



**AUDITING OF THE DOCUMENTATION OF PATIENT CARE BY
REGISTERED NURSES IN HOSPITALIZED PATIENTS AT GAHINI
DISTRICT HOSPITAL.**

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DECLARATION

I do hereby declare that this research report submitted in partial fulfillment for the Requirements for the Masters of Science degree in nursing at University of Rwanda College of Medicine and Health Science is my original work and has not previously been submitted elsewhere. Also, I do declare that a complete list of references is provided indicating all the sources of information quoted or cited.

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Signature

DEDICATION

I dedicate this work to our heavenly father for the guidance he gives me. My parents Valens MULINDAHABI and Pudentienne KANKERA, my sisters and brothers Claudine TUYISHIMIRE, Noella AKAYEZU, Lyvine MANZI, Yvonne KIBERINKA, Nadeje MUNYANA, Hilaire MULINDAHAHI, Odilo MULINDAHABI, and all my friends for support and collaboration.

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ABSTRACT

Introduction: Documentation in nursing profession is a key factor in nurses' role and tasks as patient care advocates. It is important for making sure if the quality of care was rendered to a patient to defend prior nursing actions. Default to document, omissions, and poor communication is not easy to defend.

Background: Since the time of Florence Nightingale, nursing documentation was viewed as important and now it is still crucial in nursing by ameliorating patient care. The nursing profession includes the law when it comes to caring for patients in all groups. The legal issues can only be solved when there is accurate documentation.

Many nurses do not document and the omissions have been discovered in patient files in low-income countries.

Methodology: A quantitative cross sectional study was conducted. A number of 130 files of hospitalized patient within 24 hours in five wards (Emergency Department, Pediatric ward, Internal medicine, surgical ward and Maternity) were audited. Microsoft excels and SPSS versions 20 were used to analyze data and the patient's files were coded to ensure confidentiality.

Findings: Among audited files, temperature was recorded four times on 8 files (6.8%) as recommended for the first 24 hours, pulse rate was recorded only on 14 files (11.8%), respiration rate was recorded only on 3 files (2.5%), blood pressure was recorded only on 11 files (9.2%), Oxygen saturation was recorded only on 12 files (10.1%). Fluid balance was not recorded on any files 130 (0%). The nursing process was recorded only in 7% of audited files and in 93%, the nursing process was never documented.

Conclusion: This study revealed that the nursing documentations were not carried out as per the recommendations and it needs to be improved at Gahini district hospital.

Key words: Audit, patient documentation, patient care, registered nurse.

TABLE OF CONTENTS

DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENT	iii
ABSTRACT	iv
TABLE OF CONTENTS	v
LISTS OF TABLES	viii
LISTS OF FIGURES	ix
Figure 4.2.2.8: Nursing process completed in patient file.....	42 ix
LISTS OF SYMBOLS AND ABBREVIATIONS	x
CHAPTER 1: INTRODUCION	1
1.1. INTRODUCION	1
1.2. BACKGROUND OF THE STUDY	2
1.3 PROBLEM STATMENT	4
1.4. OBJECTIVES OF THE STUDY.....	5
1.5. RESEARCH QUESTION.....	5
1.6. SIGNIFICANCE OF THE STUDY.....	5
1.7. DEFINITION OF KEY TERMS	6
1.8. STRUCTURE ORGANIZATION OF THE STUDY	7
Conclusion	7

CHAPTER2. LITERATURE REVIEW	8
2.5 CONCEPTUAL FRAMEWORK	22
CHAPTER 3: METHODOLOGY	24
3.7.4. Data collection procedure.....	29
3.8. Data analysis and result presentation	29
3.9. Ethical consideration	29
3.10. Data management.....	29
3.11. Data dissemination	29
3.12. Limitation to the study	29
Conclusion	30
Chapter 4: DATA ANALYSIS	31
4.1INTRODUCTION	31
4.2 DATA ANALYSIS AND INTERPRETATION	31
4.2.1 Section A: Demographic data	31
4.2.2: Section B.....	34
Conclusion	41
Chapter 5: DISCUSSION OF FINDINGS	42
4.2.1. SECTION A: Demographic data	42
4.2.2 Section B: completeness of vital signs and frequencies.....	43
4.2.2.2 Frequency of documentation of temperature (n=119).....	44
4.2.2.3 Frequency of documentation of pulse rate (n=119)	44

4.2.7 Frequency of documentation of respiration rate (n=119)	45
4.2.2.5 Frequency of documentation of blood Pressure (n=119)	45
4.2.2.6 Frequency of documentation of oxygen saturation (n=119)	45
4.2.2.7 Fluid balance (n=130)	46
Pain assessment	46
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS	48
5.1 INTRODUCTION.....	48
5.2 CONCLUSION	48
5.2 RECOMMENDATION	48
REFERENCES	50
ANNEXES	1
I. Distribution of the number of files in different wards.....	1
II. Number of registered nurses working in each ward.....	1
III. Patient file code (e.g : 01).....	1
IV. Distribution of the age of the audited files	2
V. Admitting diagnosis	2
VI. Completeness of patients' vital signs. Within the first 24hrs	2
VII. Completeness of nursing process in patient file, written within the first 24hrs	2

LISTS OF TABLES

Table 1.3.1 List of studies conducted on nursing documentation.....	17
Table 2.4.2.1.2: Number of registered nurses working in each ward.....	32
Table 3.4.2.1.3: Distribution of Age.....	33
Table 4.4.2.2.7: Fluid balance.....	40

LISTS OF FIGURES

Figure 1 Conceptual framework adapted from Chelagat et al. (2013).....	22
Figure 2 Map of Rwanda.....	24
Figure 2.2.1: Completeness of vital signs.....	34
Figure 4.2.2.2: Frequency of documentation of Temperature.....	35
Figure 4.2.2.3: Frequency of documentation of Pulse rate.....	36
Figure 4.2.2.4: Frequency of documentation of respiration rate.....	37
Figure 4.2.2.5: Frequency of documentation of blood pressure.....	37
Figure 4.2.2.6: Frequency of documentation of oxygen Saturation.....	39
Figure 4.2.2.8: Nursing process completed in patient file.....	41

LISTS OF SYMBOLS AND ABBREVIATIONS

ARNNL: Association of Registered Nurses of Newfoundland and Labrador

CARNA: College and Association of Registered Nurses of Alberta

CRNNS: College of Registered Nurses of Nova Scotia

DH: District Hospital

ED: Emergency Department

GDH: Gahini District Hospital.

ICN: International Council of Nursing

ICU: Intensive Care Unit

NANB: Nurses Association of New Brunswick

NCNM: National Council of Nurses and Midwives

RN: Registered Nurse

SRNA: Saskatchewan Registered Nurses' Association

USA: United State of America

WHO: World Health Organization

CHAPTER 1: INTRODUCCION

1.1. INTRODUCCION

Documentation in nursing profession is a key factor in nurses' role and tasks as a patient care advocates. It is important for making sure if the quality of care is given to a patient in line with great nursing procedures. Default to document, omissions, and poor communications are not easy to secure (Morales, 2012). The term "charting" is frequently utilized in nursing as documentation. Nurses may complete many forms in their daily activities; the crucial part of the nurses' task is that of charting of patient care.

Spending time and effort on documentation by nurses is variably described with ranges 15% - 20% to 25% - 50 %.(Hope, 2012). The literature by Chelagat et al (2013, pp. 239-240), says about examples of challenges to nursing documentation. Many talk workload as the most important barrier to nursing documentation expectation, lack of institutional policies to the process and guidelines (Nakate et al. 2016, p.1064 , Blair & Smith 2012).

To make patient centered care and the possibility to collaborate successfully between health care team members build on the value of data existing to all health care professionals (Saranto & Miettinen, 2009, p. 1). Patient documentation review is known to be the gold set for the detection of many patient problems, mainly diagnostic problems, and medication problems. (Holderried et al. 2014, p.1). The aim of this study was to audit the documentation of patient care by registered nurses in hospitalized patients at Gahini District Hospital. This chapter presents an overview of the study, starting with a detailed background of the study; the statement of the research problem; purpose and objectives of this study and the significance of the study.

1.2. BACKGROUND OF THE STUDY

Most health care providers know that correct documentation (also known as charting, recording and reporting) is a vital part of their professional and legal responsibilities. Nursing organizations have principles of practice (practice guidelines) and specific competencies that address quality documentation, not just “good” charting (CLPNA, 2014, p. 1). The frequency of documentation is based on the hospital policies, the perception and complication of the patient’s health condition, the level to which the patient’s state and planned treatments puts him/her at danger (NANB, 2015, CRNNS, 2012).

From the moment of Florence Nightingale, nurses have considered documentation like a vital characteristic of their professional practice. She described the need to document, proper use of air, light, heat, hygiene and correct variety of diet with a mean of assembling and improving information to help in suitable patient management and that, the mean of documentation in Nightingale’s moment was principally to converse completion of doctors commands (Levin & Shea, 2010, Cheevakasemsook et al.2006,p.368).

Finally, today’s nursing documentation is practical in all the steps of the nursing procedure to the assessment, diagnosis, planning, implementation, and to the evaluation. Virginia Henderson, a nurse theorist, worked for the use of documentation once she introduced the thought of utilizing the nursing care plan to converse nursing care in the 1930’s (Chelagat et al,2013, p. 236) .

Nursing documentation is one of the main parts of clinical documentation. For instance, nurses use “up about one-third” of their shift work time on writing nursing reports. In other words, reporting is an important part of nursing routine that plays an important role in the quality of care and facilitating the relationship between nurses and other members of the healthcare team (Ebrahimpour & Pelarak, 2016, p. 1764). According to International Council of Nurses (ICN, 2012), a lack of accurate and current health information is a serious threat to patient safety and quality of care. International Council of Nurses (ICN) strongly believes that health outcomes are improved through the provision of high quality evidence-based health information to all health care providers, patients and the public.

In Canada, a study conducted by College of Licensed Practical Nurses of Alberta (CLPNA) found that charting or documentation audits across all health disciplines show serious deficiencies in documentation. It was found that most documentation efforts fail to meet legal

and professional standards when examined. This is in pointed contrast to the many care providers who believe that their charting is “good” or “adequate” College committees and practice consultants also agree that deficiencies in documentation are a major question. (CRNNS, 2014, pp.4).

In psychiatric hospital department in Norway, it was found that nurses only to a limited degree document patient care according to recommendations and legal requirements. This implies that deficiencies in nursing documentation identified in other clinical specialties also apply to the clinical field of psychiatry. The item ‘quantity of progress and evaluation notes’ had the lowest score: in 86% of the records progress and outcome were evaluated only sporadically. The items ‘the patients’ personal details’ and ‘quantity of record structure’ had the highest scores: respectively 100% and 71% of the records achieved the highest score of these items (Instefjord et al. 2014, p.1).

In Uganda, nursing documentation still remains a challenge. Omissions have been observed in most of the government hospitals and some private hospitals. (Nakate et al., 2016, p. 2).

