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Record-Keeping: A Qualitative Exploration of Challenges Experienced by Undergraduate Nursing Students in Selected Clinical Settings

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Abstract

Good nursing practice requires detailed record-keeping, which should be timely, comprehensive and accurate. Undergraduate nursing students experience challenges with record-keeping. As a result, a phenomenal qualitative study aimed at exploring and describing the record-keeping challenges experienced by undergraduate nursing students was carried out in one of the northern-eastern regions, Namibia. The data were collected through three focus-group discussions with 23 second-year degree nursing students. It became evident that nursing students experienced challenges with record-keeping in clinical practice, as evidenced by the three themes: theory-practice gap, health system-related challenges and hospital staff-related challenges. This study has implications for nurse educators in terms of promoting uniformity and good record-keeping practices in clinical settings.

Keywords: record-keeping, undergraduate nursing students, clinical practice, clinical settings, qualitative study

1. Introduction

Record-keeping is an important primary tool in the practice of nursing. Records are the who, why, how, where, what and when of patient care during hospitalisation (Garba, 2018). According to Chelagat, Sum, Chebor, Kiptoo and Bundotich-Mosol (2013), since the time of Florence Nightingale, nurses viewed documentation or recording as being a very important aspect in the nursing profession. Records stand as a source of evidence of each health-care provider's accountability in the delivery of care. They also serve both as an educational tool and a method of monitoring patient status (Selvi, 2017). Record-keeping is important as it also provides data useful in research and education – be it retrospective, prospective or longitudinal. Moreover, record-keeping can help with the planning and budgeting of the hospital (Chelagat, Sum, Chebor, Kiptoo, & Bundotich-Mosol, 2013; Selvi, 2017).

Good record-keeping promotes continuity of care and demonstrates the quality of care delivered to the clients. Moreover, documentation provides the evidence necessary for any legal proceedings (Owen, 2005). However, poor record-keeping has a negative impact on care delivery and clinical decision-making. Record-keeping has, by far, become a low priority for busy nurses, and patient notes are now often poorly maintained (Jefferies, 2010). Good and quality record-keeping is linked with the improvement of patient care, while poor documentation is regarded as contributing to poor quality nursing care (Prideaux, 2011). Incomplete nursing records shows no evidence of care provided to the patient – like a saying in nursing that 'what is not recorded is not done' (Mutshatshi, Mothiba, Mamogobo, & Mbombi, 2018). Additionally, record-keeping demonstrates a full account of a nurse's assessment and care planned and provided to the patient, and includes all relevant information about patient condition at a given time and the measures a nurse took to respond to their needs.

Record-keeping demonstrates effective patient care and the response to nursing intervention. According to Mutshatshi et al. (2018), there have been complaints of poor record-keeping in hospitals, despite all the efforts to improve record-keeping challenges. Good recording ensures that hospital's management runs smoothly, but it also provides evidence of hospital accountability for its actions and forms key sources for medical statistical reports and the health information system. The art of keeping and managing health records is an issue that has generated concerns over time (Abdulazeez, Abimbola, Timothy, & Linda, 2015).

There are numerous documents to be recorded for patient care. These include six-hourly observation charts, progress reports, nursing care plans, nursing clinical records and many others. All these documents are part of the

care of the patient, and if they are incomplete, it could lead to wrong interpretations of care rendered. The nursing students are allocated to different health facilities for their practical training. Moreover, these nursing students perform routines and activities and this includes record-keeping. Poor record-keeping reflects poor care practices and nurses need to consider that this link is often exploited in court to the detriment of the nurse (Andrews & Aubyn, 2015). The previous studies focus on record-keeping challenges experienced by nursing staff; however, there is less focus on nursing students. This is in spite of one of the learning outcomes of nursing students in clinical practice in keeping accurate patient records and the appraisal of nursing care using available records. In addition, the researchers found that poor record-keeping is also a concern in most death reviews, and hence nursing staff are held accountable for poor practice because their actions were not recorded – which meant it was not done.

This study was conducted to explore and describe the challenges experienced by the Bachelor Honours Degree nursing students, with regard to record-keeping in clinical practice at selected clinical settings in north-eastern region, Namibia.

2. Methods

2.1 Design and Setting

In this study, a phenomenological qualitative design was used (Creswell, 2013). The study was conducted at the public university campus in the north-eastern region of Namibia. The campus offers the four-year undergraduate Bachelor of Nursing Science (clinical) Honours degree. The nursing students enrolled by the campus do their clinical practice at the intermediate hospital in the region, as well as at the selected regional clinics. Nursing students are placed in clinical units such as the medical ward, surgical ward, paediatric ward, casualty and outpatient department, operating theatre, maternity ward, and primary health-care clinics. They are exposed to clinical practice for two weeks a month. This commences three months after registration and extends to the fourth year of the programme.

