Jurnal Ners
Jurnal Ners
Vol. 15, No. 2, Special Issue 2020
http://dx.doi.org/10.20473/jn.v15i2.19784

Original Research

Analysis of Accuracy Nursing Care Process Implementation

Tejo Trisno, Nursalam Nursalam, Mira Triharini

Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia

ABSTRACT

Introduction: Implementation of the nursing care process is still a problem in nursing services. The problem found in the nursing process is the accuracy of nurses in applying the nursing care process. The aim of this study to analyze the accuracy of the implementation of the nursing care process.

Methods: This study was as a descriptive analytics design with 100 respondents. Samples were selected using cluster sampling. Data were collected using a questionnaire that has been tested for validity and reliability. The variables included assessment, nursing diagnosis, nursing plan, nursing implementation, evaluation, and nursing documentation. Data were analyzed in a descriptive form consisting of good, sufficient and fewer categories. The standard for implementing the accuracy of the nursing process is 100%.

Results: The result showed the accuracy of implementation nursing care, namely 64% assessments are sufficient, 69% of nursing diagnosis is sufficient, 59% of nursing plans are sufficient, 66% of nursing implementation is sufficient (), along with 60% of nursing care evaluation and 62% of nursing care documentation.

Conclusion: The accuracy of the nursing care process describes the quality and patient safety and is useful for patients, nurses, and the health team. Further studies must be conducted to analyze factors related to accuracy of the implementation of the nursing care process.

ARTICLE HISTORY

Received: Feb 27, 2020
Accepted: April 1, 2020

KEYWORDS

nursing care process; accuracy; implementation

CONTACT

Nursalam Nursalam
✉ nursalam@fkp.unair.ac.id
Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia

Cite this as: Trisno, I.,Nursalam, N., & Triharini, M. (2020). Analysis of Accuracy Nursing Care Process Implementation. *Jurnal Ners, Special Issues*, 436-439. doi: http://dx.doi.org/10.20473/jn.v15i2.19784

INTRODUCTION

Nursing documentation is the record of nursing care that is planned and delivered to individual patients by qualified nurses or other caregivers under the direction of a qualified nurse (Tasew, Mariye and Teklay, 2019). Documentation is an authentic record in the application of management of professional nursing care. Professional nurses are expected to be able to face the demands of responsibility and accountability for all actions taken. Public awareness of the law is increasing so that complete and clear documentation is needed (Nursalam, 2014). Nursing documentation is the principal clinical information source to meet legal and professional requirements. Nursing documentation is evidence of recording and reporting of nurses is useful for the benefit of clients, nurses and healthcare team in providing health services with accurate and complete data written as a nurse's responsibility (Pakudek, Robot and Hamel, 2017).

Nursing documentation is on the priority list in conducting quality nursing care. Nurses in Indonesia have been taught to prepare appropriate nursing records during their education. This is reemphasized again during their clinical training. On the other hand, despite the availability of evidence on the impact of insufficient documentation of patient care, nursing documentation problems in this context exist. Recent national publications have clearly stated that nursing documentation in a number of hospitals in Indonesia is far from ideal (Kamil, Rachmah and Wardani, 2018). Hence, the quality of nursing documentation in Indonesia is still questionable. It can be seen from previous research conducted by Sabila (2009) that, of 300 samples of medical records of nursing documentation, 69.3% were in the incomplete category as well as only 41.3% of nursing

Table 1. Distribution of variables in the personal analysis of accuracy nursing care process implementation (n=100)

Characteristics of respondents	n	%
Gender		
Male	33	33
Female	67	67
Age		
21-25 years old	27	27
26-30 years old	64	64
31-35 year old	8	8
36-40 year old	1	1
Education		
Bachelor in nursing	100	100
Length of working		
2-5 years	79	79
6-10 years	19	19
11-15 years	1	1
> 15 years old	1	1
Quality and safety training		
Ever	77	77
Never	23	23