In an informal assessment Clinical audit report in 2011 undertaken regarding documentation in one of the leading health care facilities in Kenya, the following comments were made; fragmented and incomplete information on patient care, lack of standardized method of nursing documentation, insufficient time for documentation due to acute shortage of staff, insufficient training of nurses on the importance of nursing informatics, No audits undertaken to evaluate nursing documentation. (Chelagat et al. 2013,p.237).

In Rwanda, research findings showed that nurses focus on the medical prescription charts more than they did on the nursing care plans. Just under half (48.7%) of the records were kept in permanent form. It was found that large percentages (68%) of patients' vital signs were not taken on entrance(Mbabazi & Cassimjee 2006). Although many studies have been conducted on nursing documentation in developed countries, only few studies were conducted in Africa. Hence, this study will be able to contribute more knowledge regarding nursing documentation in Rwanda.

1.3 PROBLEM STATEMENT

In order to improve patient care, nurses have to chart all of the action they perform. Health records are not only proof of care, but also clinical tools, enabling continuity of care and suitable decision making about future management. If the excellence of care provided is called into question, then health records and documents will be essential to any investigation or analysis (Beach & Oates 2014, p.45).

However many nurses do not document and the omission have been discovered in patient files in low-income country (Kiviri et al. 2015, p. 2). Poor knowledge of nurses in documentation methods could bring problems for patients and nurses like legal implications; lack of communication among health care providers and increase of adverse events to patients because as nurses, not documented, not done,(Andrews 2012,p.1).

According to Rwandan Ministry of Health in Human Resources for Health strategic plan 2011-2016, on an average, there is about one nurse for a population of 1,500,(Ministry of Health, 2016, p. 13). However, at Gahini District Hospital the admission capacity is eight beds in emergency department and 16 beds in pediatric ward. In Emergency department, only two nurse work at night and during week-end. Documentation of patients care as recommended sometimes is not possible because of shortage of nurses and there is no regular in-service education conducted for nursing documentation. In the district hospitals, the policy and procedures guidelines highlights that comprehensive information of complete patient assessment is important for decision making in patient care (Ministry of Health, 2012, pp. 9-10).

From the researcher's experience, the nursing leaders, directors of Gahini district hospital raised a concern of nurses' inability to document all the necessary information regarding patients care in the Gahini district hospital. This motivated the researcher to conduct auditing of the documentation of the patients care by registered nurses in hospitalized patients at Gahini district hospital.

1.4. OBJECTIVES OF THE STUDY

1.4.1. Main objective

To audit the documentation of patient care by registered nurses in hospitalized patient in Gahini district hospital

1.4.2. Specific objectives

1. To determine nurses adherence to Gahini hospital policy for documentation of vital signs (temperature, pulse rate, respiration rate, oxygen saturation, blood pressure and pain), fluid balance and nursing care plans.
2. To assess the completeness, timeous and frequency of routine charting by nurses at Gahini District Hospital as recommended by the hospital policy.

1.5. RESEARCH QUESTION

1. What is existing level of nurses adherence to Gahini District Hospital policy of documentation of vital signs?
2. Is the documentation completed on time as per recommendation of the hospital?

1.6. SIGNIFICANCE OF THE STUDY

Documentation is the responsibility of nurses. The findings of this study will help to identify if Rwandan nurses maintain documents for in-patients files, the content and frequency of documentation in-patient files at Gahini district hospital. This will lead to improvement of patient care by using patient documentation as a mean of communication of patient information among healthcare team, continuity and individuality of patient care. The findings of this study will assist the hospital administration to design in service training programs to strengthen nursing practice regarding nursing documentation. Nursing educators will utilize the identified gaps in nursing documentation to incorporate relevant content in the nurse training curricula.

1.7. DEFINITION OF KEY TERMS

1.7.1 Auditing

A Medical Record Audit is a type of quality assurance task which involves formal reviews and assessments of medical records to identify where a medical organization stands in relation to compliance and standards (Salem et al, 2015).

1.7.2 Patient care:

The service rendered by members of the health profession and non-professionals under their supervision for the benefit of the patient (Dorland, 2016).

In this study, a patient is a person who is sick or undergoing medical management for a sickness. Care is a process related to assistive, supportive, or enabling behavior to a person with complaints or needs to ameliorate or improve a human condition. Patient care is assistance to a person who is unwell and in need of a support.

1.7.3 Documentation

Documentation is the material that provide official information or evidence or that serves as a record (Murray, 2012).

In this study, documentation refers to any written information (including all intervention and care) about patient by registered nurses.

1.7.4 Nurse

The nurse is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country (ICN, 1987).

1.7.5 Registered nurse

According to Rwandan National Council of Nurses and Midwives (RNCNM), registered nurse is health care professional holding authentic diploma, have up-to-date clinical skills, maintain professional conduct and renew his/her license every three years.

In this study, registered nurse is a health-care professional who works autonomously and in collaboration with others to help patients to reach their best levels of safety.

1.8. STRUCTURE ORGANIZATION OF THE STUDY

The study was subdivided into six main chapters namely: Introduction, Literature review, Methodology, Results, Discussion, Conclusion and recommendation

Conclusion

In this chapter the background, problem statement, and aim of the study, significance of the study and research questions were explained and this resulted in the interest for conducting this research. Documentation is of critical importance in nurses' daily activities. Poor knowledge of nurses in documentation methods could bring problems for patients and nurses.

CHAPTER2. LITERATURE REVIEW

2.1. INTRODUCTION

This chapter is detailed with the review of the available literature related to the research under study. It addresses the conceptual framework understanding of research literature on documentation of patients care by registered nurses. The literature was gathered through various journals, articles and books and the search engines such as Google scholar, Pub med, Hinari were used

Documentation is sometimes referred to as reporting, charting or recording; it can be described as any electronic or written information or data about patient interactions or care events that meet both legal and professional principles. Documentation is one of the main communication tools that both regulated and unregulated healthcare providers use to exchange client information. (CLPNNS, 2013).

2.2. THEORETICAL LITERATURE

Documentation which reflects the nursing process shows that a registered nurse has satisfied her/his responsibility of patient care. It also shows the single involvement of nursing to the care of patient. Nurses should chart information collected through all aspects of the nursing process. As a common rule, any information that is clinically important should be charted. Failure to document evaluation is a common deficiency in charting. It is imperative to show the efficacy of care (CRNNS, 2012, pp. 8).

2.2.1. What should RN document?

Nursing documentation is supposed to be a systematic evidence of the nursing procedure. Documentation serve as a proof of the critical inquiry and judgment used to describe events, interventions and discussion with patient. To conclude what is important to document, for each event of procedure, the health record is supposed to include: a comprehensible statement of patient condition; significant assessment information; all continuing monitoring and communications; the care provided (every interventions, as well as advocacy, counseling, consultation and teaching); an evaluation of outcomes, including the patient's response and plans for follow-up; discharge planning (NANB, 2015, p.11).

Plan of Care: Effective patient-focused documentation is supposed also to contain a plan of care. It is a written chart of care for individual patients. The plan of care should be comprehensible to everybody reading the chart. A valuable plans of care have to be up-to-date and helpful to assemble the needs and desires of individual patient.(CRNNS, 2012, p. 9).

Medication: name, dosage, routes, sites date, time of medications administration, nurses signature and title.

Admission, Transfer, Transport and Discharge Information: Accurate and concise chart on admission, transfer, transport and discharge provides baseline data for successive care and follow up.

Patient Education, Incident Reports, Communications among Health Care Providers, Discharge Information are also supposed to be recorded (CRNNS, 2012, p. 9).

2.2.2. Vital signs

Abnormalities of vital signs are connected with poor outcomes in hospitalized patients. Close monitoring of such signs increases the chance of timely revealing of patient deterioration, and while followed by quick intervention has the control to decrease mortality, morbidity, hospital length and cost,(Hands et al., 2013pp 719). According to Mok et al (2015), vital signs monitoring is a crucial component of nursing care. Its frequently provide the first sign of abnormal physiological body changes. Blood pressure, heart rate, respiration rate, temperature, oxygen saturation and pain are essential in reflecting a patient's current medical status, and should be assessed always and correctly recorded. These vital signs should be the mainly consistent data in

a patient's chart. However, it is not sufficient for the nurse to monitor vital signs, (Kimberly . Johnson, Lindsey & Mueller, 2016, p. 3). There needs to be follow-up by the nurse after the observation of abnormal findings to avoid patient harm related to a worsening status (Kyriacos & Jelsma 2011). Most hospitals rely on observation charts or documents which vital signs are documented, to aware nurses of imminent deterioration (Mok, et al, 2015, p. 91). Vital signs have been shown to be reliable predictors of the necessity for life-saving interventions in trauma patients. Abnormal vital signs, like hypotension, brady- and tachycardia, and brady- and tachy-respiratory rates, have been associated with higher mortality rates and in-hospital cardiac arrest (Smith 2016, Hernández et al. 2015). Also Collins et al (2013, p. 306) confirm that nursing documentation patterns have been linked to patients' mortality so that findings were consistent with the assumption that some features of nursing documentation within electronic health records can be used to predict mortality.

2.2.3. Nursing process

The documentation of the nursing process is an important but often neglected part of clinical documentation. It is a structured, systematic approach used by nurses to meet the individualized health care needs of their patients. (Yildirim & Özkahraman, 2011, pp 261). It is the most important tool for putting nursing knowledge into practice, an organized problem solving method for determining the health care needs of patients

Nursing process promotes critical thinking, creativity, problem solving, and decision making skills in clinical practice. Providing care via the use of nursing process increases the quality of care and in turn, increases the level of satisfaction in individuals who receive care. This process consists of five phases: assessment, diagnosis, planning, intervention and evaluation (Yilmaz et al. 2015, p. 266).

2.2.4. Pain assessment

Pain assessment is vital to best pain management interventions. While pain is a greatly subjective condition, its management requires objective standards of care. Pain assessment should be documented so that all members of care team will have a clear understanding of the pain.

Assessment must identify the cause, effectiveness of treatment and impact on quality of life for the patient and their family (Republic of Rwanda, Ministry of Health 2012, p. 3).

2.2.5. Standard abbreviation in nursing documentation

Main objective of documentation in nursing is communication among health interdisciplinary team.(Ioanna et al, 2007, CRNNS ,2012b,Ebrahimpour & Pelarak, 2016).According to CRNNS (2012). Clinicians commonly report using abbreviations in the health record to save time and space while documenting the care they offer to patients. However, increasing verification suggests that this practice increases the probability for error because the abbreviations are not commonly understood. Abbreviations and symbols that are not approved and defined can guide to errors, cause misunderstanding, and waste time. The use of abbreviations, symbols or acronyms can improve efficacy in clinical documentation if they are well understood by each one in health care team, (ARNNL,2010,p.6). The documentation must be written in a way that can be simply understood by all readers (Jefferies, Johnson & Nicholls, 2011, p. 11). In Gahini District Hospital policy (Clinical documentation, GH-CL-089) is listed abbreviation and all staff members are requested to only use approved abbreviation.

2.2.6. Types of nursing documentation

2.2.6.1. Narrative documentation

Narrative documentation is the traditional form of documentation. It is a source-oriented record where in each health care provider make documentation on the patient's chart in separate section. (Hope, 2012; Lockwood, 2014).

