

INTRODUCTION

Documentation are recording activities, reporting or record the event as well as the activities carried out in the form of service delivery that are considered important and valuable**[1]**. If documentation not worked completely, it might reduce the quality of nursing care. Incomplete documentation will not be able to identify the extent of the success of nursing care that has been given. The Nurse will not have written legal force if in the future the clients demands dissatisfaction with the services **[2]**.

Documentation becomes an important element of patient care, enabling communication among the care team and all nursing shift, provide the legal record of care given to patients and act as a tool to help manage the care of patients **[3]**. Documentation is proof of responsibility and accountability of nurses in performing their duties. Documentation is an account authentic in the application of professional nursing care management. Nurses are expected to face the demands of professional responsibility and accountability to all actions. It caused due to the increasing public awareness of the law, so that complete documentation is indispensable **[4]**.

Complete nursing documentation which can be used to identify the health

status of the patient is required to record the care given and the need for research, financial, legal, and ethical quality assurance **[5]**. If the documentations were not complete, can caused many risks such as errors in communication, planning action and taking action, thus making nurses trapped in the absence of official documentation that is worth the law and may result in decline in the quality of nursing care. Nursing documentation is a vital tool in reducing the mortality and incidence of adverse patient **[3]**.

A frequent problem encountered in Indonesia and in the implementation of nursing care are many nurses who have not done according to the standard of nursing care services. Implementation of nursing care is also not accompanied by thorough documentation. To meet the appropriate standards of nursing documentation of nursing care, the nursing field can develop a model checklist that format nursing care becomes more effective and efficient.

Checklist Model in everyday use has been proven to increase documentation of outcomes that are relevant to patient safety **[6]**. It is effective for use at the Pediatric Intensive Care Unit (PICU) **[3]**. Checklist model also approach nursing care standards and become part of the hospital documentation, ensuring quality and safety in nursing care, encourage teamwork and improvements in documentation **[7,8]**. In the end the model checklist will become part of the patient record and further efforts like training model checklist indispensable **[9]**.

The results of early observations conducted by researchers at the Arosuka hospital inpatient room Solok district on January 5, 2017. The large proportion of the patient's status were not filled completely. It was because the format was empty so it takes a lot of time to fill the format. Therefore, the nurses feel bored didn't know how nursing care standards to be placed in the nursing documentation. Based on the researchers wanted to see the completeness of nursing care standards through the documentation of the model *checklist* in Arosuka hospital inpatient room.

METHODS

The design of this research was *Quasi-Experiment* design, *one group pretest and posttest design.* The population in this study were all nurses in surgical, children and internal medicine wards, totaling 45 people. The sampling technique was *total sampling*, *nurses* who worked during research in Arosuka hospitals from January to June 2017. The univariate analysis in this study was conducted to determine the characteristics of nurses (age, education, length of service and whether there is any training last 5 years). Documentation prior to treatment scale consists of 24 items, that the score of each item was 1-3. We calculated the value of each category and divided into 3 parts. Bivariate analysis in this research was to know the influence of documentation models *checklist* on the completeness of nursing care documentation standards. Statistical test analysis research variables are *paired* t- test. Paired *t-test was* used for testing the mean difference of the two measurement results to the same group.

RESULTS

The Arosuka Regional General Hospital is a hospital owned by the Solok Regency Government which was established on May 2, 2007. Based on the Decree of the Minister of Health Number: 1166/Menkes/SK/XII/2009 concerning Class Improvement of the Arosuka Regional Hospital Owned by the Regional Government of Solok Regency, the Arosuka Regional Hospital is recognized as a C-type hospital that the capacity was 100 beds. Arosuka Hospital has been accredited with 5 basic services with conditional status on January 3, 2012. The number of nurses in Arosuka Hospital were 105 people where there were 3 nurses passed Nurses School education, 39 passed Diploma three nursing, 1 nurse passed diploma three mental

nursing, S1 Nursing 9 people, Nurses 13 people (personnel section of Arosuka Hospital)

Characteristics of Nurses at Arosuka Hospital Inpatient Room

The majority of nurses aged were young adults (80%), largely nurses already working more than 5 years (84.4%), level of education was Diploma-3 (88.9%), and all of nurses (100%) never attended training for documenting in less 5 years (table.1).

Table 1: Characteristics of nurses based on age, years of service, level of education, documentation training in less of 5 years

Variable	Category	N	Frequency(%)
Age	Young Adult	36	80
	Middle Adult	9	20
Length of working	< 5 years	7	15,6
	> 5 years	38	84,4
Level of Education	Nursing School	1	2,2
	Diploma	39	86,7
	Nurses	5	11,1
Documentation training in less of 5 years	Yes	0	0
	No	45	100

Data Analysis

Table 2 : Standard Fittings Before and After Application of the Model of Nursing Care *Checklist* at Arosuka hospital inpatient room 2017

Completeness of Nursing Care standard	N	Mean	Min	Max	Std. Deviation	Mean differences	Std. Deviation	p-value
Before	45	30,22	28	30	1,312	40,53	1,424	0,000
After	45	70,76	69	72	0,082			

The mean level of the completeness of nursing care documentation standards before treatment was 30.22 with the lowest value was 28 and the highest was 30.

The completeness mean level of nursing care standards before treatment was 30.22 and the average standard with nursing care after treatment is 70.76. Thus the mean difference between before and after treatment was 40.533. Statistical test results obtained value of p = 0.000 (p <0.05), the Ha accepted which means that there was mean difference standard of fittings nursing care before and after the use of the model documentation *checklist* in hospitals Arosuka 2017 (table 2).

