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RESEARCH ARTICLE

INTERVENTIONS MOSTLY NEEDED FOR IN-SERVICE TRAINING OF NURSES ON EFFECTIVE USE OF STANDARDIZED DOCUMENTATION

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ABSTRACT

The review article on interventions mostly used for in-service training of nurses on effective use of standardized documents was conceived because most often than not documentation on patients is incomplete. The write up is relevant in that nurses can be exposed to standardized documents and use them for better patient outcomes. The objectives were to explore, outline, describe, and expose reasons for documentation, standardized documents, factors that influence effectiveness in documentation and regulatory bodies' views on documentation. Sourced information was gotten from internet, websites, textbooks, and journals.Results show that the reasons for nursing documentation are to ensure vital record of patient care, support communication among the healthcare team, enhance care coordination and provide crucial data for legal, educational, and research purposes. Nursing documentation plays a key role in patient safety, quality improvement, informs decision-making, and ensures that healthcare providers maintain continuity of care, communicate patient assessments and track interventions accurately. Standardized documents should include admission sheets, progress notes, and medication administration records (MAR), which ensures accurate and consistent patient information. Proper training on these documents, along with critical incident reporting and workload measurement enhances care coordination, reduces errors, and supports effective resource management. It was revealed that the factors influencing nurses' documentation in practice could be shortage of nurses, high volume of paperwork, literacy and documentation skills, and the fact that documentation narrow focus on physical health care.The view point of the regulatory bodies concerning documentation center onaccurate, standardized nursing documentation to ensure patient safety, compliance, accountability, and quality care across healthcare systems.This information can be relevant in organizing seminars to update in-service nurses on nursing documentation for better patient outcomes.

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INTRODUCTION

Evidence-based nursing underscores the importance of quality nursing practice, which is mainly evaluated by documenting nurses' actions in patient records (Zielstorff, 1993). Nursing documentation is a vital component of nursing information and a priority in research and development (Goodman, 1992). Accurate documentation is crucial for safe and efficient nursing care (Wilkinson, 2007), while inaccuracies can lead to misinterpretation and unsafe situations (Koczmara, 2007). The World Alliance for Patient Safety emphasizes the need for research in nursing documentation to identify improvement areas and establish best practices for national patient safety strategies (World Alliance for Patient Safety, 2008). To ensure safe care, nurses must document a patient's health status and reflect the nursing process (Gordon, 1994).

Based on assessments, nurses plan interventions and evaluate outcomes (Carpenito-Moyet, 2008; Gordon, 2003; Gordon, 2005). The structure of the nursing process is internationally recognized as essential for accurate documentation (Delaney, 1992; Gordon, 1994; McFarland, 1997). Accurate documentation should include five elements: personal information, admission data, and assessment details (Curtis, 2001; Arnold, 2008).

Statement of problem: The need for in-service training of nurses on the effective use of standardized documents is evident from several critical issues that impact both the quality of care and operational efficiency.

Table 1: Reasons for health care documentation according to different authors

Author	Reasons for nursing documentation
Belardo L. M. (14)	Nursing documentation serves as a comprehensive and accurate record of care planning and treatment, facilitating communication among healthcare teams for coordinated care (15). It supports accreditation, reimbursement, and legal evidence. Additionally, it provides valuable data for credentialing, education, research, worker's compensation, and investigations into professional misconduct or facility oversight (15).
Lapum et al (16)	Effective communication, continuity of care, and thorough documentation are vital components in clinical practice (16). Documentation provides essential clinical information, detailing a patient's health status and illnesses. It acts as a central communication tool within the interprofessional healthcare team, ensuring that patient assessments, interventions, and responses are communicated effectively. This continuous documentation enables coordinated care, supports informed clinical judgments, and ensures that patient needs are consistently met throughout their care experience (17).
Canadian Patient Safety Institute, (18)	Patient safety is closely linked to communication, with documentation playing a crucial role in safeguarding patients (18). Collaboration between healthcare providers and patients is essential to prevent harm, minimize unsafe practices, and respond to risks. Timely, clear documentation fosters shared understanding among providers, aiding informed decision-making. This includes recording safety measures like bedrails or assistive devices, and accurately documenting medication administration to prevent errors and ensure patient well-being (19).
Health Quality Ontario's System Quality Advisory Committee, (20)	Quality improvement initiatives in healthcare rely on continuous reflection and dedication to achieving optimal outcomes (20). Healthcare systems should be safe, effective, patient-centered, timely, efficient, and equitable. Chart audits and reviews play a crucial role in evaluating care quality and guiding evidence-based improvements. For instance, audits may uncover high fall rates, leading to targeted interventions. Documentation not only reflects care but drives quality improvements. Additionally, documentation supports research by analyzing factors influencing nurse-sensitive outcomes, such as nurse-to-patient ratios or discharge teaching, which informs evidence-based practice and improvements (15).

