Original Article

PRACTICE OF NURSES ON PATIENT RECORD MANAGEMENT IN TERTIARY LEVEL HOSPITALS

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ABSTRACT

Background: Patient record prescribed further state of health of the patient and determines the diagnosis of diseases by exerting the history. The study was conducted to assess the practice of patient record management among nurses in a selected government hospital, Dhaka, Bangladesh.

Methods: A descriptive type of cross-sectional study was done among 214 respondents following convenient methods of sampling from Shaheed Suhrawardy Medical College Hospital (ShSMCH), Dhaka, Bangladesh from January to December 2020. Data were collected through face-to-face interview by using a pretested semi-structured questionnaire.

***Results*:** The study revealed that about 27% of the respondents were belonging to the 26-30 age groups and the mean ± SD of age was 35.16 ± 6.93. Most of the respondents 48% were diploma in nursing. Out of 214 respondents, the pattern of nursing documentation was always filled up by about 97%, documentation practice was taken manually by 55%, management of missing files was done by 33% of respondents, and confidentiality record kept access for authorized ones was mentioned by 58%. Keeping patient records after death was made by 34.2% of respondents and preservation of medico-legal files was stored on papers narrated by 90% of the respondents. The majority of the respondents 73.4% mentioned inadequate working knowledge as a barrier in medical history training.

Conclusion: Practice of Nurses on patient record management may help the authority to identify any error in the patient care, self-evaluation, and assure the quality of care. The study has an immense value if it's possible to develop the electronic data record-keeping system in every government hospital.

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INTRODUCTION

Patient record is inevitable for monitoring patients' status and has a significant role in the education system. Health care providers excerpt a lot of information like admission registers, referrals forms, cards, treatment sheets, mortality records, images as x-rays, ultrasound scans, and magnetic resonance imaging, observation charts, ward round records, matron's report, shift management reports, and clinical anecdotal notes, etc. by using patient record. A patient record acts as a formal legal document that gives details on patient management as it provides a strong source of evidence for every health care provider in care delivery[1]. Record management practice has always been an organization's fundamental asset, without it the effectiveness and efficiency of an organization will be questioned. Each organization needs to keep patient records in order to realize lawful needs for their operations. Although the International Standard for the management of business records (ISO 15489) emphasis the need for superior records management as an efficient means for countries and organizations to fulfill their obligations along with expectations, many developing countries like Ghana has suffered a growing challenge from both

government and private institutions due to the nonexistence of effectual systems for managing data [2]. Nursing documentation is an exigent component of safe, ethical, and effective nursing practice whether the documentation is paper-based or electronic. This document describes nurses' accountability and these should be sustained with Standard of Practice, Code of Ethics, and all applicable practice guidelines as well as agency policies [3]. Keeping a patient record is part of the professional obligation of clinicians, nurses along with patients, so patient records are always kept in the attentiveness to all of them[4]. It has been stated that nursing records are often incomplete [5], inaccurate [6], and had imperfect quality [7], [8]. The challenges for documentation revealed a shortage of staff [9], deficient knowledge regarding the importance of documentation [10], patient overload, lack of on-job training [11] as well as inadequate support from nursing leadership [9]. The aim of the study was to assess the practice of patient record management among nurses in a selected government hospital, Dhaka, Bangladesh.

METHODS

A descriptive type of cross sectional study was conducted among registered nurses related to medical history taking. The study was carried out indoor at a government hospital named Shaheed Suhrawardy Medical College Hospital (ShSMCH), Dhaka. Data were collected through a convenient sampling method by pretested semi-structured questionnaire. After pretesting, the questionnaire was finalized and used for data collection by taking informed written consent from each respondent through face-to-face interviews. The questionnaire comprises of three sections, included socio-demographic questions of respondents, practice of nurses, and barrier of nurses on medical history management. Collected data were analyzed with the help of Statistical Package of Social Science (SPSS) version 26. Data were presented in frequency tables. Data were collected to maintain the confidentiality and privacy of the respondents strictly. Prior to the study ethical approval by the Institutional Review Board (IRB) of the National Institute of Preventive & Social Medicine (NIPSOM) was taken. Out of 214 registered nurses, who attended the hospital during the data collection period was included and nurses who couldn't want to give written consent were excluded from the study.

In the practice session, the questionnaire was comprised of in total 12 questions. For scoring, good practice was measured by multiplication of total patient record practice by total questions whereas poor practice was calculated by deduction of good practice score from one hundred.

