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Implementation Of Nursing Care Documentation In The Inpatient Room

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ABSTRACT

Objective, accurate and comprehensive documentation is the best factor to prove professional nursing actions and those given to patients as needed. Negligence or inaccuracies in making documentation will cause the nursing services provided to be unsustainable. Nurse workload is all activities or activities carried out by a nurse while on duty in a nursing service unit in the application of nursing care documentation. The method in this study uses a quantitative descriptive study with an observational approach to nursing care documents in the Inpatient Room at the Ciamis District Hospital. The population in this study were all 304 nurses who worked in the inpatient installation of the Ciamis District General Hospital. Sampling in this study used proportional random sampling so that the number of samples obtained was 75 nurses who worked in 13 inpatient installation rooms at the Ciamis District General Hospital. The results of the study showed that the implementation of nursing care documentation was mostly categorized as incomplete, as many as 41 people (54.7%).

Keywords: Documentation of Nursing Care, Nurses, Inpatients Room

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Introduction

Nursing services are an integral part of health services based on nursing knowledge and tips, in the form of comprehensive bio-psycho-spiritual services aimed at individuals, families, and communities, both healthy and sick, covering all processes of human life. Nursing services cannot be separated from health services as a whole, even nursing services are one of the determining factors for the quality of services and the image of the hospital in the eyes of the community. To provide quality nursing services, the nursing process is used which includes assessment, planning, nursing diagnoses, nursing implementation, and evaluation.(Kemenkes RI, 2010)

Documentation for nurses is useful for communicating things that have been done in writing, and important facts about patients to maintain the continuity of health services for a certain period. Documentation is also a record of patient needs, as a tool for identifying problems, planning actions, carrying out activities, and evaluating activities that have been given.(Pasaribu, n.d, 2019)

According to Aulia (2009), through the evaluation of nursing documentation at several RSUs in West Java, it was found that the ability of nurses to document the results of nursing records in completing medical records was an average of less than 60% met the criteria, from the results of the evaluation of the documentation of the mental nursing process at two mental hospitals it was found that less than 40% that meet the criteria.

The Director General of Medical Services, Ministry of Health, Republic of Indonesia (2010) stated that complete and accurate nursing care documentation can be used as a reference for legal basic health services (medico-legal), supporting information to improve the quality of medical services, medical research and used as a basis for assessing hospital performance. It is time for the implementation of nursing care documentation to get serious attention because it will produce fast, accurate and timely information.

Negligence or inaccuracies in making documentation will cause the nursing services provided to be unsustainable. Objective, accurate and comprehensive documentation is the best factor to prove professional nursing actions and those given to patients as needed. (Potter and Perry, 2013). Incomplete documentation can affect the value/benefit of the document such as reduced legal value, quality assurance of services, loss of communication media between colleagues or between professions, administrative (financial) value, educational value, research value, and hospital accreditation value. (Nursalam, 2011).

Documentation of the nursing process is a record of the output of all work activities of nurses which is evidence of the implementation of nursing care in hospitals using nursing methods. Documentation of the nursing care process is a display of the behavior or performance of the implementing nurse in providing the nursing care process to the patient while the patient is being treated in the hospital. Documentation of good and quality nursing care processes must be accurate, complete, and according to standards. If nursing activities are not accurately and completely documented, it is difficult to prove that nursing actions have been carried out correctly. Documentation of the nursing care process is a process that

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must be carried out by implementing nurses as part of the work standards that have been set (Nursalam, 2011).

Regional General Hospital (RSUD) Ciamis is a government-owned hospital that is classified as class C and has a vision of a Professional Hospital and is Interested in the Community. Based on staffing data, it was found that the number of nurses working in the Inpatient Room of the Ciamis Regional General Hospital was known that the number of nurses working in 14 Inpatient Rooms of the Ciamis Regency General Hospital 327 people). Ciamis Hospital has Nursing Care Standards (SAK) which consists of six standards, namely standard I nursing assessment, standard II nursing diagnoses, standard III nursing planning, standard IV nursing intervention, standard V nursing evaluation, standard VI nursing care records. (Profil RSUD Ciamis, 2018)

