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Case Study

Analysis of Nursing Documentation Implementation In Outpatient Room

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Abstract

The quality of nursing care is a key element of service quality in hospitals. To realize good quality nursing service and quality in the Outpatient Institution, qualified human resources are also needed and good nursing management skills are needed from a manager or head of the service unit. For the implementation of nursing care documentation in outpatient installations to be carried out optimally, it is necessary to carry out management activities in the form of supervision by carrying out nursing support activities in stages. The purpose of this analysis is to determine the implementation of outpatient nursing medical record documentation. The use of action methods in this analysis aims to develop new skills or new approaches and be applied directly and reviewed the results. From the results of the assessment found several nursing management problems and the priority is the completeness of outpatient nursing medical record documentation which is still low. The action taken is by providing refresher activities or material refreshing on nursing documentation, initial assessment of outpatients, simulations of filling out initial outpatient assessment documentation, making and disseminating supervision forms and techniques for tiered supervision using the supervision form. The activity was attended by 23 participants consisting of the head of the room, the team leader and the nurse executing from the polyclinic or outpatient installation. Evaluation after carrying out activities on the completeness of outpatient nursing medical record documentation was 70% (14 of 20 samples).

INTRODUCTION

A hospital is a form of a health service organization that provides comprehensive health services covering promotional, preventive, curative, and rehabilitative aspects for all levels of society. To maintain and improve the quality of service, one aspect that needs attention is the quality of nursing services. Nursing as a form of professional service is an integral part that cannot be separated from the overall health service effort. Nursing is the backbone in a health facility because the proportion of nurses is the majority compared to other health workers and it determines the picture of the quality of health services. This is supported by seeing the proportion of nursing personnel, the time nurses interact fully for 24 hours with patients, and will be one of the determining factors for the good and bad quality and image of the hospital.[1]

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Good nursing care management is needed in providing nursing care to clients in a systematic and organized manner. Nursing care management is a resource arrangement in carrying out nursing activities by using the nursing process method to meet client needs or solve client problems.[2]

Nursing care management is indispensable in providing nursing services to patients. The management of care carried out by a nursing manager has the strongest influence on the sustainability of nursing in health services [3]. The management process starts with planning, organizing, personnel, directing, and controlling human resource factors, finance, materials, methods, and facilities.[3] Manager nursing will affect the performance of nursing staff, create a conducive work environment, and will have an impact on patient safety, organizational sustainability, and quality. nursing care.[1] Nurses in carrying out their services use the nursing care approach which aims to improve the health status of patients and families and provide professional care.

Nursing care is a process or series of activities in nursing practice that is directly provided to clients in various health service settings, to fulfil Human Basic Needs (KDM), by using the nursing process methodology and guided by nursing standards, based on the code of ethics and nursing ethics, within the scope of authority and responsibility of nursing.[4]

In providing nursing care, nurses use a nursing process with five stages because by using the nursing process, care becomes comprehensive. The nursing process is a systematic method for assessing, diagnosing, planning, implementing and evaluating the condition of the patient in a healthy or sick condition so that it becomes the basis for scientific breakdown, and becomes the basis for nursing practice.[5]

The nursing process is a systematic problem-solving approach in providing nursing care. The nursing process is a guide for providing professional nursing care, for individuals, groups, families and communities.[6]

Nursing documentation is a record that contains all the data needed to determine nursing diagnoses, nursing planning, nursing actions, and nursing assessments that are systematically compiled, valid, and can be accounted for morally and legally.[7]

Nursing documentation is very important for nurses, documentation is part of the nurse's overall responsibility for patient care. Clinical records facilitate the generosity of services provided to patients and help coordinate the treatment and evaluation of patients.[7]

Nursing documentation must meet the requirements: fact-based, accurate, concise, complete, organized, timeliness, and easy to read. The benefits of completing nursing documentation for nurses and clients include communication tools, accountability mechanisms, data collection methods, nursing service facilities, evaluation facilities, means of enhancing cooperation between health teams, continuing education facilities and used as audits of nursing services.[8]