2.2 Population Sampling Strategy

The participants were second year nursing students enrolled at the satellite campus of the public university. The researchers focused on second level students because they are the only group that does clinical practice in the selected region. The third and fourth year groups go for clinical practice in other regions, outside the context of the study. First year students only practised for a period of six months and therefore do not have adequate exposure to clinical settings. The researchers approached participants face-to-face in the classroom at the university campus and the purpose and objectives of the study were explained to them. A convenient sampling was used to drew a sample of twenty three (n = 23) readily available second year nursing students from a total of 91 registered at the campus. The participants' ages ranged from 18 to 35 years; there were 14 females and 8 males.

2.3 Data Collection

Data were collected between 25 September 2018 and 10 October 2018, via focus-group discussions. The students that were willing to participate were recruited by the researchers, and the time and venue for discussions were arranged with them. A total of three focus-group discussions were conducted, which consisted of nine, seven and seven participants each. The discussions lasted about 40 to 50 minutes, and the number of discussions held was determined by data saturation (Polit & Beck, 2017). The researcher used a semi-structured focus-group discussion guide, with a prepared written topic guide prior to the discussions; however, probing questions were used to further explore participants' responses and to stimulate more detailed information (Polit & Beck, 2017). All focus-group discussions were audio recorded using a digital voice recorder. Pilot testing was conducted with a focus-group discussion of 5 second year nursing students, which helps to refine the topic guide and other data-collection plans (Creswell, 2013).

2.4 Data Analysis

The content analysis method was used to analyse the data in this study, since it was the most reliable strategy used in qualitative research (Grove, Burns & Gray, 2013). After data were transcribed, member checking was carried out by the research participants in order to ensure trustworthiness. Coded data were then categorised and themes were identified. Furthermore, trustworthiness was ensured following the principles of Lincoln and Guba (1985), which consists of the criteria of credibility, dependability, conformability and transferability.

2.5 Ethical Considerations

The study was granted ethical clearance by the School of Nursing Ethics Committee on campus, and permission to conduct the study was granted. Participation in the study was voluntary and all participants signed informed consent forms prior to commencement of the focus-group discussions. Anonymity and confidentiality was ensured

by making sure no names were recorded during data collection, and all digital recordings were safely stored in a lockable cupboard. Participants could withdraw from the study at any time without giving explanations or without being threatened.

3. Findings

Themes that emerged as findings of the study were: (i) theory-practice gap; (ii) health system-related challenges, and (iii) hospital staff-related challenges.

3.1 Theory-Practice Gap

The students felt that principles of recording taught at the university were not correlating with what was taught in the clinical area. This was confusing for them, because they did not know which principles to follow. The following quote illustrates what was expressed by one participant:

… the way we are taught here at school! (shaking head), like in midwifery, our lecturers taught us to open a partograph when the client is in the latent phase, but at the hospital they do it differently. The sisters don't allow us to open the partograph when the patient is in the latent phase, it's only when the patient is in active phase – so it's really a challenge (p2a，Note 1)

Furthermore, the students experienced challenges with record-keeping owing to inadequate provision of resources, and these included a lack of record-keeping papers. During theoretical sessions, the students are taught how to document during simulation sessions, but going to practice it becomes a challenge – because the documents or record-keeping papers are not there. One participant mentioned that:

… other challenges can be that the nursing units where we practice, some papers are not there whereby you have to do proper record keeping. Like, for example, maybe the temperature chart is not there, the fluid balance chart is not there – so even though you want to do a full record-keeping, then it will not be complete. (p7a)

Moreover, during the clinical practice of students they rotate from ward to ward, and in that rotation it was a challenge, because they had to be taught different record-keeping styles in different wards. The lack of universality in the clinical area presented challenges among the students, because there is no consistence in what they are taught in the hospital. It seemed difficult to know what was right from wrong. With every clinical rotation, the record-keeping also has to change. One participant mentioned this:

… we find it hard when it comes to the nursing care plan, because different wards use different styles (p7b).

Nursing students also indicated that lack of knowledge on how to document led them to not wanting to do record-keeping. Some students ended up recording only in the papers they knew, and ignored the ones they did not know. Participants verbalised that some of the record-keeping documents were not used during their simulation sessions, which meant that they had to learn them in the practice only:

… some documents like the matron's report form, students don't know how to record them because it's really not taught – sometimes we just leave it blank (p1b).

