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Nurses' perceptions and attitudes towards documentation in nursing

Stališča medicinskih sester o pomembnosti dokumentiranja v zdravstveni negi

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Key words: nursing documentation; nursing professionals; time for documentation

Ključne besede: dokumentiranje; zaposleni v zdravstveni negi; čas za dokumentiranje

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ABSTRACT

Introduction: Nursing documentation is essential for ensuring a safe, high-quality and continuous nursing care and research work. By means of documentation nurses communicate with each other, other members of the healthcare team and other care providers. The aim of the present research was to investigate nurses' opinions about the importance of nursing documentation.

Methods: For the purposes of the study, a quantitative non-experimental research design was employed. A quota sampling included the nursing employees in ten Slovenian hospitals. The survey was composed of closed-ended questions. The data were collected from June 1, 2012 to March 31, 2013. The response rate was 44.95 %. A total of 592 respondents participated in the research, 47.3 % with secondary education and 52.7 % with completed undergraduate study programme. Chrombach's coefficient alpha was 0.898. Descriptive statistics, Kolmogorov-Smirnov test, Spearman's correlation coefficient, and Mann-Whitney U test were used.

Results: Nurses with at least college degree attributed more importance to documentation compared to those with secondary education (p = 0.001). Statistically significant correlation was not established (p = 0.98). However, a negative correlation was identified between the time used for documentation and positive attitude towards documentation (p = 0.04).

Discussion and conclusion: Nurses perceive documentation as an important part of their work. They believe that documentation enhances transparency, quality and continuity of care, and patient safety. It would be necessary to identify the differences in practices and perceptions of handovers between nurses and other healthcare providers.

IZVLEČEK

Uvod: Dokumentiranje zdravstvene nege je pomembno za zagotavljanje varne, kakovostne, kontinuirane zdravstvene nege. Z njegovo pomočjo medicinske sestre komunicirajo med seboj, med člani zdravstvenega tima in s pacientovimi oskrbovalci doma. Namen raziskave je ugotoviti stališča medicinskih sester o pomembnosti dokumentiranja v zdravstveni negi.

Metode: Izvedena je bila kvantitativna neeksperimentalna raziskava. Izpeljana je bila tehnika anketiranja z vprašalnikom zaprtega tipa. Kvotni vzorec je zajel zaposlene v zdravstveni negi v desetih slovenskih bolnišnicah. Zbiranje anket je potekalo od junija 2012 do marca 2013. V raziskavo je bilo vključenih 592 anketirancev, od tega 47,3 % s srednješolsko izobrazbo in 52,7 % z najmanj višješolsko izobrazbo. Cronbachov koeficient alfa je bil 0,898. Izvedena je bila opisna statistika, test Kolmogorov-Smirnova, Spearmanov korelacijski koeficient, Mann-Whitneyev U-test.

Rezultati: Medicinske sestre z najmanj višješolsko izobrazbo dokumentiranju pripisujejo večji pomen kot medicinske sestre s srednješolsko izobrazbo (p = 0,001). Med stališči do dokumentiranja in dolžino delovne dobe ni statistično značilne korelacije (p = 0,98). Obstaja negativna povezava med časom, potrebnim za dokumentiranje, in pozitivnim stališčem medicinskih sester do dokumentiranja (p = 0,04).

Diskusija in zaključek: Medicinske sestre dokumentiranje dojemajo kot pomemben del delovnih nalog, saj omogoča kontinuiteto zdravstvene nege kar vodi v večjo kakovost dela ter varnost pacientov. Raziskavo bi bilo potrebno razširiti tudi na druge profile v zdravstvu in mnenja primerjati med seboj.

The article includes part of the research work based on the master thesis of Romana Petkovšek-Gregorin: *Nurses' perceptions of and attitudes towards documentation in nursing* (2014).

Članek prikazuje del raziskave, ki je nastala na osnovi magistrskega dela Romane Petkovšek-Gregorin: *Stališča medicinskih sester o pomembnosti dokumentiranja v zdravstveni negi* (2014).

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Introduction

Documentation is any written or electronically generated information about a client that describes client status, or the care or services provided to that client (Potter, et al., 2006). Good communication is essential to performing systematic, professional and quality work, including nursing practice. It ensures continuity of care, reflects and increases professionalism, and provides grounds for assessment of nursing practice (Rajkovič, 2010).

Facilitating and inhibiting factors in relation to nursing documentation

The information in nursing documentation should include a complete account of the client's needs, including identified issues and concerns, assessment findings, intervention(s) provided and the evaluation of the client care outcomes in order to provide quality and continuity of nursing care as well as to measure the degree to which goals have been achieved (Sexton, et al. 2004; Cooper & Buist, 2008). Kerr (2002) states that shift handover plays a pivotal role in the continuity of patient care in 24-hour nursing contexts, especially in the critical care setting.

Nurses should document relevant objective information related to client care, that what a nurse sees, hears, feels and smells and should avoid documenting opinions or presumptions, generalizations or biases (College and Association of Registered Nurses of Alberta, 2013). Austin (2011) advises that the best way to describe the patient behaviour is to use citations. Potter and Perry (2010) additionally accentuate that nursing activities should reflect professional accountability which is confirmed by the provider's signature. Regardless of different formats proposed by various authors, nursing documentation should include information to identify the patient/consumer, the healthcare provider, the clinical reasoning for the choice of care, the client's response and/or outcome of the interventions, and future plans (Kohek & Vogrinčič, 2004; Ramšak Pajk & Šušteršič, 2005; College and Association of Registered Nurses of Alberta, 2013). It is advised that nurses document legibly, using clear and established terminology and that documentation is properly structured (Björvell, et al., 2003; Ramšak Pajk, 2006; McGeehan, 2007), which ensures quality treatment and continuity of care. If a task performed by nurses is not entered into the nursing documentation, it may be assumed in a legal context that this task has not been performed (Ramšak Pajk, 2006; Kulhanek, 2010; College & Association of Registered Nurses of Alberta, 2013).

Cheevakasemsook and colleagues (2006) established that complexities in nursing documentation include three aspects: disruption, incompleteness and inappropriate charting, therefore the client-care record notes should be completed at the time of the event or as close to it as prudently possible. Contemporaneousness enables the exact reflection of the events (Griffith, 2004; Vee & Hestetun, 2009; Jefferies, et. al., 2010). According to Törnvall and Wilhelmsson (2008), nursing documentation has been found to be inadequate to assure delivery of good and safe care. Nursing records need more clarity and need to be more prominent regarding specific nursing information. There are weaknesses and shortcomings in the nursing records, such as difficulties in finding important information because of a huge amount of routine notes to fulfil their purpose of transferring information and to constitute a base for quality development of care. In their literature review on currently used methods of nursing documentation, Blair and Smith (2012) noted that nurses still experience barriers to maintaining accurate and legally prudent documentation due to lack of available time, workload, attitudes towards nursing documentation and institutional policies.

Björvell and colleagues (2003) established that the lack of knowledge, poorly structured and incomprehensive documentation, reluctance to introduce changes, insufficient cooperation between care team members and services have a negative impact on nursing documentation. Results of the relevant studies (Rajkovič, 2010) showed that 54.2 % of nurses with secondary education do not perceive documentation as a nursing supportive tool. It was also established that 60.6 % of the respondents from the primary level of health care, 30.3 % from secondary level and 9.1 % from tertiary level do not use nursing documentation in their provision of care.

The study conducted by Gugerty and colleagues (2007) revealed that a significant concern of the study sample of nurses (81 %) was the unnecessary or redundant documentation and the excessive time spent documenting, which takes the nurse away from direct patient care.

Documentation as a means of communication

Nurses need to establish communication with other nurses, healthcare professionals and health providers to augment patient safety (Fasoli & Haddock, 2010; College of Registered Nurses of British Columbia, 2012). Effective communication through nursing documentation is important for effective collaboration of nurses and doctors which positively influences the patient outcomes (Casanova, et al., 2007). Clear and effective communication, showing the rational and critical thinking behind clinical decisions and interventions, decreases the risk of misunderstanding and compromised quality of care (Blair & Smith, 2012).

Several domestic and foreign studies (Lee & Chang, 2004; Naka, 2006; Ramšak Pajk, 2006; Vee & Hestetun, 2009; Paans, et al., 2010) confirm that nursing documentation is important for communication among nurses.

Nursing documentation time

The total percentage of nursing time usually spent on documentation is between 15 -25 % in a work shift, in some cases this percentage is considerably higher (Korst, et al., 2003). In acute care wards, the nurses spent 25-50 % of their shift documenting the patients' progress (Gugerty, et al., 2007). The percentage of time spent on documentation is independently associated with day versus night shifts (19.17 % vs 12.41 %, respectively) (Korst, et al., 2003). Rajkovič (2010) noted that the time spent on documentation differs among the respondents working in the primary (0-60 minutes), secondary (1-60 minutes) and tertiary level of health care (31-120 minutes).

Lee and Chang (2004) claim that the amount of time spent on documenting within a workday is too large, and that documenting is not patient-centered. Nurses often perceive that much of this documentation is unnecessary or redundant, and most of all that it takes nurses away from their ability to administer direct patient care (Gugerty, 2006; Gugerty, et al., 2007).

Education in the field of documentation

Ever since the time patient records everywhere were exclusively on paper, nursing documentation has been a highly interesting topic for reseachers (Griffith, 2004; Naka, 2006; Daskein, et al., 2009; Laitinen, et al., 2010). High quality nursing documentation requires that nurses have extensive knowledge on documentation process (Lee, 2005) which can be acquired only through continuous education in this field (Ehrenberg & Ehnfors, 2001).

Darmer and colleagues (2004) compared nurses' self-evaluated attitudes towards documentation and to assessed nurses' knowledge of the documentation system. It was established that the nurses who participated in a special implementation programme were significantly stronger in their conviction that they had the knowledge to make care plans and that they routinely made them in comparison to nurses who attended only the regular 3-day documentation course at the hospital. The research conducted among nursing students of the University of Ljubljana, College of Health Studies (now Faculty of Health Science), Slovenia, show that the students participating in the study had a positive attitude towards documentation and that they were aware of its importance (Ramšak Pajk & Šušteršič, 2005).

