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Knowledge regarding recording & reporting among staff nurses and nursing students in Narayana medical College Hospital, Nellore

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ABSTRACT

Background: Documentation is a vital aspect of nursing practice. Generally, health care team members communicate with each other's by means of discussion, reports, and records. Written and general communication among health professionals is vital to the quality of client care. The client's medical record is a legal document of activities for recording client care.

Aim: The aim of the study was to compare the level of knowledge regarding recording & reporting among staff nurses and nursing students.

Objectives: 1. To assess the level of knowledge regarding recording & reporting among staff nurses & student nurses. 2. To compare the level of knowledge regarding recording & reporting between staff nurses and student nurses. 3. To find out the association between level of knowledge and selected socio demographic variables among staff nurses and student nurses.

Methods: A non-experimental comparative descriptive design with quantitative design was adopted. 15 staff nurses and 15 nursing students were selected by using Non-probability convenience sampling technique.

Results: Among staff nurses, 47% were had adequate knowledge, 40% were had moderate knowledge and 13% were had inadequate knowledge regarding recording & reporting. Regarding nursing students, 40% were had Moderate & 40% had adequate knowledge and 20% had were inadequate knowledge regarding recording & reporting.

Conclusion: It was concluded that the level of knowledge among staff nurses is comparatively higher than the student nurses.

Keywords: Recording & reporting, staff nurses, student nurses

Introduction

"Documentation is the sixth honest servant"

Documentation is a critical component to the delivery of health care. It is a tool to ensure continuity of care as it serve as a communication tool among health care providers, plan and evaluate a patient's treatment, create a permanent record for patient's future care, create a data base to evaluate effectiveness of treatment, facilitate research, substantiate billing, recollect a memory or defend care provided. A well documented chart is all about continuum of care.

Joint commission on accreditation of health care organizations (JCAHO, 2013) [4] state that nursing data related to assessment, nursing diagnosis nursing interventions and client outcomes must be permanently feed in a client information system. Each health care organization has policies about recording and reporting. The purposes of client records are communication, planning client care, auditing health agencies, research, education, reimbursement, legal documentation and health care analysis. The system in current documentation are source oriented record, problem oriented medical record, problems, interventions, education (PIE) model, focus charting, chapter by exception (CBE), computerized documentation and case management.

Need for the study

Over the years medical record department has arise as a vital part of any health care organizations or hospitals.

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The dictum is “People Forget, But Record and Reports Remember”. Medical records and reports has become a specialty in its own rights and the medical record and report officers and technicians have earned the right to be considered as specialist in their own field. This is because patient care requires a chronological records and reports of patient care and treatment and this enables the clinical team as well as the hospital administrator to evaluate the quality of medical care and effectiveness of the hospital services. Albert Boons (2014) [2] conducted a study to implementing Electronic Health Records (EHR) in hospitals. The objective of this study is to create an overview of the existing literature on EHR implementation in hospitals and to identify generally applicable findings and lessons for staff nurses. The method of the study is a systematic literature review of empirical research on EHR implementation was conducted. The search term included in EHR are implementation, and hospital based on primary empirical data, focused on hospital-wide EHR implementation, and satisfying established quality criteria. The study results out of 364 initially identified articles 21 articles that met the requirements.

Problem Statement

A Study to Assess the Knowledge Regarding Recording & Reporting Among Staff Nurses and Nursing Students at Narayana Medical College Hospital, Nellore.

Objectives

- To assess the level of knowledge regarding recording & reporting among staff nurses & staff nurses.
- To compare the level of knowledge regarding recording & reporting between staff nurses and student nurses.
- To find the association between level of knowledge and selected socio demographic variables among staff nurses and student nurses.

Delimitations

- Staff nurses working at Narayana Medical College Hospital.
- Nursing students who are posted at Narayana Medical College Hospital.
- Sample size is 30.
- Four weeks of data collection period only.

Materials and Methods

Research Approach: Quantitative Approach.

Design: Non-experimental Comparative Descriptive Design.

Setting: The study was conducted at Narayana Medical College Hospital, at Nellore.

Sample size: Sample size is 30; Out of which, 15 staff nurses who are working in Narayana Medical College Hospital and 15 nursing students who are posted in Narayana Medical College Hospital, Nellore.