Researchers conducted a preliminary study in the Ciamis Hospital Inpatient Room. From the results of observations of 10 patient statuses in the Melati Room, Mawar, and Wijaya Kusuma, although the format used is in accordance with SAK, the filling is not in accordance with the standards set in SAK. At the assessment stage, it is completely filled up with data analysis. At the nursing diagnosis stage, only Dx 1, Dx 2, and so on are written, not showing the criteria standardized in SAK. At the nursing planning stage, it is prepared based on data analysis because nursing diagnoses are not written and planning is not based on SAK but only based on what actions the nurse takes, that is what is used as treatment planning. The planning component includes: 1. Nursing priorities, according to the criteria, but only apply one criterion, namely life-threatening problems. While the second priority is problems that threaten a person's health and the third priority is problems that affect behavior are not carried out even though in the assessment there is data that supports this priority.

At this stage, the nurse only pays attention to the bio/physiology, there is no visible improvement in action or reevaluation based on the patient's response. The implementation of the action is not guided by the technical procedures that have been determined. At the nursing evaluation stage, there was no process evaluation that became the criteria in the SAK. The evaluation carried out is not clear, although brief.

Objective

Based on the above problems, further research is needed on "Implementing the completeness of Nursing Care Documentation in the Inpatient Installation of the Ciamis District General Hospital".

Method

This research is a quantitative descriptive study with an observational approach to nursing care documents in the Inpatient Room at the Ciamis District Hospital.

Results

Overview of the Implementation of Nursing Care Documentation

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No	Documentation Implementation Nursing care	F	%
1.	Completely Implemented	34	45,3
2.	Not Completely Implemented	41	54,7
	Total	**75**	**100**

It is known that in the implementation of nursing care documentation in the Inpatient Installation of the Ciamis District General Hospital in 2019, most of the respondents were categorized as not being carried out completely as many as 41 people (54.7%) and almost most the respondents categorized as being fully implemented as many as 34 people (45,3%).

Discussion

Overview of the Implementation of Nursing Care Documentation at the Inpatient Installation of the Ciamis District General Hospital in 2019.

The results of the study indicate that the implementation of nursing care documentation in the Inpatient Installation of the Ciamis District General Hospital in 2019 most of the respondents were categorized as not implemented many as 41 people (54.7%). the results of the observations obtained are not in accordance with standard operating procedures so there are still aspects of documentation of nursing care that have not been filled out completely, such as aspects of assessing current health history, nutrition, psychological, sociological, and spiritual data, medical therapy provided by doctors and types of action. only 65% filled in nursing, wrote down the date of the assessment and the name of the nurse who wrote the soap which was filled only 60% so that overall the documents filled included the category not implemented.

Nursing care documents are evidence of the implementation of nursing that describes the nursing process approach and notes about the patient's response to medical actions, nursing actions or patient reactions to illness. (Depkes, 2014).

Good quality nursing documentation will greatly assist nurses in making the right decisions in providing nursing care to patients in hospitals. Then nursing documentation must contain data that is in accordance with the development of the patient's condition or documentation must be accurate (Potter and Perry, 2013). Documentation of nursing care is evidence of the implementation of nursing that uses the nursing process approach and records of patient responses to medical actions, nursing actions, or patient reactions to illness. Nursing documentation is also written information that will form the basis for an explanation of the patient for the health team or those concerned.

This is research conducted by Sylvana (2010) implementation of documentation of nursing care in the Hospital Emergency Medical Unit. Prof. Dr. R.d Kandou Manado most of the respondents (68%) have not complied with SAK. This is also in accordance with Mardhatillah's research (2016), it is known that the activities of documenting nursing care by

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implementing nurses in the Internal Medicine, Surgery, and Nervous Inpatient Room at RSUD Doctor Soedarso Pontianak, obtained 60 percent results including the bad category.

The researcher assumes that the implementation of nursing documentation is not carried out completely because it is considered a burden, because the many forms that must be filled out to record data and nursing interventions on patients make nurses burdened that nurses should carry out as a whole because good documentation will greatly assist nurses in making decisions appropriate in providing nursing care.

Conclusion

Implementation of nursing care documentation at the Inpatient Installation of the Ciamis District General Hospital in 2019, most of the respondents were categorized as incompletely implemented many as 41 people (54.7%), and almost some respondents were categorized as complete implemented as many as 34 people (45.3 %).

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