ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF EMERGENCY MEDICINE.

ASSESMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE OF NURSES TOWARDS DOCUMENTATION AMONG NURSES WORKING IN EMERGENCY DEPARTMENTS OF SELECTED GOVERNMENTAL HOSPITALS IN ADDIS ABABA, ETHIOPIA, JUNE: 2019.

BY: BIRHANU TESFAYE (BSC, MSC CANDIDATE)

A RESEARCH THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCE, DEPARTMENT OF EMERGENCY MEDICINE AND CRITICAL CARE FOR PARTIAL FULFILMENT DEGREE OF MASTERS OF SCIENCE IN EMERGENCY MEDICINE AND CRITICAL CARE NURSING.

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Approval by the board of examiner

This thesis by Birhanu Tesfaye is accepted in its present form by board of examiners as satisfying thesis requirement for the degree of Master of Science in Emergency medicine and critical care nursing.

Examiner

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Statement of declaration

By my signature below, I hold and affirm that this thesis is my own original work in partial fulfillment of the requirements for the degree of master in emergency medicine and critical care nursing. I have abided by all ethical principles of scholarship in the prep, data aggregation, information analysis and completion of this thesis. All the sources of the materials used for this thesis and all people and institutions who gave support for this work are fully acknowledged. I confirm that I have mentioned and referenced all sources used in this text file.

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signature date

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Abbreviations and Acronyms

AAU - Addis Ababa University

AaBETH – Addis Ababa Burn, Emergency And Trauma Hospital

BSC: Bachelor Of Science

CI - Confidence Interval

ED - Emergency Department

ENA - Ethiopian Nursing Association

HMIS: Health Management Information System

KAP - Knowledge Attitude And Practice

MSC - Master of Science

SPSS - Statistical Software Package For Social Science

TASH- Tikur Anbesa Specialized Hospital

US - United State

WHO - World Health Organization

Abstract

Introduction: *Nursing documentation is a required aspect of care which provides written confirmation of discussions and actions that have been done as well as missed for specific reasons. However it draws criticism from professionals, community and different regulatory organization due to incomplete, substandard documentation. However, little has been explored about nursing documentation practice in health care facilities of Addis Ababa, Ethiopia. Therefore; this study was conducted to assess documentation knowledge, attitude, and practice among nurses working in selected public hospitals of Addis Ababa, Ethiopia.*

Objectives*: the objective of this study was to assess knowledge, attitude and practice of nurses towards documentation among nurses working in emergency departments at Black lion specialized Hospital, Zewditu memorial Hospital and AaBET Hospital, Addis Ababa, Ethiopia, 2019.*

Methods and material: *Cross-sectional design; structured self-administered questionnaires were used to assess knowledge, attitude and practice of nurses. The collected data was analyzed using SPSS version 21. Frequency table, graphs and pie chart was used to describe the result.*

Result: *A total of 243 nurses completed the survey 65% of participants were female with the mean age of 29.5 (SD± 0.86). The score of respondents' knowledge and practice towards nursing documentation was added up and dichotomized into two based on the mean knowledge score which was 3.3(D± 0.47), and 7.45 (SD ± 2.07) respectively. Attitude was assessed using likert scale and the mean score was 30(SD±0.45). Accordingly the knowledge, attitude and practice of the respondents 33.3%, 27.6%, 50.21% were poor respectively.*

Conclusion*: The study indicated that knowledge and attitude of nurses towards documentation fall in good and favorable range of mean score respectively. But the practice was poor among nurses working in emergency departments of selected governmental hospitals.*

Recommendation*: Based on the finding of this study, employing institutions need to create awareness and provide training to enhance knowledge, attitude and practice of the nurses regarding documentation. Researchers also need to carry out large scale studies in order to address the problem.*

Key words: *Nursing documentation, Practice, Nurse, Emergency department*

1. Introduction

1.2 Background

Nursing documentation is defined as any written or electronically generated information that describes the care or service provided to a patient by qualified nurses and it has been one of the most important functions of nurses since the time of Florence Nightingale because it serves multiple and diverse purposes (1).

The intention of nursing documentation is to demonstrate that an organization maintains comprehensive written evidence of its planning, delivery, assessment and evaluation of patient's care (2). It is recorded information regarding patients' problems and interventions that conducted for obviating the problems. These documents are considered as a suitable written communication device.

Despite of their basic role in improving and continuance of nursing and medical interventions provided for patients, it is also important tool for transferring patients' information to other health team members, enhance professional autonomy, critical thinking skills of nurses, development of professional knowledge and nursing education. But the most important role of it is the legal aspect, because the best witness to show health interventions provided for patients is a suitable and correct document.

The statistics from developed countries showed that in 74% of cases had errors of health care providers reported to judicial authorities. (3) Documentation is vital to safe, Ethical, and effective Nursing practice in clinical areas. Nursing practice requires documentation to ensure continuity of care, planning, and accountability, as well as in the promotion and uptake of evidence based practice. It is one of the most important practices in nursing. It sounds that nothing can reflect the total amount of nursing care giving to the patients as documentation does (4).

A nursing document, whether written or electronic, should be client focused, consists of relevant information, accurate without missing details, chronologically written, clear and concise, permanent, confidential and timely (5).

Nursing documentation in the Emergency department (ED) was the focus area of this study. An aim of emergency care is to ensure that the episode is as brief as possible. It is therefore, transient in nature with the plan to always move the patient on, whether to an inpatient

destination, to outpatients, transferred to another inpatient facility including discharge home for follow-up by the care giver(6).