2.2.6 2. Focus documentation

Focus documentation involves data, action and response group. It is a type of holistic perspective of patient's needs (Hope, 2012, Lockwood, 2014).

2.2.6.3. Problem-oriented documentation

It is used in order to give focus on the problems that patients face. With the problems listed, each health care provider can participate and team up on the plan of patient care.

The problem-oriented documentation includes:

2.2.6.3.1 SOAP/SOAPIER

SOAP/SOAPIER guidelines are a problem-oriented approach to documentation whereby the nurse clarify and lists patient needs. S: subjective information, O: objective information , A: assessment, P: plan, I: intervention, E: evaluation, R:revision .So, it includes feelings of patient as subjective, relevant of physical exam like objective, patient status, what nurse do to patient, evaluation of patient intervention and change needed to nursing care plan. (CRNBC, 2013, p. 14, Hope, 2012, Lockwood, 2014).

2.2.7. Purpose of nursing documentation

Nursing documentation serves numerous purposes: it is used for: (i) ensuring continuity and quality of care through communication; (ii) furnishing legal evidence of the process and outcomes of care; (iii) supporting the evaluation of the quality, efficiency and efficacy of patient care; (iv) providing evidence for research, financial and ethical quality-assurance purposes; (v) providing the database infrastructure supporting development of nursing knowledge; (vi) assisting in development of nursing education and principles of clinical practice; (vii) ensuring the appropriate reimbursement; (viii) providing the information for preparation future health-care; and (ix) providing the database for other purposes like risk management, learning experience for students and protection of patients' rights. (Cheevakasemsook et al, 2006, p. 367, Lockwood, 2015, p. 1, Ioanna et al, 2007, pp.1-2).

2.2.8. Role of the nurses in documentation of patients care

According to the Professional Development Committee of the Nursing Council of Hong Kong (2010), nurse's responsibilities in documentation of patient care include:

The nurse understands his/her role in documentation of care he/she individually provides to the patients.

The nurse documents all care including interdisciplinary intervention and communication about patient care.

The nurse documents all relevant information about patients in chronological order with date and time.

The nurse carries out comprehensive, in-depth and frequent documentation when patients are critically ill.

The nurse documents the patients care in a timely manner.

The nurse corrects any documentation error in a timely and direct mode.

The nurse remarks any late entry, if indicated, with both date and time of the late entry and of the actual event.

The nurse indicates his/her responsibility by adding his/her signature and title as approved by the hospital policy to each entry and correction he/she makes on the clinical documentation.

The nurse keeps the privacy, security and confidentiality of patient documentation.

The nurse updates himself/herself with present-day documentation knowledge.

2.2.9. Factors that promote documentation of patient care

Factors that promote documentation of patient care are sufficient training of nurses on patient documentation, availability of logistics facilitating documentation, regular monitoring and supervision of nurses in daily activities diminish omission in documentation (Teviu et al., 2012, p. 136) and also the system focuses on teaching nurses to document their patient's condition and care is important to improve documentation of nurses.(Jefferies et al., 2012,p. 395).

2.2.10. Barrier to nursing documentation

In different hospitals nurses face a number of challenges as far as charting is concerned and this continue to cause a lot of criticism from professional community and the regulatory organization because of incomplete and substandard charting practices . (Chelagat et al 2013,pp. 239-240).

2.2.10.1 Shortage of staff.

Majority of the hospitals particularly in the developing countries are experiencing a serious shortage of nursing staff. Fixed with a lot of duties to carry out, they are therefore left with very short time for to charting.

b) Insufficient knowledge about the significance of charting. Many nurses do not identify the importance or have limited knowledge about recording and then do not give much interest to it.

2.2.10.2 Lack of materials for charting

Nurses working in some of the hospitals occasionally experience lack of materials for charting like some forms, pens.

2.2.10.3 Many types of records necessities.

Various health care facilities require far too much paper work to document. So the nurses spend more time in documentation than in caring for the patients.

Blair and Smith,(2012, p. 164),confirmed that nurses meet main barriers to documentation like time constraints, mismatches between staffing resources and workload, not have clear guidelines for charting, hesitation towards documentation, and the bureaucratic systems and institutional policies often linked with keeping accurate documentation(Machudo& Mohidin 2015, Blair & Smith 2012).

2.2.11 Legal aspects of nursing documentation

Legal or regulatory events may happen sometime after a procedure. Timely written records are considered more believable than verbal accounts after the event (more influenced by memory). Nursing documentation is acceptable in legal proceedings and may take place without the person

being present or giving further clarification. Therefore it is essential that documentation is able to be clearly interpreted and understood over extended periods of time and as standalone information lacking further clarification or details from the person who wrote it.(NBSA, 2006.p.17) Nurses' notes are accepted as documentary proof. (CRNBC, 2013.p,11).

2.3 EMPIRICAL LITERATURE

Documentation of patient care is a fundamental, yet critical, skills used by nurses to communicate the current health status of the patient's individual needs and responses to care (Kelley et al. 2011,p.154).

In a study carried in at three public hospitals in Jamaica on an audit of nursing documentation (Hospital 1, n = 119, 48.6%; Hospital 2, n = 56, 22.9%; Hospital 3, n = 70, 28.6%) using cross-sectional method, have shown the weakness in nursing documentation and the need for increased training and continued monitoring of nursing documentation .Documentation evidence of the patient's chief complaint (81.6%), history of present illness (78.8%), past health (79.2%), and family health (11.0%) were noted; however, less than a third of the documents audited recorded adequate assessment data (e.g., occupation or living accommodations of patients). The audit noted 90% of records had a physical assessment completed within 24 hr of admission and entries timed, dated, and signed by a nurse. Less than 5% of documents had evidence of patient teaching, and 13.5% had documented evidence of discharge planning conducted within 72 hr of admission. This study highlights weakness in nursing documentation and the need for increased training and continued monitoring of nursing documentation at the hospitals studied.(Lindo et al., 2016, p. 508).

A study conducted in Bangkok , Thailand on nursing documentation complexities using both qualitative and quantitative methodologies on fifteen professional nurses and (35) patient documentation has shown that complexities of the existing nursing documentation include six themes: three themes for documentation itself and three for other related factors. Three documentation problems consisted of: (i) disruption of documentation; (ii) incompleteness in charting; and (iii) inappropriate charting. Three related factors included: (i) limited nurses' competence, motivation and confidence; (ii) ineffective nursing procedures; and (iii) inadequate nursing auditing, supervision and staff development.(Cheevakasemsook et al.2006. p, 369).

In USA, Midwestern academic medical center ED, a study done on all documentation of adult patients in ED using retrospective chart review, 62.1% of documentation had an abnormal vital sign documented. Critically abnormal values were present in 14.9%. No documentation was present in 44.6% of abnormal cases. The visiting frequency within the ED when the abnormalities were observed and the level of abnormality had major interaction to the existence of documentation. (Mueller &Winkelman, 2016, p. 3).

In Iran, nursing reports traditionally have been recorded and some studies have shown that nursing reports are unsatisfactory; in such a way that results of investigating cases based on observation sheet showed that generally 17.09% of reports are recorded properly, and 81.35% are documented partly, with 48% of the documents lacking several of the necessary information. One of the reasons of inaccurate documentation is insufficient knowledge of documentation of patients care by nurses. Iranian literature showed that the comprehensiveness and quality of nursing documentation were unsatisfactory in such a way that findings of investigating cases based on observation sheet showed that generally 17.09% of reports were well documented and 81.35% were documented incompletely, with 48% of the reports lacking some of the basic information.(Ebrahimpour & Pelarak 2016, pp.1764–1765).

Studies have indicated that medical documentation systems in low-income countries are lacking. In Ethiopia, only 14% of returning patients could find their medical documents and only 6.5% of medical documents contained complete patient information. In Ghana, 30% of patients have multiple folders (Teviu et al. 2012, p.136).

A retrospective audit of medical records of 211 adult patients following major surgery in five Australian hospitals, August 2003 – July 2005 have showed that documentation of medical and nursing review and patient vital signs was commonly incomplete. During the first 3 postoperative days, only 17% of medical records had complete documentation of vital signs and medical and nursing review. During the first 7 postoperative days, nursing review was undocumented for 5.6% of available shifts and medical review for 14.9% of available days. Respiratory rate was the most commonly undocumented observation (15.4% undocumented).(Mcgain et al. 2008,p.381).

Table 3.1 List of studies conducted on nursing documentation

Author	Research design	Sampling strategy	Data collection	Data analysis	Findings
Madineh Jasemi , Vahid Zamanzadeh , Azad Rahmani , Alireza Mohajjel , Fahime Alsa- Dathoseini, (2012).	a cross-sectional study	census sampling method	The data were collected from 170 nurses who selected to participate in the study using checklists and Kuder Richardson 21	Data were analyzed by SPSS software using One- way ANOVA and independent t t test	Nursing records and vital sign flow sheets had average quality and insufficient information Most participants (85.9%) had limited knowledge regarding nursing documentation process
Forbes Mcgain, Michelle A Cretikos, Daryl Jones, Susan	Retrospective audit August 2003 – July 2005	The three patients who had most recently undergone each of	Data was collected on 211 adult patients following major surgery in five	Data were analysed using Stata, version 10.0 SE (StataCorp, College Station,	Respiratory rate was the most commonly undocumented observation (15.4% undocumented

Van Dyk, Michael Bellomo N (2008).		the 14 surgical procedures in each hospital hospitals	Australian	Tex, USA).	
Mueller & Winkelman (2016).	An observational, retrospective chart review	all charts of adult patients (> 17 years old) assigned to a room or hallway bed in the ED	A paper data collection tool, developed by the principal investigator and reviewed by the second author, was used	Data analyses were analyzed using SPSS Statistics software, version 21	62.1% of documentation had an abnormal vital sign documented. Critically abnormal values were present in 14.9%. No documentation was present in 44.6% of abnormal cases.
Teviu, Aikins. Abdulai (2012).	Intervention study	census sampling method	records review, direct observation and tracking of folders	The Microsoft Excel 2007 software was used to compile and to analyse all data	Results revealed direct and indirect factors contributing to issuance of multiple patient folders and misfiling
Aree Cheevak asemsook, Ysanne	Both qualitative and quantitative Methods were used	The selection of 35 patient	Depth interviewing; participant observation;	The qualitative data were analysed	Complexities in nursing documentation: disruption,

<p>Chapman, Karen Francis. (2006).</p>		<p>charts with the criteria of having a 3-day admission in hospital without transferring from or referring to other settings or hospitals.</p>	<p>nominal group processing; focus group meetings; time and motion study of nursing activities; and auditing of completeness of nursing documentation.</p>	<p>by simple 'coding' from The quantitative data were analysed through simple manual calculation</p>	<p>Incompleteness and inappropriate charting.</p>
<p>Lindo, Jascinth, Rosain Stennet (2016)</p>	<p>Cross-sectional study audited a multilevel stratified sample of 245 patient records from three type B hospitals</p>	<p>A multilevel sampling strategy was employed. Three hospitals were purposely selected</p>	<p>The records were reviewed using an audit instrument from the Nursing Policy Manual, Ministry of Health Jamaica</p>	<p>Data were analyzed using the IBM SPSS Statistics version 19</p>	<p>(Hospital 1, $n = 119$, 48.6%; Hospital 2, $n = 56$, 22.9%; Hospital 3, $n = 70$, 28.6%) were audited. Documented evidence of the patient's chief complaint (81.6%), history of present illness (78.8%), past health</p>

					(79.2%), and family health (11.0%) were noted
Hector ,(2010).	A retrospective descriptive research design with a quantitative approach was applied	a stratified random sampling process	Data were collected utilizing the audit instrument	STATSITI CA Version 8.1 software was used	The nursing documentation in intensive unit was inadequate with the following mean total scores: Assessment 62.6%, nursing diagnosis 53.1%, Nursing care plans 37.1%, Implementation 72.6% Evaluation 40.5 %.
Machudo and Mohidin, (2015).	A prospective cross sectional method used to evaluate nursing 'Focus Chart' documents.	Two nurses' document ation per unit per day for two weeks was assessed	Brainstorm, workshop	The hospital's measurement tool	Research confirmed that nursing documentation should be timely, meticulous, appropriate, and accurate to meet the obligations

From the above table, it shows that many studies conducted in different countries utilizing quantitative and qualitative methods. The literature clearly reveals that nursing documentation is not carried out adequately both in developing and developed countries.

