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Original Research

Documentation of Nursing Care: Current Practices and Perceptions of Nurses in the Government Hospital's of Wollega Zones, Oromia Region, Western Ethiopia

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Abstract

Basic and fundamental source of information in health care is the patient record, of which nursing documentation is a part. Despite continuous and consistent advice from quality-improvement programs and professional bodies over several years, achieving and maintaining good, quality standards of clinical documentation is still a problem in the health profession. The aim of the study was to assess the perceptions of nurses regarding the current documentation practices and implementation of hospital policy and problem experienced on documentation of nursing care in government hospital of Wollega Zone, Oromia region, Western Ethiopia. A Cross-sectional institutional based study was conducted on 219 nurses working at different government hospitals of Wollega Zones, Oromia region, Western Ethiopia from August 1-20, 2016. Hospitals were selected by purposive sampling, while simple random sampling method was employed to select study participants. A structured self-administrated questionnaire was used to collect the data and trained BSc nursing staffs facilitated the data collection. The data was analyzed by using SPSS for windows version 20 and descriptive, Bi-variate and Multivariable logistic regression analyses were performed to summarize data. The *P*<0.05 was taken as statistically significance. More than half (56.2%) of the participants were females and majority (51.6%) were in the age group of 20 to 29 years. All most near to half (48.9%) of the participants had 6 to 10 years of work experience and 45.2% had diploma in nursing. Around 55.3% of nurses know the availability and implementation of policies pertaining to documentation of nursing care. As the work experience of the nurse's increases, the act of documentation increases by 0.002% with *P* value of 0.003. In addition, perception and feelings of nurses includes nobody reads what I have written on documents and why should I bother? were significantly associated with a *P* value of 0.002. The main reasons for not to document were, lack of awareness regarding hospitals documentation policies, supportive supervision from near managers and friends on what they document, using more pages as well as using traditional documentation system were included. Therefore, hospitals and healthcare settings should focus on increasing awareness of their staff on policies and procedures about documentation.

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INTRODUCTION

Nursing profession has witnessed a change towards a more independent practice with explicit knowledge of nursing care in the past few decades. With the change has come the obligation to document not only the performed intervention- medical and nursing – but also the decision process, explaining why a specific nursing action has been promoted (Bello Hussainat Taiye, 2015). The major health-related organizations and other related oraganizations began to develop standards, laws and regulations expressing that the nursing process should be used in nursing documentation. The organizations like WHO (1982), the International Council of Nursing Clark, 1994), the American Joint Commission on Accreditation of Hospital Nursing Service Standards (1991) and the United Kingdom Central Council (1993) promoted the use of the nursing process in nursing care. More importantly, the Swedish law on this subject was passed in 1986 (SF, 1985) and was further clarified specifically for nursing by the National Board of Health and Welfare in 1993 (SOSFS, 1993; Clark, 1994). Furthermore, there are also studies demonstrating increasingly proper nursing documentation and 119 (71%) of the 163 nursing home records are included with individual care plan in the nursing documentation (Fagrell *et al*., 1998).

Nursing documentation is defined as recording of a nursing care, which are planned and will be given to individual patients and clients by qualified nurses or other caregivers. In addition, nursing documentation can be used for other purposes such as quality assurance and archiving. The basic and fundamental source of information in health care system is the patient record, of

which nursing documentation is a part. On the other hand, the patient record is a source of information for the patient, researchers, and for the legal use. It is a source of knowledge for novice nurses and potentially for nursing theory development (Bjorvell 2009; Ehrenberg, 2001). Even though nursing documentation provides written evidence of patient progress, it should include rationales and the underlying critical thinking behind clinical decisions, interventions, and evaluations of caregivers and must comply with the established standards (Larson, 2004; Blair, 2012). Surprisingly, continuous and consistent advice from quality-improvement programs and professional bodies over several years, achieving and maintaining good standards of clinical documentation is still a problem in the health profession (Cowan, 2000; Wang, 2011). Nursing documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic Documentation Guidelines for Registered Nurses (2012). Globally, many nurses including those in Ethiopia encounter similar problems in documenting patient care. This study provides information that is important related to proper documentation and current practices. Hence, this study was performed to assess the perceptions of nurses regarding the current documentation practices and implementation of hospital policy and problem experienced on documentation of nursing care in government hospital of Wollega Zone, Oromia region, Western Ethiopia, 2016.