RESULTS

The study revealed that about 26.6% of the respondents belonged to the 26-30 age group and the mean (±SD) of age was 35.16 ± 6.93. The mean (±SD) of age was 35.16±6.93 and most (84.6%) of them were female. Most of the respondents were diploma in nursing 47.7%. Out of 214 respondents, a pattern of nursing documentation was always filled up by about 96.7%, documentation practice was taken manually by 55.1%, management of missing files was done by 33.3% of respondents, and confidentiality record kept access for authorized ones was mentioned by 58.9%. Keeping patient records after death was made by 34.2% of respondents and preservation of medico-legal files were stored on papers narrated by 90.3% of the respondents. Majority of the respondents 73.4% mentioned inadequate working knowledge as a barrier in medical history training. Among 214 respondents, 65.45% had a good practice and 34.55% had poor practice (Table1).

Table 1. Socio-demographic characteristics of the respondents (n=214)

Attributes	Characteristics	Frequency	Percentage
Age(years)	26-30	67	31.3
	31-35	54	25.2
	36-40	53	24.8
	41-45	20	9.3
	More than 45	20	9.4
	Mean ±SD		35.16 ± 6.93
Sex	Female	181	84.6
	Male	33	15.4

Education	Diploma in Nursing	102	47.7
	B.sc in Nursing	87	40.7
	Masters of Public Health	25	11.6
Monthly family income	27000-30000	77	36.0
	31000-40000	108	50.5
	41000-50000	23	10.7
	51000-60000	6	2.8
	Mean ±SD		34512.82± 6678.10
Religion	Muslim	171	79.9
	Hindu	23	10.7
	Christian	15	7.0
	Buddhist	5	2.3
Marital Status	Married	184	86.0
	Unmarried	30	14.0
Working Experience	1-5 years	36	16.8
	6-10 years	82	38.3
	11-15 years	52	24.3
	16-20 years	26	12.1
	21-25 years	10	4.7
	Mean ±SD		11.19±6.10

Figure 1 showed that out of 214 respondents 96.7% of nurses always practiced while 3.3% of nurses sometimes did documentation practice

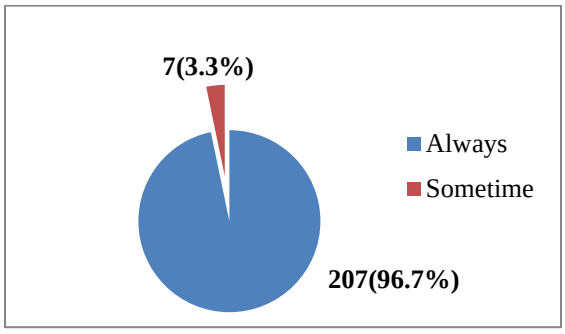

Figure 1. Pattern of documentation practice (n=214)

Figure 2 showed that 84.6% nurses preferred to document medical record at any time when convenient and 15.4% of nurses preferred at the end of shift hour.

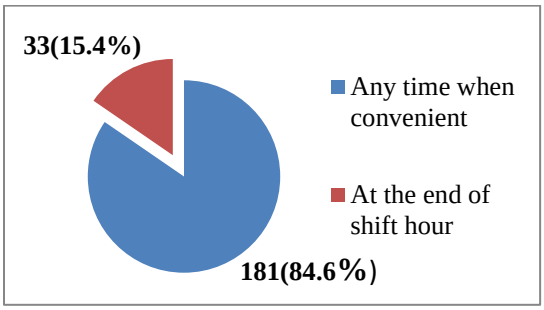

Figure 2. Practice on preference time to documentation (n=214)

Figure 3 showed that out of 214 nurses type of record management practice was done manually by 55.1% and Electronic by 6.1% of nurses.

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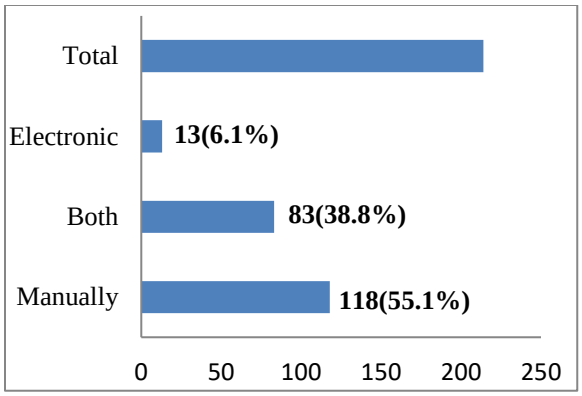

Figure 3. Types of record management practice (n=214)

Figure 4 showed that only 58.9% respondents kept confidentiality of patient record access for authorized ones and 41.1% put the records on the computer and protect it with passwords.