2.5 CONCEPTUAL FRAMEWORK

In this study the researcher used nursing documentation guidelines as conceptual framework. Nursing guidelines was used by Chelagat et al(2013) in their study Historical Perspectives , Purposes , Benefits and Challenges as faced by nurses.

2.5.1 Application of the conceptual framework in this research:

According to this conceptual framework on clinical documentation by Chelagat et al. (2013), the nursing documentation should be objective, specific, accurate, complete, confidentiality and patient centered. All the relevant information should be recorded and communicated to the other members of the healthcare team.

In this research, the concepts mentioned in the conceptual framework were applied and utilized to collect the relevant data.

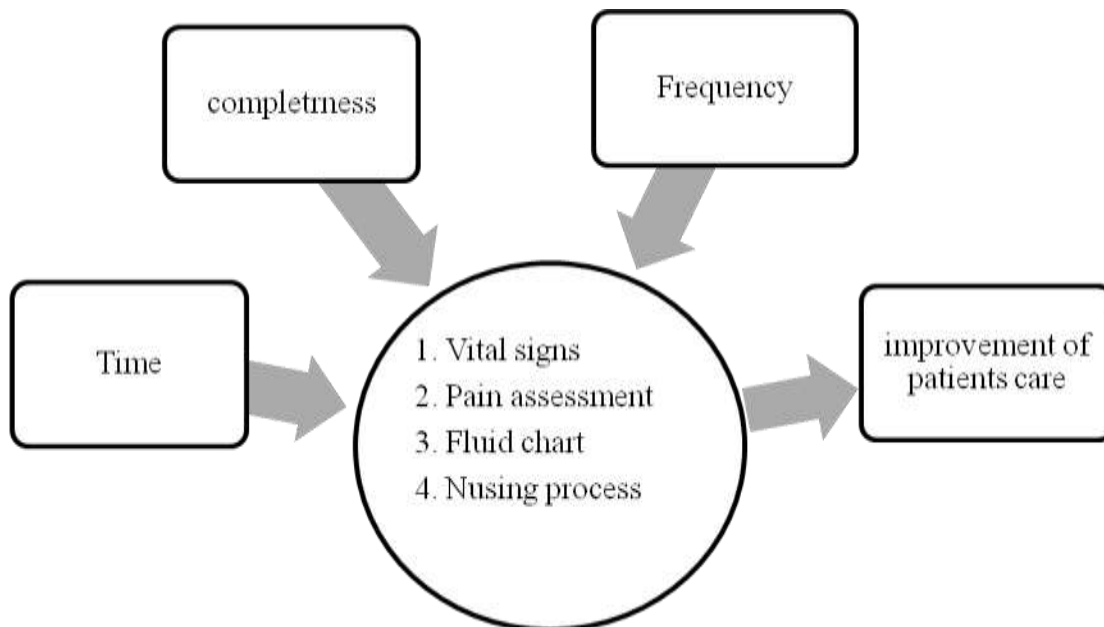


Figure 1.2 Conceptual framework adapted from Chelagat et al. (2013).

Conclusion

In summary, the effective nursing documentation in the health system is of vital importance for the quality of care which is provided to the patient. It is evident in the literature that nursing documentation at the different part of the world is not sufficient and this make patient care to be ineffective. It is in nurses' responsibility to document all patients care timely and in comprehensive manner. The conceptual framework on clinical documentation also was explained in this study.

CHAPTER 3: METHODOLOGY

3.1. INTRODUCTION

This chapter presents, explain and justify the methodology used in order to fulfill the objectives of the study. In this chapter the researcher describes the research methodology that was followed in this research study. There is a study design, research approach, study setting, population, sampling method, data collection tool, and data analysis, ethical consideration, Data management, dissemination and limitations

3.2 RWANDA PROFILE



Figure 2.1 Map of Rwanda from: <http://www.rwandapedia.rw/page/rwanda-country-profile>

Rwanda is a small mountainous and land locked country of 26,338 square kilometers and lying just south of the equator with an average elevation of 1,700 meters. Approximately 35 percent of the land is fit for cultivation. Population census conducted in 2012 by National Institute of Statistics of Rwanda estimated the population to be around 10.5 million. (Rwanda Ministry of Health 2015,p. 2).

3.2.1 Overview of health care system in Rwanda

After the 1994 genocide in Rwanda, the number of nurses remaining in practice in Rwanda was seriously low. From that time the leaders of Rwanda have worked diligently to raise both the number of nurses in Rwanda and their level of education. They have also set goals for the number of healthcare workers that should be in each facility according to the population in the catchment area(Munyiginya & Mill 2016, Gitembagara, Relf & Pyburn, 2015, p. 26). Although Rwanda has made huge strides in improving both the numbers of nurses and midwives in practice and their level of education, much work still remains to be done. Levels of staffing in both health centers and district hospitals are below recommended government guidelines, especially in health centers, and the percentage of registered nurses and midwives remains low at only 27.02% in health centers and 43% in district hospitals.(Gitembagara, Relf, & Pyburn 2015,p.30).

Health care delivery is organized around a decentralized referral system with a pyramid structure. At the top are the referral hospitals, which provide tertiary care. The district hospitals (one for each of the country's 30 districts) deal with secondary care, There are currently 406 health centers which provide primary health care. The community health insurance scheme, or the Mutuelle de Santé, is used to respond to low utilization of health services by improving financial access to health services, particularly for underserved populations. (Rodriguez & Samuels 2011, p. 8).

3.3. Research setting

This study was conducted at Gahini District Hospital which is located in Eastern Province, Kayonza District, Gahini sector, Urugarama Village, 89 km from Kigali. It was been built in 1925 by the Missionary Anglicans. Since 1927 it became an integrated hospital and it is managed by the Ministry of Health. It has the capacity of 158 beds for a catchment area of 196,424 peoples.

Gahini DH has different services: Clinical and para-clinical such as service of Emergency, Anesthesia and Reanimation, Surgery, Gynecology and Obstetrics, Internal medicine, Pediatric, Ophthalmology, Dentistry, Physiotherapy and Orthopedic, Laboratory, Radiology and Pharmacy. This area has been chosen because GH is one of district hospital and is supposed to offer quality care.

3.4. Study design

A cross-sectional descriptive design was used in this study. A cross-sectional design consists of collection of data from participants at once time. (Polit & Beck, 2010, pp. 238-239) The purpose of descriptive studies is to observe, describe, and document aspects of a situation. The descriptive-cross-sectional design was chosen as appropriate since the purpose of the study is to identify, justify and make judgment on the status of practice in question that meets the design purpose.

3.4.1 Research approach

A quantitative research which is the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design, (Polit & Beck 2010, p. 581) was used in this study to audit the documentation of patient care by registered nurses in hospitalized patients.

3.5. Study population

A study population is known as the whole set of individuals or objects having some general characteristics (Polit & Beck 2010, p. 563). In this study the population was all files of patients who were hospitalized in ED and all files of patients who were hospitalized in Pediatric ward, Internal medicine, Maternity ward and surgical ward. The data were collected about files of the first 24 hours after admission during the month of February, 2017.

3.5.1. Inclusion criteria

All files of patients who were hospitalized in Emergency Department, Maternity unit, Internal medicine, surgical ward and pediatric ward within 24hours of hospitalization.

All files of patients who were hospitalized in pediatric ward, maternity ward, surgical ward and internal medicine within 24 hours

3.5.2. Exclusion criteria

Files of patient who had exceed 24 hours of hospitalization and files of out-patients were excluded to create a homogenous sample in terms of the required frequency of documentation.

3.6. Sampling method

Sampling is the process of selecting a portion of the population to represent the entire population. A sample is a subset of population elements (Polit & Beck 2010, p.310) In this study, a total population purposive sampling approach which involves examining the entire population was used

3.6.1 Study sample

A sample size is a small group of cases selected from the population and used to represent the same larger group (Polit & Beck 2010, p.310). Approximately daily admission in ED is 20 patients, pediatric ward five patients, Maternity ward 20 patients, surgical ward five patients, and internal medicine six patients. The sample size was composed of 130 files of patients who were hospitalized within 24hours. Emergency Department (30 files), Pediatric ward (30files), Maternity ward (30files), Surgical ward (20 files) and Internal medicine (20 files).Among files audited medical conditions were (n=103) , surgical condition were (n=27).

3.6.2 Sampling strategy

In this study a no-probability sampling method was used where a purposive sampling technique that involves the examining of the entire population was used

3.7. Data collection and management

3.7.1. Data collection tools

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives and questions of the study(Hector 2010, p.10). The checklist was used to audit the documentation of patient care by registered nurses in hospitalized patient in Gahini District Hospital. The tool was showing the distribution of the number of files in different wards, number of registered nurses working in each ward, distribution of the age of the audited files, admitting diagnosis and was measuring completeness and frequency of vital signs, fluid balance and nursing process in patients' files.

3.7.2. Validity and reliability

“According to (Highway & Parsian, 2009,p.3) validity is defined as the ability of an instrument to measure the attributes of the construct under study. Face validity refers to the language and presentation of the tool in relation to participants' context. The face validity and content validity were tested by expert and the instrument was valid because it has been used in other research.

Reliability is defined as the measure of true scores and includes an examination of stability or equivalence, referring to “the instrument's ability to measure an attribute consistently” (Highway and Parsian, 2009 p.4). The instrument was also reliable because it has been used at Public Hospitals in Jamaica. The name of tool was “Documentation Audit Instrument” The permission was obtained from the author “Rosain Stennett, MPH, BSc2” Instrument was in English and it was adapted to this study.

3.7.3. Pilot study

After receiving the ethical approval and permission to access the hospital, a pilot study was conducted in five wards: Pediatric ward, Internal Medicine, Surgical ward, Maternity unit and Emergency Department. All the obtained data in the pilot study were excluded from the main study data. The necessary modification of the tool including modification of questions and removal of unnecessary items were done to reach the finalized form.