MATERIALS AND METHODS

Study Area

The study was conducted in Wollega Zones of Oromia region, Western Ethiopia. Wollega hosts four Zones; East Wollega zone, West wollega zone, Horo Guduru Zone and Kelem Wollega Zone. East Wollega Zone hosts two government hospitals, Nekemte Referal Hospital and Gida Ayana Hospital. Nekemte Referal is Hospital located in Nekemte town, which is the capital of the Zone. Nekemte is 331km from the Addis Ababa, the capital city of Ethiopia. West Wollega Zone hosts two government hospitals, Gimbi Hospital and Nedjo Hospital. Gimbi Hospital is located in Gimbi town, which is the capital city of the Zone. Gimbi Town is 441 km and 110 km from Addis Ababa and Nekemte town respectively. Horo Guduru Wollega is one of the zones of Wollega in Oromia Region Ethiopia. The seat of the Zonal administration cabinet is in Shambu Town. Shambu Hospital is located in Shambu town. Kellem Wollega Zone hosts one governmental hospital, Dembi Dollo hospital. Dembi Dollo hospital is located in Dembi Dollo town which is the capital of the zone. The town is 642 km from the Addis Ababa, the capital city of Ethiopia and 311 km far from Nekemte Town. Target population is the aggregate of cases about which the research would like to generalize. In the present study the target population is the practical nurses working in Government Hospitals in Wollega Zones, Oromia region.

Study Design, Period, Sample Size and Sampling Procedures

Institutional based descriptive cross-sectional study was employed from 1–20 August 2016. The sample size was determined using a formula for estimation of single population proportion with the assumption of 95% confidence interval, 5 % margin of and prevalence of 50%, and design effect of 2. To compensate for the non-response rate, 10% of the determined sample was added up on the calculated sample size and the final sample size was found to be 219.

The selection of the hospital was performed by using purposive sampling method, while simple random sampling method was employed to select study participants. For the selection of representative numbers of participants (nurses), the ratio of nurses in the respective types was considered. The sample size was allocated for the Hospitals using population proportion to the sample for each selected Hospitals, size being the number of nurses in each Hospital. Finally, proportional numbers of participants (nurses) were selected by simple random sampling technique. The sampling frame was obtained from the staff registration books of the respective Hospital administrative.

Data Collection Procedure and Tools

To collect the data self-administered questionnaire was employed. The questionnaires was adopted and modified from different literatures after reviewing relevant literature (Tapp, 1990; Heartfield, 1996; Aydin *et al*., 2003; Ammenwerth *et al*., 2003; Isola, Muurinen and Voutilainen, 2004; Carpenito-Moyet, 2004; Erickson and Karkainnen Coyle, 2003; Hamilton and Heinen, 2004; Butler *et al*., 2006; Aaron Mtsha, 2009;). The self-administered questionnaire comprises of Part A (Demographic Data) and Part B (Structured questionnaire related with factors and so on).

Five Nurses were recruited for data collection with Bachelors nursing degree. They were given a day training to familiarize them with the objectives and relevance of the study, confidentiality of information, participants' rights and informed consent. Three postgraduate colleagues from nursing and midwifery background were supervised the data collection procedures. The supervision of the data collectors includes reviewing all questionnaires at the end of every day, checking for completeness of the questionnaires.