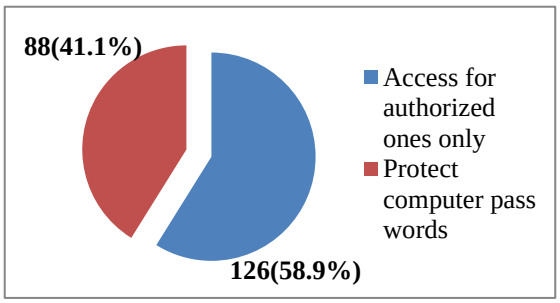

Figure. 4 Ways to keep confidentiality of record (n=214)

Table 2. showed out of 214 respondents 79.9% mentioned patient record file was taken to the outdoor department and 73.4% stated inadequate working knowledge as a barrier to medical records.

Table 2. Barriers related to patient record practice*

Respondents barrier	Frequency	Percentage
Inadequate working knowledge	157	73.4
Inadequate staff	112	52.3
Lack of time	140	65.4
Lack of work motivation	135	63.1
Lack of orientation training	121	56.5
Patient record file was taken to the outdoor department	171	79.9

*multiple responses

Table 3 showed patient record management practice level of the respondents and score. Out of 214 respondents, 65.45% had a good practice and 34.55% had poor practice.

Table 3. Practice of nurses on patient record management

S/N	Practice of nurses patient record	Percentage	Good practice	Poor Practice
1	Pattern of nursing documentation	96.7		
2	Preference time to documentation	84.6		
3	Type of record management practice	55.1		
4	Way of managing error record(correction patient file)	25.2		
5	Reading colleague's note	98.6		
6	Control incomplete record	91.6		

7	Sending the patient record file statistician	89.7	65.45%	34.55%
8	Patient file management	33.2		
9	Respondents file damaged	19.6		
10	Keeping patient record after death	99.1		
11	Preservation of medico-legal file management	92.1		
12	Duration of preservation of a medico-legal record	0		

DISCUSSION

A descriptive type of cross-sectional study was done among 214 respondents in the present study. The study revealed that the majority 26.6% of the respondents belonged to the 26-30 age group and the Mean ±SD of age was 35.16±6.93. Another study stated that a total of 290 respondents participated and the ages of the respondents ranged from 15-to 42 with a mean age of 26.5 ± 2.0 [12]. The study expressed that among the respondents, females were 84.6% and males were 15.4%. Similarly, the finding was found where female respondents were more, 65.5% were females and 34.5% were males [12]. This study described that a total of 214 had a master of public health 11.6%, B.Sc. in nursing 40.7%, 47.7% diploma in Nursing (Table 1). The results were narrated where 6% nurses had MPH, 88.3% had B.Sc., 5.7% nurses had a diploma, and [12]. The present study revealed that out of 214 respondents, 96.7% of nurses always practiced patient records documentation while another study found 59.5% of respondents practiced patient records documentation [13]. In the present study, 84.6% of respondents preferred any convenient time for documentation of patient records whereas another study [13] enrolled 37.3% of respondents for documentation of patient records at their convenient time. In the present study, 55.1% of respondents enrolled that they practiced record management manually whereas another study revealed that 83% of the respondents preferred electronic records management for proper and safer records keeping [11]. The present study stated that 79.9% of respondents narrated patient record files was taken to the outdoor department as the most frequent barrier related to medical record practice where another study found lack of time, lack of knowledge, organization obstacles, difficulty in writing, and inappropriate patient record forms as barriers related to medical record practice [14]. The present study stated that 58.9% of respondents mentioned that they provide access to a confidential record only for the authorized one and in Ethiopia, a study found 54% of respondents provide access only for the authorized one. Out of 214 respondents present study narrated that 65.45% of respondents had a good practice [13]. The present study found that among 214 respondents, 65.45% had a good practice and 34.55% had poor practice. A study conducted at the University of Gondar Hospital revealed that good nursing care documentation practice among nurses was 37.4% [15]. In another study in Ethiopia, the result showed that practice nursing care documentation was inadequate (47.8%) [13].

During conducting the study various limitations were faced, such as lack of electronic patient record practice due to insufficient training, reduce sample size and the chance of selection bias as a convenient sampling technique was used**.** The findings were not represented the whole population of Bangladesh. Electronic patient records practice was required and adequate training must be provided for the nurses to enlighten their technical skills.

CONCLUSION

The study was conducted to assess the practice of medical history among nurses in a selected government hospital, Dhaka, Bangladesh. Good practice showed the practice of Nurses on medical history management may help the authority to identify any error or gap in the patient care, self-evaluation& assure the quality of care. The study has an immense value if we can develop the electronic data record-keeping system in every government hospital.

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