3.7.4. Data collection procedure

Official letters was prepared and delivered to the director of nursing services administration and in charge of ED, Pediatric ward, internal medicine, surgical ward and Maternity at Gahini DH to obtain the approval to collect data for this study. For each of selected files, all requisite data were located then copied onto the relevant spaces on the data collection tool. Data were collected in two weeks utilizing every Monday, Tuesday and Wednesday in each week.

3.8. Data analysis and result presentation

Microsoft excels and SPSS version 20 was used to analyze data. Results were presented in tables and graphs in form of frequencies and percentage.

3.9. Ethical consideration

Nursing research must not only have the potential to generate and refine knowledge, but must be ethical in its development and implementation(Polit and Beck 2010, p.118). That is why before conducting a study, a written permission offered by CMHS caring out the research was sought. I presented the proposal to Gahini DH and the permission from them was sought to collect data. Checklist was used to audit documentation of patient care by registered nurses and patients file was coded to ensure confidentiality.

3.10. Data management

The collected data from checklist were stored safely in the research computer and locked with a password. Only the researcher had an access to the data

3.11. Data dissemination

Data from this study will be disseminated in the form of seminar and in-service education to the relevant stakeholders.

3.12. Limitation to the study

Financial support for conducting this study, small sample size, the shortage time for collecting data, busy schedule of nurses to help me and non-availability of patient files.

This study has been conducted in one district hospital hence the results cannot be generalized to the others hospitals.

The number of files audited may not depict complete situation of documentation in the Gahini district hospitals because some patients' files were not included in this study like neonatology files and out-patients files, and the study was done on files of first 24 hours of admission.

Conclusion

In this chapter, the researcher explained and discussed the research methodology related to the study that was implemented. The study was conducted at Gahini District hospital on auditing of the documentation of patients care by registered nurses in hospitalized patients using cross sectional design. A sample of (130) patients file from five wards (Emergency Department, Maternity unit, Internal medicine, Surgical ward and Pediatric ward) were audited. The data analysis and interpretation of findings are discussed in chapter 4.

Chapter 4: DATA ANALYSIS

4.1 INTRODUCTION

In this chapter the data analysis and the findings of the collected data from the research is presented. All the data from completed checklists were transferred to the computer by the statistician working together with the researcher. The data are presented, analyzed and interpreted in this chapter

4.2 DATA ANALYSIS AND INTERPRETATION

4.2.1 Section A: Demographic data

1. Distribution of the number of files in different wards.

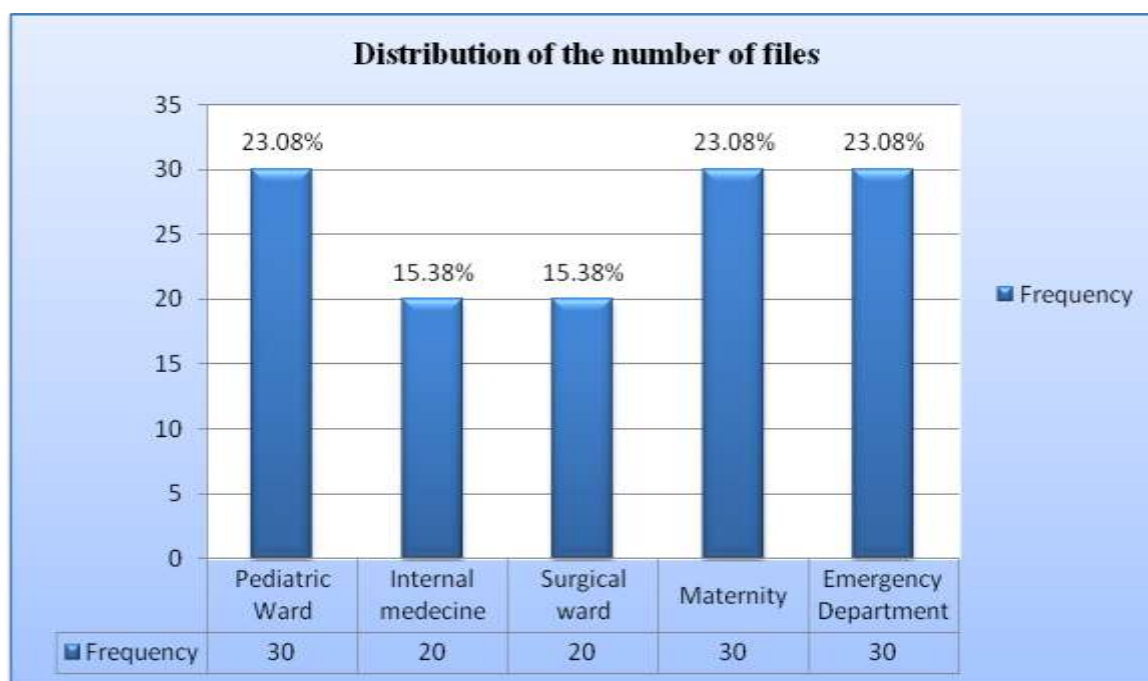


Figure 4.2.1.1: Distribution of the number of files in different wards (n=130)

The figure 4.2.1.1 shows the number of patients files audited in each ward 23.08% (n=30) were from Pediatric Ward, 23.08% (n=30) were for Maternity, 23.08% (n=30) were for Emergency department. 15.38% (n=20) were from Internal Medicine and 15.38% (n=20) were for surgical ward.

2. Number of registered nurses working in each ward

Table 4.2.1.2: Number of registered nurses working in each ward

Wards	Number of registered nurses
Emergency department	9
Maternity unit	11
Internal Medicine	8
Surgical ward	7
Pediatric ward	5

Number of registered nurses working in the ward			
Nurses	Minimum	Maximum	Mean
	5	11	8.08

The table 4.2.1.2 shows number of registered nurses working in each wards nine nurses work in Emergency Department,(11) nurses work in Maternity unit, eight nurses work in internal medicine, seven nurses work in surgical ward. And five nurses work in pediatric ward

On average, there are eight nurses work in every ward. The number of registered nurses in every ward is between five and 11.

3. Distribution of the age of the audited file

Distribution of the age of the audited file				
Ward detail		Age category		Total
		Child	Adult	
	Pediatric Ward	30	0	30
	Internal medicine	0	20	20
	Surgical ward	10	10	20
	Maternity	0	30	30
	Emergency Department	12	18	30
Total		52	78	130
Percent (%)		40%	60%	100%

Table 4.2.1.3: Distribution of the age of the audited file (n=130)

The table 4.2.1.3 shows distribution of age of the audited files. 60% (n=78) were for Adult, yet others 40% (n=52) were for Children.

4.2.2: Section B

1. Completeness of patients' vital signs within the first 24hrs

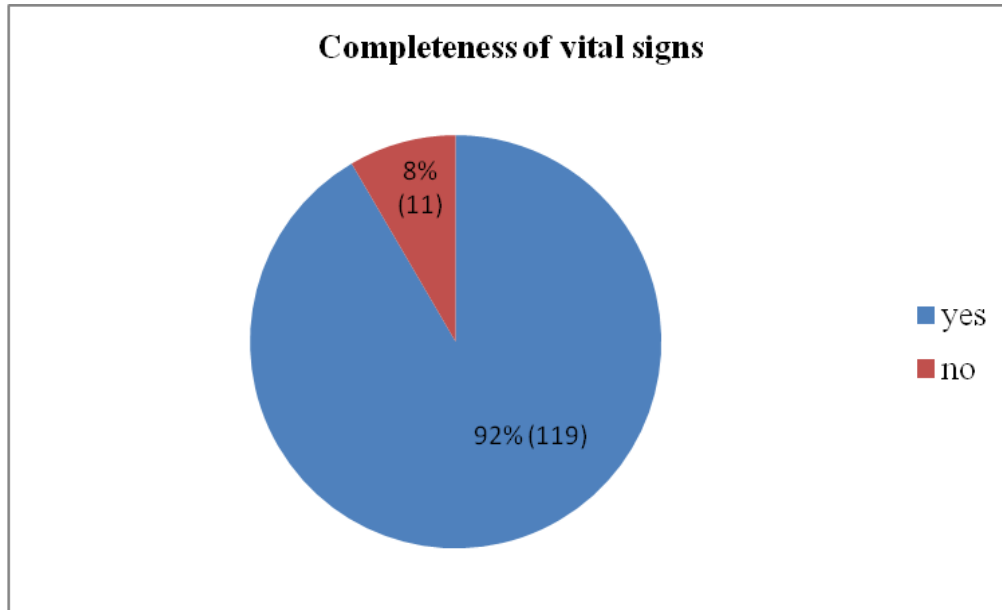


Figure 2.2.1: Completeness of vital signs (n=130)

The figure 4.2.2.1 shows documentation of vital signs in patients files within 24 hours. 92% (n=119) had the vital signs completed within 24hours, 8% (n=11) had no vital signs completed in 24hours

2. Frequencies of vital signs in patients' files within 24hours

4.2.2.2: Frequency of documentation of temperature

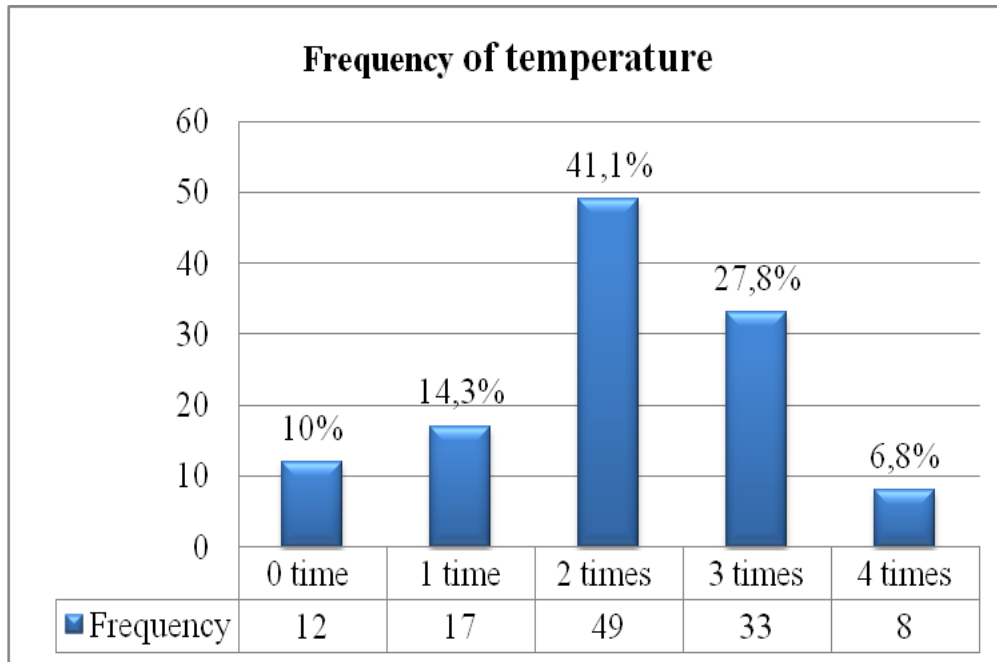


Figure 4.2.2.2: Frequency of documentation of temperature (n=119)