Table 2. Parameters for use of standardized documents

Parameter	Approach
Admission Sheets	Typically, the first document in a client's record, admission sheets provide critical information such as the client's name, contact details, next of kin, and health-related information including allergies and current medications. Training nurses on standardized admission sheets helps ensure that key information is consistently captured, allowing for seamless transitions between healthcare providers (21).
Progress and Interdisciplinary Notes	Progress notes allow for detailed, open-ended documentation by multiple healthcare providers involved in the patient's care. These sections facilitate the recording of assessments, interventions, and the client's response to care. By emphasizing standardized approaches, such as the use of specific documentation methods (e.g., SOAP or SBAR), training can help nurses maintain structured, consistent records across interdisciplinary teams (22).
Diagnostic, Laboratory, and Therapeutic Orders	These sections of the medical record typically include physician or nurse practitioner orders for diagnostic tests, laboratory assessments, and therapeutic interventions. Standardization in how these orders are documented ensures clarity and reduces the risk of miscommunication, particularly in institutions where electronic health records are used (23).
Medication Administration Record (MAR)	The MAR is a vital tool for tracking medications, their doses, and administration times. Nurse training on standardized MAR documentation, particularly regarding the recording of allergies and the special handling of controlled substances, reduces medication errors and ensures compliance with regulatory guidelines (22)
Flow Sheets and Graphic Records	Nurses often document physiological data such as vital signs and pain levels in flow sheets or graphic records. Standardizing the documentation of such data through consistent use of flow sheets helps healthcare teams quickly identify trends and make informed decisions about interventions (21)
Kardex or Summary Sheets	Kardex sheets serve as quick reference tools for nurses, summarizing essential information about the client's care needs. Although often not part of the legal record, ensuring standardized use of Kardex forms ensures that critical updates are accurately communicated and captured in the permanent medical record (24).
Nursing Care Plans	Nursing care plans, which include nursing diagnoses and care goals, should be consistently formatted to ensure that all members of the care team are aligned on patient outcomes. Training nurses on the effective use of standardized care plans helps streamline care delivery and enhance patient outcomes (25).
Consent Forms and Resuscitation Directives	Legal documentation such as consent forms, resuscitation orders, and healthcare directives require standardization to ensure that patients' wishes are clearly documented and followed. Training nurses on the importance of proper documentation in these areas ensures compliance with institutional policies and legal requirements (20)
Critical Incidents Documentation for In-Service Nurse Training	One key aspect of standardized documentation relevant to in-service nurse training is the accurate reporting of critical incidents. According to the Public Hospitals Act (1990), a critical incident is defined as an unintended event occurring during patient care in a hospital, resulting in death, serious disability, injury, or harm. This outcome must not be primarily due to the patient's underlying condition or a known risk of treatment. Hospitals in Ontario, for example, are mandated to report all critical incidents involving medication or IV fluids to ensure that unsafe practices are mitigated (18). Understanding and following critical incident reporting procedures is crucial in nurse training programs as it enhances patient safety and informs necessary changes in healthcare practices. These reports help identify how incidents occur and promote a culture of learning from errors, making in-service training critical in preventing future unsafe acts (17).
Workload Measurement Documentation for In-Service Nurse Training	Another essential aspect of standardized documentation in the context of in-service training for nurses is workload measurement. This type of documentation involves systems such as GRASP or internally developed tracking mechanisms that help monitor patient care needs and determine nurse staffing requirements (26). Such systems allow nurses to report the number of hours spent on different tasks, such as administering medications, caring for wounds, or taking vital signs. These reports are valuable for quality improvement initiatives, funding allocation, and decision-making regarding nurse distribution. Proper training on workload documentation helps nurses enhance their time management skills, improves patient care, and ensures resources are appropriately distributed. Training programs focused on these systems are essential for the effective use of standardized documentation in daily nursing practice.