From five nursing processes, intervention was the most prominent part of the enhancement after using the checklist model documentation from 28.02% to 100%. This was because in the documentation of the checklist model, all of interventions needed to address nursing problems are already available and the nurses just by tick. By the same token in the assessment, the escalation was from 37.96% to 93.52% after using the checklist model documentation because the nurse just ticked the patient data according to what was obtained during the assessment in the characteristic limit column. Implementation also increased from 37.04% to 100% after using the checklist model because nurses just check the implementation based on the interventions that are already available too. Furthermore, the evaluation from 33.7% to 100% after using the checklist model because nurses only filled out the evaluation in the form of numbers.

DISCUSSION

The observations of nursing care documentation conducted by researchers showed that nurses perform rudimentary documentation of nursing care to patients, nursing care documentations were not in accordance with the existing standard of nursing care, the nurse simply write the patient's complaints in time, therapeutic treatment from doctors and nurses actions performed on the patient as well as the evaluation of nursing on integrated patient progress notes (CPPT), without being equipped with the nursing diagnosis, objectives or outcomes of nursing, and nursing interventions. It caused instead of nurses do not have any proof of the ability of the patient's status will be returned to the medical record centre, although not a perfect complement. This is caused by nurses who are less aware of the importance of nursing documentation and the available

formats require a long time to fill. This result was accordance with Prabowo opinion which states that the factors that inhibit the documentation are: lack of understanding of the fundamentals of nursing documentation, so that the documentation handling did not comply with the standards set and eventually the nursing documentation was not complete and qualified, lack of awareness of the importance of nursing documentation, nursing documentation was not regarded as a determining factor for the quality of nursing care, lack of human resources in terms of both quality and quantity, format available was inadequate, limited time as a nurse many do homework non nursing e.g. taking blood, delivering the patient and employment non other nursing **[10]**.

In this research, the increased of nursing care documentation caused by the checklist model were easier and simpler than the narrative model. In the checklist model, almost everything needed by nurses for documenting nursing care were already available. The checklist model in particular was very helpful in nursing documentation **[11]**. Documenting the checklist model also saves time and money, because documenting a nursing diagnosis can use one sheet of paper in three days of treatment. This is in accordance with Prabowo's opinion (2015) which states that the advantage of using the checklist model is that the nursing documentation process is faster and more efficient.

Standard equipment prior to the application of the nursing care checklist *Arosuka hospital inpatient room*

According to the researcher analyzes the increase in nursing care standard equipment in addition to the user documentation models *checklist* as well as the nurses have training documentation in the form of treatment given to the respondent by the researchers. Less (2010) explains that the increased knowledge and understanding acquired through training will support a more complete documentation **[12]**. Notoatmodjo said that in order to improve the ability, a person needs to be trained **[13]**. Regular training is essential conducted in hospitals with the aim to enhance the knowledge of employees in all areas, especially the training documentation is written proof of all the nursing care activities that have been done by nurses. Documenting correct and in accordance with established standards will bring great influence on the quality of nursing services. Besides the availability of an effective and efficient format and appropriate existing standards is essential in completing documentation of nursing care in the hospital, because that format will make it easy for nurses in performing nursing care documentation.

This research proves that there is increase documentation of nursing care standard due to the model checklist easier and simpler model than the narrative. According to the Windsor Regional Hospital, the model *checklist* focusing recording provides many advantages, one of which is to improve the ability of nurses in near-standard documentation **[14]**. The checklist model ensures quality and safety in nursing care, encourages teamwork and improvements in documentation **[15]**.

Nursing care documentation includes the statement about the assessment and reporting (data collection), nursing diagnosis, nursing actions plans, nursing actions and evaluation of nursing. Documentation which effectively ensure continuity of service, saving time and minimizing the risk of error and problem oriented recording in narrative form less enthused by the nursing agency largely because of the format used is very diverse and less subjective analysis so inclined **[16]**.

Documentation of good nursing care and quality must be accurate, complete and standards-compliant. Windsor Regional Hospital set the focus to the shape of recording format *checklist* to overcome the poor documentation that is done in the hospital. Timby (2009) said that the checklist model is the documentation which the appearance or performance of nurses is

contained in a list. Furthermore, Timby explains that the model *checklist* is very helpful when nurses working in conditions that are likely to be different clients from day to day **[17]**.

CONCLUSION

Based on the results of this study concluded that:

1. Characteristics of nurses showed that largely nurses working in Arosuka hospitals inpatient aged were young adults, largely nurses already working at inpatient ward > 5 years, largely nurses educated nursing Diploma-3, and all of the nurses never training for nursing documentation in the last 5 years.
2. Completeness of nursing care standards before the application of the *checklist* on average 30.22 and was at the low range of nursing equipment standard care. After using the *checklist* model, the mean was 70.76 (in the high range).
3. Mean differences of standard fittings nursing care before and after the implementation of the model *checklist was* 40.533, deviation standard was 1.424 with p value = 0.000. This means that there wera mean difference of nursing care standard equipment before and after of using *checklist* model form at Arosuka Hospitals 2017.

Suggestions

1. The Leader of Arosuka Hospital suggested to the director to work on improving the quality of hospital services, especially the improvement of services in the field of nursing. By creating a policy for the use of nursing care documentation format models *checklist* so that the completeness of nursing care standards can be met.
2. The field of nursing in nursing in order to continue efforts to improve the completeness of nursing care standards by making one of the rooms of hospitalization or third room that had been trained as a room, *pilot project* thus improving the standard of nursing care does not stop until here.
3. Head of nursing ward, in order to improve the functioning of direction and evaluation, especially in the field of nursing care documentation. And to improve the knowledge and skills of especially pemgetahuan and skills in the field of nursing care documentation so that service quality can be improved.

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