The chart 4.2.2.2 shows frequency of temperature documentation in hospitalized patients files within 24hours .6.8% (n=8) had temperature documented four times, 27.8% (n=33) had vital signs documented three times, 41,1% (n=49) had temperature documented two times,14,3% (n=17) had temperature documented one time and 10% (n=12) had no temperature documentation within 24hours,

4.2.2.3: Frequency of documentation of Pulse rate

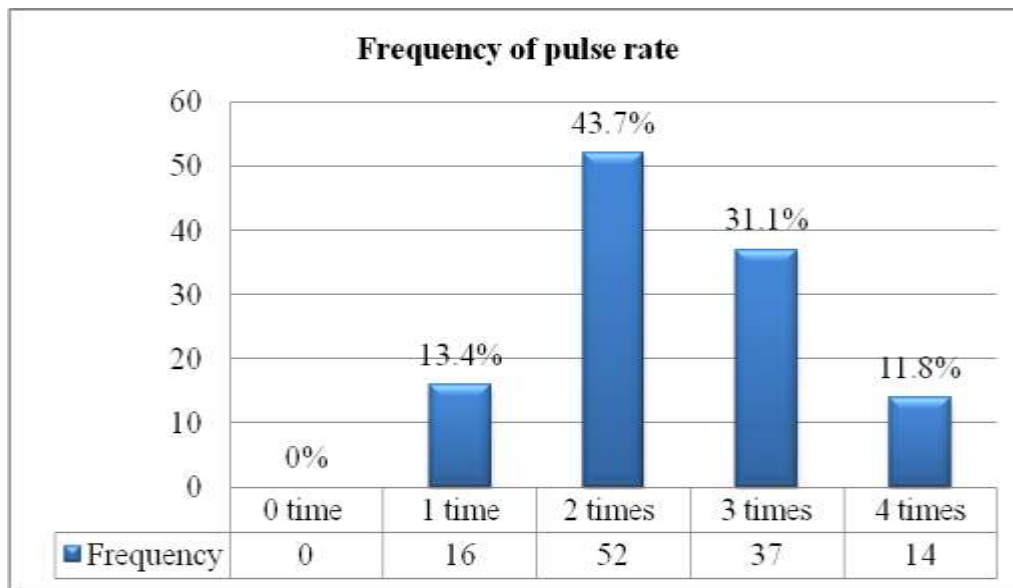


Figure 4.2.2.3: Frequency of documentation of Pulse rate (n=119)

The figure 4.2.2.3 shows frequency of pulse rate documentation in hospitalized patients' files within 24 hours. 11.8% (n=14) had pulse rate documented four times, 31.1% (n=37) had pulse rate documented three times, 43.7% (n=52) had pulse rate documented two times within 24 hours, A number of 13.4% (n=16) files have pulse rate documented 1 time.

4.2.2.4: Frequency of documentation of Respiration rate

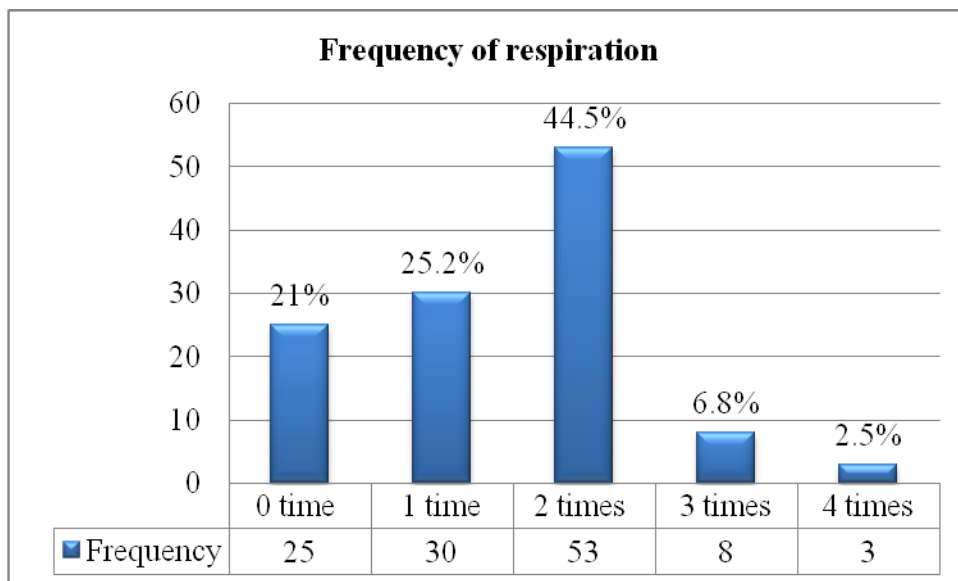


Figure 4.2.2.4: Frequency of documentation of Respiration rate (n=119)

The figure 4.2.2.4 shows frequency of respiration documentation in hospitalized patients' files within 24hours. 2.5% (n=3) had respiration rate documented four times, 6.8% (n=8) had respiration rate documented three times, 44.5% (n=53) had respiration rate documented two times, 25.2% (n=30) had respiration rate documented one time and 21% (n=25) had no respiration rate documented within 24hours.

4.2.2.5: Frequency of documentation of Blood Pressure

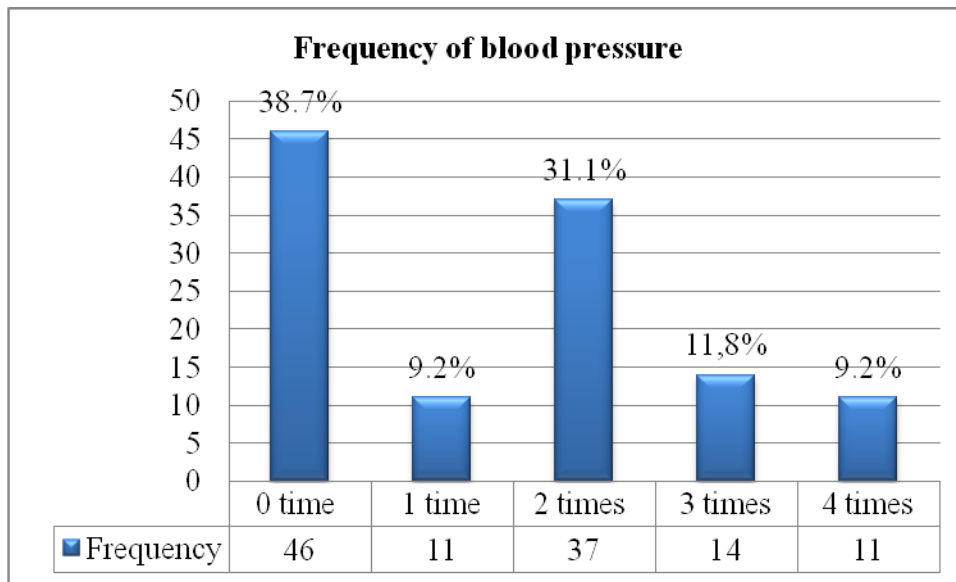


Figure 4.2.2.5: Frequency of documentation of Blood Pressure (n=119)

The figure 4.2.2.5 shows frequency of blood pressure documentation in hospitalized patients' files within 24hours. 9.2% (n=11) had blood pressure documented four times, 11.8% (n=14) had blood pressure documented three times, 31.1% (n=37) had blood pressure documented two times, 9.2% (n=11) had blood pressure documented two times and 38.7% (n=46) had no blood pressure documentation within 24hours.

4.2.2.6: Frequency of documentation of oxygen saturation

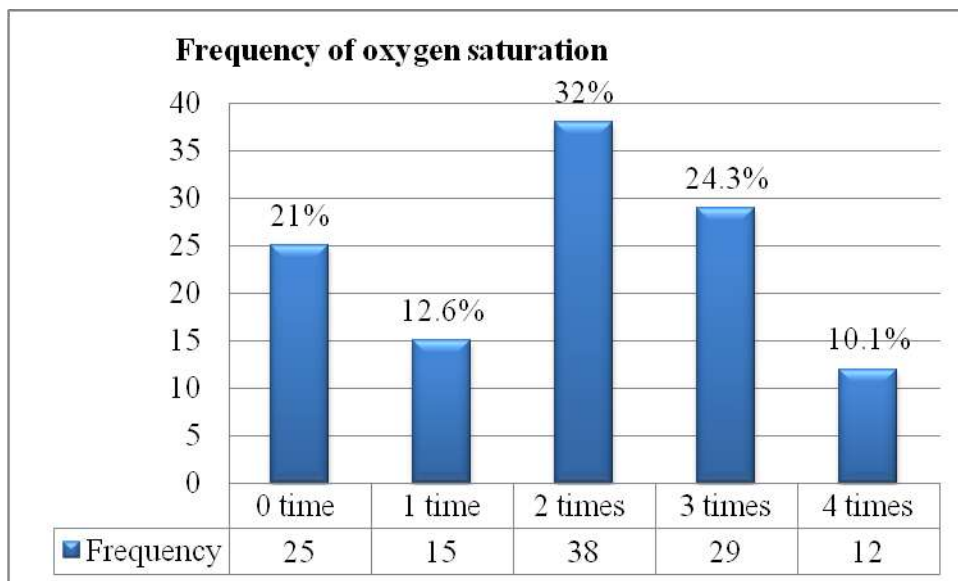


Figure 4.2.2.6: Frequency of documentation of Oxygen Saturation (n=119)

The figure 4.2.2.6 above shows frequency of oxygen saturation documentation in hospitalized patients' files within 24hours. 10.1% (n=12) had oxygen saturation documented four times, 24.3% (n=29) had oxygen saturation documented three times, 32% (n=38) had oxygen saturation documented two times, 12.6% (n=15) had oxygen saturation documented one time, and 21% (n=25) have no oxygen saturation documentation within 24 hours.

4.2.2.7: Documentation of Fluid balance

Fluid balance			
Ward detail		Fluid balance	Total
		0	
	Pediatric Ward	30	30
	Internal medicine	20	20
	Surgical ward	20	20
	Maternity	30	30
	Emergency Department	30	30
Total		130	130
Percent (%)		100%	100%

Table 4.2.2.7: Documentation of Fluid balance (n=130)

The table 4.2.2.8 shows fluid chart documentation in hospitalized patients' files. All 100% (n=130) had no fluid chart documentation within 24hours.