In Ethiopia, nursing documentation practice is mostly limited to hand written in most of health settings even though an electronic method called HMIS has been rolled out across different hospitals (7)

The research done in Gondar, shows that Most (62.4%) of the nursing care provided remains undocumented (8).

The intent of this study is to assess the nurses' knowledge attitude and practice towards nursing documentation among nurses working in emergency departments of selected governmental hospitals in Addis Ababa, Ethiopia.

1.3 Statement of Problem

The transient nature of emergency nursing care requires that a rapport between the nurse and their support person or people is rapidly established. This is to enable a thorough assessment, diagnosis, plan and treatment, with an evaluation of outcomes and any relevant discharge planning and education. These need to be fully documented prior to the patient's discharge, transfer or admission which should be done as soon as possible after their arrival in the ED. (9)

It is unfortunate that nursing documentation continues to draw criticism from professionals, community and regulatory organization because of incomplete, substandard charting practice (10).

Nurses' actions are typically described as compassionate, committed and caring. But these attribute are often difficult to recognize in the nursing documentation. Most of nurses' actions are not documented and thus creates a great problem when it comes to evaluation of client care (11).

Poor documentation in nurses has been shown to have negative impacts on the health care of patients and may lead to harmful consequences like exposing the care provider for medication administration error (12). Quality of patient care can also be impeded by an absence of sufficient documentation of data (13). On the other hand, a good documentation improves credibility of the institution, and makes the nursing profession visible and the situation may lead to the extent that can affect the reputation of the health care facilities because health care facilities are evaluated by the quality of documents they keep in most cases(14)

Some studies from sub Saharan Africa have identified deficiencies in various aspects of nursing documentation. One study from South Africa reported deficiency in attitudes, knowledge and practice behaviors (15) while the Ugandan study reported knowledge and attitude deficiency towards the practice of nursing documentation among nurses (16).

In Ethiopia, inadequacy of data collection with lack of quality was found to be a problem (17). Despite the barely observable deficiencies, studies conducted on this issue of interest are very minimal.

Even if the care given at emergency department is a prompt lifesaving, nursing documentation should have to be complete and it minimizes hindrance of communication between care givers, medical teams and the continuity of patient care. Therefore, this research was aimed to assess the knowledge attitude and practice of nurses towards Nursing documentation in Emergency departments of selected governmental Hospitals in Addis Ababa, Ethiopia.

1.4 Significance of study

Poor nursing documentation practice can be a significant challenge for provision of quality health care. Nurses are expected to keep accurate, timely and complete records regarding patient care not only to assess client progress, but also to protect self because it may be used as evidence in legal proceedings such as lawsuits. The identification of gaps in nurses' practice of patient care documentation in public hospitals of Addis Ababa may be used to solve the problem. The finding would also be used as an additional input for further studies since this area needs to be much exploited. The recommendations given if considered are going to benefit the country at large on the proper and standard documentation of nurses working in any emergency unit of health institutions.

2. Literature Review

2.2 Concept of Nursing Documentation

The appropriate practices for improving nursing care documentation are employee participation, managerial accountability, nurses' adherence to documentation standards, improved leadership style, and continuous monitoring and control (18).

Nursing documentation is reported to take up to 50% of nurses' time per shift (19). It serves a number of important functions, including communication amongst healthcare workers for continuity of care. Poor communication, in a broader sense, is known to contribute significantly to the occurrence of adverse events in healthcare (20) and is therefore an important target of initiatives to improve patient safety. Additionally, nursing documentation is important for education, research, quality assurance and for reimbursement by third party claimants (21). It can serve as an indicator of quality nursing practice (22). Also Nursing documentation could be used to predict mortality (23). Nursing documentation meets seven criteria: (a) patient-centered, (b) contains the actual work of nursing, (c) reflects the nurses' clinical judgment, (d) is presented in a logical sequence, (e) is written in real time, (f) records variances in care and (g) fulfills legal requirements(24).

The quality of nursing documentation in many countries remains poor due to numerous reasons which different authors articulated (25). A Dutch study found inadequate documentation of important aspects of assessment and other related nursing care, including inaccuracy of documentation (26).

2.3 Knowledge of nurses about documentation

A Swedish study reported incongruence between what is documented and actual physical patient status (27). These inadequacies could be related to challenges in two areas: the nurses' individual characteristics and work environments (28).

According to the study done in Uganda the knowledge of participant nurses about the importance of nursing documentation was found to be positively affected by the motivation and support of nursing leadership (29).

The research done in Public hospital of Harari, East Ethiopia showed that the knowledge of nurses about nursing documentation was low (47.1) and these was associated with low access of short or long term training (30).

2.4 Attitude of nurses about documentation

Studies in various settings found that whilst nurses consider documentation important for nursing professionalization, They consider it as a burdensome secondary task that takes nurses away from direct patient care (31). As nurses consider increasing liability for their practice, their documentation may be negatively affected (32).

According to the research done in Tabariz university, Iran , the attitude scores revealed that most of the participant nurses (85.8%) had high attitude towards nursing documentation reflecting prominent status (33). The research done in public hospital of Harari, regarding nurse's attitude towards the nursing documentation reveals that (52.9%) were favorable attitude and the rest were unfavorable attitude(34).

2.5 Practice of nurses about documentation

The workplace environment can contribute to poor documentation. Heavy workloads, laborious documentation forms, fragmentary language (i.e. documentation language that is not understood beyond the local context), inadequate resources and hospital culture all impact the quality of nurses' documentation (35).