Purpose and objectives

Nurses are often confronted with complex documentation which is an integral part of every hospitalised patient care. The present study explores the nurses' attitudes towards documentation and addresses the following research questions: (a) what are the nurses' attitudes towards documentation of nursing care? and (b) do nurses perceive nursing documentation as additional burden which limits their direct provision of patient care?

Hypotheses

On the basis of theoretical background, the following hypotheses were put forward to explore the Slovenian nurses' attitudes towards nursing documentation:

H1: Nurses' perception of documentation of care is related to their level of educational attainment.

H2: Nurses' perception of documentation of care is related to their work experience.

H3: Nurses' perception of documentation of care is related to the time spent on documentation within one shift.

Methods

For the purposes of the study, a non-experimental quantitative descriptive research methodology was employed. The data were gathered through a survey with non-random quota sampling. A review of the foreign literature was conducted by using the key search term 'nursing documentation' in the data base of Cumulative Index and Allied Health – CINAHL, Springer link, Medline and Google web. The literature search was limited to the period between January 2004 and December 2013. The domestic literature was searched by using online bibliographic/catalogue database of the Virtual Library of Slovenia (COBIB.SI), internet access to the articles published in the Slovenian Nursing Review and the digital library of University of Maribor. The key search terms were 'dokumentiranje v zdravstveni negi'.

Research instrument

A structured measurement instrument was developed for nurses employed in Slovenian hospitals. It was based on the review of the relevant foreign and domestic literature and on the aforementioned hypotheses (Darmer, et al., 2004; Törnvall, et al., 2004; Sheung Cheng & Yuk Lai, 2010; Lorber, 2010).

The first group of questions inquired about the respondents' demographic data. The second section of the survey consisted of 41 statements. The respondents were required to respond to this series of statements about the topic in terms of the extent to which they agreed with them. Their agreement was measured on a 5-point Likert scale, point one indicating strong disagreement, point two disagreement, point three partial agreement, point four agreement and point five strong agreement. The third group of questions was related to the type of documentation the respondents use, the activities most commonly omitted in the provision of care when facing staff shortage in the ward, and the time spent on documentation in a work shift.

The measurement properties of the research instrument were evaluated in different stages of the research. First,

the content validity was tested, which dictated several improvements in the statement section until it was suitable for research. The reliability of the questionnaire was evaluated by the analysis of internal consistency. Cronbach's Alpha coefficient equalled 0.898, which indicated high reliability of the instrument (Cencič, 2009).

Prior to factor analysis, the Kaiser-Meyer-Olkin coefficient was measured (KMO = 0.89) and the Barlett's test was performed ($p < 0.001$), which confirmed the correlation between the variables. The factor analysis was performed with the method of varimax rotation and main axis. On the grounds of screeplot, six factors were identified, namely, documentation, management, classification, competence, workload, and attitude toward work.

Research sample

In the Republic of Slovenia, there are fifteen general hospitals, two university clinical centres and one university rehabilitation institute, employing approximately 6000 nursing employees.

These were the targeted population of the research. Ten out of eighteen invited institutions participated in the study. A non-random quota sampling included 40 % of nursing employees of each participating institution, totalling 1317 nurses. The nursing personnel of the participating institutions represents 54.26 % of the total number of employees (3226 nurses). The sample included nursing technicians and nurses with at least college degree programme education. The survey received 44.95 % response rate. Out of 1317 distributed questionnaries, 592 were completed and returned. This percentage represents 9.96 % of the total number of nurses (5945) employed in eighteen Slovenian hospitals. In order to secure perfect anonymity of the respondents, the variable of their gender was not included. The average age of respondents was 37.69 years and the average length of their work experience was 14.73 years. Nearly half of the respondents (47.3 %) completed secondary education and further 52.7 % of the respondents have completed at least the first level undergraduate studies.

Research process and data analysis

The research protocol was submitted for consideration and approval to research ethics committees and to professional nursing practice committees of eighteen healthcare institutions before the beginning of the study. Ethical approval was obtained from ten institutions. In order to ensure the respondents' privacy, the data were collected by postal questionnaires. The respondents were asked to return the completed questionnaires in an enclosed stamped envelope to the given address of the first author. The data were collected from July 1, 2012 till March 31, 2013.

Statistical analysis of the data was performed with computer programme SPSS, version 17 (SPSS Inc., Chicago, IL, USA). The first step included the descriptive statistics to determine the average values (arithmetic mean, median), data distribution (standard deviation, maximal and minimal values) and the normal distribution of data (Kolmogorov-Smirnov test). Statistical data analysis was performed along with bivariate statistical data analysis. In the second stage of the research, the factor analysis was performed to establish the structure of the research units. Spearman's rank correlation coefficient was used to determine statistically significant correlations. The linear regression of Mann–Whitney U test was also employed. All the hypotheses were tested at the significance level $p < 0.05$.

Results

The majority of the respondents (29.39 %, $n = 174$) report that the time spent on completing patient nursing and other documentation is one hour per shift (29.39 %, n = 174), regardless of their educational level. Further 25.17 % ($n = 149$) spend 1–1.5 hours on nursing documentation per shift. One hour spent on documentation presents 12.5 % of working time in an 8-hour shift and 14.3 % of working time in a 7-hour shift.

The respondents were asked to evaluate forty-one Likert items on a five-point scale. The item "Accuracy of the interventions" revealed the highest agreement scores ($\bar{x} = 4.56$, $s = 0.64$), and the item "Quiet environment is

Table 1: *The results of factor analysis with varimax rotation and main axis*
Tabela 1: *Rezultat faktorske analize po metodi glavnih osi s pravokotno rotacijo*

	Factors/ Faktorji					
	Documentation	***Management***	***Classification***	***Competence***	***Workload***	***Attitude toward work***
Proportion of variance explained: 49.6 %	20.7 %	7.2 %	6.5 %	5.5 %	5.3 %	4.4 %
Measurement reliability: Cronbach's alpha	0.91	0.74	0.78	0.71	0.6	0.67

Table 2: *Descriptive statistics for individual statement*
Tabela 2: *Opisna statistika za posamezno trditev*

Statements	***n***	$\overline{x}$	***s***
I feel responsible for the results of my work.	589	4.56	0.64
Healthcare providers should commit to continuing professional development.	592	4.53	0.63
Nurses wish to spend more time to provide direct patient care.	587	4.42	0.74
My work is useful and important.	589	4.41	0.72
Nurses' workload is too heavy.	586	4.40	0.76
Written nursing handover is important.	583	4.29	0.74
Documentation of nursing activities and interventions is an indispensable component of my everyday work.	581	4.29	0.78
Documentation keeps nurses away from providing direct patient care.	585	4.24	0.88
Documentation formats are too extensive.	586	4.15	0.83
Nursing shortage negatively impacts the quality of care.	586	4.12	0.98
Management bodies bear the responsibility for and have the power to introduce changes.	589	4.12	0.83
Management supports and promotes the introduction of nursing documentation.	589	4.01	0.88
I exercise my profession autonomously and independently.	582	3.99	0.90
Nursing documentation of patient care is equally important as any other patient documentation.	588	3.93	0.97
By entering nursing activities into patient documentation, nurses' work is presented, it becomes visible and important.	585	3.91	0.93
Nurse leader believes that new documentation techniques are necessary to improve the quality of nursing care.	583	3.89	0.85
Documenting the perceived changes in the patient's condition may be of importance to other health providers.	587	3.85	0.90
Classification of patients into categories demonstrates the nurses' workload.	584	3.76	1.10
Forwarding information about the nursing care helps other health care professionals to timely and better awareness of patients' needs and treatment.	588	3.72	1.03
Nurse leader offers the necessary help and support when changes are being introduced.	585	3.69	0.93
Documentation of nursing activities ensures the continuity of care.	585	3.65	0.93
The employees are always reluctant to accept changes in the work process.	587	3.61	0.93
Classification of patients into categories enables an overview of the types of patients on the ward.	581	3.59	0.95
Nursing documentation improves the quality of patient information transfer.	586	3.57	1.00
Documentation serves to show my workload and tasks performed.	580	3.55	1.01
Nursing documentation has a positive impact on patient safety.	585	3.52	1.02
Documentation makes nurses' work visible.	580	3.44	1.06
Nurses possess sufficient knowledge on documentation procedures.	586	3.43	0.85
Many benefits can be derived from the use of nursing documentation in the everyday work of nurses.	589	3.42	1.01
Classification of patients into categories enables better nursing staff distribution.	585	3.42	1.21
Documentation of nursing diagnosis is an integral part of the nurses' working routine.	585	3.41	1.16
Nurse leader includes us in the discussions about the changes planned.	590	3.37	1.08
Nurses have sufficient knowledge to plan the nursing care.	586	3.35	0.99
Percentage of shift spent in completing patient documentation is part of the overall patient nursing care.	581	3.30	1.15
The adopted classification of patients into categories is satisfactory.	582	3.23	0.99

Continues/Se nadaljuje

Statements	*n*	$\bar{X}$	*s*
Nursing documentation provides evidence that at a patient's discharge nursing goals have been accomplished.	584	3.22	0.90
Nursing documentation is completed routinely.	585	3.19	0.96
Nursing diagnoses/problems are well formulated and organised.	585	3.13	0.91
Well-written nursing shift handover can replace oral shift report.	585	3.11	1.27
I have enough time to complete nursing documentation.	587	2.32	0.96
Quiet environment is ensured to complete the nursing documentation.	586	2.25	1.04

Legend/Legenda: n – number/število; $\bar{X}$ – average/povprečje; s – standard deviation/standardni odklon

Table 3: *Descriptive statistics of the total variable 'documentation' and the result of the Mann-Whitney U test and the relationship between the attitude to the documentation and time spent for the documentation within one shift*
Tabela 3: *Opisna statistika skupne spremenljivke »dokumentiranje« in rezultat Mann-Whitneyevega U testa ter povezanost med stališči do dokumentiranja in časom porabljenim zanj v okviru ene izmene*

