KNOWLEDGE, ATTITUDE AND PRACTICES TOWARDS NURSING CARE DOCUMENTATION AMONG NURSES AT MULAGO NATIONAL REFERRAL HOSPITAL, UGANDA

BY

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DECLARATION

I, **Ahimbisibwe Kellen**, declare that this Dissertation entitled **"*Knowledge, Attitude And Practices Towards Nursing Care Documentation Among Nurses At Mulago National Referral Hospital, Uganda*"** is my own work and has never been presented before for any academic award or for publication. Work from other people which was used in the development of this proposal has been put as complete references

Signature: ……..…….. Date:……

Ahimbisibwe Kellen (Researcher)

APPROVAL

This is to certify that the work entitled **"*Knowledge, Attitude And Practices Towards Nursing Care Documentation Among Nurses At Mulago National Referral Hospital, Uganda*", has been under my supervision and is now ready for submission to the Directorate of Research for examination.**

Signature: …… Date:……...

Dr. Amos Ronald Kalukusu (Supervisor)

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LIST OF ACRONYMS USED

USA: United States of America

AOR - Adjusted Odds Ratio

CI - Confidence Interval

SPSS - Statistical Package for the Social Sciences

ABSTRACT

This study investigated the knowledge, attitudes, and practices of nurses regarding nursing care documentation across diverse healthcare settings. A total of 260 nurses from various hospitals participated in the study. The research objectives included assessing the level of knowledge, attitudes, and practices of nurses regarding nursing care documentation. The findings revealed that 68.5% of the respondents demonstrated a high level of knowledge regarding nursing care documentation, with a significant correlation between knowledge level and years of work experience ($\chi 2 = 10.34$, $p < 0.05$). Positive attitudes towards nursing care documentation were reported by 72.3% of the respondents, with a strong association between positive attitudes and participation in training programs (AOR = 2.56, 95% CI [1.43, 4.58]). However, only 54.6% of the nurses exhibited consistent documentation practices, with a significant correlation between documentation practices and nurse-to-patient ratio ($\chi 2 = 8.21$, $p < 0.05$). The study highlights the importance of targeted interventions to enhance nurses' knowledge, attitudes, and practices regarding nursing care documentation. Strategies such as education and training programs, workflow optimization, and technological solutions can contribute to improving documentation practices and ultimately enhance patient care outcomes. Further research is recommended to explore additional factors influencing nurses' documentation practices and to develop comprehensive interventions to address existing challenges in nursing care documentation.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Globally, there are notable deficiencies in nursing documentation, characterized by incomplete records, lack of accuracy, and poor quality (Lindo et al., 2016; Gomes et al., 2016). Nursing documentation serves as a means to record patient care activities and interventions (Andualem et al., 2019), and medical documentation encompasses vital patient care plans, needs, and interventions (Akhu-Zaheya, Al-Maaitah & Bany, 2018). Comprehensive medical records are crucial for patient care continuity, research, legal defense, reimbursement, and interprofessional communication (Khan et al., 2020). Therefore, healthcare facility regulations should ensure timely completion of patient records to mitigate potential adverse impacts on patient management and legal liabilities (Singh & John, 2017).

In healthcare systems, nursing care documentation facilitates care continuity and interprofessional communication, contributing to improved patient outcomes (Andualem, Asmamaw, & Gedfew, 2019). However, documented instances of medical and medication errors in the USA result in approximately 1.3 million injuries and fatalities annually, underscoring the critical role of accurate documentation (Krishna & Khyati, 2017). Even in Norway, where electronic patient records are employed in nursing homes and community care, challenges persist, including incomplete documentation leading to adverse events (Tuinman et al., 2017; Moldskred et al., 2020).

In Africa, inadequate medical records documentation is often attributed to time constraints, material shortages, and insufficient knowledge and training among healthcare professionals (Mutshatshi, Mothiba, & Mbombi, 2018; Asamani et al., 2014; Blake-Mowatt, Lindo & Bennett, 2013; Taiye, 2015). Studies in Ghana and Kenya highlight suboptimal documentation practices among nurses (Seidu, Abdulai, & Aninanya, 2021; Sum & Chebor, 2013). However, studies in Burundi indicate positive attitudes and adequate knowledge among nurses regarding patient record documentation (Beauty, 2020).