Given the significance of nursing documentation and the reality of poor documentation practices, it is not surprising that there have been resolute calls and subsequent efforts to improve its quality (36). Poor documentation has been shown to have negative impacts on the health care outcome, the health care providers' effectiveness and on the profession in general. The research done in Jimma University Medical center, shows that (51.4%) of Nursing documentation practice was poor among nurses (37).

Training nurses to improve knowledge, skills and documentation practices has been a widely used strategy, For example, writing coach programm used to improve documentation quality (38). Training has been augmented by using written practice standards (39). According to the research done in public hospital of Harari, east Ethiopia revealed that almost half of the participants (48.9%) practice complete nursing documentation (40).

3. Objectives of the study

3.2 General objective

Assessment of knowledge, attitude and practice of nurses towards documentation among nurses working in Emergency departments of selected governmental hospitals in Addis Ababa, Ethiopia, 2019.

3.3 Specific objectives

- To Assess knowledge of Nurses towards documentation among nurses working in emergency department of selected governmental hospitals in Addis Ababa,
- To Assess attitude of Nurses towards documentation among nurses working in emergency department of selected governmental hospitals in Addis Ababa,
- To Assess practice of Nurses towards documentation among nurses working in emergency department of selected governmental hospitals in Addis Ababa

4. Methods

4.2 Study area and period:

The study was conducted in selected governmental hospitals of Addis Ababa. Addis Ababa is the capital city of Ethiopia. It has an estimated population of 3,384,569 according to the 2007 census and 527 square kilometer of area (41).

There are 13 governmental hospitals among which Amanuel Specialized Psychiatric Hospital and Mahatma Ghandi Memorial Hospital provide specific service that is Psychiatric and Obstetrics and Gynecology cases respectively. The rest eleven hospitals provide general emergency service in their emergency department. Among these Tikur Anbessa Specialized Teaching Hospital, Zewditu memorial hospital and AaBET Hospitals are selected purposely for this study considering their high flow of patients, high number of nurses at emergency departments and the organized emergency service. The study was conducted from march 11/2019 to april 8/2019.

4.3 Study Design

An institution-based cross sectional quantitative study was used to assess nurses' knowledge attitude and practice towards documentation at emergency department of selected governmental hospitals of Addis Ababa. Data was collected by using a structured and pre-tested self-administered questionnaire.

4.4 Population

4.4.1 Source population:

The source populations for this study were all nurses who were working in emergency departments of governmental hospitals in Addis Ababa city.

4.4.2 Study population:

This study was confined to nurses working in emergency departments of Tikur Anbessa specialized Hospital, AaBET Hospital, and zewditu memorial Hospital.

4.5 Inclusion and Exclusion criteria

4.5.1 Inclusion criteria

Nurses who were working in emergency departments of selected governmental hospitals and those who have worked at least for six months were included in this study.

4.5.2 Exclusion criteria:

-Nurses who were not available during the data collection period were excluded from the study.

4.6 Sample size determination

All the nurses working in the emergency departments of the selected governmental hospitals who fulfill the inclusion criteria were included by non-probability survey sampling.

The number of emergency nurses in Tikur Anbesa specialized hospital, AaBET hospital, and Zewditu memorial hospital is 119, 80, and 47 respectively. The total number of nurses was 243.

4.7 Sampling Technique/Procedure

In this study three hospitals were selected purposely considering high patient flow, high number of nurses at emergency department and organized emergency service.

Study participants were all nurses working in emergency departments of selected governmental hospitals.

4.8 Variables of the study

4.8.1 Dependent variables

- knowledge of nurses towards documentation
- attitude of nurses towards documentation
- practice of nurses towards documentation

4.8.2 Independent variables

Nurses demographics:-

- Age
- Marital status
- Sex
- year of experience
- Educational level
- Type of nursing specialty

4.9 Operational Definition

- **Nursing documentation:** Is the record of nursing care that is planned and delivered to individual clients by qualified nurses
- **Emergency Department:** is a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment.
- **Good knowledge**: Those respondents who scored above or equal to the mean score of knowledge questions.
- **Poor knowledge**: Those respondents who scored below the mean score of the knowledge questions.
- **Favorable Attitude**: Those respondents who scored above or equal to the mean score of attitude questions.
- **Unfavorable Attitude**: Those respondents who scored below the mean score of the attitude questions.
- **Good practice:** Those respondents who scored above or equal to the mean score of practice questions.
- **Poor practice:** Those respondents who scored below the mean score of practice questions.

4.10 Data collection methods

4.10.1 Data collection tools

A structured self-administered questionnaire was developed in English language and it

Was developed based on the national guideline prepared by the Federal ministry of health (FMOH), Ethiopian Hospital Reform Implementation Guidelines(EHRIG)(44), previously studied literatures and standards of nursing documentation (42) and (43) . Data was collected by using pretested, structured self-administer questionnaire which comprises four sections: (1)socio-demographic information, (2)knowledge questions, (3)Attitude questions and (4)Practice questions of nurses working in emergency department about nursing documentation.

4.10.2 Data collection procedure

Data was collected by Data collectors those were four BSC holder nurses including one supervisor. Training was given for one day on clarification of some terms and assessment tools, aim of the study, concerning need for strict confidentiality of respondents information, time of data collection, timely collection and reorganization of the collected data and submission on due time. The questionnaire was filled by nurses working in emergency departments of three governmental hospitals. Data was collected for approximately one month including training and pretest. It was facilitated by data collection facilitators and supervisor.