Data Analysis

Each completed questionnaire was coded on pre-arranged coding sheet by the principal investigator to minimize errors. The data were cleaned accordingly and then entered into a computer using Epi-info for windows version 3.5.1 statistical program. The data was exported to SPSS for Windows 20.0 for analysis. The descriptive analysis including proportions, percentages, frequency distribution and measures of central tendency was performed initially and bivariate and multivariate logistic regressions were used to observe effect of independent variables on the dependent variable by controlling confounders. Statistical significance was evaluated at 95% levels and P value<0.05 were considered as statistically significant. Tables, pi char and bar graphs were used to present the data.

Ethical Considerations

Ethical clearance and permission was obtained from Institutional Research Review Board, Wollega University. Permission was secured from each hospital through a formal letter. Hospital medical directors were briefed on the relevance and objectives of the study. The purpose of the study was explained to the participants and written informed consent was obtained from each participant.

RESULT

A total of 219 nurses were participated in the study making response rate of 100%. The participants' mean age was found to be 25 years. The majority (51.6%) were in the age group of 20 - 29 years. More than half of the participants 56.2% were females and 43.8% were males. Most of the participants 59.4% were protestant in their religion and greater than half (62.10%) of them were married. All most near to half (48.9%) of the participants had 6-10 years of work experience and majority (45.2%) of the participants had diploma in nursing (Table 1).

Table 1: Socio-demographic characteristics of nurses working in Government Hospitals of Wollega zone, Oromia region, Western Ethiopia, 2016 (n= 219).

Variables	Characteristics	no	%
Gender	Female	123	56.2
	Male	96	43.8
	Total	219	100
Age of respondent	20-29	113	51.6
	30-39	86	38.7
	40-49	19	8.7
	50-60	1	.5
	Total	219	100
Religion	Protestant	130	59.4
	Orthodox	57	26
	Catholic	4	1.8
	Muslim	13	5.9
	Others	15	6.8
	Total	219	100
Marital Status	Single	76	34.7
	Married	136	62.1
	Widowed	2	.9
	Divorced	5	2.4
	Total	219	100
Qualification	Diploma in nursing	99	45.2
	Diploma in midwifery	25	11.4
	BSc nursing	77	35.2
	BSc midwifery	14	6.4
	BSc mental health	3	1.4
	Others	1	.5
	Total	219	100.0
Experience	<5 years	85	38.8
	6-10 years	107	48.9
	11- 15 years	19	8.7
	16 - 20 years	4	1.8
	21 years or longer	4	1.8
	Total	219	100
Type of hospital	Referral hospital	49	23.6
	Zonal hospital	77	37.0
	District hospital	82	39.4
	Total	219	100.0
Ethnicity	Oromo	136	65.4
	Amhara	47	22.6
	Gurage	17	8.2
	Tigre	8	3.8
	Others	9	4.3
	Total	219	100

More than half (55.3 %) of the respondents respond that, as they had have policies relating to documentation of nursing care. Whereas 29.7% (65) respondents stated that, there are no policies and 15.1% (33) respondents stated that, they do not know about nursing care documentation policies (Table 2)

Table 2: Policies pertaining to documentation of nursing care in Government Hospitals found in Wollega zone, Oromia region, Western Ethiopia, 2016.

Documentation Policies	no	%
Yes	121	55.3
No	65	29.7
Do not know	33	15.1
Total	**219**	**100**

The 61.2% (134) respondents are aware that the patients' vital signs recorded in the nursing care system and 28.8% (63) of the respondents know that, as it is recorded in the computer system. While, the remaining 7.8% (17) and 2.3% (5) respondents stated that, as it recorded in the physician's order sheet and not recorded respectively.

Table 3: Hospital policy of patients' vital signs documentation in government hospitals found in Wollega zone, Oromia region, Western Ethiopia, 2016.