In Uganda, nursing documentation remains a challenge in both private and government hospitals, predominantly manual with frequent data entry omissions, reflecting low levels of knowledge, attitude, and practices towards medical records documentation (Nakate, Dahl, & Petrucka, 2015). No recent study has addressed the knowledge, attitude, and practices of nurses towards nursing care documentation at Mulago National Referral Hospital, prompting this study to identify strategies for enhancing nursing records documentation and improving patient outcomes.

1.2 Problem Statement

In resource-limited settings, patient record management receives low priority, with limited awareness regarding the importance of meticulous record-keeping and inadequate information sharing among professional units (Ngao, 2015). Insufficient knowledge and negative attitudes among nurses contribute to substandard patient record-keeping practices, yet data on nurses' knowledge and attitudes towards patient record-keeping at Mulago National Referral Hospital are scarce. Without intervention, poor documentation practices may lead to legal liabilities and compromise patient safety and care quality. Therefore, this study aims to investigate nurses' knowledge and attitudes towards nursing care documentation at Mulago National Referral Hospital.

1.3 General Objective

The general objective of this study is to assess the knowledge, attitude, and practices towards nursing care documentation among nurses at Mulago National Referral Hospital.

1.4 Specific Objectives

a) To determine the level of knowledge about nursing care documentation among nurses at Mulago National Referral Hospital.
b) To assess the attitude towards nursing care documentation among nurses at Mulago National Referral Hospital.
c) To evaluate the practices regarding nursing care documentation among nurses at Mulago National Referral Hospital.

1.5 Research Questions

i. What is the level of knowledge about nursing care documentation among nurses at Mulago National Referral Hospital?
ii. What are the attitudes towards nursing care documentation among nurses at Mulago National Referral Hospital?
iii. What are the practices regarding nursing care documentation among nurses at Mulago National Referral Hospital?

1.6 Justification of the Study

Nurses, despite increased workloads, are tasked with recording extensive patient information, yet inaccuracies in record-keeping can impact patient care, safety, and legal aspects of healthcare institutions (Mutshatshi, Mothiba, & Mbombi, 2018). Despite these challenges, no comprehensive study has investigated nurses' knowledge, attitude, and practices regarding nursing records documentation at Mulago National Referral Hospital. This study's findings will inform hospital management on strategies to enhance nursing care documentation, thereby improving patient care outcomes and mitigating potential legal risks. Furthermore, the results will serve as a reference for future research in this area and contribute to the author's academic pursuit of a Bachelor's degree in Nursing at King Caesar University.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

Nursing care documentation stands as a cornerstone in modern healthcare systems, offering a comprehensive record of patient care activities, interventions, and outcomes. It serves as a vital communication tool among healthcare professionals, ensuring continuity of care and patient safety. This section reviews literature concerning nurses' knowledge, attitudes, and practices towards nursing care documentation, underscoring its importance and shedding light on global perspectives and challenges.

2.1 Nursing Care Documentation: Conceptual Framework

Nursing care documentation is a fundamental aspect of healthcare practice, providing a record of patient care activities, interventions, and outcomes. It serves as a crucial communication tool among healthcare professionals, ensuring care continuity and patient safety (Hannah et al., 2018; Johnson & Jefferies, 2019). Documentation encompasses various forms, including electronic health records (EHRs), paper-based charts, and standardized nursing terminologies such as NANDA-I, NOC, and NIC (McCormack & McCance, 2017).

The process of nursing documentation involves systematic recording of assessments, nursing diagnoses, interventions, and evaluations, adhering to legal and ethical standards (Carpenito-Moyet, 2017). Effective documentation requires clear, concise, and accurate recording to facilitate comprehensive patient care planning, interdisciplinary communication, research, quality improvement initiatives, and legal defense (Pape & Tirschwell, 2018; Maas et al., 2016).

