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Implementation of Documentation of Nursing Care in Wates Hospital

Erna Kurniawandari[1], Fatma Siti Fatimah[2], Mutiara Dewi Listiyanawati[2]

Alma Ata University
Jl. Brawijaya No. 99, Tamantirto, Yogyakarta
Email : fatmasitifatimah@gmail.com

Abstrak

Dokumentasi asuhan keperawatan adalah bagian penting tugas perawat, dokumentasi terbaik dari proses asuhan keperawatan yang melihat terbaik dan memiliki kualitas tertentu harus akurat, lengkap, dan standar. Dokumentasi perawatan keperawatan saat ini di Rumah Sakit Wates secara praktis belum dilakukan sesuai dengan Prosedur Operasional Standar. Penelitian ini bertujuan untuk mengetahui gambaran dokumentasi asuhan keperawatan di Ruang Rawat Inap Rumah Sakit Wates. Penelitian ini adalah deskriptif kuantitatif yang mengambil sampel dari dokumentasi rawat inap asuhan keperawatan pada bulan Maret 2017. Populasi adalah sekitar 1106 dokumen rekam medis yang diambil sampel sebanyak 111 dokumen. Teknik pengambilan sampel menggunakan cluster random. Penelitian ini diadakan pada Juni 2017. Pengumpulan data menggunakan rekam medis pasien. Analisis data univariat menggunakan distribusi frekuensi. Penelitian ini menunjukkan bahwa kelengkapan pendokumentasian asuhan keperawatan pada aspek penilaian (77,5%), diagnosis (93,7%), perencanaan (73,9%), tindakan (45,9%), evaluasi (76,6%) %), catatan asuhan keperawatan (45%). Kelengkapan dokumentasi asuhan keperawatan di Ruang Rawat Inap Rumah Sakit Wates Kulon Progo diklaim lengkap (27,9%).

Kata kunci *: Dokumentasi keperawatan, proses keperawatan*

Abstract

The documentation of nursing care is the important part nurse duty, the best documentation of nursing care process that sees best and have a certain quality should be acurate, complete, and standard. Curently documenting of nursing care in Wates Hospital is practically not yet done according to Standard Operational Procedure. This study aims to know the description of the nursing care of documentation in Inpatient Room of Wates Hospital. This research is descriptive quantitatif which take the sample from inpatient documentation of nursing care in March 2017. The population was about 1106 documents of medical records which the sample obout 111 documents. The technique to take the sample was using cluster random. The research was held on June 2017. The data collection used medical record of patient. The univariat of data analysis used frequency distribution. This research showd that the completeness os documenting of nursing care in assessment aspect (77,5%), diagnosis (93,7%), planning (73,9%), action (45,9%), evaluation (76,6%), nursing care note (45%). The completeness of documentation of nursing care in Inpatient Room of Wates Hospital Kulon Progo is claimed complete (27,9%).

Keywords: *Nursing documentation, nursing process*

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INTRODUCTION

Nurse profession is currently a profession that has a very high legal risk. in carrying out nursing care the need for documentation so that it can become documentation of evidence in court, quality (quality of service) as communication between health workers, cost reference, educational references, object of research, can assess the extent of the role of nurses in providing nursing care, errors in his job can drag the nurse to court. Therefore all activities carried out on patients must be well documented and clear. Documentation is written communication so nurses are required to document correctly. Effective documentation allows nurses to communicate to other personnel (1).

Documentation is a means of communication between health workers in the framework of recovering the health of patients, without proper and clear documentation the nursing service activities in the form of nursing care that have been carried out by professional nurses cannot be accounted for. Documentation can be used as evidence must be identified in full, clear, objective, and signed by the nurse, the date and need for avoidance of writing that lead to incorrect interpretation (1–3).

PERMENKES No. 148 of 2010 and the Nursing Act 38 of 2014 states that nurses are authorized to perform nursing care and are obliged to systematically record nursing care and standards. Nursing care standards are enforced through the Decree of the Director General of YanMed No. YM.00.03.26.7637 1993 The standard of nursing care is a measuring tool to maintain and improve the quality of nursing care. The standard serves as a measuring tool for knowing, monitoring, and concluding whether nursing care services held in hospitals have followed and fulfilled the requirements set by these standards (4).

The reality in Indonesia in the implementation of documenting nursing care has not been carried out optimally, studies on the description of the implementation of documenting nursing care show that the average completeness of nursing care documentation is 50.77% -71.6%. The factors that influence the implementation of documenting nursing care include high workloads, nurses' motivation in carrying out documentation, human resources (HR), training and explanation of the implementation of documenting nursing care, implementation time, complicated documentation format (5–8).

