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Relationships of Providers' Accountability of Nursing Documentations in the Clinical Setting

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Abstract— *Documentation demonstrates the unique contribution of nursing to the care of clients. This study investigated the relationships of Providers accountability of nursing documentations in the clinical settings. Judgmental and simple random sampling techniques were used to select documented nursing actions for 264 clients. One research question and four null hypotheses guided the study. The instrument used for data collection was checklist on Nursing documentation in the clinical setting. Descriptive statistics of frequency, means and standard deviation (SD) were used to summarize the variables. Pearson Product Moment correlation was used to answer the research question, while analyses of variance (ANOVA) was adopted in testing the null hypotheses at 0.05 level of significance. The result indicated that significant correlation existed between legal implications of nursing documentation and the core principles of nursing documentation. Significant differences were also observed among providers' accountability of nursing documentations with regard to promotion of interdisciplinary communication, legal implications of documentation, impacts on quality assurance and nursing science.*

Keywords— Relationships, Care Providers, Accountability, Nursing documentations, Clinical Setting.

I. INTRODUCTION

Tools are needed to support the continuous and efficient shared understanding of a patient's care history that simultaneously aids sound intra and inter-disciplinary communication and decision-making about the patient's future care (Joint Commission on the Accreditation of Healthcare Organisations, 2005). Such tools are vital to ensure that continuity, safety and quality of care endure across the multiple handovers made by the many clinicians involved in patient care. Generally, tools are implements held in the hands, which in the healthcare setting refer to documentation. Potter and Perry (2010) describe documentation as anything written or electronically generated that describes the status of a client or the care or services given to that client. Nursing documentation refers to written or electronically generated client information obtained through the nursing process (ARNNL, 2010). 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, it is an integral part of nursing practice and professional patient care rather than something that takes away from patient care, and it is not optional.

According to Potter and Perry (2010), nursing documentation must provide an accurate and honest account of what and when events occurred, as well as identify who provided the care. The documentation should be factual, accurate, complete, current (timely), organized and compliant with standards (Professional and Institutional). Potter and Perry (2010) further stated that these core principles of nursing documentation apply to every type of documentation in every practice setting.

Documentation in nursing covers a wide variety of issues, topics and systems (Yocum, 2002; Huffman, 2004, Lindsay et al 2005; Johnson et al 2006). Such areas of coverage include all aspects of nursing process, plan of care, admission, transfer, transport, discharge information, client education, risk taking behaviours, incident reports, medication administration, verbal orders, telephone orders, collaboration with other health care professionals, date and time of any event as well as signature and designation of the recorder.

The primary purpose of documentation is to facilitate information flow that supports the continuity, quality and safety of care. Potter and Perry (2010) pointed out that data from documentation allow for communications and continuity of care, quality improvement/ assurance and risk management, establish professional accountability, make provision for legal coverage, funding and resource management, and also expand the science of nursing. Potter and Perry (2010) also explained that clear, complete and accurate health records serve many purposes for the clients, families, registered nurses and other health care providers.

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DeLauna and Ladner (2002) further affirmed that documentation is the professional responsibility of all health care practitioners, and that it provides written evidence of the practitioner's accountability to the client, the institution, the profession and the society.

Literature has revealed that the tensions surrounding nursing documentation include the amount of time spent in documenting, the number of errors in the records, the need for legal accountability, the desire to make nursing work visible, and the necessity of making nursing notes understandable to the other disciplines (Spraque and Trapanier 1999; Castledine, 1998; Dimond, 2005; Pearson, 2003). This study therefore intends to examine the relationships of Providers accountability of nursing documentations in the clinical settings.

Research Question.

- To what extent does the legal implications of nursing documentation relate with the core principles of the documentation?.

Hypotheses.

- Promotion of interdisciplinary communication does not significantly differ in the nursing actions documented by the Primary, Secondary and third party providers.
- There is no significant difference in the legal implications of the nursing documentations by the primary, secondary and third party providers.
- Quality assurance of documented nursing actions does not significantly differ among the primary, secondary and third party providers of the documentation.
- The impact of the documented nursing actions on Nursing Science does not significantly differ among the primary, secondary and third party providers of the documentation.

II. MATERIALS AND METHODS

Design and Sampling.