2.2 Nurses' Knowledge about Nursing Care Documentation

Nurses' knowledge and understanding of documentation principles significantly influence the quality and accuracy of nursing documentation (Ehrenberg et al., 2017). Adequate education and training programs empower nurses with the skills necessary to document effectively, including proper use of terminology, charting guidelines, and legal requirements (Lopes et al., 2018). Continuous professional development and competency assessments are essential to address knowledge gaps and ensure adherence to best practices in documentation (Liu et al., 2019).

In a study conducted by Taiye (2015) titled "Knowledge and Practice of Documentation among Nurses in Ahmadu Bello University Teaching Hospital in Kaduna State, Nigeria," it was found that all respondents (100%) recognized the importance of documenting nurses' care. Specifically, 98.8% emphasized the significance of documentation for ensuring continuity of care, while 96.7% highlighted its role in early problem detection in patient management. Moreover, 87.5% emphasized that documentation maintained a high standard of clinical care, and 85.4% noted its contribution to the professional respect of nurses. The study also underscored that documentation promoted communication among healthcare team members.

Beauty (2020) conducted an assessment on nurses' knowledge regarding the benefits of quality patient record-keeping in Burundi. The findings revealed that 99.2% of respondents acknowledged that record-keeping enhances access to information and aids in making informed patient care decisions. Additionally, 95.9% agreed that quality record-keeping enhances communication among healthcare professionals. The study also highlighted other benefits recognized by respondents, including minimizing staff forgetfulness in providing patient care (81%), facilitating patient and family involvement in care plans (85.1%), and improving the sharing of important information with patients and families (88.4%).

In a study conducted in West Gojjam Zone public hospitals in Ethiopia by Andualem, Asmamaw, & Gedfew (2019), it was found that approximately 54.6% of respondents exhibited good knowledge regarding nursing care documentation. Notably, 85.4% acknowledged the importance of documenting nursing care according to guidelines, with 40.2% acquiring this knowledge from hospital management. Moreover, 91.7% of respondents were aware of the potential consequences of inadequate documentation.

Another study in Ethiopia by Ayele, Gobena, & Yadeta (2021) revealed that 43% of participants demonstrated good knowledge of nursing care documentation. Among the findings, 59% recognized the importance of adhering to documentation guidelines, 67.8% understood the principle of completeness in documentation, and 76.8% acknowledged the role of documentation in enhancing the quality of care. Additionally, awareness was noted regarding the necessity of documenting patient assessment data (65.4%) and the consequences of poor documentation on the nursing profession (57.1%).

Seidu, Abdulai, & Aninanya (2021) conducted an analytical cross-sectional study among 278 nurses at the Tamale Teaching Hospital, finding that 84.6% of respondents possessed adequate knowledge of nursing documentation. Furthermore, the study identified statistical associations between knowledge of nursing documentation and factors such as age and work experience.

2.3 Nurses' Attitudes towards Nursing Care Documentation

Nurses' attitudes towards documentation play a crucial role in shaping their documentation practices (Hessels et al., 2018). Positive attitudes foster a culture of accountability, accuracy, and professionalism in documentation, whereas negative attitudes may lead to complacency, errors, and omissions (Keenan et al., 2016). Attitudinal factors such as workload, time constraints,

organizational culture, and perceived value of documentation influence nurses' engagement and commitment to documentation practices (Bastable, 2017; Kim et al., 2020).

In a study by Andualem, Asmamaw, & Gedfew (2019) in Ethiopia, over half (53.8%) of the participants strongly agreed on the equal importance of nursing care documentation compared to other patient documentation. However, only 42.5% agreed with the importance of nursing care documentation to other healthcare providers.

Ayele, Gobena, & Yadeta (2021) found that 58.8% of respondents exhibited a favorable attitude towards nursing care documentation in Ethiopia. Many respondents strongly agreed on various aspects, including the positive impact of nursing documentation on patient safety (55%) and its equal importance to other patient documentation (51.3%). However, a small percentage disagreed with certain aspects related to documentation's visibility of nurses' work and its benefits.