The standards of nursing care aim to determine nursing responsibilities and accountability, protect patients from incompetent nursing actions and protect nurses from neglect. This can be measured from the quality of service and nursing care with the indicator value is the value of nursing documentation. Every action taken to the patient must avoid mistakes by using the nursing process approach and accurate documentation (9).

The results of a preliminary study at Wates Kulon Progo District Hospital against 15 inpatient medical records observed the completeness of nursing care documentation, obtained results in the assessment phase of 7 documents (42%) complete assessment, and 8 documents (58%) incomplete, this was due to recording not in accordance with assessment guidelines. The stage of nursing diagnosis, as many as 11 documents (70%) complete diagnosis and 4 documents (30%) are incomplete, there is a nursing diagnosis that does not consist of components of the problem, etiology, and symptoms. The planning stage was obtained as many as 8 documents (53%) complete and 7 documents (47%) planning was incomplete, nurse planning was not arranged according to priorities, plans did not refer to goals. The implementation phase found 11 documents (70%) complete and 4 documents (30%) incomplete, nurses did not write all the actions taken. The evaluation phase obtained 11 documents (70%) complete

and 4 documents (30%) incomplete, there were evaluations that did not refer to the objectives.

Based on the background described above, the general objective in this study was to find out the descriptio of implementation of documentation nursing care at Wates Hospital.

MATERIALS AND METHODS

This research is a quantitative descriptive study, which is a study to describe the characteristics of subjective populations by using descriptive statistics in the presentation of the data, carried out in a retrospective manner on nursing care documentation (10).

Sampling with cluster random sampling technique, which is by grouping sample techniques by region or population location, how to calculate for sampling with a population of more than 1,000, the formula for determining the minimum sample size in this population uses the formula 10% - 20% of the population (11). Retrieval of research data through patient documentation in March 2017 was 1.106x10% =110.6 rounded to 111 samples divided into 12 existing spaces in Wates Hospital Kulon Progo, inclusion criteria in this study were medical records of patients hospitalized in the month inpatient room March 2017. Exclusion criteria are medical records of deceased inpatients and medical records of midwifery inpatients

The variables in this study are one variable, namely the implementation of documenting nursing care. This study uses an instrument for documenting nursing care checklists, which are compiled based on a literature review. Containing the quality of the process of nursing care documentation with alternative answers is complete and incomplete, the number of questions is 24 items. Each answer option is given code 1 = (if the documentation is complete) and 0 = (if the documentation is incomplete).

RESULTS AND DISCUSSION

Documentation description of nursing care is reviewed from each aspect of the research in the table and presented

Table 1. Completeness of nursing assessment documentation at Wates Hospital

Assessment	amount	%
Complete	86	77,5
Incomplete	25	22,5
Total	**111**	**100**

Source: Primary Data 2017

Based on Table 1 shows a total of 86 documents (77.5%) complete and 25 documents (22.5%) incomplete.

Table 2. Frequency distribution of completeness of nursing assessment documentation at Wates Hospital

Assessment Items	Complete		Incomplete		Total	
	f	%	f	%	f	%
Record the data reviewed according to guidelines	88	79,3	23	20,7	111	100
Grouped data Biopsycho-socio-spiritual)	110	99,1	1	0,9	111	100
Data is reviewed since the patient enters until exiting	111	100	0	0	111	100
Formulate a problem	108	97,3	3	2,7	111	100

Source: Primary Data 2017

Based on Table 2, the distribution of assessments on aspects of assessment shows that recording the data reviewed according to guidelines is the most incomplete action done, namely as many as 23 documents (20.7%)

Table 3. Completeness of Nursing Diagnosis Documentation at Wates Hospital

Assessment	amount	%
Complete	104	93,7
Incomplete	7	6,3
Total	111	100

Source: Primary Data 2017

Based on Table 3, the complete documentation on aspects of nursing diagnoses is in full category there are 104 documents (93.7%) and incomplete there are 7 documents (6.3%).

Table 4. Frequency distribution of completeness of nursing diagnoses documentation at Wates Hospital

Assessment Items	Complete		Incomplete		Total	
	f	%	f	%	f	%
Nursing diagnosis is based on patient problems	107	96,4	4	3,6	111	100
Nursing diagnoses include PE / PES	109	98,2	2	1,8	111	100
Formulate actual / potential nursing diagnoses	106	95,5	5	4,5	111	100

Source: Primary Data 2017

Table 4 shows that the act of formulating an actual or potential nursing diagnosis is the most incomplete action performed by the nurse, which is 5 documents (4.5%).

Table 5. Completeness of nursing plan documentation at Wates Hospital

Assessment	amount	%
Complete	82	73,9
Incomplete	29	26,1
Total	111	100

Source: Primary Data 2017

Table 5 shows that the complete category of nursing plan documentation is 82 documents (73.9%) and incomplete as many as 29 documents (26.1%).