Policy on pt v/s record	No	%
In computer	63	28.8
In the nursing care system	134	61.2
Signed in a physician's order sheet	17	7.8
Not recorded	5	2.3
Total	**219**	**100**

Among the total number of respondents, the 53% (116) are responded as manual documentation of nursing care must be takes place every day, while 17.4% (38), 15.5% (34) and 14.2 % (31) respondents are stated that, as a manual documentation of nursing care carried once a month, it must be recorded twice a week and it must be recorded once at least within 2 hours of commencing shift per day respectively (Figure 1)

Near to half (46.1%) of nurses' working in Wollega zone hospitals responded that, all nursing procedures are recorded in computer, the 22.8% (50) of the respondents knows only about physical assessment is recorded in computer, while the rest of the respondents 47 (21.5 %) and 21 (9.6 %) responded as they are aware that, other information of the patients as well as therapeutics and diagnostics procedures were recorded in computer respectively (Figure 2).

The 49.3% (108) nurse's working in hospitals found in Wollega Zone responded that, the individual handwriting may be illegible was found to be the most responded answer, 24.2% (53) respondents stated that, the manual documentation is time consuming. While, 13.7% (30) and 12.8% (28) respondents stated that, the manual documentation not written in clear understandable language and written in the English language respectively (Table 4).

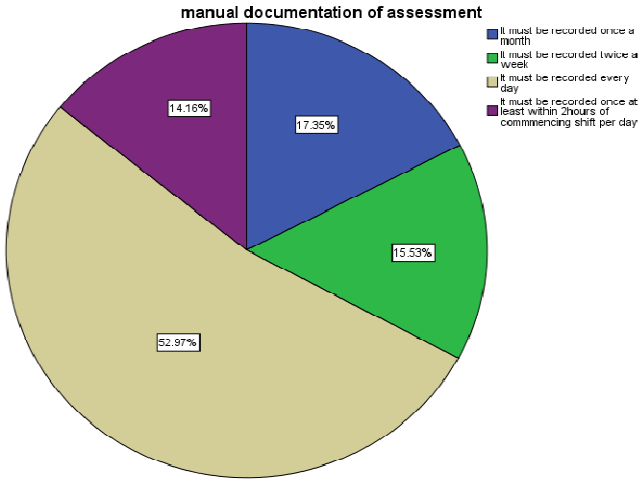

Figure 1: Manual Documentation of nursing care in government hospitals found in Wollega Zone, Oromia region, 2016.

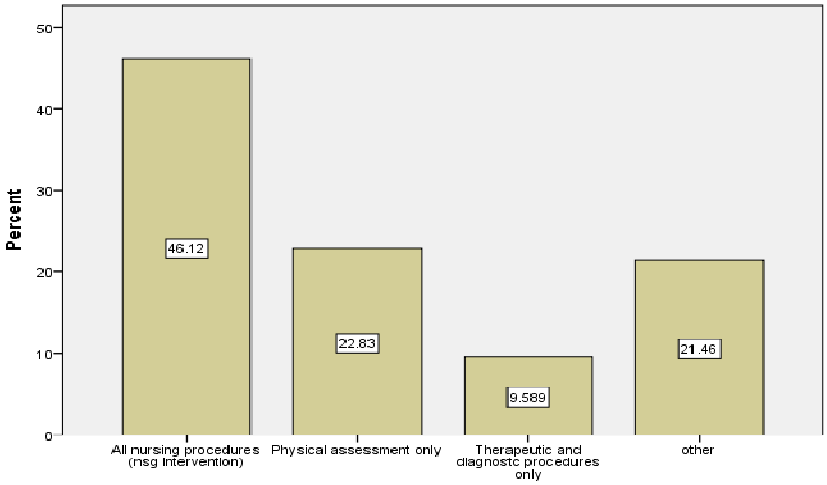

Figure 2: Nursing care recorded in computer of in governmental hospitals found in Wollega Zone, Oromia region 2016.

Majority (70.3%) of the respondents indicated that, the electronic documentation is not used in their unit, when they need to document nursing care. While, 18.7% (41) and 11% (24) respondents stated that, there is only one computer in each ward and computer system may be down by the time of documentation respectively. These are the main problems they experienced during electronic documentation (Table 4) by the nurses.

Table 4: Problems experienced with documentation in Government hospitals found in Wollega Zone, Oromia region, Western Ethiopia, 2016.