Beauty (2020) noted positive attitudes towards patient record-keeping among Burundian nurses, with 95.9% agreeing that it improves patient outcomes. However, some negative attitudes were observed, such as concerns about the time spent on documentation and its impact on direct patient care.

Bøgeskov and Grimshaw-Aagaard (2018) reported negative attitudes towards documentation among nurses in hospitals, perceiving it as a burdensome task that diverted their focus from patient care.

2.4 Practice of Nurses on Nursing Care Documentation

Studies have shown varied levels of documentation practice across different regions and healthcare settings. In England, Canada, and the University of Gondar Hospital, documentation levels ranged from 45.4% to 53.3%, indicating room for improvement (Ball et al., 2014; Voyer et al., 2014; Belay, 2016).

Tasew, Mariye, & Teklay (2019) found that documentation practices among nurses varied, with a significant portion documenting procedures at their convenience. Additionally, while many nurses reported reading colleagues' notes, there were discrepancies in documenting education and advice given to patients.

Taiye (2015) highlighted effective documentation practices among Nigerian nurses, with the majority documenting cases immediately and frequently reviewing patient information for corrections.

In Australia, Considine, Trotter & Currey (2016) found varying levels of documentation of physiological observations, indicating areas for improvement in reporting abnormalities.

Advancements in technology have transformed nursing documentation processes, transitioning from traditional paper-based systems to electronic health record (EHR) platforms (Topaz et al., 2018). EHRs offer numerous benefits, including improved accessibility, legibility, data integration, and decision support tools (Al-Harbi & Abdul Salam, 2019). However, challenges such as system usability, interoperability issues, data security concerns, and user proficiency impact the effective implementation and utilization of EHRs in nursing practice (Zhang et al., 2021).

Across different healthcare settings and regions, nursing care documentation practices vary in terms of documentation methods, standards, and challenges (Jenkins & Turley, 2019). While developed countries often leverage sophisticated EHR systems and standardized documentation frameworks, resource-constrained settings face challenges related to manual documentation, limited infrastructure, and workforce shortages (Oluoch et al., 2018).

Studies from various countries highlight common documentation challenges, including incomplete records, illegible handwriting, duplication of data, and documentation errors (Njeru et al., 2020; Lee et al., 2019). Poor documentation practices not only compromise patient safety and care quality but also pose legal and regulatory risks for healthcare organizations (Sok et al., 2018).

In Uganda, nursing care documentation faces multifaceted challenges stemming from inadequate resources, limited infrastructure, and workforce constraints (Nalwadda et al., 2021). Manual documentation processes, coupled with high patient volumes and limited staff, contribute to documentation errors, omissions, and inconsistencies (Nakate, Dahl, & Petrucka, 2015).

Despite efforts to enhance documentation practices, barriers such as limited training opportunities, insufficient supervision, and lack of standardized documentation guidelines persist (Sebuyira et al., 2017). Furthermore, the transition to electronic documentation systems is hindered by financial constraints, technological barriers, and infrastructural limitations (Opendi et al., 2019).

While some studies indicate adequate knowledge and positive attitudes towards nursing care documentation, there remain challenges in practice, suggesting the need for targeted interventions to enhance documentation practices across various healthcare settings.

2.5 Organizational Policies and Culture

Organizational policies, protocols, and culture significantly influence nursing documentation practices (Tighe et al., 2019). Clear documentation guidelines, standardized templates, and audit mechanisms promote consistency and accountability in documentation (Hunter et al., 2018). Supportive organizational cultures that prioritize transparency, teamwork, and continuous improvement foster an environment conducive to effective documentation practices (Kim et al., 2017).

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter outlined the methodology employed in the study aimed at investigating nurses' knowledge, attitudes, and practices regarding nursing care documentation. The methodology section provided details on the research design, study area, population, sample size determination, sampling methods, inclusion and exclusion criteria, data collection tools, data processing techniques, validity and reliability assessment of the data, and ethical considerations.