Based on Table 6 the distribution of assessment on planning aspects shows that nurses do not prioritize well as many as 26 documents (23.4%) are the most frequently not carried out activities.

Table 7. Completeness of Documentation of Nursing Actions at Wates Hospital

Assessment	amount	%
Complete	51	45,9
Incomplete	60	54,1
Total	111	100

Source: Primary Data 2017

Based on Table 7 it is known that the documentation Complete category nursing action is 51 documents (45.9%), and incomplete about 60 documents (54.1%).

Table 8. Frequency Distribution of Completeness of Documentation of Nursing Actions at Wates Hospital

Assessment Items	Complete		Incomplete		Total	
	f	%	f	%	f	%
Actions carried out refer to the treatment plan	73	65,8	38	34,2	111	100
The nurse observes the patient's response to nursing actions	104	93,7	7	6,3	111	100
Revision of actions based on evaluation results	97	87,4	14	12,6	111	100
All actions that have been carried out are recorded concisely and clearly	77	69,4	34	30,6	111	100

Source: Primary Data 2017

Table 6. Frequency Distribution of Completeness of Documentation Nursing Plans in Wates Hospital

Assessment Items	Complete		Incomplete		Total	
	f					
Based on nursing diagnosis	88	79,3	23	20,7	111	100
Arranged according to priority	85	76,6	26	23,4	111	100
The formulation of the objectives contains the components of the patient, behavior changes, the condition of the patient / family	92	82,4	19	17,1	111	100
The action plan refers to the goal with the command sentence, detailed and clear, and or involves the patient/ family	93	83,8	18	16,2	111	100
Action plans describe the involvement of patients/ families	94	84,7	17	15,3	111	100

Source: Primary Data 2017

Based on Table 8 shows that the actions taken by nurses referring to the treatment plan are the most incomplete actions, namely as many as 38 documents (34.2%).

Table 9. Completeness of Documentation of Nursing Evaluation at Wates Hospital

Assessment	amount	%
Complete	85	76,6
Incomplete	26	23,4
Total	111	100

Source: Primary Data 2017

Based on Table 9, there are 85 documents (76.6%) were complete and 26 documents (23.4%) were incomplete.

Table 10. Frequency Distribution of Completeness of Documentation of Nursing Evaluation at Wates Hospital

Assessment Items	Complete		Incomplete		Total	
	f	%	f	%	f	%
Evaluation refers to the goal	86	77,5	25	22,5	111	100
evaluation recorded	107	96,4	4	3,6	111	100

Source: Primary Data 2017

Table 10 shows that evaluation refers to the objective is the activity most often not carried out, namely there are 25 documents (22.5%) incomplete.

Table 11. Complete Documentation of Nursing Records at Wates Hospital in March 2017 (n=111)

Nursing Record	amount	%
Complete	50	45
Incomplete	61	55
total	111	100

Source: Primary Data 2017

Based on Table 11 shows that 50 documents (45%) complete nursing records and 61 documents (55%) are incomplete.

Based on Table 12 shows that 32 documents (28.8%) records have not been carried out according to the actions taken, and 49 documents

Table 12. Frequency Distribution of Complete Documentation of Nursing Records in Wates Hospital in March 2017 (n=111)

Assessment Items	Complete		Incomplete		Total	
	f	%	f	%	f	%
Write in the default format	103	92,8	8	7,2	111	100
Recording is carried out in accordance with the actions taken	79	71,2	32	28,8	111	100
Recording is written clearly, concisely, standard terms and correct	94	84,7	17	15,3	111	100
Each action / activity of the nurse includes a clear initial / name, and the date the action is taken	62	55,9	49	44,1	111	100
The nursing record file is stored in accordance with applicable regulations.	109	98,2	2	1,8	111	100

Source: Primary Data 2017

(44.1%) nurses have not specified the initial name, and the date or time of each action.

Table 13. Completeness of Documentation of Nursing Care in Wates Hospital in March 2017 (n=111)

Nursing Documentation	Amount	%
Complete	31	27,9
Incomplete	80	72,1
total	111	100

Source: Primary Data 2017

Based on Table 13 shows that as many as 31 nursing documents (27.9%) are complete and as many as 80 nursing care documents (72.1%) are incomplete.

The complete documentation on the assessment aspects was 86 documents (77.5%) complete and 25 documents (22.5%) incomplete, in contrast to the research conducted by Nurjanah (2013) in Pandanarang Hospital which showed incomplete results of 42%. The results

of interviews with nurses in Bangsal Wijaya Kusuma review have been fully documented but sometimes there are still incomplete studies because in March the patients were full and the nurses who guarded the afternoon and evening shifts were only 2 people. The lowest result of the assessment was to record the data studied in accordance with the guidelines. We had to look at the points that exist because of the long and indistinguishable format. children, adults, and the elderly, so nurses must sort out the points that must be filled according to the characteristics of the patient (5).