4.11 Data quality management

Data quality was ensured during collection, coding, entry and analysis. Before actual data collection, pretest was done on 10% of similar population out of study area in Yekatit 12 hospital. During data collection, adequate training and follow up was provided to data collectors and supervisor.

Codes were given to the questionnaires during the data collection so that any identified errors were tracked back using the codes. The filled questionnaires were checked for completeness by data collectors, supervisor and Principal investigator on a daily basis. Collected Data was initially checked manually for completeness then coded and entered into Epi-Data version 4.4 and was cleaned thoroughly and then data was transferred to SPSS version 21 for further analysis.

4.12 Data processing and analysis

The collected data was checked for its completeness, consistency and accuracy before analysis. Data was coded, entered and cleaned using Epi-data 4.4 and exported to SPSS 21 for analysis. It was processed and analyzed by using descriptive statistics like percentage, and frequency.

Result was presented by text, table, and pie chart.

4.13 Ethical Consideration

Ethical clearance was obtained from Addis Ababa University, College of Health Science, Department of Emergency Medicine and Research Review Board Committee. Approvals were obtained from the participating hospitals and explanation was done to study participants about the aims, objectives, benefits and harms of the study and a written consent was obtained from each respondent. Confidentiality was ensured as well through anonyms of the questionnaire and safe storage of the filled questionnaire.

4.14 Dissemination of Result plan

The final report of this study will be presented at University of Addis Ababa College of Health Science school of Medicine Department of Emergency Medicine. A copy of the research report will be disseminated to Addis Ababa health bureau, the nursing library through AAU website and each hospital under the study. The findings of the study will be sent for publication on scientific journals so that it will be accessed by various researchers and leaders.

5. Result

5.2 Socio demographic characteristics of study participant

Out of the 246 estimated nurses to be enrolled in the study, 243 nurses gave complete response making response rate of 98.8%. From a total of 243 nurses who participated in this study, 158 (65%) were females. The mean age of them was 29.5 (SD± 0.86).

Of the total respondents, most of them 173 (71.2%) fall within the ranges of 25-34 years age group and Most of the respondents 206 (84.8%); were bachelor degree holders. College diploma and MSc holders were 25 (10.3%), and 12 (4.9%) respectively. More than half 129(53.1%) of the participants were single, 112(46.1%) married and 2(0.8%) divorced.

113 (46.5%) of the study participants worked as a nurse for 5 years or less, 91(37.4%) worked for 5-10 years and the rest 39(16%) of them stayed in the profession for more than ten years. Regarding Monthly income of the participants, 71(29.2%) were within the range of 5000-5999 ET birr and 19(7.8%) were with in the range of 2000-2999 Ethiopian Birr.

(see table 1 below)

Table 1:- Socio demographic characteristics of nurses working in Emergency departments of selected public hospitals of Addis Ababa, Ethiopia, 2019

Variables		Frequency(n=243)	Percent (%)
Sex	Male	85	35
	Female	158	65
Age group of respondents (in year)	≤ 24	22	9.1
	25-34	173	71.2
	35-44	42	17.3
	45-54	6	2.5
Level of education	College diploma	25	10.3
	Bachelor degree	206	84.8
	MSc and above	12	4.9
Marital status	Married	112	46.1
	Single	129	53.1
	Divorced	2	0.8
Respondents work experience (in year)	<5 year	113	46.5
	5-10 year	91	37.4
	>10 year	39	16
Monthly income (in Eth birr)	2000-2999	19	7.8
	3000-3999	21	8.6
	4000-4999	66	27.2
	5000-5999	71	29.2
	>5999	66	27.2

5.3 Knowledge of respondents towards nursing documentation

The score of respondents' knowledge towards nursing documentation practice was added up and dichotomized into two based on the mean knowledge score which was 3.3(D± 0.47). Based on the cut-off point, 66.7 % (n = 162) of the study participants had a good knowledge of nursing care documentation and 33.3 % (n=82) of respondents had poor knowledge of nursing documentation.

(see figure 1 below)