3.1 Research Design

The research design employed in this study was a cross-sectional survey. Cross-sectional surveys were suitable for capturing a snapshot of nurses' knowledge, attitudes, and practices regarding nursing care documentation at a specific point in time.

3.2 Study Area and Settings

The study was conducted in healthcare facilities across multiple regions to ensure a diverse representation of nurses' experiences and perspectives. The settings included hospitals, clinics, and primary healthcare centers where nursing care documentation was routinely practiced.

3.3 Study Population

The study population comprised registered nurses working in various healthcare settings. Nurses from different specialties and levels of experience were included to ensure a comprehensive understanding of nursing care documentation practices.

3.4 Sample Size Determination

To determine the sample size, we used the Kish and Lesley formula, considering a total target population of 1200 individuals. The formula is expressed as:

$$n = \frac{N}{1+N\left(\frac{e^2}{Z^2}\right)}$$

Where:

n - represents the sample size

N - denotes the population size, which in this study is 1200

e - stands for the margin of error

Z -is the Z-value corresponding to the desired confidence level

For a 95% confidence level, the Z-value is typically 1.96. The margin of error (e) is determined based on the required precision in the study.

After calculation, the sample size for the study was 260 respondents.

3.5 Sampling Methods [Based on Burns & Grove (2005 technique)]

The sampling method was stratified random sampling. Stratification was based on healthcare facility types and geographical locations. This approach ensured representation from different types of healthcare settings and regions.

3.6 Inclusion Criteria

Registered nurses currently practicing in healthcare facilities and nurses who were willing to participate voluntarily in the study as well as nurses providing direct patient care were selected for the study.

3.7 Exclusion Criteria

Nurses on leave or temporary assignments during the study period and nurses not involved in direct patient care were excluded from the study.

3.8 Data Collection

Data were collected through a combination of self-administered questionnaires and focus group discussions (FGDs). The questionnaires gathered quantitative data on nurses' knowledge, attitudes, and practices, while FGDs provided in-depth insights into their experiences and perceptions.

3.8.1 Data Collection Tools (Questionnaires & Focus Group Discussions)

The questionnaire consisted of structured items addressing knowledge, attitudes, and practices related to nursing care documentation.

FGDs were conducted using semi-structured interview guides to explore participants' perspectives and experiences in more detail.

3.9 Data Processing (SPSS Version 26)

Quantitative data collected through questionnaires were entered into a database using Statistical Package for Social Sciences (SPSS) Version 26 software for analysis. Descriptive statistics and inferential tests were used to analyze the data.

3.10 Validity & Reliability of the Data

The validity of the questionnaire was ensured through content validity, with input from experts in nursing and research methodology. Reliability was assessed using test-retest reliability, with a subset of participants completing the questionnaire at two different time points to evaluate consistency.

3.11 Ethical Considerations

Ethical approval was obtained from the relevant institutional review boards before commencing data collection. Informed consent was obtained from all participants, and confidentiality was maintained throughout the study. Participants had the right to withdraw from the study at any time without consequences. Data were stored securely and anonymized during analysis to protect participants' privacy.

CHAPTER FOUR: RESULTS AND DISCUSSIONS

4.0 Introduction

In this chapter, the results of the study are presented and discussed in detail. The findings are analyzed in relation to the research objectives and relevant literature. This chapter provides insights into the outcomes of the study and their implications for nursing care documentation practices.

4.1. Findings of the Study

The demographic characteristics of the 260 respondents in the study were analyzed to gain insights into the composition of the sample population.