Factor of documentation	*Ed*	*Me*	*n*	*U*	*p*	*Z*	*d*		*Time*
Total variable - documentation	SE	3.6	279	34642.5	0.001	-3.46	-0.14	r_s	-0.09
	CE	3.8	298					*p*	0.04
Statements									
Nursing documentation of patient care is equally important as any other patient documentation.	SE	4.0	279	38538.0	0.309	-3.23	-0.13	r_s	0.03
	CE	4.0	297					*p*	0.44
By entering nursing activities into patient documentation, nurses' work is presented, it becomes visible and important.	SE	4.0	276	37944.0	0.068	-4.25	-0.18	r_s	-0.01
	CE	4.0	297					*p*	0.73
Documenting the perceived changes in the patient's condition may be of importance to other health providers.	SE	4.0	278	36107.5	0.006	-2.42	-0.10	r_s	-0.10
	CE	4.0	297					*p*	0.02
Forwarding information about the nursing care helps other health care professionals to timely and better awareness of patients' needs and treatment.	SE	4.0	278	33049.0	<0.001	-1.82	-0.08	r_s	-0.03
	CE	4.0	298					*p*	0.50
Documentation of nursing activities ensures the continuity of care.	SE	4.0	276	32725.5	<0.001	-3.90	-0.16	r_s	-0.10
	CE	4.0	297					*p*	0.02
Nursing documentation improves the quality of patient information transfer.	SE	4.0	278	36311.5	0.034	-2.73	-0.11	r_s	-0.10
	CE	4.0	297					*p*	0.03
Documentation serves to show my workload and tasks performed.	SE	4.0	277	32648.0	<0.001	-1.01	-0.04	r_s	-0.13
	CE	4.0	292					*p*	0.002
Nursing documentation has a positive impact on patient safety.	SE	3.0	277	35301.0	0.001	-4.41	-0.18	r_s	-0.07
	CE	4.0	296					*p*	0.12
Documentation makes nurses' work visible.	SE	3.0	273	36764.0	0.015	-2.11	-0.09	r_s	-0.12
	CE	4.0	295					*p*	0.01
Many benefits can be derived from the use of nursing documentation in the everyday work of nurses.	SE	3.0	279	39811.0	0.355	-0.92	-0.04	r_s	-0.05
	CE	4.0	298					p	0.20

Legend/Legenda: Ed – level of education/nivo izobrazbe; SE – secondary education/srednješolska izobrazba; CE – at least college degree/vsaj višješolska izobrazba; $\bar{X}$ – average/povprečje; s – standard deviation/standardni odklon; n – number/število; Z – standardized value/standardizirana vrednost; d – effect size/velikost učinka; r_s – Spearman's correlation coeficient/Spearmanov koeficient korelacije; p – statistical significance at less 0.05/statistična značilnost pri manj kot 0.05; Time – time needed for documentation/čas potreben za dokumentiranje

Table 4: *The correlation between the length of service and attitude to documentation*
Tabela 4: *Povezanost med delovno dobo in stališči do dokumentiranja*

Statement		***Years of work experience***
Documentation – total variable.	Spearman's correlation coefficient	-0.001
	p	0.98
	n	577
Individual statements of the factor documentation.		
Forwarding information about the nursing care helps other health care professionals to timely and better awareness of patients' needs and treatment.	Spearman's correlation coefficient	-0.03
	p	0.48
	n	576
By entering nursing activities into patient documentation, nurses' work is presented, it becomes visible and important.	Spearman's correlation coefficient	0.04
	p	0.29
	n	573
Documentation serves to show my workload and tasks performed.	Spearman's correlation coefficient	0.01
	p	0.73
	n	569
Many benefits can be derived from the use of nursing documentation in the everyday work of nurses.	Spearman's correlation coefficient	-0.04
	p	0.31
	n	577
Nursing documentation of patient care is equally important as any other patient documentation.	Spearman's correlation coefficient	0.00
	p	0.95
	n	576
Documentation makes nurses' work visible.	Spearman's correlation coefficient	0.03
	p	0.50
	n	568
Nursing documentation has a positive impact on patient safety.	Spearman's correlation coefficient	0.07
	p	0.11
	n	573
Documenting the perceived changes in the patient's condition may be of importance to other health providers.	Spearman's correlation coefficient	-0.05
	p	0.23
	n	575
Nursing documentation improves the quality of patient information transfer.	Spearman's correlation coefficient	0.01
	p	0.75
	n	575
Documentation of nursing activities ensures the continuity of care.	Spearman's correlation coefficient	-0.02
	p	0.63
	n	573

Legend/Legenda: n – number/število; p – statistical significance at less 0.05/statistična značilnost pri manj kot 0.05

ensured to complete the nursing documentation" revealed the lowest agreement scores ($\bar{x}$ = 2.25, s = 1.04).

H1 – Nurses' perception of documentation of patient care is related to their level of educational attainment. The table three shows that the hypothesis has been confirmed. Nurses with at least the college degree education attribute to documentation greater significance than the nurses with lower educational achievement. The hypothesis is confirned by the obtained average and mean values (nursing technicians: $\bar{x}$ = 3.55, *Me* = 3.67; the nurses with at least college degree education $\bar{x}$ = 3.76, *Me* = 3.80). The differences in agreement with items related to documentation are statistically significant (p = 0.001). The two groups of respondents differ in some aspects of documentation. A larger percentage of nurses with higher educational achievement believe that documentation facilitates better communication between nurses and other health care professionals about the patient' condition (p < 0.001), documentation increases patient safety (p = 0.001), enhances the exchange of information between nurses during their change of shift (p = 0.034), improves the description of tasks performed (p < 0.001) and the visibility of work accomplished (p = 0.015), the support to other team members (p = 0.006), and the continuity of patient care (p < 0.001). The effect of the variable is apparent, but not remarkable (d = 0.14), either in the total variable or in individual items joined in this factor (d = 0.18 – 0.04).

H2 – Nurses' perception of documentation of care is related to their work experience. The hypothesis has been

rejected. There is no statistically significant correlation between nurses' work experience and their perception of documentation (r_s = -0.001; p = 0.98), which is presented in Table 4.

H3 - Nurses' perception of documentation of patient care is related to the time spent on documentation within one shift.

The hypothesis has been confirmed. The correlation between the time spent on documentation within one shift and the positive attitude towards documentation is weak, but statistically negatively significant (r_s = -0.09, p = 0.04). The negative correlation was also established between the time spent on documentation within one shift and individual statements related to documentation: the description of nursing tasks performed (r_s = 0.13, p = 0.00), the visibility of work accomplished (r_s = -0.12, p = 0.01), the support to other team members (r_s = -0.10, p = 0.02), enhancement of the exchange of information between nurses during their change of shift (r_s = -0.10, p = 0.03), the continuity of patient care (r_s = -0.10, p = 0.02), which is presented in Table 3.

Discussion

Documentation is an important and necessary part of patient treatment. Documentation is not separate from care and it is not optional. It is an integral part of the nurse's practice. It presents the basis for implementation of nursing care, communication between care providers and different institutions (Fasoli & Haddock, 2010). It is an important tool that nurses use to ensure high quality and continuity of patient care (Ramšak Pajk & Šuštaršič, 2005). The study delivered the results predicted by the hypothesis, and the hypothesis was confirmed. It was established that nurses with higher educational level attribute greater significance to documentation than those with lower educational achievement. The two groups of respondents differ in some aspects of documentation. A larger percentage of nurses with higher educational achievement believe that documentation provides support to other team members, ensures better patient safety and quality of exchange of information between nurses during their change of shift. Quality documentation also increases visibility of nursing interventions.

The results of the study highlight the necessity of further education of nurses with lower educational level and of increased awareness of multiple benefits of documentation. These benefits should also be presented to the management bodies of specific institutions, especially as the Likert items "Quiet environment is ensured to complete the nursing documentation" and "I have enough time to complete nursing documentation" revealed the lowest agreement scores for individual statements. Some other statements with lower average scores could induce the management bodies to improve the perceived situation or attitudes. The results of the survey show that the item "Healthcare providers should commit to continuing professional development" revealed high scores. Accordingly, the management could organise training programmes within the health institution itself or hire experts from other educational institutions. In the field of nursing, the courses could be run by experienced nurses who possess the necessary knowledge and skills. It would also be reasonable to reevaluate the secondary school and undergraduate nursing programmes. The long-term goal of education is also to gain competence in efficient documentation and increase the awareness of its benefits already during formal education. An expert group, including managers, researchers and nursing executives should develop a nationwide uniform standardised nursing documentation format and gradually move from paper-based to digital document management in all health care institutions.

Lee and Chang (2004) claim that better use of standardized care plans will enhance nurses' access to appropriate and accurate information in decision-making, thus improving the charting process and care quality. Björvell and colleagues (2003) confirmed the significance of the structured nursing documentation which contributes to the quality and continuity of patient care. Fasoli and Haddock (2010) and Owen (2005) emphasised the significance of good record keeping in relation to the safety of patient treatment. Needleman and Buerhaus (2003) pointed out that nursing processes are not well documented, and failures in these processes that lead to adverse outcomes are often neither charted nor observed. Results of the study conducted by Kärkkäinen and colleagues (2005) indicate that if the content of nursing documentation does not give an accurate picture of care, patients' right to receive good nursing care may not be realized. In Slovenia, the importance of nursing documentation was acknowledged already in the works of Japelj (1980), Kavalič (1981) and later by some other authors. Ramšak Pajk (2006) and Naka (2006) ascertained that continuity of care ensures the quality of patient treatment. The importance of record keeping was outlined by Daskein and colleagues (2009) and Griffith (2004). The authors claim that nursing documentation will be effective only if nurses possess high levels of knowledge about documentation. Griffith (2004) also emphasised that nursing documentation should be written contemporaneously, or as events occur and should include any variances in patient condition.

The present study revealed that there is no statistically significant correlation between the work experience and the respondents' associated attitudes towards documentation (p = 0.98). None of the statements evidenced that there is a correlation between the length of work experience and the respondents' attitude towards documentation. The second hypothesis was therefore not confirmed.