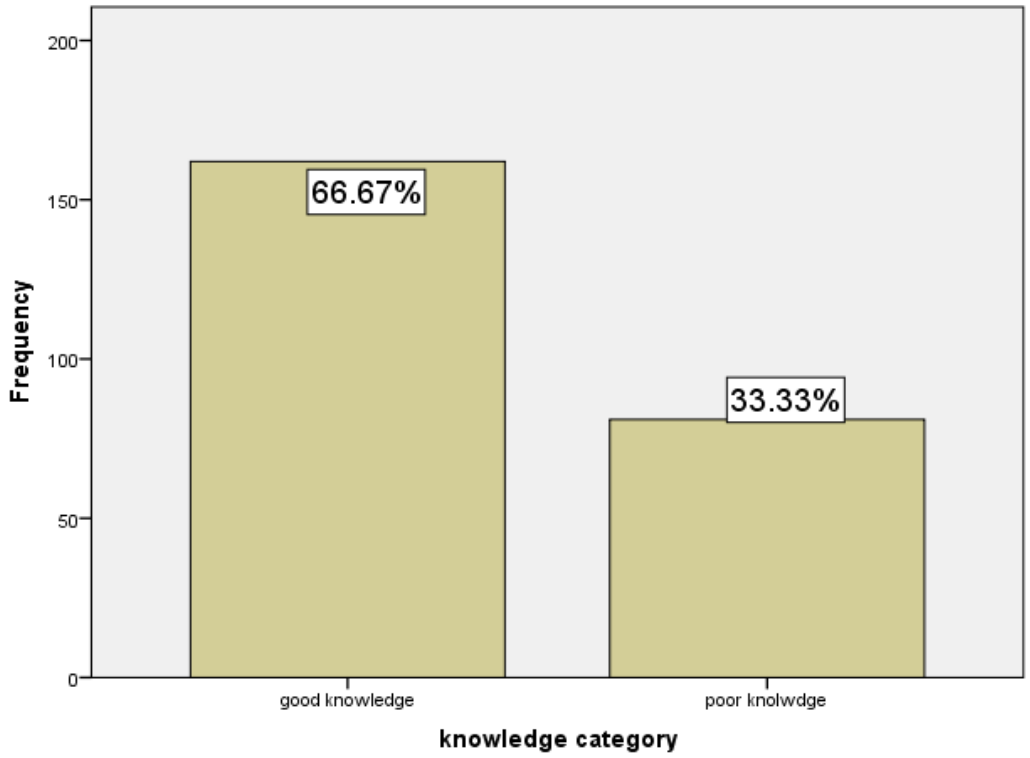

Figure 1:- Knowledge of nurses towards documentation among nurses in Emergency departments of public hospitals of Addis Ababa, Ethiopia, 2019.

Out of total respondents who have participated in the study, 226 (93%) of them knew that what nursing documentation principle comprises. Almost all respondents 238 (97.9%) said that using non standard abbreviations during nursing documenting leads to error, confusion and time wastage. 155(63.8% of respondents said that Potential consequences of inadequate documentation can be Possible imprisonment and 174(71.6) Poor development of nursing profession. (see table 2 below)

Table 2:- Knowledge of Respondents towards nursing documentation among nurses working in Emergency departments of selected public hospitals of Addis Ababa, Ethiopia, 2019.

Variables		Frequency(n=243)	Percent (%)
Principles of documentation	Error free	152	62.6
	Complete	181	74.5
	Easily readable	154	63.4
	Chronological	143	58.8
	I don't know	17	7.0
Advantages of documentation	improve quality of care	184	75.7
	better communication with health care staff	194	79.8
	education and research	155	63.8
	legal protection and health planning	173	71.2
	I don't know	1	0.4
Nursing activities expected to be documented	Assessment data	169	69.5
	Progress of patients	180	74.1
	Transfer and discharge of patients	160	65.8
	Care provided and evaluation of outcomes	187	77.0
Potential consequences of inadequate documentation	Possible imprisonment	155	63.8
	Loss of salary increment	159	65.4
	Severe injury or death of a client	164	67.5
	Poor development of nursing profession	174	71.6
Effects of using non standard abbreviations in documentation	Leads to errors	194	79.8
	Wastes time	152	62.6
	Causes confusion	179	73.7
	I don't know	5	2.1
Nursing documentation serves as the way of communication for medical teams about the patient.	Yes	237	97.5
Informed consent should be documented before intervention	Yes	224	92.2
Components of documenting medication administration	Names of medications	194	79.8
	Date and time	211	86.8
	Routes and dosage	199	81.9
	Nurses name and signature	178	73.3
	I don't know	6	2.5
Which is recorded on nursing documentation	Vital sign	234	96.3
	subjective data	158	65.0
	Objective data	166	68.3
	medication name	179	73.7
Action of documentation do you know protects you from legal suit	Documenting the date and time of care	189	77.8
	Recording only what you saw or did	182	74.9
	Recording in a chronological order	157	64.6
	Recording frequently	164	67.5
	I don't know	8	3.3

5.4 Attitude of nurses towards nursing documentation

Attitudes were assessed via a Likert scale, with scores ranging from strongly agree (5) to strongly disagree (1). The total mean score was 30 (SD±0.45). Among all respondents, most 154 (63.4%) of them agreed that nursing documentation enables medical staff to detect changes in patient's condition.

153(63%) of them said that nursing documentation help nurses gain knowledge about patients and 116 (47.7) said accurate documentation enhance professional autonomy.
In this study 72.4% (n=176) of respondents were found to have favorable attitude.
(See table 3 below)

Table 3:- Attitude of nurses towards documentation among nurses working in Emergency departments of selected public hospitals of Addis Ababa, Ethiopia, 2019.

Variables	Disagree		Neutral		Agree	
	N	%	N	%	N	%
Nursing documentation has a positive impact on care given	64	26.3	55	22.6	124	51.0
Nurses should spend sufficient time to document the report	128	52.7	21	8.6	94	38.7
Accurate documentation enhance professional autonomy	104	42.8	23	9.5	116	47.7
Nursing documentation is an important competency for nursing practice	66	27.2	28	11.5	149	61.3
Nursing documentation help nurses gain knowledge about patients	70	28.8	20	8.2	153	63.0
Nursing documentation can protect the patient's right	73	30.0	28	11.5	142	58.4
Nursing documentation improves interaction between medical team members	76	31.3	27	11.1	140	57.6
It will be better to put emphasis on nursing care rather than documentation	93	38.3	35	14.4	115	47.3
Nursing documentation leads to reduced workload pressure on nurses	102	42.0	35	14.4	106	43.6
It is essential to document all nursing interventions	79	32.5	20	8.2	144	59.3
Nursing documentation enables medical staff to detect changes in patient's condition	69	28.4	20	8.2	154	63.4
Documenting nursing interventions is a valuable skill	69	28.4	23	9.5	151	62.1

5.5 Practice of respondents towards nursing documentations

The mean score for practice questions was 7.45 (S.D ±2.07)

From the 243 respondents who participated in the study 49.8 % (n=121) had good nursing care documentation practice and 50.2 % (n=122) had poor nursing care documentation practice.