Type of Documentation	Problems	no	%
Manual	Handwriting may be illegible b/c of the individuals handwriting	108	49.3
	Notes are written in a clear understandable language	28	12.8
	Notes are written in the English language	30	13.7
	It is time consuming	53	24.2
	Total	**219**	**100**
Electronic	Computer system may be down by the time of documentation	24	11.0
	Computer documentation system is not used in this unit	154	70.3
	Only one computer in this unit	41	18.7
	Total	**219**	**100**

The majority (63%) of the respondents informed that, they do not depend on a computer for documentation followed by 32.9% (72) expressed their idea on use of paper freely with no space constraints. Additionally, 4.1%(9) of nurses indicated that, there is no need for computers which could cause space constraints (Table 5).

The 45% (99) respondents indicated that, some of the handwriting are not easy to read. Furthermore, 21.9% (48) and 20.5% (45) of respondents stated that, they can always refer to what they had written, a written paper can be torn apart and thrown in a trash bin respectively. While, the 12.3% (27) stated that, it is not a requirement for nursing care procedures (Table 5).

Table 5: Nurses response regarding Advantages /disadvantages of paper documentation in government hospitals of Wollega zone, Oromia region, Western Ethiopia, 2016

	Traditional Documentation	No	%
Advantages	Do not depend on the computer to do documentation	138	63.0
	Can express myself on paper freely with no space constraints	72	32.9
	No need for computers, no space constraints	9	4.1
	Total	**219**	**100.0**
Disadvantages	Some of the handwriting are not easy to read	99	45.2
	You can always refer to what you have written	48	21.9
	A written paper can be torn apart and thrown in a trash bin	45	20.5
	It is not a requirement for nursing care procedures	27	12.3
	Total	**219**	**100.0**

Only few 6.8% respondents perceive that, as it increases the quality of documented information and 58.4% (128) of respondents agreed that, the information shall be safely kept in the computer. While, the 17.8% (39) and 16.9% (37) respondents stated that, it requires username and password to access information and the information is safely kept because username is required respectively (Table 6).

All most half of 53.9% (118) of the nurse's work in hospitals found in Wollega zone indicated that, one of the disadvantages of electronic documentation are difficult to complete the documentation when computers is down and 30.1% (66) said that, more time will be spent on documentation, the rest 16% (35) respondents stated that, it need a lot of computers to do it (Table 6).

Table 6: Nurses response regarding advantages/disadvantages of electronic documentation in government hospital of Wollega zone, Oromia region, Western Ethiopia,2016 (219).

	Electronic Documentation	No	%
Advantages	It is safely kept in the computer	128	58.4
	Required username and password to access information	39	17.8
	Increased quality of documentation	15	6.8
	Information is safely kept, username is required	37	16.9
	Total	**219**	**100**
Disadvantages	When the computer system is down you cannot complete the documentation	118	53.9
	Increased time spent on documentation	66	30.1
	Need a lot of computers to do it	35	16.0
	Total	**219**	**100**

The 4.1% (9) of respondents replied that, the frequent down times, which had an impact on their nursing care documentation on the computer. On the other hand, 53.9 % (118) of respondents indicated that, there are not enough computers to use for documentation. In addition, 22.8% (50) of nurses' work in Wollega zone hospitals express their experiences and felling that as nobody reads what they have written so why should we bother. Other than this, 19.2% (42) of respondents stated that as computer were best systems used for documentation of nursing care (Table 7).