Sampling Technique: Non-probability convenience sampling technique.

Description of the tool

The Tool consists of two parts

Part-I: Demographic variables of staff nurses and student nurses.

Part-II: Consists of self structured questionnaire to assess the knowledge level regarding recording & reporting. It consists of 30 questions.

Results and Discussion:

Part-I: Demographic findings of staff nurses & student nurses

Among 15 nurses, All of them (100%) were between 20-25 yrs, all nurses (100%) were females, majority of them (80%) were completed BSc. Nursing, 60% of nurses had below 1 year of professional experience, 33% of nurses had source of information from clinical experience and 53% of them had attended CNE programme on recording & reporting.

Among student nurses, Majority of them (67%) were between 20-21yrs, all of them (100%) were studying BSc. Nursing, 67% of them studying 4th year and 47% of their source of information was from Books & Journals, teacher & Peers and class teaching.

Part-II: Level of Knowledge among Staff Nurses & Student Nurses (N=30)

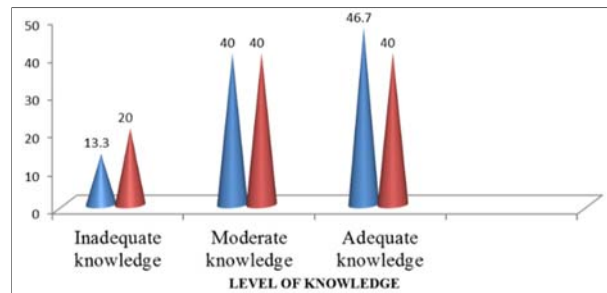


Fig 1: Percentage distribution of level of knowledge among staff nurses and nursing students

Part-III: Comparison of mean and standard deviation among staff nurses and nursing students. (N=30)

Table 1

Sample categories	Mean	Standard deviation
Staff nurses	19.8	3.37
Nursing students	19.4	4.03

Part-IV: Association between level of knowledge and demographic variables among staff nurses & student nurses

Regarding association among staff nurses & student nurses, none of the demographic variable has got significant association with level of knowledge.

Major Findings of the Study

- Among staff nurses, 47% were had adequate knowledge, 40% were had moderate knowledge and 13% were had inadequate knowledge regarding recording & reporting.
- Regarding nursing students, 40% were had Moderate knowledge and another 40% had adequate knowledge and 20% had were inadequate knowledge regarding recording & reporting.

- Staff nurses mean score was 17.62 and standard deviation was 3.62. And student nurses mean score was 13.87 and standard deviation was 3.04.

Conclusion

It was concluded that the level of knowledge among staff nurses is comparatively higher than the student nurses.

Recommendations

- A similar study can be replicated on a large sample to generalize the findings.
- A comparative study can be done on various recording system.
- An experimental study can be conducted to assess the effectiveness of teaching programme on recording and reporting.
- Similar study can be done on different hospital settings.

References

1. Anuhya. An observational study to assess the practice regarding admission procedure among nurses who are working in Narayana Hospital at Nellore, Andhra Pradesh. NNJ.2014; [cited November 23, 2016]; 3(1): 56-58.
2. Albert Boons *et al.* Fundamentals of Nursing, 7th Edition, Lendon Person Education in. 2005, 1340-1343.
3. Beil R Kirk Wook. Medical statistics USA, Black Well Scientific Publication. 1998, 12-14.
4. JCAHO, Fundamentals of Nursing, 5thedition, Addison werley Publications, 2013, 1130-1143.
5. Potter, Perry. Fundamentals of Nursing, 6thedition, Published By Elsevier, New Delhi, 101-110.
6. ErwinE. Recording and Reporting, British journal of India. 2012; 1:43-46.
7. Gibbson RJ. Documentation, The nursing journal of India. 2013; 2:37-40.
8. Georgia. Recording and reporting, 2013. Med Central: www.medlars.com.
9. Linda Clondy. Documentation. Pubmed, 2012. Central: <http://www.pubmedcentral.nih.gov/> Retrieved on June 16.
10. Jennifer Medding. Recording and reporting. PLOS: Public Library of Science, 2012. www.pols.org Retrieved on Nov. 15.