The study was a retrospective research design. Judgmental sampling technique was adopted in selecting one Teaching Hospital and one specialist Hospital (tertiary Health Institutions) in Anambra State of Nigeria. Simple random sampling was used to select two General Hospitals (Secondary Health Institutions) and two comprehensive Health Centres (Primary Health Institutions) out of the 24 General Hospitals and 10 comprehensive Health Centres in Anambra State. This was to give all the primary and secondary health institutions equal chance of being selected for the study (Nworgu, 1991).

Nursing documentations on Clients were obtained from three units (medical, surgical and maternity units) of each of the selected health institutions. Other units (e.g. Emergency unit, Out-patient Department, and other special units) were excluded in the study. Documented nursing actions for 96 clients were obtained from the selected tertiary health institutions, 72 were obtained from the secondary health institutions and 96 from the primary health institutions. On the whole nursing documentation for 264 clients were used for the study. Ethical approval were obtained from the six institutions used for the study. Informed consent was also obtained from the clients whose records were used. Confidentiality was ensured by not including the names of the health institutions in the data collection. Alphabetical codes were used to represent the selected health institutions while numerical codes were used for the patients whose records were obtained for the study. Generally, records of nursing documentation done from July – September 2015 were used for the study.

Instrument.

The instrument used for data collection in the study was checklist titled Checklist on Nursing Documentation in the clinical setting (CNDCS). Section A of the instrument provided general information of the health institution (eg level of health institution, clinical specialty, form of documentation, client's clinical diagnosis, documentation of accountability, section B of the instrument was made up of eight sub-sections designed to measure documented nursing actions (eg admissions, transfers, discharges, plan of care, client education, medication, incident reports, vital signs, etc), extent of ensuring core principles in the documentation (eg whether factual, accurate, complete, timely, organized and compliant with standards), ensuring promotion of interdisciplinary communication (eg name(s) of the people involved in the collaboration, date and time of the contact, information provided to or by healthcare provider, responses from healthcare provider, etc), timeliness of the documentation (eg how timely, chronological and frequency), preciseness of the documentation (eg objectivity, unbiased, legibility, clear and concise, etc), Legal implication (eg use of authorized abbreviations, informed consent, advanced directive, etc), impact on quality assurance/ improvement (eg facilitates quality improvement initiative, facilitates risk management, and used to evaluate appropriateness of care), and impact on the science of nursing (eg provides data for nursing/health research, used to assess nursing intervention and client outcomes, etc). The instrument was designed in a 4 – point

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scale ranging from 1 to 4 with poor/many omissions having I point, 2 points for fair/incomplete with few omissions, 3 points for good/almost complete, and 4points for very good/complete.

The instrument was subjected to reliability test by collecting data from nursing documentations for 15 patients from three levels of health institutions (primary, secondary and tertiary) in another State of Nigeria that was not used for the study. The instrument test/ retest reliability was 0.65.

Data Analysis.

Standard descriptive statistics of frequency, means and standard deviation were used to summarize the variables. Mean score, standard deviation and Pearson Product moment correlation (r) were used to answer the research question while Analysis of variance (ANOVA) was adopted in testing the null hypotheses at 0.01 and 0.05 levels of significance respectively. SPSS version 21 was used in the data analysis.

III. RESULT

Table.1: General Information of the Health Institutions used for the study

Variable	Frequency	Percentage
Level of Health Institution:		
Primary	96	36.4
Secondary	72	27.3
Tertiary	96	36.4
Clinical Specialty:		
Medical unit	97	36.7
Surgical unit	63	23.9
Maternity unit	104	39.4
Form of Documentation:		
Written documentation	262	99.2
Electronic documentation	2	0.8
Client Diagnoses:		
Obstetric condition	105	39.8
Medical condition	93	35.2
Surgical condition	61	23.1
Sepsis/Infection	5	1.9
Demonstration of Accountability:		
Primary provider	247	93.6
Secondary provider	15	5.7
Third party provider	2	0.8

Total N = 264

Table 1 shows the general information of the health institutions used for the study. Primary Health Centre constituted 36.4% of the Health institutions, 27.3% constituted secondary level while tertiary level constituted 36.4%. The clinical specialties of the health institutions that were used for the study were medical unit 36.7%, surgical unit 23.9% and maternity unit which formed 39.4%. Out of the forms of nursing documentations, 99.2% was written documentation while electronic documentation formed 0.8%; 39.8% was obstetric conditions, medical conditions 35.2%, surgical conditions 23.1% while documented infective conditions constituted 1.9%. For demonstration of accountability in the documented nursing actions, 93.6% was done by primary providers, 5.7% by secondary providers, while third party providers accounted for 0.8% of the documentations. Total number of each variable was 264.