3.2 Health System-Related Challenges

The participants reported challenges relating to how the hospital system is operating. Record-keeping papers were described as being complicated and too numerous. Participants felt that some papers were unnecessary and strenuous, which led to some documents being left out when record-keeping is done. Participants mentioned a few documents they found to be complicated: the nursing care plan, the fluid balance chart, the matron's report and the 6-hourly temperature chart. This was indicated as follows:

… I have experienced that there are a lot of things that you have to record, some of them are really not necessary (p2c)

Furthermore, participants conveyed that there is an increase in patients and there are but few staff, which resulted in record-keeping being straining. There is an overburden on staff and it is tiring – leading to some documents being left out and undocumented because the staff are tired and want to rest. Staff shortage has a negative impact on record-keeping, as few nurses attend to the many patients which have to be recorded in many papers. Students stressed they had to do a lot of work related to the patient, and this led to poor recording. Some participants mentioned that:

… there is really a challenge, sometimes we don't do patients' evaluation due to the fact that there are a lot of patients … we only evaluate critical patients because the number is really large and the ward is congested; there's really a shortage of staff (p 1c).

… patients are many, and that means there is a lot of documentation to do, and we end up forgetting to write in some findings (p 9a).

Concerns about record-keeping being a time waster were stressed. Participants felt they spent more time recording than actually attending to the patients. The participants highlighted how they spent more time filling in all the forms for record-keeping. During assessment of patients, students felt they spend a lot of time documenting – rather than focusing on patient observations. Moreover, it seemed that because of the time spent on filling in the forms, students ended up forgetting to put in other records such as statistic books. One participant stated:

... we spend more time recording, imagine walking from patient to patient and doing recording. After that you get tired, and don't even have time to spend with the patient, you just do a quick observation because you want to go rest (p3b).

3.3 Hospital Staff-Related Challenges

Since the participants have limited knowledge of record-keeping, often they were not allowed to record in patient files. In some cases, they were told to not record some findings and procedures that they had done, which seemed to be a challenge because they felt that not recording would not help them learn the documentation of clinical procedures. Moreover, it seemed as if nurses preferred students doing the routine work, but not record-keeping. This was expressed as follows:

… on maternity records, uh! Students are not allowed to write in the green files (maternity records). Normally during client's evaluation in the maternity ward, students write on the piece of paper and the sisters copy information into the maternity records (p4c).

… I have faced one challenge, especially in the maternity ward, when we do parameters. They (the sisters) tell us to not record abnormalities in the files (p6a).

In clinical settings, one of the roles of a registered nurse is to teach students, but it seems this was another challenge experienced by participants. Participants stated that some nurses did not give them direction when it came to record-keeping. Since what they were taught in theory does not correlate with what they were taught in the clinical area, participants felt nurses not giving them assistance on how to do record-keeping was a big challenge. One participant stated:

…some students don't know how to record in some documents, [and] now when they ask the sisters to explain how to do it, sometimes they refuse and say that they are not our lecturers (p2b).

The participants experienced challenges with how some hospital staff would write in patients' files – and participants felt it was hard for them to read and carry out tasks, particularly doctors' notes in cases of a prescription. Moreover, the participants felt that poor handwriting leads to many mistakes being made in the clinical area – especially with students. This was expressed thus:

… some challenges with record keeping, especially in doctor's notes. Most doctors who deal with the surgical patients, uh, their handwriting is not easy to read. So we find it difficult to read unless you have to go [and] ask them to explain (p 2a)

4. Discussion

Record-keeping is an important primary tool in nursing practice, because the whole idea behind it is to provide better care of the patient through careful recording of every detail relating to their case (Inan & Dinç, 2013). This study highlighted some of the challenges experienced by nursing students in clinical practice. Despite the importance of record-keeping in clinical practice, the key findings in this study reveal a theory–practice gap and other challenges related to the health system and hospital staff.

Landers (2008) indicates that theory provides the basis for understanding the reality of nursing, and therefore the content learned in the classroom should correlate with what students experience in wards. However, during the researcher's discussions with participants, they expressed the opposite: how what they were taught at university did not correlate with what they were taught in hospital. This gap in the learning process is affecting the students, as it left them confused about what to do and what not to do. The participants said they were confused as they believed that what they were taught about record-keeping at university was correct and not what they were taught in the clinical area. Nevertheless, students followed what they were taught in clinical practice instead.

This study also revealed how a lack of resources resulted in poor record-keeping. Students stated how some wards did not have record-keeping papers and that even when they really wanted to do proper record-keeping, it would be incomplete because of other missing recording documents. Mutshatshi et al. (2018) supports the findings of this

study – that an inadequate supply of recording materials leads to incomplete recordings. Logan (2015) also confirms that a lack of resources is a challenge in the health system, as it leads to inaccurate or incomplete records. Furthermore, nurses can perform various activities and plan patient care, but such activities are not completely recorded due to a lack of recording materials.