Table 7: Personal experiences, feelings on paper and computer system documentation of nurses work in government hospitals found in Wollega zone, Oromia region, Western Ethiopia

	Personal experiences and feelings	No	%
Paper System	A lot of paper to write on and it is time consuming	109	49.8
	Because of a lot of paperwork i have less time with my patient	57	26.0
	Lack of time and lots of paperwork	23	10.5
	Nobody ready what i have written so why should i bother	30	13.7
	Total	**219**	**100**
Computer System	Nobody reads what i have written so why should i bother	50	22.8
	Not enough computers to use	118	53.9
	Best systems used for documentation	42	19.2
	Frequent down times which has an impact on my nursing care	9	4.1
	Total	**219**	**100**

More than half 53% (116) of respondents perceived that, it is safely kept until needed when entering some of nursing procedures in computer instead of paper (Table 8). In addition to this more than one fourth (32.4%) of the respondents stated their perception that, hand writing will be maintained in the same format. While, the 14.6% of respondents perceive that there is no need to write the time and date as, it is already there.

Table 8: Advantages of entering procedures in computer instead of paperwork in government hospitals of Wollega zone, Oromia region, Western Ethiopia (n=219).

Advantages	No	%
When it is entered safely kept until when it is needed	116	53.0
Do not need to write time and date it is already exist	32	14.6
Hand writing will be maintained in the same format	71	32.4
Total	**219**	**100**

Table 9 shows that the, majority (40.2%) of the respondents indicated that vital signs and pain are documented electronically. The 27.4% (60) and 25.6% (56) of respondents replied that, specific practice and procedures documented are physical assessment and vital signs respectively.

Table 9: Specific practices and procedures documented electronically in government hospitals of Wollega zone, Oromia region, Western Ethiopia, 2016

Specific procedures	No	%
Vital signs, Pain assessment	88	40.2
Physical assessment and vital signs	56	25.6
Medications (ordered and administered)	15	6.8
Physical assessment	60	27.4
Total	**219**	**100**

Table 10 shows that, the 129 (58.9%) of the respondents indicated that disputes between staff members should be documented, while 41.1% (90) respondents are opposing to the idea of documenting disputes between staff in the patients' files.

Very few (2.7%) respondents had consider that, good nursing documentation is to show nurses beautiful hand writing, more than half (74%) of the respondents indicated that, good documentation identified clear communication about the patient's general condition, where as others 23.3% (51) respondent indicated that, good nursing documentation includes writing about the nurse's personal feelings and preferences about documentation (Figure 3).

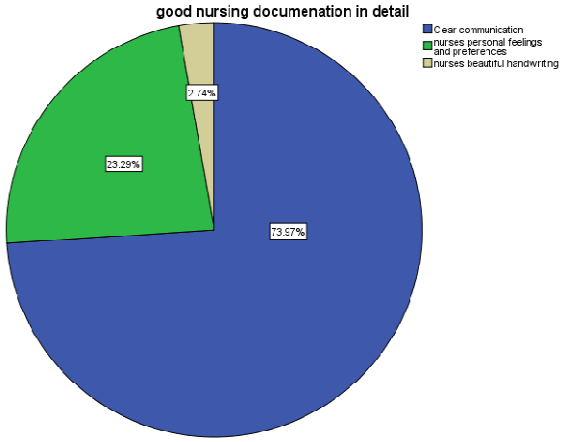

Figure 3: Perception of nurses on good nursing documentation in governmental hospitals found in Wollega zone, Oromia region, Western Ethiopia 2016.

Table 10 shows that, the majority (86.3%) of respondents indicated legibility of documentation is important to show a person who reads the documentation that they understand it and the 13.7% (30) respondents stated that, legibility in documentation is to show how beautiful the nurse's handwriting can be.

Around 73.5% (161) of the respondents replied that, as a professional obligation that nursing care was rendered and to communicate to other staff members about the patient's condition, while the rest respondents replied that just for fun and the sake of doing it, nurse feels like doing it and has time for it 18.7% (41) and 7.8% (17) respectively (Table 11).

The 3.7% (8) of the respondents replied that, patients nursing documentation should access to their colleagues. But, on contrary more than half (58.4%) of the respondents indicated that the multidisciplinary team members taking care of the patient should have access to the patient's file while the rest 37.9% (83) respondents stated that, the family members should have access to the patient's file to make sure that the multidisciplinary team members are providing adequate care to their relative (Table 12).