Table 3: Factors and ways of influencing documentation

Factors	Effective Nurses' Documentation
Shortage of nurses	The factor forces nurses to work longer shifts, often under mandatory overtime. This contributes to fatigue, limiting their capacity for thorough documentation (18). Additionally, work overload caused by caring for a higher number of patients leads to hurried care and incomplete or rushed documentation (15). The frequent admissions and discharges in settings with shorter patient stays also escalate the volume of documentation, adding more tasks in the form of assessments and paperwork (25)
High volume of paperwork	The high volume of paperwork imposed by regulatory and reimbursement agencies complicates effective nursing documentation, often requiring repetitive information across multiple forms, which increases nurses' workload (23). This bureaucratic burden detracts from patient care and fosters apathy towards documentation, further reducing its quality (15). Discrepancies in interpreting clinical events among nurses and patients also affect consistency (19). Research shows acute care nurses spend 25% of their time documenting, and home care nurses up to 60% (24,25). Reducing this burden could improve care quality and staff morale (26). Recognizing this, the American Nurses Association advocates for reforms to reduce unnecessary documentation, allowing nurses to focus more on patient care (23)
Literacy and documentation skills	Literacy and documentation skills among nurses vary, affecting the clarity and accuracy of records (20). The stress and fatigue from mandatory overtime, long shifts, and excessive documentation further decrease the quality of documentation as nurses are physically and mentally strained (16). According to a survey commissioned by the American Hospital Association (AHA) (27), in emergency and acute care settings, for every hour spent on patient care, an additional 30 to 60 minutes are spent on mandatory paperwork, indicating the time-consuming nature of documentation.
Documentation's narrow focus on physical health	Taylor (28)argues that healthcare documentation often focuses primarily on physical health, neglecting holistic care elements like emotional, spiritual, and social needs. This narrow approach can reduce care effectiveness by failing to address critical aspects of patient well-being, ultimately affecting recovery, quality of life, and overall health outcomes.

Table 4: Regulatory bodies and approaches in determining standards of nursing documentation

Regulatory Bodies	Approaches
New York State Department of Health (NYSDOH)	This state agency oversees healthcare regulations within New York, enforcing standards that directly impact nursing documentation to ensure patient safety, compliance, and proper care practices (28). NYSDOH's guidelines emphasize accurate and comprehensive record-keeping to support healthcare decisions and legal accountability.
The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	JCAHO plays a pivotal role in establishing national accreditation standards for healthcare facilities (29). Its focus on patient safety and quality of care includes strict documentation guidelines that healthcare organizations must follow to maintain accreditation. JCAHO's requirements often serve as a benchmark for maintaining high-quality clinical records.
Centers for Medicare & Medicaid Services (CMS)	Formerly known as the Healthcare Financing Administration (HCFA), CMS regulates nursing documentation in relation to the provision of services under Medicare and Medicaid (30). The agency's focus is on ensuring compliance with federal standards to secure funding and reimbursement, making accurate documentation a key element of patient care for those insured under CMS programs.
Cameroon Nurses Association (CAN)	Cameroon Nurses Association (CAN) plays a key role in defining and promoting professional nursing standards, including documentation requirements. The association advocates for accurate record-keeping, patient confidentiality, and the use of standardized documents as critical components of quality nursing care (31). CAN works closely with regulatory authorities to enforce guidelines that align with global best practices.
Ministry of Public Health (MoPH)	The Ministry of Public Health (MoPH) (32) in Cameroon establishes healthcare policies, including nursing documentation standards that emphasize consistency, accuracy, and completeness in patient records. These standards ensure continuity of care, accountability, and improved patient outcomes. Regular audits and inspections by the MoPH assess compliance, promoting professionalism and legal accountability within healthcare institutions (29).
Cameroon Nursing and Midwifery Council (CNMC)	The Cameroon Nursing and Midwifery Council (CNMC) (33) regulates the nursing profession, emphasizing thorough documentation in clinical settings. This ensures nurses provide evidence-based care, uphold patient safety, and comply with legal and ethical standards. By focusing on standardized documentation, the CNMC promotes consistency across healthcare settings, ultimately contributing to improved healthcare delivery in the country (30) In nursing practice, consistent documentation is essential for effective communication, continuity of care, and legal protection. It ensures critical information is shared appropriately, safeguarding both patients and nurses. Inadequate documentation can lead to errors and patient harm, making adherence to standards crucial for enhancing care outcomes (34)