Like the incompatibility between hospital teaching and university teaching, this study revealed a lack of uniformity between the wards. With each unit students practised, record-keeping was done differently and they had to adjust to it. However, even so, the knowledge taught from that ward was only for that ward and was not carried across to another ward, because it would also have a different way of recording. Slone et al. (2013) agree with the findings of this study that there is inconsistency in record-keeping. A nurse in one country should have to read the work of a nurse in another country and make sense of what the person was recording. However, inconsistency in how nurses record things, breaks the universality code.

Another record-keeping challenge was complexity of the recording forms. Participants detailed how some of the recording forms were too complicated for their understanding, and the record-keeping papers were numerous. Nurses perceive that they spend much time on manual recording – leading to incomplete recording (Mutshatshi et al., 2018). Furthermore, participants itemized how the recording forms were sometimes misunderstood and questioned if they were even necessary – and this was also challenge. Students in this study felt the large number of patients was a challenge because they become over worked, and were too tired and stressed out. The expansion in the number of patients also meant that recording was increased. One patient has about 5-10 forms to be recorded and you need to multiply this by the number of patients with only a few staff available. There are many factors emerging from the personnel shortage and negative attitudes of nursing personnel towards recording (Mutshatshi et al., 2018). Portoghese, Galletta, Coppola, Finco and Campagna (2014) support the findings of this study that nurses and student nurses are not recording because of their high workload. Students found it difficult to cope with the increased workload associated with documenting patient information on multiple records.

Another record-keeping challenge in this study is that recording was time-consuming and it took most of nurses' time. It seemed that more time was spent on recording and not attending to patient needs. This concurs with Mutshatshi et al. (2018), who indicated that record-keeping takes too much of nurses' time and they end up exhausted and this leads to documentation being half done or not at all. Keeping good records is regarded as an essential professional and legal requirement of being a nurse, and postponement of documenting patient information right after an event might lead to medico-legal hazards (Inan & Dinç, 2013). However, in this study the participants expressed how they left work undone because they were tired and wanted to rest for a while – and sometimes they then forgot to go back to the necessary recording.

Furthermore, nursing students experience challenges with hospital staff, and this included all categories of nurses, medical practitioners and allied health professionals. Nursing students felt that some nurses were not willing to teach them how to record, and often negative comments were made if they did not know how to record some files. Students expressed having less knowledge on how to record in some documents, and because they did not get guidance from nurses, they wrote incorrectly in patient files. This agrees with Shihundla, Lebese and Maputle (2016), who stated that record-keeping is a vital part of nursing and education needs to be provided to everyone accessing the records – including students. However, in this study, participants felt they were just delegated to only do routine work, which included bed making and taking of parameters – but not recording in the files. This was not supported by nursing students, because they are in training, and for them learning how to do record-keeping is vital.

Despite the computer revolution, information in clinical records continues to be handwritten. The originator may understand what has been written, but difficulties may arise when other parties are involved (Sokol & Hettige, 2006). Nursing students in this study experienced challenges with how hospital personnel were writing in patient files. Being students they would find it very hard to read what had been written. This made nursing care deficient, because personnel handwriting was hard to read and thus students needed to either ask for assistance to help with the reading or they ignored the orders, which now affected patient care. Landers (2008) indicates that nurses are mentors and role models in the clinical area; they are also teachers and students look up them. Therefore they are required to do proper recording with legible handwriting so that nursing students can learn the correct practices. Poor record-keeping reflects poor practice and nurses need to consider that this link is often exploited in court to the detriment of the nurse (Andrews & Aubyn, 2015). Nurses not doing it properly sets a bad example for students.

In understanding the findings of this study, the following limitations need to be considered: Despite the findings being consistent with the current literature, generalisability is limited because it was a qualitative study. In addition, this study did not include challenges experienced by nursing staff such as registered and enrolled nurses – it only

focused on the record-keeping challenges of nursing students. Therefore a study exploring hospital staff recording challenges would address issues faced by nurses of other categories. There are also certain areas in this study that need to be explored further – such as contributing factors to the theory–practice gap.

5. Conclusion and Implications

The study explored nursing student record-keeping challenges in clinical practice. The study concluded that challenges of recording were more to do with clinical settings related to practical and theory gap, hospital-related challenges and hospital staff-related challenges.

This study has implications for teaching and the learning of nursing students; record-keeping challenges are known and therefore nurse educators need to work toward attaining uniformity to lessen the theory–practice gap. Nurse educators in clinical settings and training institutions need to work together to follow the same recording principles in order to avoid confusion among students. As it was suggested that nursing staff are overloaded with work, the training institutions need to hire clinical instructors that follow up on students during their clinical placement – in order for them to demonstrate some procedures in the clinical area. All these factors will ensure that nursing students master the principles of record-keeping, which is a skill that should accompany procedural performance skills. Things

Competing Interests Statement

The authors declare they have no competing or potential conflicts of interest.

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Notes

Note 1. Participant code.

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