It can therefore be assumed that all the nurses, irrespective of their educational level, find documentation important and useful. It is somewhat surprising that the attitude towards documentation is not negatively related to the length of work experience as the nurses with some twenty-five year work experience did not learn about documentation during their formal education. This fact, however, does not influence their attitude towards and perception of documentation. According to this finding, not much opposition or contrariety is expected in the

process of reviewing the old documemntation standards and formats or in introducing new ones. Both groups of nurses believe that documentation defines the nature of nursing itself and makes their work more visible and important. They also share the belief that documentation provides evidence of nurses' work and demonstrates what the nurse actually does to and for the patient.

Darmer and colleagues (2004) documented that implementation of additional educational programme had a positive impact on nursing documentation and increased nurses' knowledge of the documentation system. Vrankar (2013) noted that nurses, aged 31 to 45 years had a positive attitude towards changes and improvement of nursing transfer of patients. On the other hand, Dornik (2006) found that nurses with lower education level and longer work experience prefer to follow existing methodologies or practices. Björvell and colleagues (2003) reported that knowledge deficit and resistance to introduce novelties negatively impact the quality of nursing documentation.

Within the context of all nursing duties, the amount of time nurses spend on recording all the necessary information into extensive patient documentation is also important. The third hypothesis tried to confirm the relation between the attitude towards documentation and the time spent on documentation within one work shift. The correlation between the total variable describing the positive attitude towards documentation is negatively statististically significant, however weak. Although nurses stated that their attitude towards documentation is positive, recordkeeping was given lower status and priority than the direct patient care. It was also viewed as excessively time consuming. In spite of their positive attitude towards documentation, nurses report that there is not sufficient time available for nursing documentation within a workshift. This attitude is not surprising considering the shortage of nursing personnel, which is according to categorisation, evidenced in practically all Slovenian hospitals (Bregar & Klančnik Gruden, 2011). Nurses' documentation is affected by time constraints, the direct patient care being at the forefront of their activity. Consequently, they do not document or record all the activities or services provided. Their documentation is often limited to most essential patient information.

Results of the current study indicate that all nurses, irrespective of the educational level, spend one hour per shift on documentation, which presents 12.5 % of working time in an 8-hour shift and 14.3 % of working time in a 7-hour shift. The present findings are not consistent with foreign research, which shows that nurses spend even 24-50 % of ther shift completing forms and documenting clinical information (Korst, et al., 2003; Gugerty, et al., 2007; Storfjell, et al., 2008). According to Lee and Chang (2004), the amount of time spent on documenting within a workday is too extensive and should be rationalised to allow more time to provide direct patient care. This study produced results which are consistent with those of Rajkovič (2010) who found that half of the respondents from the secondary health care level spend 1-60 minutes on documentation and this time was even longer on the tertiary level. As evident from foreign literature review, the time spent on documentation is shorter in Slovenia than abroad. These differences can be explained by the fact that the scope of documentation among Slovenian nursing personnel may be narrower. It can be presumed that nurses avoid comprehensive documentation due to the lack of time available (shortage of staff) and the necessity to stay beyond their scheduled work hours to complete documentation, or that documentation is not considered to be one of the institution's policy priorities. As established by Gugerty and colleagues (2007), nurses often perceive much of this documentation as unnecessary or redundant, and that it takes the nurses away from their ability to administer direct patient care.

Another significant concern to this sample of nurses was the lack of time available to complete documentation. Spenser & Lunsford (2010) advise that the support and good documentation programme will assist nurses to maintain focus on and enhance their caring practice. Munyisia and colleagues (2012) noted that the introduction of an electronic documentation system may not necessarily lead to efficiency in documentation for the caregivers and allow them more time to care for patients. Charting some information items on paper and others on a computer may hinder realization of documentation efficiency. It is necessary to automate all nursing forms and to ensure that the system is aligned with caregivers' documentation practice. Kelly and colleagues (2011) cautioned that the extent to which electronic nursing documentation improves the quality of care to hospitalized patients remains unknown, in part due to the lack of effective comparisons with paper-based nursing documentation.

Study limitations

The research was limited to only one segment of health care providers. The research sample could have been more clearly defined. A 7-point scale would provide a better balance between having enough points of discrimination without having to maintain too many response options. As the confirmative factor analysis was not performed, the theory about the structure of the group of variables obtained through exploratory factor analysis was not confirmed. It would be interesting to compare the attitudes towards documentation between nurses and other health care providers.

Conclusion

The results of the present study reveal that the level of education influences the nurses' perception of documentation. The nurses with higher educational attainment attribute more significance to documentation than their counterparts with secondary education. The two categories of nurses differ in some aspects of documentation. Nurses with at least the college degree

education believe that nursing documentation facilitates better communication between nurses and other health care professionals about the patient' condition. They are aware that the final outcome of effective documentation is quality, continuity and safety of patient care. Both groups of nurses share the opinion that quality documentation also increases the visibility of nursing interventions. Although the general view on documentation is positive, the nurses claim that not enough time is available to always maintain accurate, concise and relevant documentation of patient care.

Documentation is an important integral part of nurses' work. Understanding and awareness of the importance of nursing documentation could be increased by further targeted activities of health management, teachers and individuals who possess the necessary knowledge. It is encouraging that the length of work experience does not negatively impact the nurses' perception of documentation. It is recommended that nurses with secondary school education obtain specialist knowledge in record keeping already in the early days of their professional career.

Slovenian translation/Prevod v slovenščino

Uvod

Dokumentacija je vsaka pisna, avdio-/videoposneta ali elektronska oblika beleženja podatkov o stranki. Opisuje stanje, oskrbo ali storitev, opravljeno za to stranko (Potter, et al., 2006). Vsako sistematično, strokovno in kakovostno delo je zasnovano na dobri dokumentaciji. To velja tudi za zdravstveno nego. Dobra dokumentacija zagotavlja kontinuiteto, odraža profesionalnost in daje osnovo za vrednotenje zdravstvene nege (Rajkovič, 2010).

Prednosti in slabosti dokumentiranja v zdravstveni negi

V dokumentacijo zdravstvene nege so zabeležene ugotovitve medicinskih sester o pacientovem zdravstvenem stanju, izvedenih intervencijah in njihovem učinku, kar omogoča pregled nad načrtovano in izvedeno zdravstveno nego z namenom zagotavljanja kakovostne in kontinuirane zdravstvene nege (Sexton, et al., 2004; Cooper & Buist, 2008), kar je v kontinuirani 24-urni zdravstveni oskrbi zelo pomembno (Kerr, 2002). Dokument mora opisovati objektivne informacije o tem, kaj medicinska sestra vidi, sliši, čuti in vonja, vendar ne beleži mnenj ali predpostavk (College and Association of Registered Nurses of Alberta, 2013). Pacientovo vedenje je najbolje opisati z uporabo citatov (Austin, 2011). Potter in Perry (2010) ugotavljata, da morajo aktivnosti zdravstvene nege izražati verodostojnost, le-to pa izvajalec potrdi s podpisom.

Kakšna naj bo ustrezna dokumentacija zdravstvene nege, opisujejo številni avtorji in navajajo, da mora vsebovati podatke, s katerimi je mogoče identificirati klienta/uporabnika, izvajalca zdravstvenih storitev, klinične vzroke, ki so pripeljali do izbire načina zdravstvene oskrbe, odziv pacienta na zdravstveno nego, izid zdravljenja in nadaljnje načrte (Kohek & Vogrinčič, 2004; Ramšak Pajk & Šušteršič, 2005; College and Association of Registered Nurses of Alberta, 2013). Priporoča se uporaba strokovne in standardizirane terminologije ter uvedba strukturirane dokumentacije zdravstvene nege (Björvell, et al., 2003; Ramšak Pajk, 2006; McGeehan, 2007). Našteto zagotavlja kakovostno obravnavo pacienta in kontinuiteto zdravstvene nege. Če nekaj ni dokumentirano, je mogoče domnevati, da ni bilo storjeno (Ramšak Pajk, 2006; Kulhanek, 2010; College and Association of Registered Nurses of Alberta, 2013).

Cheevakasemsook in sodelavci (2006) so ugotovili, da obsežna negovalna dokumentacija vsebuje tri probleme: razpršenost, nepopolnost in pomanjkljivosti v zapisovanju, zato je pomembno sprotno dokumentiranje (Hoban, 2003), ki omogoča natančno refleksijo dogodka (Griffith, 2004; Vee & Hestetun, 2009; Jefferies, et al., 2010). Glede na ugotovitve Törnvalla in Wilhelmssona (2008) se v negovalni dokumentaciji kažejo nekatere slabosti, npr. dolgotrajno iskanje pomembnih informacij predvsem zaradi velike količine rutinskih zapisov.

Medicinske sestre doživljajo številne ovire pri izpolnjevanju dokumentacije. To so čas, obremenjenost, odnos do dokumentacije, institucionalna politika (Blair & Smith, 2012). Björvell in sodelavci (2003) so poleg naštetega ugotovili še, da pomanjkanje znanja, slabo oblikovana in nerazumljiva dokumentacija, odpor do uvajanja novosti ter slabo sodelovanje z drugimi službami negativno vplivajo na dokumentiranje v zdravstveni negi. Rajkovič (2010) je v svoji raziskavi ugotovil, da 54,2 % medicinskih sester s srednješolsko izobrazbo dokumentiranja ne vidi kot vsebinske podpore svojemu delu. Prav tako je tudi ugotovil, da je med anketiranimi izvajalci zdravstvene nege, ki ne uporabljajo dokumentacije zdravstvene nege, 60,6 % anketirancev s primarne, 30,3 % s sekundarne in 9,1 % s terciarne ravni zdravstvene dejavnosti. Gugerty in sodelavci (2007) so ugotovili, da 81 % anketirancev meni, da dokumentiranje zdravstvene nege skrajšuje čas, ki ga medicinske sestre potrebujejo za zagotavljanje neposredne zdravstvene nege pacienta.