(see figure 2 below)

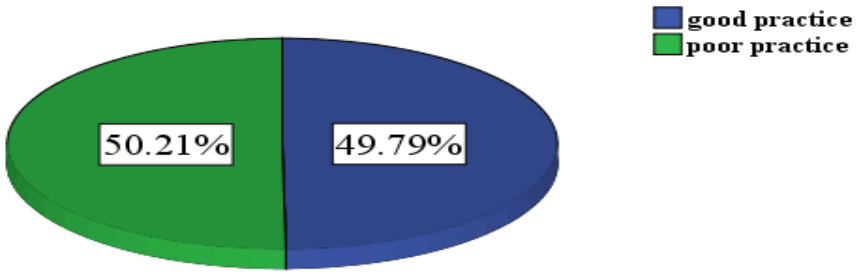

Figure 2: Level of nursing documentation practice among nurses working in Emergency departments of selected public hospitals of Addis Ababa, Ethiopia, 2019 (n=243).

Respondents were asked for when they document what they had done, and only 37.4% (n=91) of them Complete documentation in timely manner - during, or as soon as possible after, the care or event. More than half 58.85(n=100) of the respondents document the nursing care provided in a chronological order.

(See Table 4 below)

Table 4 :- practice of nursing documentation among nurses working in Emergency departments of selected public hospitals of Addis Ababa, Ethiopia, 2019.

Variables	Yes		No	
	N	%	N	%
Document the nursing care provided in a chronological order	100	41.2	143	58.8
Document both objective and subjective data	196	80.7	47	19.3
Document significant communication with family members/significant others, substitute decision makers	77	31.7	166	68.3
Document any advocacy that was undertaken on the client's behalf	68	28.0	175	72.0
Document legibly and in permanent ink when using paper documentation forms	168	69.1	75	30.9
Document advice, care or services provided to an individual, group, communities.	73	30.0	170	70.0
Document informed consent for treatments or interventions performed	187	77.0	56	23.0
Complete documentation in timely manner - during, or as soon as possible after, the care or event	91	37.4	152	62.6
Document the date and time that care was provided and when it was recorded	103	42.4	140	57.6
Refrain from deleting, altering or modifying anyone else's documentation	164	67.5	79	32.5
Document your own observations and actions	196	80.7	47	19.3
Refrain from co-signing entries unless agency policy clearly dictates the reason for the cosignatories	163	67.1	80	32.9
Maintain confidentiality of client health information	225	92.6	18	7.4

5.6 Factors associated with knowledge and attitude of nursing documentation at selected governmental hospitals in Addis Ababa 2019.

The Bivariate analysis showed that age, sex, level of education and marital status were not statistically significant with knowledge of nurses towards documentation but monthly income was significantly associated with knowledge of nurses towards documentation at both bivariate and multivariate analysis. (See table 5 below)

Table-5- Bivariate and multi-variants predictors of nursing documentation related to knowledge of respondents at selected governmental

Character		Knowledge		Odds ratio(95% CI)			
		Inadequate Freq. (%)	Adequate Freq. (%)	COR (p<0.25)	p-value	AOR (P<0.05)	p-value
Monthly income in ETB	2000-2999	10	9	1		1	
	3000-3999	11	10	9.365(2.839,30.897)	0.000	11.198(1.845,67.98)	0.009
	4000-4999	20	46	9.271(2.904,29.596)	0.000	14.538(2.717,77.779)	0.002
	5000-5999	33	38	3.665(1.427,9.411)	0.007	6.442(1.503,27.608)	0.012
	>=6000	7	59	7.32(2.941,18.217)	0.000	11.83(2.981,46.954)	0.000

p <= 0.25, CI- 95 %(Confidence Interval), COR- crude odds ratio, AOR-adjusted odds ratio

Remained statistically significant ($p < 0.05$) in adjusted odds ratio.

The study participants who earn >=6000 ETB monthly income are 11.83 times more likely knowledgeable than those participants who earn 2000-2999ETB monthly income. AOR 95%, CI 11.83(2.981, 46.954) p=0.000

The result revealed that those participants who earn monthly income of 4000-4999 were 14.5 times more knowledgeable than those who earn monthly income of 2000-2999 ETB. AOR (14.538(2.717, 77.779) p=0.012.

The level of income increases as the work experience increases, therefore as the work experience increases the knowledge of nurses towards documentation increases.

Table 6:- Bivariate and multivariate predictors related to attitude of respondents towards nursing documentation

Character		Attitude		Linear regression(95% CI)			
		Unfavourable Freq. (%)	favourable Freq. (%)	COR (p<0.25)	p-value	AOR (P<0.05)	p-value
Sex	Male	17	68	0.54(0.288,1.012)	0.209	0.469(0.236,0.933)	0.031
	Female	50	108	1		1	
Educational level	Diploma	3	22	1		1	
	Degree	57	149	0.097(0.018, 0.515)	0.006	0.074(0.01, 0.551)	0.011
	MSc nurses	7	5	0.273(0.083,0.896)	0.032	0.212(0.056,0.798)	0.022

p <= 0.25, CI- 95 %(Confidence Interval), COR- crude odds ratio, AOR-adjusted odds ratio

Remained statistically significant (p < 0.05) in adjusted odds ratio

The Bivariate analysis showed that age, monthly income and marital status were not statistically significant with Attitude of nurses towards documentation but sex and level of education were significantly associated with attitude of nurses towards documentation at both bivariate and multivariate regression.