3. Completeness of nursing process in patient file, written within the first 24hours

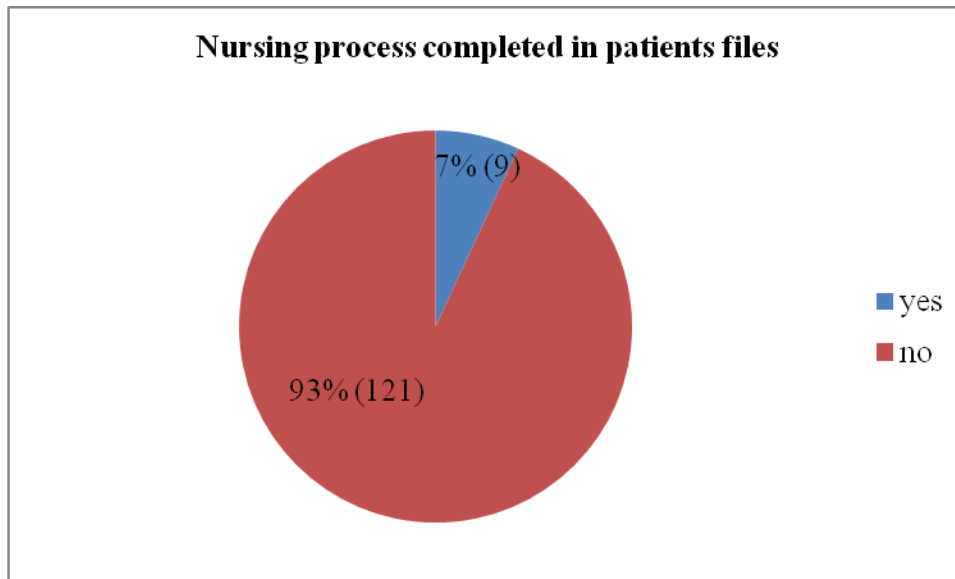


Figure 4.2.2.8: Nursing process completed in patients files (n=130)

The figure 4.2.2.9 shows nursing process documentation in the patients' files within 24hours. 93% (n=121) had no nursing process documentation within 24 hours and 6.9% (n=9) had no nursing process documented within 24hours.

Conclusion

In this chapter the researcher focused on the analysis and interpretation of data gathered using the measurement instrument. The information about nursing documentation of vital signs and nursing process was obtained. Visibly nursing documentation is poor, however, inadequate documentation of patient care gives rise to lack of continuity of care and lack of communication among health workers therefore impede patient quality care. In the following chapter discussion of findings is detailed.

Chapter 5: DISCUSSION OF FINDINGS

This chapter will discuss the key issues identified from the data collected and results presentation.

4.2.1. SECTION A: Demographic data

Distribution of the number of files in different wards (n=130)

The figure 4.2.1.1 showed that a larger number of patients files audited 23.08 % (n=30) were from Emergency department, 23.08% (n=30) from pediatric ward and 23.08% (n=30) from maternity unit. Other files 15.38% (n=20) were from Internal medicine and 15.38% (n=20) from surgical ward. Emergency department, Maternity ward and pediatric ward receive more patients per day rather than surgical ward and internal medicine ward.

Number of registered nurses working in every ward

The table 4.2.1.2 showed the number of registered nurse working in interested wards. Nurses were widely distributed between medical ward with maternity unit having larger number (11) nurses and pediatric ward having lowest number; five nurses. On average, there were eight nurses working in every ward. The number of registered nurses in every ward was between five and (11). At emergency department two nurses work at night and week-end duty, one in ED and one on ambulance. Bed capacity is seven beds for admission and one for minor surgery. In Pediatric ward, only one nurse works on night duty and week-end; bed capacity is 16 beds. Maternity unit, bed capacity is 32beds and three delivery beds. Internal medicine, bed capacity is 46 beds. Surgical ward; bed capacity is 60beds.

A shortage nursing staff was showed in Rwandan Ministry of Health in Human Resources for Health strategic plan 2011-2016, (Ministry of Health, 2016, p. 13) where an average of about one nurse for a population of 1,500 was reported. In Rwanda, as in many other countries, a 1:1 nurse-patient ratio is generally considered adequate to meet the needs of critically ill patients. This includes unstable patients requiring several simultaneous nursing activities and complex therapies to support multiple organ failure. A 1:2 or greater nurse-patient ratio is used for stable patients.(Munyiginya,Brysiewicz & Mill 2016,p.56). This is one of barriers to nursing documentation

Nurses are the “backbone” of any healthcare system and their workload is multifaceted and very complex. However, there is a nursing shortage as can be seen all over the world and Nursing fatigue has been associated with medication errors, documentation errors and medical decision errors as supported by many researches (International Council of Nurses 2015, p.6, Shammika et al. 2015, p.75, Emergency Nurses Association 2014, p.5) Mismatches between staffing resources and work load is a barrier to nursing documentation.(Blair, Wendy 2012,p.164)

Distribution of age of the audited files (n=130)

The table 4.2.1.3 showed age category of patients in medical wards. Majority of patients are adults N=78(60%) and N=52(40%) are children. Adult patients are admitted in internal medicine, Maternity, surgical ward and critical case in Emergency department. Children are admitted in pediatric ward, surgical ward with physical trauma and burns, or with orthopedics case and there are critical ill children in Emergency department.

4.2.2 Section B: completeness of vital signs and frequencies

1. Completeness of patients’ vital signs within the first 24hrs (n=130)

The figure 4.2.2.1 showed the completeness of vital signs in patients’ files. A larger number 92% (n=119) had vital signs completed in 24 hours and the remaining 8% (n=8) have no vital signs completed within 24 hours. Vital signs were completed sufficiently

Medical care and prescriptions, and nursing care are based on the results of vital sign measurements, therefore it was expected that 100% would have completed vital signs. Measuring the vital signs accurately provide insight to the patient's physiological status. Inaccurate data leads to inappropriate treatments. (Moore & Sanko 2010, p.5)

2. Frequencies of vital signs documentation within 24 hours (n=130)

As it has explained in literature review, the frequency of documentation is based on the hospital policies, the perception and complication of the patient’s health condition. Gahini District Hospital policy recommends documentation of vital signs by registered nurses every six hours. Some of audited patients’ files had critical admitting diagnosis like: stroke, severe pneumonia, cerebral malaria, head injury, asthma, hemorrhagic shock, post partum hemorrhage but for those patients nursing documentation was not as per expectation. It is evident that those patients

needed close monitoring of vital signs, nursing process and fluid balance monitoring to evaluate their conditions and to receive appropriate quality care.

However nurses do not correctly document vital signs in patients' files as recommended, this is in accordance with a study which have indicated that vital signs are not consistently measured, documented or reported (Mcgain et al. 2008, p.383,) and that the failure to undertake timely monitoring of vital signs has a significant impact on the effectiveness of the rapid response. (Mok et al. 2015, p.208). Ward nurses are often overwhelmed with heavy workload affecting the quality of vital signs assessment.(Mok et al. 2015).

4.2.2.2 Frequency of documentation of temperature (n=119)

The figure 4.2.2.2 shows the frequency of temperature documentation in patients' files within 24 hours. The lowest file number 6.8% (n=8) had temperature documented four times as recommended by GDH policy and the larger number 41.1% (n=49) had temperature documented two times instead of four times, 27.8% (n=33) had temperature documented three times instead of four times, 14.3% (n=17) had temperature documented only one time and 10% (n=12) had no temperature documentation within 24hours. One of purpose of nursing documentation is providing the information for preparation future health care (Ioanna et al, 2007, pp.1-2) According to results , temperature was not documented correctly this is in contrast with research conducted by Tysinger (2014,p.69) blood pressure measurements were collected only 25.1 percent of the time while the highest collection rate was 88.4 percent for temperature recordings

4.2.2.3 Frequency of documentation of pulse rate (n=119)

The figure 4.2.2.3 shows the frequency documentation of pulse rate in patients' files at GDH. Only 11.8% (n=14) had pulse rate documented four times as recommended, the majority 43.7% (n=52) had pulse rate documented two times instead four times, , other files 31.1% (n=37) had pulse rate documented three times and 13.4% (n=16) had pulse rate documented one time. This is similar to Tysinger (2014,p.72) findings who identified the omissions in pulse rate on 14.4% of patients at emergency department

4.2.7 Frequency of documentation of respiration rate (n=119)

The figure 4.2.2.4 shows frequency of respiration documentation in hospitalized patients' files within 24hours. Respiratory rate is a vital component of clinical assessment and monitoring (Philip et al. 2015,p.2). The low number of patients files audited 2.5% (n=3) have respiration rate documented four times as recommended and 21% (n=25) have no respiration rate documentation within 24hours, 6.8% (n=8) have respiration rate documented 3 times instead of four times, a larger number 44.5% (n=53) have respiration rate documented 2 times and 25.2% (n=30) have respiration rate documented only one time in 24 hours.

Respiration rate is not documented timely as recommended at GDH. This is similar with a studies showed that the level of documentation of vital signs in many hospitals is extremely poor, and respiratory rate, in particular, is often not documented (Cretikos et al. 2011, Elliott 2016)

4.2.2.5 Frequency of documentation of blood Pressure (n=119)

The figure 4.2.8 shows the frequency documentation of blood pressure in patient's files at GDH within 24hours. The majority 38.7% (n=46) had no blood pressure documented within 24hours, only 9.2% (n=11) had blood pressure documented four times as recommended,11.8% (n=14) had blood pressure documented three times and 31.1% (n=37) had blood pressure documented two times instead of four times as recommended. At GDH, there were no materials of blood pressure measurement for pediatric patients. Shortage of material is one of barriers for the documentation of patients care by nurses. A similar situation was identified in Kenya by Chelagat et al. (2013, p.240), nurses working in some of the hospitals occasionally experience shortages of materials for documentation

4.2.2.6 Frequency of documentation of oxygen saturation (n=119)

The figure 4.2.2.6 shows the frequency of oxygen saturation documentation in hospitalized patients' files within 24hours. Only 10.1% (n=12) had oxygen saturation documented four times as recommended, 21% (n=25) had no oxygen saturation documentation within 24 hours, the majority 32% (n=38) had oxygen saturation documented two times instead of four times the remaining 12.6% (n=15) files had oxygen saturation documented one time. In maternity unit also there were no materials for oxygen saturation measurement, so it was a barrier for documentation of oxygen saturation by nurses.

4.2.2.7 Fluid balance (n=130)

The table 4.2.2.8 showed that all audited 100% (n=130) had no fluid chart documentation within 24 hours. Although fluid chart was recommended at Gahini District Hospital, it was not documented by registered nurses. According to the files audited (n=99) were required to monitor the fluid intake. However, it is important to monitor fluid chart in hospitalized patients. A study by Shepherd (2011,p.16) support that the nurse caring for a particular patient is responsible for ensuring that fluid balance charts are documented regularly and with accuracy, using the correct notation throughout to avoid complications such as dehydration and over hydration, both of which can have serious clinical consequences. In this regards, Asfour (2016,p.61) in a study of Fluid Balance Monitoring Accuracy in Intensive Care Units reported the causes of inaccuracy of fluid balance monitoring by nurses like time management, workload, lack of skills/ training and lack of knowledge.

Pain assessment

Pain assessment was not recommended at Gahini District Hospital. Files of patients with surgical conditions were (27). As a district hospital practicing minor surgeries, caesarian section and receiving patients with painful conditions, pain assessment would be very essential. This is in contrast with Republic of Rwanda , Ministry of Health recommendation (2012, p. 3) which states that pain assessment is crucial to optimal pain management interventions. While pain is a highly subjective experience, its management necessitates objective standards of care. Pain assessment should be documented so that all members of care team will have a clear understanding of the pain.