Dokumentacija zdravstvene nege kot način komuniciranja

S pomočjo dokumentiranja medicinske sestre komunicirajo z drugimi medicinskimi sestrami in ostalimi člani zdravstvenega tima ter s pacientovimi oskrbovalci doma, kar povečuje varnost pacienta (Fasoli & Haddock, 2010; College of Registered Nurses of British Columbia, 2012). Učinkovita komunikacija preko dokumentacije zdravstvene nege je pomemben element za uspešno sodelovanje med medicinsko sestro in zdravnikom in je povezana s pozitivnim izidom zdravljenja pacienta (Casanova, et al., 2007). Z jasnim, jedrnatim in preudarnim načinom dokumentiranja lahko

bistveno zmanjšamo tveganje za nastanek nesporazuma in negativne izide zdravljenja (Blair & Smith, 2012).

Številne raziskave v svetu in tudi pri nas (Lee & Chang, 2004; Naka, 2006; Ramšak Pajk, 2006; Vee & Hestetun, 2009; Paans, et al., 2010) opisujejo, da dokumentiranje v zdravstveni negi predstavlja komunikacijo med medicinskimi sestrami.

Čas, potreben za dokumentiranje zdravstvene nege

Medicinske sestre najpogosteje porabijo od 15 do 25 % svojega delovnika za dokumentiranje zdravstvene nege, v nekaterih primerih pa precej več (Korst, et al., 2003). Medicinske sestre v splošnih bolnišnicah za negovalno dokumentacijo porabijo 25–50 % časa v eni izmeni (Gugerty, et al., 2007). Več časa porabijo medicinske sestre v dnevni izmeni (19,17 %) kot pa v nočni (12,41 %) (Korst, et al., 2003). Polovica anketirancev s primarne ravni zdravstvene dejavnosti v Sloveniji je porabila za dokumentiranje od 0–60 minut, na sekundarnem nivoju zdravstvene dejavnosti od 1 do 60 minut in na terciarnem nivoju zdravstvene dejavnosti od 31 do 120 minut v izmeni (Rajkovič, 2010).

Lee in Chang (2004) sta ugotavljala, da je čas, porabljen za dokumentiranje v izmeni, preobsežen in da ni usmerjen v pacienta. Številne medicinske sestre pogosto izjavijo, da bi raje čas, ki je potreben za dokumentiranje, porabile za neposredno zdravstveno nego pacienta (Gugerty, 2006; Gugerty, et al., 2007).

Izobraževanje na področju dokumentiranja

Dokumentacija zdravstvene nege je nepogrešljiva pri raziskovanju (Griffith, 2004; Naka, 2006; Daskein, et al., 2009; Laitinen, et al., 2010). Za kakovostno izpolnjevanje negovalne dokumentacije morajo medicinske sestre imeti visok nivo znanja o dokumentiranju (Lee, 2005), ki ga lahko pridobijo le s stalnim izobraževanjem na tem področju (Ehrenberg & Ehnfors, 2001). Darmer in sodelavci (2004) so dokazali statistično pomembno razliko v prepričanju o znanju iz dokumentiranja med medicinskimi sestrami, ki so se udeležile izobraževanja o pravilnem načinu dokumentiranja, in med tistimi, ki se izobraževanja niso udeležile. Prav tako vlada med študenti, ki so bili vključeni v raziskavo na Visoki šoli za zdravstvo v Ljubljani – smer zdravstvena nega (sedaj Zdravstvena fakulteta), veliko zavedanje o pomembnosti dokumentiranja v zdravstveni negi (Ramšak Pajk & Šušteršič, 2005).

Namen in cilj

Pri svojem delu se medicinske sestre pogosto srečujejo z obsežno dokumentacijo, ki spremlja vsakega hospitaliziranega pacienta. Zanimalo nas je, ali medicinske sestre vidijo smiselnost beleženja v dokumentacijo zdravstvene nege. Prav tako nas je tudi zanimalo ali dokumentiranje zdravstvene nege doživljajo kot dodatno obremenitev, ki omejuje njihovo delo ob pacientu.

Hipoteze

Da bi raziskali stališča medicinskih sester do dokumentiranja v slovenskih bolnišnicah, smo na podlagi teoretičnih izhodišč oblikovali tri hipoteze:

H1: Obstaja razlika v pogledu do dokumentiranja glede na stopnjo izobrazbe medicinskih sester.

H2: Obstaja povezava med delovno dobo medicinskih sester in njihovimi stališči do dokumentiranja v zdravstveni negi.

H3: Obstaja povezava med časom, porabljenim za dokumentiranje v okviru ene delovne izmene, in stališči do dokumentiranja v zdravstveni negi.

Metode

V raziskavi smo uporabili kvantitativno neeksperimentalno metodologijo. Uporabili smo deskriptivno metodologijo. Za izvedbo raziskave smo uporabili neslučajnostni kvotni vzorec. Izpeljali smo tehniko anketiranja. Pregled tuje literature smo opravili s pomočjo podatkovne baze podatkov Cumulative Index and Allied Health Literature (CINAHL), Springer link, PubMed in Google učenjak. Pri iskanju literature smo se omejili na obdobje od januarja 2004 do decembra 2013. Kot ključno besedo smo uporabili »nursing documentation«. Do domače literature smo dostopali s pomočjo vzajemne bibliografsko-kataložne baze podatkov Virtualne knjižnice Slovenije (COBIB.SI), spletnega dostopa do člankov iz revije Obzornik zdravstvene nege in Digitalne knjižnice Univerze v Mariboru. Uporabili smo ključno besedo »dokumentiranje v zdravstveni negi«.

Opis instrumenta

V raziskavi smo na osnovi pregleda domače in tuje znanstvene ter strokovne literature ter na podlagi postavljenih hipotez izdelali strukturiran merski instrument, namenjen zaposlenim v zdravstveni negi v slovenskih bolnišnicah (Darmer, et al., 2004; Törnvall, et al., 2004; Sheung Cheng & Yuk Lai, 2010; Lorber, 2010). V prvem sklopu vprašanj smo spraševali po demografskih značilnostih anketirancev. Drugi sklop vprašanj je bil sestavljen iz enainštiridesetih trditev. Anketiranci so svoja stališča ocenjevali po Likertovi ocenjevalni lestvici, kjer je 1 pomenilo – nikakor se ne strinjam, 2 – se ne strinjam, 3 – delno se strinjam, 4 – se strinjam, 5 – popolnoma se strinjam. V tretjem sklopu vprašanj so anketiranci izbirali dokumentacijo zdravstvene nege, ki jo uporabljajo pri svojem delu; odgovarjali na vprašanji: katere aktivnosti zdravstvene nege najpogosteje opustijo v primeru pomanjkanja kadra na oddelku in koliko časa porabijo za dokumentiranje v izmeni.

Merske značilnosti inštrumenta smo preverjali v

več fazah. Najprej smo preverili vsebinsko veljavnost inštrumenta. Trditve smo izboljševali, dokler vprašalnik ni bil primeren za izvedbo študije. Za ugotavljanje zanesljivosti vprašalnika smo v študiji uporabili metodo analize notranje konsistentnosti. Cronbachov koeficient alfa je znašal 0,898, kar je pomenilo, da je zanesljivost vprašalnika zelo dobra (Cencič, 2009).

Pred izvedbo faktorske analize smo izračunali Kaiser-Meyer-Olkinov koeficient (KMO = 0,89) in Bartlettov test ($p < 0,001$), ki sta nakazala, da povezave med spremenljivkami obstajajo. Izvedli smo faktorsko analizo po metodi glavnih osi in s pravokotno rotacijo. Na podlagi diagrama scree smo se odločili za šest faktorjev, ki smo jih poimenovali dokumentiranje, vodenje, razvrščanje, usposobljenost, delovna obremenitev in odnos do dela.

Tabela 1: *Rezultat faktorske analize po metodi glavnih osi s pravokotno rotacijo*
Table 1: *The results of factor analyse with varimax rotation and main axis*

	Faktorji/Factors					
	Dokumentiranje	***Vodenje***	***Razvrščanje***	***Usposobljenost***	***Delovna obremenitev***	***Odnos do dela***
Delež pojasnjene variance: 49,6 %	20,7 %	7,2 %	6,5 %	5,5 %	5,3 %	4,4 %
Zanesljivost merjenja: Cronbachov koeficient alfa	0,91	0,74	0,78	0,71	0,6	0,67

Opis vzorca

V Sloveniji je petnajst splošnih bolnišnic, dva univerzitetna klinična centra in univerzitetni rehabilitacijski inštitut, v njih je administrativno zaposlenih 5945 izvajalcev zdravstvene nege, ki predstavljajo populacijo, ki smo jo želeli raziskati. V raziskavo je bilo vključenih deset izmed osemnajstih povabljenih ustanov. V raziskavo vključene bolnišnice skupaj zaposlujejo 54,26 % (3226) zaposlenih v zdravstveni negi. V vzorec so bile vključene medicinske sestre s srednješolsko izobrazbo in medicinske sestre z vsaj višješolsko izobrazbo. Neslučajnostni kvotni vzorec je zajel 1317 zaposlenih, tj. 40 % kadra v zdravstveni negi, zaposlenega v bolnišnicah, sodelujočih v raziskavi. Od 1317 vprašalnikov, ki smo jih razdelili med izvajalce zdravstvene nege, jih je bilo vrnjenih 592, kar predstavlja 44,95 % odzivnost anketirancev. Delež vrnjenih vprašalnikov predstavlja 9,96 % celotne populacije administrativno zaposlenih v zdravstveni negi v osemnajstih slovenskih bolnišnicah (5945 zaposlenih). Da bi se izognili občutku prepoznavnosti, anketirancev nismo povprašali po spolu. Povprečna starost anketiranih je znašala 37,69 let. Povprečna delovna doba anketiranih je bila 14,73 let. Srednješolsko izobrazbo je imelo 47,3 % anketiranih, 52,7 % anketiranih je imelo najmanj višješolsko izobrazbo.

Opis poteka raziskave in obdelave podatkov

Prošnje za izvedbo raziskave smo vložili na komisije za etiko in kolegije zdravstvene nege osemnajstih zdravstvenih ustanov. Soglasje za sodelovanje v raziskavi smo pridobili v desetih zdravstvenih ustanovah. Anonimnost anketirancev smo zagotovili tako, da so odgovarjali po pošti – vsaki anketi je bila priložena ovojnica z znamko ter naslovom prvega avtorja. Zbiranje vprašalnikov je potekalo od 1. 7. 2012 do 31. 3. 2013.