Table.2:Descriptive Statistics of the Measured Variables

Variable	N	Minimum	Maximum	Mean	SD
Nursing Action Documentation	264	23.00	76.00	54.6402	9.86811
Core principles of Documentation	264	11.00	24.00	19.2462	2.38101
Promotion of interdisciplinary communication	264	9.00	36.00	30.8485	5.61433

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Timeliness of Documentation	264	6.00	12.00	9.5568	1.32703
Preciseness of Documentation	264	18.00	40.00	31.9470	3.30299
Legal implication	264	11.00	24.00	19.6439	2.47153
Impact on Quality Assurance	264	4.00	12.00	9.6250	1.63129
Impact on Nursing Science	264	4.00	16.00	13.7462	2.43860
Valid N (Listwise)	264				

Table 2 shows the descriptive statistics of the measured variables. Out of the 264 documented nursing actions, the mean was 54.6402 and the standard deviation (SD) was 9.86811. Mean for the core principles of the documentation 19.2462 with SD of 2.38101. For promotion of interdisciplinary communication, the mean was 30.8485 with SD of 5.61433. Timeliness of documentation had a mean of 9.5568 with SD of 1.32703. Mean for preciseness of the documentation was 31.9470 with SD of 3.30299. For legal implications, the mean was 19.6439 with SD of 2.47153. Impact of the documentation on quality assurance had a mean of 9.6250 with SD of 1.63129, while impact on Nursing Science had a mean of 13.7462 with SD of 2.43860.

Table.3: Relationship between Legal implications of nursing action documentation and the core principles of documentation.

Variables	**N**	**$\bar{X}$**	**SD**	**r**	**Critical value**	**Level of significance**
Legal implication of documentation	264	19.6439	2.47153	** 0.543	0.000	0.01
Core principles of documentation	264	19.2462	2.38101			

**Correlation was significant at 0.01 level (2 – tailed).

In table 3, the correlation value (r) for the relation between legal implications of documentation and the core principles was 0.543, and it was significant at 0.01 level.

Table.4: ANOVA showing comparison of the nursing action documentations by the Primary, Secondary and third party providers for promotion of interdisciplinary communication, legal implications, impacts on quality assurance and nursing science.

Variable	**Providers/ Accountability**	**N**	**$\bar{X}$**	**SD**	**Source**	**Sum of squares**	**df**	**Mean squares**	**F-cal**	**F-crit (sig)**
Promotion of Interdisciplinary communication	Primary Provider	247	30.9595	5.47559	Between Groups	240.611	2	120.305	3.901	0.021
	Secondary provider	15	30.4667	5.55321						
	Third party provider	2	20.0000	15.55635	Within Groups	8049.328	261	30.840		
	Total	264	30.8485	5.61433		8289.939	263			
Legal Implication of documentation	Primary Provider	247	19.6316	2.44074	Between Groups	53.323	2	26.662	4.480	0.012
	Secondary provider	15	20.4667	2.38647						
	Third party provider	2	15.0000	2.82843	Within Groups	1553.207	261	5.951		
	Total	264	19.6439	2.47153		1606.530	263			
Impact on Quality Assurance	Primary Provider	247	9.6032	1.57614	Between Groups	3.824	2	1.912	0.717	0.489
	Secondary provider	15	10.0667	2.18654						
	Third party provider	2	9.0000	4.24264	Within	696.051	261	2.667		

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					Groups					
	Total	264	9.6250	1.63129		699.875	263			

NB: Probability: 0.05 level of significance.

Impact on nursing science	Primary Provider	247	13.7692	2.37522	Between Groups	28.417	2	14.208	2.415	0.091
	Secondary provider	15	13.8667	2.32584						
	Third party provider	2	10.0000	8.48528	Within Groups	1535.579	261	5.883		
	Total	264	13.7462	2.43860		1556.996	263			

Table 4 shows that with regard to providers accountability of nursing action documentation, the calculated F-ratio for promotion of interdisciplinary communication was 3.901; for legal implications of documentation, impacts on Quality assurance and nursing science, the F-ratios were 4.480, 0.717 and 2.415 respectively. These results were more than the critical values. Therefore the null hypotheses are rejected. Scheffe Post-Hoc (Akuezuilo and Agu, 2004) test of multiple comparison of mean was used to determine the order of significant differences across the Primary, Secondary and third party providers of accountability.