Completeness Documentation on aspects of nursing diagnoses shows a number of 104 documents (94%) complete. This is different from Nurjanah's research in 2013 in Pandanarang Hospital which obtained results of complete diagnostic aspects of 67 documents (70.5%) sources (12). One of the important ways of documenting nursing diagnoses is the clinical decision about the response of individuals, families, and the public about actual or potential health problems as a basis for selection of nursing interventions or achieving the goal of nursing care (2,13). The lowest result is the point of formulating actual and potential nursing diagnoses. The nurse does not compose a diagnosis that matches the priority of the problem faced by the patient at that time, because he lacks understanding of the order of the patient's problems and only writes one diagnosis.

The complete documentation of the nursing plan shows that there are 29 incomplete documents (26.1%), nurses do not rank the priority well because of errors or shortcomings in the initial documentation, especially at the diagnosis stage. This is different from Azizah's research in 2012 in the RSCM PJT Nursing Room which obtained 100% incomplete planning aspects (14). When enforcement of the diagnosis has not been carried out properly, then planning nursing actions cannot be done properly. The things that hinder the documentation of planning are the lack of cooperation between nurses and patients and families. The planning stage needs to be arranged priorities for patients. These priorities are classified into 3, namely: hight priority, intermediate priority, and low priority (2).

Complete documentation of nursing actions showed 60 documents (54.1%) were incomplete. This is different from Azizah's research in 2012 in the RSCM PJT Nursing Room where 64.4% (14) incomplete nursing actions were obtained. From interviews with several nurses, the action format was less able to describe the revised actions based on the evaluation results because of several observations of documents that were not written hours and signed, there were also documents describing the nurse not writing every action taken, because the nurse wrote routine activities in general only. The results of interviews with nurses in one room, the reason for not writing this was because the number of patients there was not comparable to nurses who were on guard, so they thought the time would run out if they wrote a lot.

Completeness of nursing evaluation documentation shows as many as 26 documents incomplete documentation (24%), this is different from Azizah's research in the RSCM PJT Nursing Room which obtained results of an incomplete evaluation aspect of 100% (10). Incomplete documentation of implementation of nursing can affect the evaluation process, documentation of nursing evaluations is carried out periodically, systematically, and plans to assess patient progress after nursing actions (13).

Complete documentation of 61 incomplete nursing care records (55%). Every time an action or activity is carried out, the nurse does not include the initials or clear names and date, hours of action, from the results of interviews with nurses in one room, the reason for not writing names, signatures, dates is because they are

too busy, forgetful and lazy if every time you have to carry a name stamp. Documentation of nursing care has very important meaning seen from the aspects of law, communication, finance, research, service quality, education, and accreditation (13). When there is a problem with the law and there is no written evidence, then this situation will make it difficult for the nurse in the resolution. Documentation of nursing care is also a means of communication between health teams, so that if it is not made properly it will cause problems in providing care and service to patients.

The complete description of nursing care documentation shows the results obtained from 111 documents, there are 80 documents (72.1%) incomplete, this is in line with Siswanto's research in 2013 regarding factors related to documentation, not yet complete (71,6 %) and the dominant factors affecting the completeness of documentation are training and workload (6).

The results of this study compared with Azizah's research got better results, namely the achievement of document completeness of 27.9%, while Azizah obtained a complete 0% result. Compared with the results of Nurjanah's lower research, the achievement of document completeness was 31%. Compared with the research conducted by Azizah viewed from the sample distribution, it would better illustrate the implementation of documentation in the hospital, because samples were taken from all rooms in the hospital while Azizah only took from one room (14).

CONCLUSIONS AND SUGGESTIONS

Based on the results and discussion, it can be concluded that the documentation of nursing care in the aspects of assessment, diagnostic aspects, planning aspects, evaluation aspects, is stated complete with a percentage above 70% in Wates Hospital Kulon Progo.

The hospital should use the results of the study as an evaluation material about the implementation of nursing care documentation and as a consideration for determining policies in an effort to improve the quality of nursing documentation. Hospitals improve nurse's knowledge with non-formal education efforts (seminars, symposiums, workshops, journal reading) related to nursing care documentation on a regular basis. Hospitals should use standard assessment sheets from the Ministry of Health of Republic of Indonesia to evaluate the implementation of nursing care documentation. Educational institutions should be able to share knowledge with the hospital about the development of documenting nursing care in the hospital so that students will get the latest knowledge. Nurses are expected to know and improve knowledge about nursing care documentation and improve the implementation of nursing care documentation at Wates Hospital in Kulon Progo. The next researcher should pay attention to the factors that influence the nurse in documenting nursing care so that it is beneficial for the nursing profession.

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