Written policies are often not adhered to in practice, and even when care is delivered, it is frequently undocumented or incorrectly documented. Conflicting policies further complicate practice, leading to confusion among staff (Belardo, 2006). Additionally, inadequate instruction regarding new policies, procedures, and forms hampers proper implementation, as outdated forms continue to be used in certain areas, and new policies are not consistently disseminated. Illegible or incomplete handwritten documentation, non-compliance with documentation standards such as abbreviations and corrections, and the use of forms from other facilities contribute to inconsistencies. Furthermore, the lack of clear instructions on multiple charting methods creates further challenges in ensuring standardized, accurate, and complete documentation across the facility.

Objectives

- To explore the reasons for health care documentation among nursing staff
- To outline the use of standardize documentsfor in-service training of nurses
- To describe factors that influence effective nurses' documentation in practices
- To identify regulatory bodies that determine standards of nursing documentation

REASONS FOR HEALTH CARE DOCUMENTATION AMONG NURSING STAFF: The reasons for nursing documentation in health care settings has been explored by different authors to be of utmost importance in patient outcomes as elaborated bellow.

Written policies are often not adhered to in practice, and even when care is delivered, it is frequently undocumented or incorrectly documented. Conflicting policies further complicate practice, leading to confusion among staff (Belardo, 2006). Additionally, inadequate instruction regarding new policies, procedures, and forms hampers proper implementation, as outdated forms continue to be used in certain areas, and new policies are not consistently disseminated. Illegible or incomplete handwritten documentation, non-compliance with documentation standards such as abbreviations and corrections, and the use of forms from other facilities contribute to inconsistencies. Furthermore, the lack of clear instructions on multiple charting methods creates further challenges in ensuring standardized, accurate, and complete documentation across the facility.

USE OF STANDARDIZE DOCUMENTS FOR IN-SERVICE TRAINING OF NURSES

In-service training of nurses on the effective use of standardized documents is crucial for ensuring consistent and accurate documentation in healthcare settings. The components that comprise a client's medical record may vary depending on the institution or practice environment but generally include standardized sections such as admission sheets, progress notes, referrals, diagnostic orders, and discharge summaries. Familiarizing nurses with these components during in-service training improves both the quality of care provided to patients and the continuity of care across disciplines.

FACTORS THAT INFLUENCE EFFECTIVE NURSES' DOCUMENTATION IN PRACTICES: Nursing documentation is a critical component of care, yet numerous factors hinder its effectiveness.

REGULATORY BODIES THAT DETERMINE STANDARD OF NURSING DOCUMENTATION

Various regulatory bodies enforce nursing documentation standards, with some requirements consistent across organizations and others varying by agency. Key agencies like the New York State Department of Health (NYSDOH), The Joint Commission (JCAHO), and The Centers for Medicare & Medicaid Services (CMS) establish guidelines that ensure healthcare quality and accountability, shaping nursing documentation practices (Taylor, 2003).

CONCLUSION

The reasons for healthcare documentation have been found to be important in nursing practice. Documentation aims to ensure vital record of patient care, support communication among the healthcare team, enhance care coordination and provide crucial data for legal, educational, and research purposes.while the standardized documents include, admission sheets, progress notes, and medication administration records (MAR). The factors that influence effective nurses' documentation were shortage of nurses, high volume of paperwork, literacy and documentation skilland the regulatory bodies were New York State Department of Health (NYSDOH), The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Centers for Medicare & Medicaid Services (CMS), Cameroon Nurses Association (CAN), Ministry of Public Health (MoPH) and Cameroon Nursing and Midwifery Council (CNMC), working on aspects like standardized nursing documentation to ensure patient safety, compliance, accountability, and quality care across healthcare systems.

RECOMMENDATIONS

- Nursing documentation and reasons be made available for use in all units.
- Standardized documents be made available for all nursing staff.
- Seminars should be organized on effective documentation practices.
- Experiences of regulatory bodies be imbibed and made use of.

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