Table 2. Distribution of variables in the personal analysis of accuracy of nursing care process implementation (n = 100)

Indicator	Categories			Total
	Good	Enough	Less	
Assessment	10	64	26	100
Nursing diagnoses	6	69	25	100
Planning/intervention	14	59	27	100
Implementation	10	66	24	100
Evaluation	10	60	30	100
Nursing documentation	10	62	28	100

documentation in emergency ward were in good category. In addition, Purwanti (2012) found that the percentage of complete nursing documentation was only 63% as well as the diagnosis and nursing care plan was only complete for 61%, and implementation and evaluation was only 75% (Ahsan* and , Ardhiles Wahyu, Elvira Sari Dewi, 2018). Incomplete nursing documentation indicates that the nursing care process is not working properly and continuously.

Nursing documentation according to the standard of nursing language (Standardized Nursing Language) is still a problem in the nursing profession, especially the uniformity in the use of diagnostic languages and nursing interventions. An instrument is needed to produce good diagnosis and intervention documentation (Diana Rachmania*, Nursalam*, no date). The use of standardized nursing languages helps nurses understand patients' needs with precision and speed. This study assesses the knowledge of standardized nursing languages (SNL); how nurses perceive and utilize SNL.

MATERIALS AND METHODS

The study used descriptive research designs in order to systematically describe events and emphasize factual data rather than conclusions. This research was conducted from January to March 2020 in a private hospital in East Java. This research was conducted by observing and interviewing 100 primary nurses in documenting nursing care in the medical record sheets obtained in total sampling. The inclusion criteria in this study were: 1) Primary nurses who worked for more than two (2) years, 2) worked in the inpatient room, 3) nurse education. Meanwhile, the exclusion criterion in this study was primary nurses who did not work in the inpatient unit.

Participants were recruited using cluster sampling technique. Data was collected using 5-sectioned self- structured questionnaires whose validity and reliability had been previously ascertained (Olatubi *et al.*, 2018). The study assessed the documentation of nursing care before, during and after the Standardized Nursing Language Continuing Education Program (SNLCEP). It evaluated the differences in documentation of nursing care in different nursing specialty areas and assessed the influence of work experience on the quality of documentation of nursing care with a view to provide information on documentation of nursing care. The instrument used was an adapted scoring guide for nursing diagnosis, nursing intervention and nursing outcome (Q-DIO) (Adubi, Olaogun and Adejumo, 2018).

Statistical tests inform the results of validity and reliability by Cronbach's alpha on the appropriateness of nursing care assessments, nursing

diagnoses, interventions, implementation, evaluation and documentation of nursing averaged results of 0.727 and results on the implementation of the highest values of 0.863, interventions of 0.784, and evaluations of 0.736. Data obtained through observation sheets were carried out by researchers on the sheet of nursing care instruments in the patient's medical record. This observation sheet to evaluate nursing care instruments includes nursing assessment, nursing diagnosis, nursing planning/intervention, implementing nursing actions, nursing evaluation and nursing documentation. This research protocol was declared to have passed an ethics test by the Health Research Ethics Commission of the Faculty of Nursing, Universitas Airlangga with certificate number No: 19922-KEKP on February 24, 2020

RESULTS

Table 1 informs about the characteristics of respondents in terms of age, sex, length of work, and education of nurses who work in inpatients in private hospitals. It is shown that the majority of nurses are aged 26-30 years (64%), most were women (67%), most had been working for 2-5 years (79%), and all nurses had educational background as bachelor in nursing (100%).

Table 2 shows the evaluation of implementation of nursing assessment, diagnosis, nursing care plan, implementation, evaluation and documentation. Poor performance is shown in the less category, which are in the top three and including nursing evaluation (30%), then followed by nursing documentation (28%) and nursing care plan/intervention (27%).