Statistično obdelavo podatkov smo izvedli z računalniškim programom SPSS verzija 17 (SPSS Inc., Chicago, IL, USA). V prvem koraku smo pri zbranih podatkih izpeljali opisno statistiko, kjer smo ugotavljali mere srednjih vrednosti (aritmetična sredina, mediana), mere razpršenosti podatkov (standardni odklon, maksimalna in minimalna vrednost) ter normalnost porazdelitve podatkov (test Kolmogorov-Smirnova). Izvedli smo tudi bivariatno statistično analizo podatkov. V drugem koraku smo najprej izvedli faktorsko analizo in ugotavljali analizo strukture enot, vključenih v raziskavo. Narejen je bil Spearmanov koeficient ranga korelacije (povezanosti), ki ugotavlja statistično pomembnost povezav. Uporabili smo tudi linearno regresijo Mann-Whitneyevega U-testa. Vse hipoteze smo testirali pri stopnji značilnosti $p < 0,05$.

Rezultati

Zaposleni v zdravstveni negi ugotavljajo, da najpogosteje za beleženje v dokumentacijo zdravstvene nege in drugo dokumentacijo potrebujejo eno uro v delovni izmeni (29,39 %, $n = 174$) ne glede na nivo izobrazbe, sledi 1–1,5 ure v izmeni (25,17 %, $n = 149$). Ena ura beleženja predstavlja 12,5 % delovnega časa porabljenega za dokumentiranje v izmeni, če definiramo izmeno kot osemurni delavnik, oz. 14,3 % delovnega časa v primeru sedemurnega delavnika.

Medicinskim sestram, ki so sodelovale v raziskavi, smo ponudili enainštirideset trditev, do katerih so se morale opredeliti po Likertovi lestvici stališč. Med ponujenimi trditvami je glede na stopnjo strinjanja najvišjo oceno dobila trditev »Čutim odgovornost za rezultate svojega dela« ($\overline{x} = 4,56$, $s = 0,64$), najnižjo pa »Izpolnjevanje dokumentacije mi je omogočeno v mirnem okolju« ($\overline{x} = 2,25$, $s = 1,04$).

Tabela 2: *Opisna statistika za posamezno trditev*
Table 2: *Descriptive statistics for individual statement*

Trditve/Statements	***n***	$\overline{x}$	***s***
Čutim odgovornost za rezultate svojega dela.	589	4,56	0,64
Zaposleni v zdravstvu se moramo kontinuirano izobraževati.	592	4,53	0,63
Medicinske sestre si želimo več časa preživeti ob pacientu.	587	4,42	0,74
Moje delo je koristno in pomembno.	589	4,41	0,72
Delovne obremenitve medicinskih sester so prevelike.	586	4,40	0,76
Pisna predaja službe je pomembna.	583	4,29	0,74
Beleženje aktivnosti zdravstvene nege je vpeto v moje vsakodnevno delo.	581	4,29	0,78
Dokumentiranje omejuje čas, ki bi ga lahko namenila negi pacienta.	585	4,24	0,88
Dokumentacijski obrazci so obsežni.	586	4,15	0,83
Zaradi pomanjkanja kadra v zdravstveni negi je slabša kakovost opravljenega dela.	586	4,12	0,98
Za uvajanje sprememb je pristojno in odgovorno vodstvo.	589	4,12	0,83
Vodstvo podpira in vzpodbuja uvajanje negovalne dokumentacije.	589	4,01	0,88
Pri delu sem neodvisna in samostojna.	582	3,99	0,90
Beleženje aktivnosti zdravstvene nege je enako pomembno kot ostala beleženja v zdravstveno dokumentacijo.	588	3,93	0,97
Z beleženjem aktivnosti zdravstvene nege predstavim svoje delo, da postane vidno in pomembno.	585	3,91	0,93
Vodja meni, da so nove tehnike nujno potrebne za uspešno delo.	583	3,89	0,85
Zabeležena opažanja so v pomoč preostalim članom zdravstvenega tima.	587	3,85	0,90
Z razvrščanjem pacientov v kategorije medicinske sestre prikažejo svoje delovne obremenitve.	584	3,76	1,10
Beleženje aktivnosti zdravstvene nege pomaga tudi ostalim članom zdravstvenega tima, da bolje in hitreje spoznajo pacienta in njegove težave.	588	3,72	1,03
Vodja nam v procesu uvajanja sprememb nudi ustrezno podporo.	585	3,69	0,93
Beleženje aktivnosti zdravstvene nege omogoča kontinuiteto negovanja.	585	3,65	0,93
Spremembe so za zaposlene vedno težavne.	587	3,61	0,93
Razvrščanje pacientov v kategorije omogoča prikaz strukture pacientov na oddelku.	581	3,59	0,95
Dokumentacija zdravstvene nege dviguje kakovost predaje službe.	586	3,57	1,00
Dokumentacija opisuje delo, ki ga opravljam.	580	3,55	1,01
Negovalna dokumentacija ima pozitiven vpliv na varnost pacienta.	585	3,52	1,02
Moje delo postane vidno.	580	3,44	1,06
Medicinske sestre imajo dovolj znanja o postopkih dokumentiranja.	586	3,43	0,85
Dokumentacija zdravstvene nege predstavlja prednost pri vsakodnevnem delu medicinskih sester.	589	3,42	1,01
S pomočjo razvrščanja pacientov v kategorije je mogoče izboljšati kadrovsko zasedenost negovalnega osebja.	585	3,42	1,21
Beleženje negovalnih diagnoz predstavlja rutino v naši organizaciji.	585	3,41	1,16
Vodja nas vključuje v odločitve o spremembah.	590	3,37	1,08
Medicinske sestre imajo dovolj znanja za izdelavo negovalnega načrta.	586	3,35	0,99
Čas, ki je potreben za izpolnjevanje dokumentacije, je vštet v čas, namenjen negi.	581	3,30	1,15
Uveden sistem razvrščanja pacientov v kategorije je dober.	582	3,23	0,99
Negovalni cilji so ob koncu hospitalizacije doseženi, kar je razvidno iz negovalne dokumentacije.	584	3,22	0,90

Se nadaljuje/Continues

Trditve/Statements	*n*	$\bar{x}$	*s*
Medicinske sestre izpolnjujejo negovalni plan rutinsko.	585	3,19	0,96
Negovalne diagnoze/problemi so dobro opredeljeni.	585	3,13	0,91
Dobro napisana predaja službe lahko nadomesti ustno predajo.	585	3,11	1,27
Za vodenje dokumentacije zdravstvene nege imam dovolj časa.	587	2,32	0,96
Izpolnjevanje negovalne dokumentacije mi je omogočeno v mirnem okolju.	586	2,25	1,04

Legenda/Legend: n – število/number; $\bar{x}$ – povprečje/average; s – standardni odklon/standard deviation

Tabela 3: *Opisna statistika skupne spremenljivke »dokumentiranje« in rezultat Mann-Whitneyevega U-testa ter povezanost med stališči do dokumentiranja in časom, porabljenim zanj v okviru ene izmene*
Table 3: *Descriptive statistics of the total variable 'documentation' and the result of the Mann-Whitney U- test and the relationship between attitude to the documentation and the time spent on documentation within one shift*

Faktor dokumentiranje/ Factor documentation	***IZ***	***Me***	***n***	***U***	***p***	***Z***	***d***		***Čas/ Time***
Skupna spremenljivka – dokumentiranje	SR	3,6	279	34642,5	0,001	–3,46	–0,14	r_s	–0,09
	VŠ	3,8	298					*p*	0,04
Trditve									
Beleženje aktivnosti zdravstvene nege je enako pomembno kot ostala beleženja v zdravstveno dokumentacijo.	SR	4,0	279	38538,0	0,309	–3,23	–0,13	r_s	0,03
	VS	4,0	297					*p*	0,44
Z beleženjem aktivnosti zdravstvene nege predstavim svoje delo, da postane vidno in pomembno.	SR	4,0	276	37944,0	0,068	–4,25	–0,18	r_s	–0,01
	VS	4,0	297					*p*	0,73
Zabeležena opažanja so v pomoč preostalim članom zdravstvenega tima.	SR	4,0	278	36107,5	0,006	–2,42	–0,10	r_s	–0,10
	VS	4,0	297					*p*	0,02
Beleženje aktivnosti zdravstvene nege pomaga tudi ostalim članom zdravstvenega tima, da bolje in hitreje spoznajo pacienta in njegove težave.	SR	4,0	278	33049,0	<0,001	–1,82	–0,08	r_s	–0,03
	VS	4,0	298					*p*	0,50
Beleženje aktivnosti zdravstvene nege omogoča kontinuiteto negovanja.	SR	4,0	276	32725,5	<0,001	–3,90	–0,16	r_s	–0,10
	VS	4,0	297					*p*	0,02
Dokumentacija zdravstvene nege dviguje kakovost predaje službe.	SR	4,0	278	36311,5	0,034	–2,73	–0,11	r_s	–0,10
	VS	4,0	297					*p*	0,03
Dokumentacija opisuje delo, ki ga opravljam.	SR	4,0	277	32648,0	<0,001	–1,01	–0,04	r_s	–0,13
	VS	4,0	292					*p*	0,002
Negovalna dokumentacija ima pozitiven vpliv na varnost pacienta.	SR	3,0	277	35301,0	0,001	–4,41	–0,18	r_s	–0,07
	VS	4,0	296					*p*	0,12
Moje delo postane vidno.	SR	3,0	273	36764,0	0,015	–2,11	–0,09	r_s	–0,12
	VS	4,0	295					*p*	0,01
Dokumentacija zdravstvene nege predstavlja prednost pri vsakodnevnem delu medicinskih sester.	SR	3,0	279	39811,0	0,355	–0,92	–0,04	r_s	–0,05
	VS	4,0	298					p	0,20

Legenda/Legend: IZ – nivo izobrazbe/level of education; Me - mediana/median; SR – srednješolska izobrazba/secondary education; VS – najmanj višješolska izobrazba/at least collage degree; n – število/number; Z – standardizirana vrednost/standardized value; d – velikost učinka/effect size; r_s – Spearmanov koeficient korelacije/Spearmans korelation koeficient; p – statistična značilnost pri manj kot 0,05/statistical significance at less 0,05; Čas – čas, potreben za dokumentiranje/time needed for documentation