Male were 53.1% less likely had favorable attitude than female towards nursing documentation AOR 95% CI, 0.469(0.236, 0.933) (p=0.031).

The study revealed that those participants with masters holders were 78.8% less likely had favorable attitude than that of diploma holders.

In this study practice was not significantly associated with age, sex, marital status, level of education and work experience. So the statistical table for practice was omitted.

6. Discussion

Poor documentation in nurses has been shown to have negative impacts on the health care of patients, the health care providers and on the profession in general. Various studies have shown that documentation problem is still a critical issue in both developed and under developed countries, especially in Sub-Saharan Africa including Ethiopia. Nursing documentation in many countries remains poor due to numerous reasons which different authors articulated (25). A Dutch study found inadequate documentation of important aspects of assessment and other related nursing care, including inaccuracy of documentation (26).

This study showed that from the total of the 246 estimated nurses to be enrolled in the study, 243 nurses gave complete response making response rate of 98.8%. From a total of 243 nurses who participated in this study, 158 (65%) were female and, most of the participants 173 (71.2%) were within the age group of 25-34 years.

The result of this study showed that 49.8% (n=121) of nurses have good nursing care documentation practice. It is Similar to the research done in Jimma University medical center, (48.6.4%) of nursing documentation practice was good (37) and also other study conducted in Harar accounted for 48.9% of of nurses had good nursing documentation practice (40). But it is more than the study conducted in the University of Gondar hospital which was identified that good nursing documentation practice of 37.4%(8). This discrepancy might be due to difference in the number of staff in the study areas and also it can be related with the availability of the required nursing documentation materials.

Concerning the attitude of participants, this study found 72.4 % of good attitude level which is comparable to the study conducted in Tabariz University, Iran (85.8%) of participant

nurses had high attitude towards nursing documentation (33). Similar to the result of this study the research conducted in public hospital of Harari, reveals that (52.9%) of study participants had favorable attitude towards nursing documentation (34). This similarity might be due to the related awareness level of nurses towards documentation in those study areas.

In this study 66.7 % (n = 162) of the study participants had a good knowledge of nursing care documentation. Similarly the research done in Debremarkos Hospital 58.1 % of participant nurses had good knowledge concerning nursing documentation. In contrast the study conducted in Uganda shows that the knowledge of participant nurses about the nursing documentation was found to be low 48% (29).This discrepancy might be related to the training offered for the nurses. Out of total respondents who have participated in the study, almost all of them 226 (93%) knew that what nursing documentation comprises. Almost all respondents 238 (97.9%) said that using non standard abbreviations during nursing documenting leads to error, confusion and time wastage.

7. Strength and limitation of the study

7.2 Strength

Coverage of larger study population (compared to the study conducted in Gondar University Hospital, Harari public hospital); so it may be possible to generalize the finding to the source population.

In this study structured and pre-tested questionnaire was used.

7.3 Limitation

No adequate literatures were found on similar topic especially in Ethiopian context making it difficult for comparison.

Since self-administered questionnaires were used to collect data; the study may be subjected to response bias from each respondent

8. Conclusion and recommendations

8.2 Conclusion

The study indicated that the knowledge and attitude of nurses towards documentation fall in good and favorable range of mean score respectively. But the practice was poor among nurses working in emergency departments of selected governmental hospitals (Tikur Anbessa specialized Hospital, AaBET hospital and Zewditu memorial hospital).

8.3 Recommendations

It has been accepted that nursing documentation is a very important aspect of professional practice to nurses. Based on the finding of this study, the following recommendations are forwarded for:

1. Health institutions to provide opportunities for nurses to create awareness, familiarize them with the guideline regarding documentation, enhance their knowledge and develop their documenting skill.

2. Nursing leaders (matrons /nursing directors) should support and motivate the employees and avail the necessary documenting materials.

3. Researchers to carry out large scale studies in order to address the problem in wider context. Researchers also need to carry out large scale studies in order to address the problem.

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10. Annexes

Annex I: Information sheet and consent form

Addis Ababa University

College of Health Science Department of Emergency medicine

Information sheet

Good morning/Good afternoon!

My name is _____I am conducting the research on the assessment of Knowledge, attitude and practice of documentation among nurses working in emergency departments of Black lion specialized hospital, Abet hospital and Zewditu hospital, Addis Ababa, Ethiopia, 2019.

The study is made for the partial fulfillment of Master's Degree in Emergency Medicine and critical care nursing, Addis Ababa University College of Health Science Department of Emergency Medicine. The results of the study will be used as base line information to design appropriate intervention strategies to increase nurses' knowledge, attitude and practice of documentation especially at emergency department. The questionnaire will be provided in self-administered form. You are therefore kindly requested to provide genuine answer to the questions. The information you provide is confidential and is used only for the purpose of this study. If you have any question, don't hesitate to ask the data collector. Your cooperation and participation until the completion of the questionnaire is very necessary for the successful completion of the study.

We therefore ask your genuine willingness. However, you have the right to refuse if you are not voluntary to participate by making thick mark in -No' in the box below.