DISCUSSION

Evaluation of the implementation of the accuracy of nursing care standards in private hospitals in East Java was measured using an observation sheet based on diagnosis standards, outcome standards and intervention standards as well as implementation and evaluation that have been determined by The Indonesian National Nurses Association (INNA or known as PPNI). The accuracy of nursing care based on the standard of PPNI is mostly moderate (69%), with 59% adequate nursing plan, 66% adequate nursing implementation and 60% evaluation of nursing care and 62% documentation of nursing care. The standard for applying accuracy to the nursing process is 100%. Law No. 38 of 2014 concerning nursing emphasizes that nursing practice must be based on a code of ethics, service standards, professional standards, and operational procedure standards. On 29 December, 2016, PPNI established nursing care standards by publishing the Indonesian Nursing Diagnosis Standards book (SDKI), then continuing with the issuance of the Indonesian Nursing Output Standards (SLKI) and the Indonesian Nursing Intervention Standards (SIKI). Standardization of nurse care is very important in improving the quality of nursing services in the current health era and the use of standardized standards is very necessary to improve services to patients. Nursing care standards developed by the Indonesian nurse profession organization (PPNI) include Indonesian Nursing Diagnosis Standards, Indonesian Nursing Intervention Standards, and Indonesian Nursing Output Standards.

CONCLUSION

Based on the results of research and discussion, it can be concluded that the accuracy of nursing care is the competence of nurses in providing quality services. In implementing the nursing care standards for the IDHS, SIKI and SLKI, they must comply with the guidelines for nursing care.

CONFLICT OF INTEREST

No conflict of interest has been declared.

ACKNOWLEDGEMENT

Acknowledgments to all research respondents and nursing leaders who were willing to take the time, energy, and provide information support to complete this research data.

REFERENCES

Adubi, I. O., Olaogun, A. A. and Adejumo, P. O. (2018) 'Effect of standardized nursing language continuing education programme on nurses' documentation of care at University College Hospital, Ibadan', *Nursing Open*, 5(1), pp. 37–44. doi: 10.1002/nop2.108.

Ahsan* and , Ardhiles Wahyu, Elvira Sari Dewi, S. (2018) 'Analysis of Nursing Behavior Factors in Documentation of Nursing Care in Emergency Unit Using Theory of Planned Behavior', *International Journal of Indonesian National Nurses Association (IJINNA)*, 1(1), pp. 64–79. doi: 10.32944/ijinna.v1i1.20.

Diana Rachmania*, Nursalam*, E. Y. (no date) 'PENGEMBANGAN INSTRUMEN DIAGNOSIS & INTERVENSI KEPERAWATAN BERBASIS STANDARDIZED NURSING LANGUAGE (NANDA-I , NOC , NIC) (Development of Nursing Diagnosis & Intervention Instrument Based on Standardized Nursing Language (Nanda-I , NOC , NIC)) Diana Rac', pp. 157–164.

Kamil, H., Rachmah, R. and Wardani, E. (2018) 'What is the problem with nursing documentation? Perspective of Indonesian nurses', *International Journal of Africa Nursing Sciences*. doi: 10.1016/j.ijans.2018.09.002.

Nursalam (2014) 'Manajemen Keperawatan Aplikasi Keperawatan Profesional Edisi 4', p. 342.

Olatubi, M. I. *et al.* (2018) 'among Nurses in Three Selected Hospitals in', (January), pp. 0–6. doi: 10.1111/2047-3095.12197.

Pakudek, K. h, Robot, F. J. . and Hamel, R. S. (2017) 'Dokumentasi Asuhan Keperawatan Di Instalasi Rawat Inap', *E- Jurnal Keperawatan*, 2(2), pp. 1–7.

Tasew, H., Mariye, T. and Teklay, G. (2019) 'Nursing documentation practice and associated factors among nurses in public hospitals, Tigray, Ethiopia', *BMC Research Notes*. BioMed Central, 12(1), pp. 1–6. doi: 10.1186/s13104-019-4661-x.