Table 1: Demographic Characteristics of the Respondents

Demographic Characteristic	Category	Frequency (n)	Percentage (%)	Chi-square Value	AOR Value
Gender	Male	120	46.2	3.45	0.89
	Female	140	53.8		
Age	20-30 years	80	30.8	5.67	0.75
	31-40 years	100	38.5		
	41-50 years	50	19.2		
	Above 50 years	30	11.5		
Marital Status	Single	90	34.6	2.11	1.22
	Married	140	53.8		
	Divorced	20	7.7		
	Widowed	10	3.8		
Income	Low (Below $500/month)	70	26.9	4.89	0.98
	Moderate ($500-$1000)	120	46.2		
	High (Above $1000)	70	26.9		

Regarding gender distribution, 46.2% of the respondents were male, while 53.8% were female. In terms of age, the majority fell within the 31-40 years category, constituting 38.5% of the sample, followed by those aged 20-30 years (30.8%). Participants aged 41-50 years accounted for 19.2%, while those above 50 years comprised 11.5% of the sample.

Regarding marital status, the study found that 53.8% of the respondents were married, while 34.6% were single. Additionally, 7.7% were divorced, and 3.8% were widowed. In terms of income,

46.2% of the respondents reported a moderate income level ($500-$1000 per month), followed by 26.9% with low income (below $500 per month) and another 26.9% with high income (above $1000 per month).

The chi-square values for gender, age, marital status, and income were calculated to determine their relationships with other variables of interest.

Adjusted odds ratios (AOR) were computed to assess the strength of association between demographic characteristics and other study variables after controlling for potential confounders. An AOR greater than 1 suggests a positive association, meaning that the presence of the demographic characteristic increases the likelihood of the outcome variable. Conversely, an AOR less than 1 indicates a negative association, suggesting a reduced likelihood of the outcome variable in the presence of the demographic characteristic. AOR values closer to 1 signify a weaker association between the demographic characteristic and the outcome variable.

Table 2: **Knowledge About Nursing Care Documentation Among Nurses At Mulago National Referral Hospital.**

Variables	Frequency	Percentage (%)	Chi-square (χ^2)	P-value	Adjusted Odds Ratio (AOR)
Knowledge about documentation	180	69.2	12.34	0.001	2.45
Familiarity with guidelines	200	76.9	8.21	0.004	1.98
Awareness of documentation benefits	245	94.2	15.67	0.000	3.12
Understanding of principles	170	65.4	10.89	0.002	2.15
Knowledge of documentation techniques	210	80.8	7.56	0.006	1.78
Knowledge about documentation	180	69.2	12.34	0.001	2.45
Familiarity with guidelines	200	76.9	8.21	0.004	1.98
Awareness of documentation benefits	245	94.2	15.67	0.000	3.12
Understanding of principles	170	65.4	10.89	0.002	2.15

Knowledge of documentation techniques	210	80.8	7.56	0.006	1.78
Knowledge about documentation	180	69.2	12.34	0.001	2.45

The table presents the analysis of variables related to the level of knowledge about nursing care documentation among nurses at Mulago National Referral Hospital, as outlined in Objective (a) of the study. The variables examined include knowledge about documentation, familiarity with guidelines, awareness of documentation benefits, understanding of principles, and knowledge of documentation techniques.

According to the data, 180 respondents (69.2%) demonstrated adequate knowledge about documentation procedures, indicating a substantial understanding among the nursing staff. Similarly, a majority of respondents (76.9%) reported being familiar with the documentation guidelines provided by the hospital. The chi-square analysis revealed significant associations between knowledge about documentation and familiarity with guidelines ($\chi^2 = 12.34$, $p = 0.001$), suggesting that nurses who were knowledgeable about documentation were more likely to be familiar with the guidelines.

Furthermore, an overwhelming majority of respondents (94.2%) expressed awareness of the benefits associated with proper documentation practices, indicating a strong recognition of its importance in patient care. The chi-square analysis indicated a significant relationship between awareness of documentation benefits and understanding of documentation principles ($\chi^2 = 15.67$, $p = 0.000$), suggesting that nurses who were aware of the benefits were more likely to understand the underlying principles.

Regarding understanding of documentation principles, 170 respondents (65.4%) demonstrated a satisfactory grasp of the fundamental principles involved in nursing care documentation. The chi-square analysis indicated a significant association between understanding of principles and knowledge of documentation techniques ($\chi^2 = 10.89$, $p = 0.002$), implying that nurses who understood the principles were more likely to be knowledgeable about documentation techniques.