Table 10: Legibility in documentation in government hospitals found in Wollega zone, Oromia region, Western Ethiopia

Legibility in documentation	No	%
To understand what has been written	189	86.3
How beautiful hand writing	30	13.7
Total	**219**	**100**

Table 11: Nursing documentation in a patient's file, in Wollega zone, Oromia region, Western Ethiopia, 2016

Documentation in a patient's file	No	%
As nursing care was rendered and to communicate to other staff	161	73.5
Just for fun and the sake of doing it	41	18.7
Nurse feels like doing it and has time for it	17	7.8
Total	**219**	**100**

Table 12: Access of nursing documentation and rationale in governmental hospitals of Wollega zone, Oromia region, Western Ethiopia

Access of Nursing Documentation	no	%
Multidisciplinary team members taking care of the patient –to communicate and monitor pt.'s progress	128	58.4
Family members - to make sure that multidisciplinary members are providing adequate care to their relative	83	37.9
Patient's occupational colleagues- to read and correct whatever has been written about the patient	8	3.7
Total	**219**	**100**

In this study with the control of socio-demographic and other variables, work experience of nurses increased perception on documentation of nursing care increase 0.3% times with *P*-value of 0.003. In addition, perception and feeling of nurses like a lot of paper to write on and it is time consuming is associated with *P*-value 0.010 and nobody is read what I have written on documents and so why should I bother were significantly associated with *P*-vale of 0.002 (Table 13). Nurses who perceive that, nobody read what they have written on documentation were 15.9% times less likely to exercise documentation practice with AOR of 15.93% at 95%CI (-2.769, -91.719).

Table 13: Nurses perception regarding paper documentation of nursing care in governmental hospitals of Wollega zone, Oromia region, Western Ethiopia, 2016

Predictors	*P*- value	95 % CI
A lot of paper to write on record and it is time consuming	.010	8.636(1.669,44.686)
Nobody is read what i have written on documentation so why should I bother.	.002	-15.936(-2.769,-91.719)
Work experience	.003	0.292(.0131,.649)

DISCUSSION

Nursing documentation is an important component of nursing practice. The quality of nursing care can be evaluated, assuming that what has been recorded has also been performed. Poor documentation could lead to poor care or even failure to document valuable and critical information while good documentation may drive higher quality of care, which is cornerstone for better productivity of health care organizations. This study assessed perceptions of nurses regarding the current documentation practices and implementation of hospital policy and problem experienced on documentation of nursing care.

Overall, 55.3% of nurses know the availability and implementation of policies pertaining to documentation of nursing care. This indicates almost near to half of nurses are not familiar and implement which might contribute for breakdown in the continuity as well as decrease in quality of nursing care. As a result poor communication among health care team may happen which expose individual client to stay long in hospital, increased health care cost and poor patient care out comes. A similar finding was reported in (Nakate *et al*., 2015).

The 24.2% respondents stated that, the manual documentation is time consuming as well as nurses working in Wollega Zone hospital reported about problems experienced with manual documentation as if handwriting may be illegible because of the individual's handwriting. It can be generalized that, in order to provide quality care not all nurses were committed or not interested to fulfill their responsibilities as well as in ability to see the benefit of nursing documentation. This might be lack of supervision from nearest managers to involve their staff in such activities. Therefore, daily visit from unit managers may mandatory to review and support the documentation and adjust/guide the staff were necessary. Study done in Saudi Arabia indicates that more than threefold (73.7%) of this study (Aaron Mtsha, 2009).

Majority (49.8%) of the nurses in this study indicated that, a lot of paper to write and it is time consuming to document on paper. All most similarly and similar finding was reported from Saudi Arabia (56.3%) (Aaron Mtsha, 2009) as well as Stockholm Sweden. Study done in Maryland (81%) indicated that documentation reduces and directly affects time spent in providing direct patient care (Brian Gugerty, 2007).