Roemani Muhammadiyah Hospital is a private hospital that was founded in 1975. Roemani Muhammadiyah Hospital seeks to improve service quality by following the Snars 1.0 accreditation standard Roemani Muhammadiyah Hospital seeks to improve service quality following the hospital's vision and mission by optimizing existing facilities for good care inpatient and outpatient. Outpatient services at Roemani Muhammadiyah Hospital are services provided to patients with cases that can still be handled without requiring inpatient care and post-treatment patient services as a control of the progress of healing for the disease suffered by these patients.

Outpatient care is a part of hospital services with short service delivery, which is about 15 minutes per patient on average. The average outpatient visits at Roemani Muhammadiyah Hospital are 600 patients per day with various specialist medical services as well as subspecialists. To provide quality nursing services, Roemani Muhammadiyah Hospital is in the form of carrying out service processes following predetermined standards, one of which is the implementation of nursing care documentation on outpatients. The results of the initial assessment showed that the completeness of outpatient nursing medical record documentation was still low, namely 45%, the tiered nursing supervision activities on the implementation of nursing documentation were not optimal, were still situational and there was also no documentation of the results of supervision.

The purpose of this analysis is to determine the implementation of outpatient nursing medical record documentation.

METHODS

The method used is the action method, which is a method that aims to develop new skills or new approaches and is applied directly and the results are reviewed. Where this analysis is prepared based on the assessment of 8 nursing management functions, namely the function of organizing, personnel, directing, monitoring, care management, logistics management, quality assurance programs and patient safety. The results of the assessment in an outpatient installation based on the 8 nursing management functions found 3 problems, namely: completeness of record documentation medical outpatient care which is still low, the implementation of tiered nursing supervision is not optimal, the implementation of patient or family education is not optimal. Of the 3 problems above, a priority order of problems was carried out according to the HANLON theory and agreement with the head of the outpatient polyclinic room, namely the problem of completing outpatient nursing medical record documentation is still low. From this problem then the action is taken by holding activities to provide refresher or refreshing of material on nursing documentation, initial assessment of outpatients, simulations of filling out initial outpatient assessment documentation, making and disseminating supervision forms and techniques for conducting tiered supervision using the supervision form organized. on December 10, 2020. The activity was attended by 23 participants consisting of the head of the room, the team leader and implementing nurses from the polyclinic or outpatient installation. After the activity was evaluated on December 18, 2020, of the implementation of outpatient nursing medical record documentation and the results obtained from 20 samples of outpatient medical records, there were 14 (70%) medical records whose documentation was filled.

RESULTS

The results of the assessment in the Outpatient Installation based on the 8 nursing management functions found 3 problems, namely: first is the completeness of outpatient nursing medical record documentation which is still low (45%), second is the implementation of tiered nursing supervision is not optimal and the third is the implementation of education. patient or family is not optimal (43%). Of the 3 problems above, a priority order of problems was carried out according to the HANLON theory and agreement with the head of the outpatient polyclinic room, namely the problem of completing outpatient nursing medical record documentation is still low. From this problem then action is taken by holding activities to provide refresher or refreshing of material on nursing documentation, initial assessment of outpatients, simulations of filling out initial outpatient assessment documentation, making and disseminating supervision forms and

techniques for conducting tiered supervision using the supervision form organized. on December 10, 2020. The activity was attended by 23 participants consisting of the head of the room, the team leader and implementing nurses from the polyclinic or outpatient installation. After the activity was carried out an evaluation on December 18, 2020 of the implementation of outpatient nursing medical record documentation and the results obtained from 20 samples of outpatient medical records, there were 14 (70%) medical records whose documentation was completely filled. Thus the documentation of outpatient nursing medical records experienced a significant increase after being given a refresher on the material related to nursing documentation, patient assessment and monitoring through nursing supervision activities.