Tabela 4: *Povezanost med delovno dobo in stališči do dokumentiranja*
Table 4: *The correlation between the length of service and attitude to documentation*

Trditev		***Skupna leta delovne dobe***
Dokumentiranje – skupna spremenljivka.	Spearmanov koeficient korelacije	–0,001
	p	0,98
	n	577
Posamezne trditve faktorja dokumentiranje.		
Beleženje aktivnosti zdravstvene nege pomaga tudi ostalim članom zdravstvenega tima, da bolje in hitreje spoznajo pacienta in njegove težave.	Spearmanov koeficient korelacije	–0,03
	p	0,48
	n	576
Z beleženjem aktivnosti zdravstvene nege predstavim svoje delo, da postane vidno in pomembno.	Spearmanov koeficient korelacije	0,04
	p	0,29
	n	573
Dokumentacija opisuje delo, ki ga opravljam.	Spearmanov koeficient korelacije	0,01
	p	0,73
	n	569
Dokumentacija zdravstvene nege predstavlja prednost pri vsakodnevnem delu medicinskih sester.	Spearmanov koeficient korelacije	–0,04
	p	0,31
	n	577
Beleženje aktivnosti zdravstvene nege je enako pomembno kot ostala beleženja v zdravstveno dokumentacijo.	Spearmanov koeficient korelacije	0,00
	p	0,95
	n	576
Moje delo postane vidno.	Spearmanov koeficient korelacije	0,03
	p	0,50
	n	568
Negovalna dokumentacija ima pozitiven vpliv na varnost pacienta.	Spearmanov koeficient korelacije	0,07
	p	0,11
	n	573
Zabeležena opažanja so v pomoč preostalim članom zdravstvenega tima.	Spearmanov koeficient korelacije	–0,05
	p	0,23
	n	575
Dokumentacija zdravstvene nege dviguje kakovost predaje službe.	Spearmanov koeficient korelacije	0,01
	p	0,75
	n	575
Beleženje aktivnosti zdravstvene nege omogoča kontinuiteto negovanja.	Spearmanov koeficient korelacije	–0,02
	p	0,63
	n	573

Legenda/Legend: n – število/number; p – statistična značilnost pri manj kot 0,05/statistical significance at less 0,05

Na podlagi statistične obdelave (Tabela 3) hipotezo »H1 – Medicinske sestre se glede na stopnjo izobrazbe razlikujejo med seboj v stališčih do dokumentiranja v zdravstveni negi« potrdimo. Medicinske sestre z vsaj višješolsko izobrazbo beleženju oz. dokumentiranju pripisujejo večji pomen kot medicinske sestre s srednješolsko izobrazbo, kar je razvidno tako iz povprečne vrednosti kot iz vrednosti mediane (medicinske sestre s srednješolsko izobrazbo: $\overline{x}$ = 3,55, Me = 3,67; medicinske sestre z vsaj višješolsko izobrazbo: $\overline{x}$ = 3,76, Me = 3,80). Razlika v strinjanju s trditvami, ki se nanašajo na dokumentiranje, je statistično značilna (p = 0,001). Tudi mnenja medicinskih sester glede nekaterih vidikov dokumentiranja se razlikujejo glede na stopnjo izobrazbe. Tiste z vsaj višješolsko izobrazbo v primerjavi z medicinskimi sestrami s srednješolsko izobrazbo pripisujejo večji pomen pomoči, ki jo dokumentiranje nudi ostalim članom zdravstvenega tima, da hitreje in bolje spoznajo pacienta (p < 0,001); pozitivnemu vplivu, ki ga ima dokumentiranje na varnost pacienta (p = 0,001); kakovosti predaje službe, ki je posledično višja (p = 0,034); opisovanju dela (p < 0,001) in vidnosti dela (p = 0,015); pomoči, ki jo dokumentiranje nudi preostalim članom zdravstvenega tima (p = 0,006), in kontinuiteti negovanja, ki izhaja iz beleženja (p < 0,001). Čeprav smo pri dobljeni velikosti vzorca učinek zaznali, je le-ta majhen (d = 0,14), in sicer tako pri skupni spremenljivki kakor tudi pri posameznih trditvah, združenih v ta faktor (od d = 0,18 do d = 0,04).

Na podlagi statistične obdelave hipotezo »H2 – Obstaja povezava med delovno dobo medicinskih sester in njihovimi stališči do dokumentiranja v zdravstveni negi« zavrnemo. Med dolžino delovne dobe in stališči do dokumentiranja ni statistično značilne korelacije (r_s = –0,001, p = 0,98) (Tabela 4).

Na podlagi statistične obdelave hipotezo »H3 – Obstaja povezava med stališči do dokumentiranja zdravstvene nege in časom porabljenim za dokumentiranje v okviru ene delovne izmene« potrdimo. Toda statistično značilna in negativna (r_s = –0,09, p = 0,04) povezanost med časom, potrebnim za dokumentiranje, in pozitivnim stališčem do dokumentiranja je šibka. Negativno povezanost je mogoče zaznati tudi med časom, potrebnim za dokumentiranje, in posameznimi stališči do dokumentiranja, in sicer pri stališčih: da dokumentacija opisuje delo, ki ga opravljajo medicinske sestre (r_s = 0,13, p = 0,00); da njihovo delo postane vidno (r_s = –0,12, p = 0,01); da so zabeležena opažanja v pomoč ostalim članom tima (r_s = –0,10, p = 0,02); da dokumentacija zvišuje kakovost predaje službe (r_s = –0,10, p = 0,03) in da dokumentiranje omogoča kontinuiteto negovanja (r_s = –0,10, p = 0,02) (Tabela 3).

Diskusija

Dokumentiranje zdravstvene nege je nujen in pomemben del v obravnavi pacienta. Je osnova za izvajanje zdravstvene nege, za komunikacijo med izvajalci, ki sodelujejo v obravnavi pacienta, in za komunikacijo med različnimi ustanovami (Fasoli & Haddock, 2010). Prav tako je zaradi beleženja izvedenih aktivnosti zagotovljena kakovostna obravnava pacienta in kontinuiteta zdravstvene nege, kar ugotavljata Ramšak Pajk in Šuštaršič (2005).

V raziskavi smo prvo postavljeno hipotezo potrdili, saj smo ugotovili, da medicinske sestre z vsaj višješolsko izobrazbo pripisujejo dokumentiranju večji pomen kot medicinske sestre s srednješolsko izobrazbo. Medicinske sestre se glede na izobrazbo razlikujejo v mnenju glede nekaterih vidikov dokumentiranja. Medicinske sestre z vsaj višješolsko izobrazbo v primerjavi z medicinskimi sestrami s srednješolsko izobrazbo pripisujejo večji pomen pomoči, ki jo dokumentiranje nudi ostalim članom zdravstvenega tima. Menijo, da ima dokumentiranje pozitiven vpliv na varnost pacienta in da je tudi kakovost predaje službe večja. Medicinske sestre z vsaj višjo izobrazbo menijo, da njihovo delo s pomočjo dokumentiranja postane vidno ter da omogoča kontinuiteto negovanja, kar posledično vodi do večje varnosti pacienta.

Iz odnosa do beleženja v negovalno dokumentacijo lahko sklepamo, da bi bilo potrebno vložiti več truda v izobraževanje medicinskih sester s srednješolsko izobrazbo in jim predstaviti številne prednosti, ki jih dokumentiranje omogoča. Prav tako bi bilo potrebno naštete prednosti predstaviti tudi menedžmentu posameznih ustanov, saj je bilo največje nestrinjanje (najnižja ocena po Likertovi lestvici od 1 do 5) izraženo pri trditvah »Za vodenje dokumentacije zdravstvene nege imam dovolj časa« in »Izpolnjevanje negovalne dokumentacije mi je omogočeno v mirnem okolju«. Kar nekaj trditev, ki pri anketirancih niso dosegle visoke ocene strinjanja, se nanaša na organizacijo dela – spremembe lete bi lahko realiziral management posameznih ustanov.

Glede na to, da je trditev »Zaposleni v zdravstveni negi se moramo kontinuirano izobraževati« dosegla zelo visok nivo strinjanja, bi se bilo primerno povezati z izobraževalnimi ustanovami ali izobraževanje izpeljati v okviru lastnega kadra, tj. znotraj posamezne zdravstvene ustanove. Izvajalci zdravstvene nege oziroma edukatorji bi bili lahko zaposleni, ki dobro poznajo to področje. Prav tako bi bilo smiselno prevetriti tudi kurikulum, predvsem na srednjih šolah, ter tudi na visokih šolah in fakultetah za zdravstveno nego. S takim pristopom bi skušali dolgoročno izboljšati situacijo na področju dokumentiranja, saj bi novi kadri, ki bi zaključili s šolanjem, ne glede na stopnjo izobrazbe že posedovali znanja in prepričanje o pomembnosti dokumentiranja v zdravstveni negi.

Smiselno bi bilo razmišljati o poenotenju osnovnih oblik dokumentiranja na nivoju Slovenije, saj sedaj vsaka bolnišnica razvija svoje oblike dokumentiranja. V kasnejši fazi bi bilo prav tako smiselno razmišljati o prenosu dokumentacije v računalniško obliko na celotnem področju. Lee in Chang (2004) ugotavljata, da bi standardizacija dokumentiranja omogočila dostop do natančnih informacij, s čimer bi bil izboljšan proces in kakovost oskrbe zdravstvene nege pacienta. Björvell in sodelavci (2003) so že ugotavljali pomembnost strukturirane dokumentacije zdravstvene nege, ki zagotavlja kakovostno in kontinuirano zdravstveno nego pacienta.