Table.5: Scheffe Post-Hoc test of multiple comparison of the means of promotion of interdisciplinary communication and the legal implications of nursing action documentation across the primary, secondary and third party providers.

Dependent variable	**(1) providers of Documentation**	**(J) Providers of Documentation**	**Mean Difference (1 – J)**	**Standard Error**	**Sig (F – Crit)**
Promotion of interdisciplinary communication	Primary Provider	Secondary Provider	0.49285	1.47678	0.739
		Third party provider	10.95951*	3.94272	0.006
	Secondary provider	Primary provider	-0.49285	1.47678	0.739
		Third party provider	10.46667*	4.18045	0.013
	Third party provider	Primary provider	-10.95951*	3.94272	0.006
		Secondary provider	-10.46667*	4.18045	0.013
Legal Implications of documentation	Primary provider	Secondary provider	-0.83509	0.64871	0.199
		Third party provider	4.63158*	1.73193	0.008
	Secondary provider	Primary provider	0.83509	0.64871	0.199
		Third party provider	5.46667*	1.83636	0.003
	Third party provider	Primary provider	-4.63158*	1.73193	0.008
		Secondary provider	-5.46667*	1.83636	0.003

Key: *The mean difference was significant at 0.05 level

Table 5 shows that for promotion of interdisciplinary communication, the mean difference of 10.95951 between primary, secondary and third party providers was in favour of the primary providers; also the mean difference of 10.46667 between secondary and third party providers was in favour of secondary provider. For legal implications of documentation, the mean difference of 4.63158 between primary and third party providers was in favour of primary providers, while the mean difference of 5.46667 between secondary and third party providers was in favour of secondary providers.

IV. DISCUSSION

Findings from the study indicate significant correlation (r=0.543) between legal implications and core principles of nursing documentation (table 3). Failure to document

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appropriately is a key factor in clinical mishaps and a pivotal issue in many malpractice cases (Springhouse, 1995) because the client's medical record is a legal document, and in the case of a lawsuit the record serves as the description of exactly what happened to a client. Lyer and Camp (1999) noted that in 80% to 85% of malpractice lawsuits involving client care, the medical record is the determining factor in providing proof of significant events. DeLaune and Ladner (2002) pointed out that legal issues of documentation require legible and neat writing, proper use of spelling and grammer, use of authorized abbreviations as well as factual and time-sequenced descriptive notations. These features are elements of effective documentation which invariably constitute the characteristics of the core principles of nursing documentation (Porter and Perry, 2010).

The study revealed significant differences in the providers' accountability of nursing documentation with regard to promotion of interdisciplinary communication, legal implications of documentation, impacts on quality assurance and nursing science (tables 4 and 5). According to Kozier et al (2004), each health care organization has policies about recording and reporting client data, and each nurse is accountable for practicing according to these standards. Agencies also indicate which nursing assessments and interventions that can be recorded by registered nurses (RNs) and which interventions that can be charted by unlicensed personnel (Kozier et al 2004). The role of the nurse varies with the needs of the client, the nurse's credential, and the types of employment setting (Kozier et al, 2004). CRNNS (2012) indicate that legislation and standards of practice of a profession require nurses to document the care they provide demonstrating accountability for their actions and decisions. First hand knowledge means that the professional who is doing the recording is the same individual who provided the care. The RN who has the primary assignment is expected to document the assessment, interventions and clients response noting as necessary the role of other care providers. Third party recordings include documentations by non-professionals such as auxiliary staff, designated recorders, client/ family and students (SRNA, 2011). Certainly, proficiency should not be expected from these unlicensed personnel, hence the significant difference observed in this study about the documentations of the primary, secondary and third party providers. CRNNS (2012) pointed out that quality documentation is an integral part of professional RN practice; it reflects the application of nursing knowledge, skills and judgment, the clients' perspective and interdisciplinary communication.

V. CONCLUSION

This study indicates that significant correlation exists between the legal implications of nursing documentation and the core principles of the documentation. It also revealed that quality nursing documentation requires accountability of the professional RN.

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