Majority (70.3%) of the respondents indicated that, the electronic documentation is not used in their unit, when they need to document nursing care. On the other hand, study done in Maryland, is almost similar to this study. 64% of respondents reported not using electronic documentation in their practice. Little variation between this study and current study might be difference between organization systems, introduction of the system and may be development of the countries.19.2% of respondents stated that as computer were best systems used for documentation of nursing care. This indicates hospitals should focus on digitalization of nursing documentation which is ideal for over-burdened ward which helps to easy access and retrieve patients' information. Additionally, it saves time, increase efficiency, especially if it can be designed in such a way that they can just tick and write only a few lines. But study done in Saudi Arabia is three fold greater than this study. The difference between may be due to early introduction computer system documentation and set up of each countries (Brian Gugerty, 2007).

More than half (53%) of respondents perceived that, it is safely kept until needed when entering nursing procedures in computer instead of paper. This implies that, in each ward hospitals should have to use computers, to document and found easily patients' information. Sometimes you cannot find patients folders at the Records Department. When a folder gets missing, it is difficult to continue with care (Beatric Bella, 2011). Additionally, decrease the time spent on registering information, we are going to have an important database regarding the patient and not only his/ her current hospitalization, but also the previous ones.

Nurses' works in Wollega zone hospitals express their experiences and felling (Many respondents believed) that the documentation they completed would not be read by other health professionals in both paper (13.7%) and computer (22.8%) system. This might be due to nurses lacked the confidence to document their findings formally, and felt that documentation would not be referred by colleagues on the ward. Periodical visits and internal auditing routinely by nurse managers should made in the units as a form of motivation for staff to absorb the culture of effective documentation as soon as an activity is carried out, and to provide opportunity for the staff to ask questions in areas of thought. Hospital managers in collaboration with and significant others were directed to review daily documentation notes in their areas and to guide the nurses accordingly as well as to reduce the risks of a lawsuit against them self, the organization at which they are working, and any other employer. This is consistency with the study done in London (Lesley *et al*., 2010).

Regarding documenting procedures like Vital signs and physical assessment were documented 40.2% and 27.4% respectively. On the other hand majority (74%) of the respondents agreed that good documentation identified clear communication about the patient's general condition as well.

As accessing documentation to multidisciplinary team members to taking care of the patient –to communicate and monitor patients' progress (58.8%). This indicates that as nursing team of the health care try to carry out policy of documentation regarding documentation of procedures, but still it needs strengthening as well as increasing their knowledge regarding documentation of all procedures in clear , understandable manner. All most near finding was reported from Saudi Arabia (Aaron Mtsha, 2009).

This study shows that, nurses perceptions like nobody read what I have written on documentation so why should I, bother, a lot of paper to write on record and it is time consuming as well as work experience were significantly associated with documentation of nursing care with *P*-value of 0.002, 0.01 and 0.003 respectively. Nurses who perceive that, nobody is read what I have written on documentation so why should I bother were 15.9% less likely to document what they perform. In addition, as the work experience of nurses increase act of documentation increase by 0.2%. This indicates that, those nurses had the required knowledge and skills on documentation of nursing care, experience, confidently document what they perform in order to improve quality documentation.

CONCULSIONS

In this study, 55.3% of the nurses know the availability and implementation of policies pertaining to documentation of nursing care. The study also demonstrated that, the most important factors influencing documentation of nursing care are work experience, perception of nurse like, nobody read what I have written on documentation so, why should I bother, a lot of paper to write on record and it is time consuming in nature. The main reasons of not to document were lack of awareness regarding hospitals documentation policies, supportive supervision from near managers on what they document and minimizing number of page as well as digitalizing documentation system.

Hospitals found in Wollega zones had paucity in, increasing awareness of their staff regarding their policy, monitoring and providing frequent feedback as well as provide training on documentation and digitalization of their documentation system. Therefore, this study implies that effort should be made to increasing awareness of their staff on policies of documentation. It is recommended that, the continuous updating, in service training and monitoring to be done to encourage the nurses on documentation in addition to digitalization of their documentation system.

Conflict of interest

None declared.

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