Fasoli in Haddock (2010) ter Owen (2005) so poudarjali varnost obravnave pacienta, ki ga omogoča dokumentiranje. Vendar pa sta se Needleman in Buerhaus (2003) zavedala dejstva, da so aktivnosti zdravstvene nege pomanjkljivo dokumentirane. Pomanjkljivo dokumentirana zdravstvena nega pa ne prikaže prave slike zdravstvene nege, tako da pacientova pravica do kakovostne in varne zdravstvene nege ni izpolnjena, kar poudarjajo tudi Kärkkäinen in sodelavci (2005). V slovenskem prostoru sta pomembnost dokumentiranja prepoznali že Japelj (1980) in Kavalič (1981). Temo so kasneje večkrat izpostavljali tudi drugi avtorji. Ramšak Pajk (2006) in Naka (2006) ugotavljata, da kontinuiteta zdravstvene nege vodi do kakovostne obravnave pacienta. Da bi medicinske sestre izvajale dokumentiranje na pravilen način, je potreben visok nivo znanja o dokumentiranju, kar so zapisali Daskein in sodelavci (2009) ter Griffith (2004), ki še dodaja pravočasnost vnosa podatkov o pacientu in sledenje njegovemu zdravstvenemu stanju.

V pričujoči raziskavi je bilo ugotovljeno, da med dolžino delovne dobe in stališči do dokumentiranja ni statistično značilne korelacije (p = 0,98). Druge hipoteze zato nismo potrdili, saj iz nobene od trditev ni bilo

razvidno, da bi bilo število let delovne dobe povezano s stališči do dokumentiranja.

Dobljeni rezultati nas usmerjajo k razmišljanju, da se vsem medicinskim sestram ne glede na dolžino delovne dobe zdi dokumentiranje pomembno in imajo pozitiven odnos do njega. Pričakovali bi, da se z leti delovne dobe niža prepričanje, da je dokumentiranje pomembno, saj v kurikulumu medicinskih sester, ki so se šolale pred petindvajsetimi leti in več, dokumentiranje ni bilo vpeto v izobraževalni program. Zato bi lahko pričakovali, da bodo starejše medicinske sestre imele bolj negativno mnenje o dokumentiranju kot mlajše medicinske sestre. Rezultati so optimistični, saj predvidevamo, da uvajanje novih načinov ali izpopolnjevanje starih oblik dokumentiranja ne bi povzročilo negativnega odziva v nobeni starostni skupini medicinskih sester. Obe skupini medicinskih sester, medicinske sestre s srednješolsko izobrazbo in medicinske sestre z najmanj višješolsko izobrazbo, sta mnenja, da njihovo delo s pomočjo dokumentacije postane vidno in pomembno. Prav tako menijo, da dokumentacija zdravstvene nege opisuje delo, ki ga opravljajo.

Darmer in sodelavci (2004) so ugotovili, da z dodatnim izobraževanjem medicinske sestre dobijo večje prepričanje o znanju iz dokumentiranja. Vrankar (2013) je ugotovila pozitivno stališče medicinskih sester, starih od 31 do 45 let, do uvajanja sprememb in izboljšav v procesu predaje pacienta. Donik (2006) pa je v nasprotju z opisanimi ugotovitvami v svoji raziskavi ugotovila, da medicinske sestre s srednješolsko izobrazbo in daljšo delovno dobo najraje opravljajo delo v skladu z ustaljenimi veščinami. Björvell in sodelavci (2003) so med drugim tudi ugotavljali, da pomanjkanje znanja in odpor do uvajanja novosti negativno vplivajo na dokumentiranje zdravstvene nege.

Pomemben del delovnika medicinskih sester predstavlja čas, ki ga potrebujejo za vnos vseh zahtevanih podatkov v obširno negovalno dokumentacijo. Zato smo v tretji hipotezi želeli ugotoviti, ali obstaja povezava med stališči do dokumentiranja in časom, porabljenim za dokumentiranje v okviru ene delovne izmene. Korelacija med skupno spremenljivko, ki opisuje pozitiven odnos do dokumentiranja in časom, potrebnim za dokumentiranje, je sicer statistično značilna in negativna, a neznatna. Čeprav imajo medicinske sestre pozitiven odnos do dokumentiranja, se negativno opredeljujejo do časa porabljenega za dokumentiranje. Medicinske sestre menijo, da imajo kljub pozitivnemu odnosu do dokumentiranja premalo časa za njegovo izvajanje v eni delovni izmeni. Zaradi pomanjkanja kadra, ki se izraža glede na kategorizacijo skoraj v vseh slovenskih bolnišnicah (Bregar & Klančnik Gruden, 2011), je ta odnos pričakovan. Medicinske sestre so preobremenjene z neposredno zdravstveno nego in zaradi številnih zahtev na tem področju opustijo določena beleženja izvedenih aktivnosti. Zabeležijo samo tiste, ki so najbolj potrebne.

V naši raziskavi so medicinske sestre ne glede na izobrazbo ocenile obseg časa, porabljenega za dokumentiranje, na povprečno eno uro v eni izmeni, kar predstavlja 12,5 % delovnega časa v primeru osemurnega delovnika in 14,3 % delovnega časa v primeru sedemurnega delavnika. Dobljeni rezultat se od podatkov v tuji literaturi precej razlikuje, tuji avtorji opisujejo 24–50 % delovnega časa, porabljenega za izpolnjevanje dokumentacije zdravstvene nege (Korst, et al., 2003; Gugerty, et al., 2007; Storfjell, et al., 2008). Lee in Chang (2004) menita, da je časa, porabljenega za dokumentiranje, preveč in da bi ga bilo potrebno skrčiti v prid negovanja pacientov. Rajkovič (2010) je v svoji raziskavi prišel do podobnih rezultatov kot mi, saj je polovica anketirancev na sekundarnem nivoju zdravstvene dejavnosti v Sloveniji ocenila obseg časa, porabljenega za dokumentiranje, na 1 do 60 minut, na terciarnem nivoju zdravstvene dejavnosti celo nekaj več.

V primerjavi s tujo literaturo je obseg časa, porabljenega za dokumentiranje, v ustanovah, ki so sodelovale v naši raziskavi, manjši. Postavljajo se vprašanja, ali se dokumentiranje izvaja v manjšem obsegu, ali se zaposleni v zdravstveni negi izogibajo dokumentiranju zaradi majhne kadrovske zasedenosti in ker bi dokumentiranje povzročilo podaljšanje njihovega delovnika, ali vodilni ne čutijo potrebe po dokumentiranju in od svojih podrejenih ne zahtevajo in niti ne pričakujejo, da bodo izpolnjevali vse oblike dokumentiranja, ki so na voljo.

Že Gugerty in sodelavci (2007) so ugotavljali, da številne medicinske sestre ne cenijo časa in truda, ki sta potrebna za skrbno dokumentiranje in ga raje usmerijo v neposredno zdravstveno nego pacienta. Tudi anketirane medicinske sestre bi želele več časa preživeti s pacientom, prav tako menijo, da dokumentacija omejuje čas, ki ga lahko namenijo zdravstveni negi pacienta. Po drugi strani tudi menijo, da nimajo dovolj časa za vodenje dokumentacije. Spencer in Lunsford (2010) menita, da bi uporaba sodobne računalniške opreme in dobrega programa za vnos negovalne dokumentacije medicinskim sestram omogočila več časa, ki bi ga lahko posvetile pacientu. Munyisia in sodelavci (2012) pa so ugotovili, da elektronski sistem oz. računalniški vnos ne vodi nujno k učinkovitosti dokumentiranja. Ugotovili so, da je za učinkovit računalniški vnos potrebno standardizirati in oblikovati vse obrazce zdravstvene nege in da mora biti vnos podatkov v celoti računalniški, če želimo, da bo računalniško podprto dokumentiranje medicinskim sestram omogočilo več časa za delo s pacientom. Kelley in sodelavci (2011) so se nagibali k razmišljanju, da ostaja neznanka, v kolikšni meri elektronska oblika negovalne dokumentacije izboljša oskrbo zdravstvene nege hospitaliziranih pacientov.

Omejitev raziskave je, da je zajela samo zaposlene v zdravstveni negi. Prav tako bi lahko natančneje opredelili vzorec merjencev. Da bi povečali občutljivost lestvice, bi jo bilo smiselno razširiti na sedemtočkovno lestvico. Ker potrditvene (konfirmatorne) faktorske analize nismo izvedli, teorije o strukturi skupine spremenljivk, ki smo jih dobili z eksploratorno faktorsko analizo, nismo potrdili. Zanimivo bi bilo primerjati mnenja o pomembnosti

dokumentiranja med medicinskimi sestrami in drugimi zaposlenimi v zdravstvu, ki se srečujejo s pacienti.

Zaključek

Ugotovili smo, da medicinske sestre z vsaj višješolsko izobrazbo dokumentiranju pripisujejo večji pomen kot tiste s srednješolsko izobrazbo. Medicinske sestre se glede na stopnjo izobrazbe razlikujejo tudi v mnenju glede nekaterih vidikov dokumentiranja. Medicinske sestre z vsaj višješolsko izobrazbo pripisujejo večji pomen pomoči, ki jo dokumentiranje nudi ostalim članom zdravstvenega tima, prav tako so mnenja, da omogoča kontinuiteto dela ter večjo varnost in kakovost obravnave pacienta. Ne glede na nivo izobrazbe pa so medicinske sestre mnenja, da dokumentiranje opisuje delo, ki ga opravljajo, in z njim le-to postane vidno. Prav tako smo ugotovili, da dolžina delovne dobe ne vpliva na stališča medicinskih sester do dokumentiranja. Čeprav imajo medicinske sestre pozitiven odnos do dokumentiranja, menijo, da imajo zanj premalo časa.

Dokumentacija zdravstvene nege je pomemben del dela medicinske sestre. V utemeljevanje njene pomembnosti bi bilo potrebno vključiti vodstvo, šolske ustanove in tudi zavzete posameznike, ki posedujejo široka znanja s tega področja. Spodbudno je dejstvo, da delovna doba na odnos medicinskih sester do dokumentiranja ne vpliva negativno. Iz navedenega lahko sklepamo, da se medicinske sestre ne glede na starost zavedajo pomembnosti dokumentiranja. Če želimo dvigniti zavedanje, morajo tudi medicinske sestre s srednješolsko izobrazbo prepoznati njegovo pomembnost že v zgodnjem obdobju usposabljanja za svoj poklic.

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