Completeness of nursing process in patient file, written within the first 24hrs

The figure 4.2.2.8 showed completeness of nursing process in patients' files within 24 hours. The majority 93% (n=121) had no nursing process documented in 24 hours, only 7% (n=9) had nursing process completed within 24hour.

Nursing process encourages the nurses to assess, plan and carry out expected nursing care in a scientific way. This process consists of five phases: assessment, diagnosis, planning, intervention and evaluation (Yilmaz et al. 2015,p.266)

At Gahini District Hospital, there was no regular in-service education conducted for nursing documentation. Evidence of a study by Björvell and Wredling, (2000, p.6-7) supported that the purpose of the nursing process is to have easily accessible in the clinical settings that describe the patient's needs and wishes and the nursing interventions that have been planned for the patient. It is used to establish the continuity of care among caregivers. Nursing process documentation at Gahini district hospital was inadequate. This is similar with findings of the study done at the academic hospital in the Western Cape which also showed that the nursing documentation was inadequate (Hector, 2010). Nurses lack knowledge in understanding and applying the concepts of the nursing process(Mamseri 2012) Conceptual framework highlights that confidentiality, patient-centered, frequency, accuracy, consistency,completeness should be applied in nursing documentation. (Chelagat et al, 2013,p.238). Poor nursing documentation can place patients, staff and organizations at considerable risk of physical and legal harm. (Taiye 2015, p.2).

Conclusion

This chapter was focusing on the discussion of data collected using the measurement tool. The data collected, verifies the conclusions reached. The link between the analysis and the findings is logical, justified, accurate and clear.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The preceding chapter contains discussions of the research findings. This chapter presents the summaries of the primary findings of the research study presented in chapter 5. The findings are concluded to determine if the objectives and research questions of the study were achieved. In this chapter, conclusions and recommendations are offered.

5.2 CONCLUSION

Effective communication among healthcare professionals is vital to the delivery of safe patient care (Braaf et al. 2011, p.1024). Nursing documentation is crucial in communication among health worker team and the continuity of the patients care. The main objective of this study was to audit the documentation of patients care by registered nurses in hospitalized patient at Gahini District Hospital. The sample was (130) files. The descriptive-cross sectional design was used to audit patients' documentation whether vital signs and nursing care plan are documented as per the hospital policy and to audit the nurse's routine documentation for consistency, timely and completeness as per hospital policy. For vital signs documented four times as recommended by Gahini District Hospital; temperature 6. 8%, pulse rate 11.8%, respiration rate 2.5%, blood pressure 9.2%, and oxygen saturation 10.1%, fluid balance 0%. Then for nursing process; only 7% had nursing process documented within 24hour and 93% had no nursing process documented within 24hours.

The results of this study showed that documentation of patient care by registered nurse at GDH among hospitalized patients was lacking.

5.2 RECOMMENDATION

Basing on findings of this study carried out at Gahini district Hospital on auditing the documentation of patients care by registered nurses in hospitalized patients, the following recommendations are offered to improve documentation of patients care by registered nurses. Recommendations are divided into 3 parts: practice, research and education.

Nursing practice

Nursing documentation should be a communication tool among the professionals of the health care system, through the exchange of information that concerns the patient. Nurses should be supervised and supported in their daily work to discover weakness and barrier to nursing documentation.

The nurses have to have the knowledge, skill and attitude about nursing documentation to make it part of their professional practice as a nurse.

Regular in-service education, seminars should be conducted for nursing documentation

Nursing research

The information that is contained in a patient file should form a valuable source of elements for research. The nursing process and vital signs should bring up useful information on the improvement of care for many patients.

This research was conducted at one district hospital; more research should be conducted to other district hospitals and referral hospitals in order to improve patients care.

Nursing education

With adequate education, the influence of some of the key factors contributing to the inadequate nursing documentation might be eliminated.

Students in various schools of the health science are future nurses. They should often use patients' files as educational tools.

Nursing students should be highlighted the importance documentation during their training and practicum.

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<http://www.rwandapedia.rw/page/rwanda-country-profile>

ANNEXES

CHECKLIST FOR AUDITING OF THE DOCUMENTATION OF PATIENT CARE BY REGISTERED NURSES IN HOSPITALIZED PATIENT AT GAHINI DISTRICT HOSPITAL WITHIN 24 HOURS

I. Distribution of the number of files in different wards.

The answer will be marked by X next to the correct answer.

	WARDS	ANSWER
Ward detail	1.Pediatric Ward	
	2.Internal Medicine	
	3.Surgical Ward	
	4.Maternity	
	5.Emergency Department	

II. Number of registered nurses working in each ward

Write the number of registered nurses working in this ward

Number ()

III. Patient file code (e.g : 01)

File ()

IV. Distribution of the age of the audited files

Adult?

Child?

V. Admitting diagnosis

VI. Completeness of patients' vital signs. Within the first 24hrs

Are vital signs completed in patient file? Yes (). No ().

Check vital signs elements noted in the file

	1x	2x	3x	4times as recommended	Recommended At Gahini DH	Not recommended
1. Temperature						
2. Pulse rate						
3. Respiration rate						
4. Oxygen saturation						
5. Blood pressure						
6. Pain assessment						
7. Fluid balance						

VII. Completeness of nursing process in patient file, written within the first 24hrs

Check nursing process elements noted in the file

Is nursing process completed in patient file? Yes () No ()

MINISTRY OF HEALTH



EASTERN PROVINCE
KAYONZA DISTRICT
GAHINI HOSPITAL
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TITLE: VITAL SIGNS

Policy code/ Number: CL-059	Effective Date: December 2014	Revision date: December 2017
Department: Clinical Department	Applies to: All patients, Nurses	
Responsible Person: Clinical Director	Approvals: Titles Clinical Director Hospital Director	

Purpose

1. To monitor physical status of patients at Gahini District Hospital.
2. Early detection & treatment of the deteriorating patient via the Gahini District Hospital.
3. To discuss the meaning of routine vital signs.

Gahini District Hospital
Vital signs Policy and procedures
Originated date: December 2014
Last revision: December 2017

Policy Statement

Vital sign assessment is essential in the determination of a patient's health status and a core function of the Nurse/Midwife at Gahini District Hospital. The accurate assessment of vital signs is an important and crucial part of nursing care. Careful measurement techniques and knowledge of the normal range in vital signs for a particular patient will ensure that patients at GDH are suitably monitored to enable clinicians to carefully monitor therapy and prevent adverse events.

Responsibilities

Monitoring of vital signs is an essential component of caring for all patients at GDH in order to assess treatment effects, detect procedural complications and identify early signs of clinical deterioration. At all times staff should use their clinical judgment regarding the frequency of observations.

- The Nurse/Midwife caring for the patient is responsible for vital signs measurement and recording.
- All hospitalized patients should have vital signs (respiratory rate, pulse, blood pressure, temperature and oxygen saturation) recorded on admission and then four times/24 hours.
- Unstable patients may need continual observation and frequent monitoring of vital signs until they are reviewed and stabilized.
- All observations must be charted at the time they are measured
- Staff should wait 30 minutes following any activity before attending vital sign measurement.
- Vital sign monitoring should be undertaken at the commencement of a nursing shift as part of a nursing assessment for each patient.
- Vital sign frequency should then be established for the rest of the shift based on the initial assessment.

OBSERVATION/VITAL SIGNS SHEET

Frequency	Blood Pressure																		
	Pulse																		
	Respiratory Rate																		
	Temperature																		
Temperature	42																		
	41																		
	40																		
	39																		
	38																		
	37																		
	36																		
	35																		
	34																		
	33																		
	32																		
	31																		
	30																		
Blood Pressure/Pulse	220																		
	210																		
	200																		
	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
	80																		
	70																		
	60																		
	50																		
	40																		
30																			
20																			
Pneumonia Risk	60																		
	50																		
	40																		
	30																		
	20																		
	10																		
	0																		
	O ₂ Saturation																		
	WEIGHT																		
	Fluid Input Total																		
	Fluid Output Total																		
	Fluid Balance																		
	Nurse Initials																		

Measurements in Gray areas should be repeated and if you get the same measurement take action and report to the Doctor immediately

Kigali, 09/01/2017
Ref: CMHS/IRB/012/2017

TUYISENGE Francine
School of Nursing and Midwifery , CMHS, UR

Dear TUYISENGE Francine

RE: ETHICAL CLEARANCE

Reference is made to your application for ethical clearance for the study entitled "*Auditing Of The Documentation Of Patient Care By Registered Nurses In Hospitalized Patients At Gahini District Hospital*"

Having reviewed your protocol and found it satisfying the ethical requirements, your study is hereby granted ethical clearance. The ethical clearance is valid for one year starting from the date it is issued and shall be renewed on request. You will be required to submit the progress report and any major changes made in the proposal during the implementation stage. In addition, at the end, the IRB shall need to be given the final report of your study.

We wish you success in this important study.

Far Professor Kato J. NJUNWA
Chairperson Institutional Review Board,
College of Medicine and Health Sciences, UR


Vice - Chair



- Cc:
- Principal College of Medicine and Health Sciences, UR
 - University Director of Research and Postgraduate studies, UR

SCHOOL OF NURSING AND MIDWIFERY

Kigali, on 30 / 01 /2017

Ref. No: *F.S.* / UR-CMHS/SoNM/17

TO WHOM IT MAY CONCERN

Dear Sir/Madam.

Re: Request to collect data

Referring to the above subject, I am requesting for permission for **TUYISENGE Francine**, a final year student in the Masters of Science in nursing at the University of Rwanda/College of Medicine and Health Science to collect data for his/her research dissertation entitled: **AUDITING OF THE DOCUMENTATION OF PATIENT CARE BY REGISTERED NURSES IN HOSPITALIZED PATIENTS AT GAHINI DISTRICT HOSPITAL.**

This exercise that is going to take a period of 2 months starting from 13th February 2017 to 12th April 2017 will be done at **GAHINI DISTRICT HOSPITAL.**

We are looking forward for your usual cooperation.

Sincerely,

for Dr. Donatilla MUKAMANA, RN, PhD
Dean, School of Nursing and Midwifery
College of Medicine and Health Sciences



REPUBLIC OF RWANDA



EASTERN PROVINCE
KAYONZA DISTRICT
GAHINI HOSPITAL
P.O BOX 75 RWAMAGANA
Email:gahinih@yahoo.fr

GAHINI on 6th February, 2017

RE: Authorization for Research data collection

Dear, Francine

Reference is made to the letter dated 30th Jan 2017 with the afore said subject this serves to let you know that you are allowed to conduct data collection in Gahini Hospital ,in relation with your research on the topic **AUDITING OF THE DOCUMENTATION OF PATIENT CARE BY REGISTERED NURSES IN HOSPITALIZED PATIENTS AT GAHINI DISTRICT HOSPITAL.**

You will be given green rights to access all needed data through Hospital departments of your interest and this authorization will remain valid for 12 months.

Furthermore, we would request you to share with the Hospital management results of your research and recommendations to build on for further progress.

We wish you a successful research.

Dr. MUSABYIMANA Joseph

Ag. Hospital Director