If you are voluntary Yes ☐ No ☐

Thank you in advance for your cooperation

Data collectors Name_____, date _____sign: _____

Questionnaire code: _____

If you have questions regarding this study or would like to be informed of the results after its completion, please feel free to contact the principal investigator through the following address:

Address of the principal investigator: Birhanu Tesfaye

Tel: +251-916077817, Email = bire085@gmail.com

Consent form

In signing this document, I am giving my consent to participate in the study entitled "Assessment of knowledge attitude and practice of nurses towards documentation among nurses working in emergency departments of selected governmental hospitals, in Addis Ababa".

I have understood that participation in this study is entirely voluntarily. I have been told that my answers to the questions will not be given to anyone else and no reports of this study ever identify me in any way. I have also been informed that my participation or non-participation or my refusal to answer questions will have no effect on me.

I understood that Birhanu Tesfaye is the contact person if I have questions about the study or about my rights as a study participant.

Address of Principal investigator: Birhanu Tesfaye

Phone +251 916077817

Email: bire085@gmail.com

Do you agree to participate? Yes -------- No ----------

If yes proceed to the next page.

THANK YOU!

Annex II: Questionnaire

Part I: Socio-demographic characteristics of participants

S. No:	Socio-Demographic	Response
101	Sex	1. Male 2. Female
102	Age	_____in years
103	Level of education	1. Diploma 2. Degree 3. Masters 4. Other (specify) ____
104	Marital status	1. Married 2. Single 3. Divorced 4. Widowed
105	Service year	1. <5 yrs. 2. 5-10 yrs. 3. >10 yrs.
106	Monthly income	---------- Ethiopian birr

Part II: Questions to assess Knowledge of nurses about documentation among nurses working in emergency departments of selected governmental hospitals in Addis Ababa.

Instruction: -Please read the following questions carefully and **encircle** on the correct answer option as honest as possible. Please note that **more than one answer is possible** except for questions 6 and 7.

S. No:	Questions	Response	Remark
201.	What are some of the principles needed to be followed while documenting?	1. Error free 2. Complete 3. Easily readable 4. Chronological 5. I don't know	
202.	What are the advantages of patient care documentation?	1.To improve quality of care 2. For better communication with health care staff 3. For education and research 4. For legal protection and health planning 5. I don't know	
203.	What are the main nursing activities you are expected to document?	1. Assessment data 2. Progress of patients 3. Transfer and discharge of patients 4. Care provided and evaluation of outcomes	
204.	What are the potential consequences of inadequate documentation?	1. Possible imprisonment 2. Loss of salary increment 3. Severe injury or death of a client 4. Poor development of nursing profession	

205.	What are the effects of using non standard abbreviations when documenting patient care?	1. Leads to errors 2. Wastes time 3. Causes confusion 4. I don't know	
206.	Nursing documentation serves as the way of communication for medical teams about the condition of the patient.	1, Yes 2, No	
207.	Informed consent should be documented before intervention	1, Yes 2, No	
208.	What are the components of documenting medication administration?	1. Names of medications 2. Date and time of medications administered 3. Routes and dosage of medications administered 4. Nurses name and signature 5. I don't know	
209.	Which of the following is recorded on nursing documentation?	1, Vital sign 2, subjective data 3, Objective data 4, Name of medication	
210.	Which of the following actions of documentation do you think protects you from legal suit?	1. Documenting the date and time of care 2. Recording only what you saw or did 3. Recording in a chronological order 4. Recording frequently 5. I don't know	

Part III: Questions to assess the attitude of nurses towards documentation

Instruction- Please read the following statements carefully and put a check mark on the option that best agrees with your opinion. Tick "Neutral" if you neither want to agree nor disagree with the opinion.

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
301. Nursing documentation has a positive impact on care given					
302. Nurses should spend sufficient time to document the report					
303. Accurate documentation enhance professional autonomy					
304. Nursing documentation is an important competency for nursing practice					
305. Nursing documentation help nurses gain knowledge about patients					
306. Nursing documentation can protect the patient's right					
307. Nursing documentation improves interaction between medical team members					
308. It will be better to put emphasis on nursing care rather than documentation					
309. Nursing documentation leads to reduced workload pressure on nurses					
310. It is essential to document all nursing interventions					
311. Nursing documentation enables medical staff to detect changes in patient's condition					
312. Documenting nursing interventions is a valuable skill					

Part IV: Questions to assess the practice of nurses about nursing documentation

Instruction- Please read the following statements carefully and put a check mark on the option if you perform the given tasks on the table mark "Yes" if not mark "No".

S. No		Yes	No	Remark
401	Document the nursing care provided in a chronological order?			
402	Document both objective and subjective data?			
403	Document significant communication with family members/significant others, substitute decision makers?			
404	Document any advocacy that was undertaken on the client's behalf?			
405	Document legibly and in permanent ink when using paper documentation forms?			
406	Document advice, care or services provided to an individual within a group, communities or populations (for example, group education sessions)?			
407	Document informed consent for treatments or interventions performed?			
408	Complete documentation in timely manner - during, or as soon as possible after, the care or event?			
409	Document the date and time that care was provided and when it was recorded?			
410	Never delete, alter or modify anyone else's documentation?			
411	Document her/his own observations and actions?			
412	Refrain from co-signing entries unless agency policy clearly dictates the reason for the cosignatories?			
413	. Maintain confidentiality of client health information?			