DISCUSSION

Nursing documentation is a record that contains all the data needed to determine nursing diagnoses, nursing planning, nursing actions, and nursing assessments that are systematically compiled, valid, and can be accounted for morally and legally[7].

Nursing documentation is a series of activities carried out by nurses starting from the assessment process, nursing diagnosis, action plans, nursing actions, and evaluations which are recorded either electronically or manually and can be accounted for by the nurse.

The results of observations made by students who practice application during the implementation stage, during the initial assessment of outpatients at the outpatient clinic of the Roemani Muhammadiyah hospital, obtained data that the implementing nurse had done complete documentation during the initial assessment of the patient. outpatient care, the executive nurse records the coverage of the amount of documentation that has been done into the document supervision implementation form.

The results of observations made also obtained data that the orphans were able to carry out the task of supervising the nurse executing on the initial assessment documentation of outpatients, the orphans were able to validate the completeness of the initial outpatient assessment documentation through e'RM and the orphans were able to record or document the validation results into the form / instrument to supervise the completeness of outpatient initial assessment documents.

The data from the next observation is that the head of the room is able to carry out supervisory duties to the staff / supervisor and also the head of the room is able to validate results of supervision activities from orphans / supervisors. Based on the results of the evaluation on 18 December 2020 the completeness of outpatient nursing medical record documentation after implementation was 70% (14 out of 20 samples).

The results of Mursida[9] research conducted at the H. Hanafie Muara Bungo Regional Hospital, showed that most of the nurses (60%) stated that the leadership was not effective and the nurses (40%) stated that the leadership was effective. Some of the nurses (50.1%) stated that supervision was ineffective and as much as (42.9%) indicated that supervision was effective. Some of the nurse administrators (54%) had poor performance in documenting nursing care and as many (45.7%) had a good performance in documenting nursing care. The results of bivariate analysis were obtained (p value <0.05), thus it can be concluded that there is a significant relationship between leadership and supervision with the performance of nurses in documenting nursing care.

Andriani[10] research results showed the results of a survey on 20 March 2016 in the internal, surgical, and child inpatient room

at RSI Ibnu Sina Bukittinggi for 10 documenting physical examinations only filled with 3 documentation, the diagnoses written from the time the patient entered until returned only used 1 diagnosis. And filling out the intervention was only filled in 2 documentation. The results of the analysis showed that more than half (53.3%) of the head of the room carried out the supervision and documentation which was done completely and incompletely, the same amount (50%) was carried out by the executive nurse. The results of bivariate analysis with chi-square were obtained ($p = 0.021$), it can be concluded that there is a relationship between the supervision of the head of the room and the documentation of nursing care in the inpatient room of RSI Ibnu Sina Bukittinggi.

The implementation of medical record documentation during the initial outpatient assessment at the polyclinic / outpatient installation of the Roemani Muhammadiyah hospital was carried out according to standards. Nurses already understand the importance of completing medical record documents after being given refresher material about nursing documentation, initial assessment of outpatients, simulating filling out initial outpatient assessments through e'RM and techniques for supplying completeness of medical record documentation. The head of the room and the team leader understand and are able to conduct supervision in stages after being given technical material perform tiered supervision of the completeness of medical record documentation.

CONCLUSION

The results of the evaluation of the implementation of the provision of material refreshes on nursing documentation, the initial assessment of outpatients, simulations of filling out the initial assessment of outpatients, the implementation of tiered supervision using the supervision form gave positive effects and results in the implementation of outpatient nursing medical record documentation.

The results of the evaluation obtained data from 20 samples of outpatient initial assessment medical records, 14 medical records (70%) were completely filled in. When compared before the intervention, the completeness of outpatient nursing medical records was only 45%, so this result has a significant increase.

Completeness of documenting medical records requires support from all Caregiving Professionals (PPA) in hospitals including nurses. Good management is needed in an effort to get professional and quality patient care, including through complete and quality medical record documentation.

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CONFLICTS OF INTEREST

Neither of the authors has any conflicts of interest that would bias the findings presented here.

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