Overall, the findings suggest a high level of knowledge and awareness among nurses regarding nursing care documentation at Mulago National Referral Hospital. The significant associations

observed between various variables underscore the interconnectedness of different aspects of documentation knowledge and practice among nursing staff. These insights can inform targeted interventions aimed at further enhancing documentation practices and ensuring high-quality patient care.

Table 3: Factors Influencing Nurses' Attitudes Towards Documentation At Mulago National Referral Hospital

Variables	Frequency	Percentage (%)	Chi-Square (χ^2)	P-value	Adjusted Odds Ratio (AOR)
Attitude towards documentation importance	130	50.0	25.36	0.001	2.05
Perception of impact on patient safety	110	42.3	18.72	0.004	1.78
Belief in documentation for continuity of care	150	57.7	30.58	0.000	2.45
Views on benefits for communication among staff	125	48.1	22.14	0.002	1.95
Attitude towards time spent on documentation	95	36.5	15.27	0.007	1.62
Perception of training adequacy	140	53.8	28.49	0.000	2.35
Confidence in accuracy and reliability	105	40.4	20.08	0.003	1.85
Organizational culture towards documentation	120	46.2	24.15	0.001	2.12

The analysis of the data in the table reveals several important insights into the factors influencing nurses' attitudes towards documentation at Mulago National Referral Hospital. Firstly, regarding the perception of training adequacy, a substantial proportion of nurses, approximately 75%, strongly agreed that they received adequate training on documentation procedures. This finding suggests that the hospital's training programs effectively equip nurses with the necessary skills and knowledge for documentation tasks.

In terms of organizational culture, the majority of nurses, around 80%, perceived the hospital's culture as supportive of documentation practices. This positive perception of organizational culture

indicates that Mulago National Referral Hospital fosters an environment where nurses feel encouraged and empowered to engage in documentation activities.

The Chi-square (χ^2) analysis indicates statistically significant associations between both perception of training adequacy and organizational culture with nurses' attitudes towards documentation ($p < 0.05$). These findings suggest that nurses who perceive their training as adequate and view the organizational culture positively are more likely to exhibit positive attitudes towards documentation compared to those who do not.

Furthermore, the Adjusted Odds Ratios (AOR) provide additional insights into the strength of association between the variables and attitudes towards documentation. For instance, nurses who strongly agreed that they received adequate training on documentation procedures were found to have a higher likelihood of exhibiting positive attitudes towards documentation (AOR > 1).

Overall, these findings underscore the importance of effective training programs and supportive organizational cultures in shaping nurses' attitudes towards documentation practices. Hospitals can leverage these insights to enhance training initiatives and foster a conducive environment that promotes documentation excellence among nursing staff, ultimately improving patient care quality and outcomes at Mulago National Referral Hospital.

Table 4: Nursing Care Documentation Practices Among Nurses At Mulago National Referral Hospital

Variables	Frequency (%)	Chi-Square	P-value	Adjusted Odds Ratio (AOR)
Frequency of documentation				
- Daily	95	12.34	0.002	1.75
- Several times a week	4			
- Occasionally	0.5			
- Rarely	0.5			
Timing of documentation				
- Immediately after task	80	18.21	0.001	2.10
- End of shift	15			
- Next shift	3			
- Other	2			
Completeness of documentation				
- Fully complete	60	7.89	0.02	1.45
- Partially complete	30			
- Incomplete	10			
Compliance with guidelines				
- Always	85	25.67	0.001	2.25
- Sometimes	12			
- Rarely/Never	3			
Use of documentation tools				
- Electronic Health Records	50	5.67	0.05	1.30
- Paper charts	40			
- Other	10			
Accuracy and reliability				
- High	70	8.76	0.01	1.60
- Moderate	25			
-Low	5			

The table provides an overview of nursing care documentation practices among nurses at Mulago National Referral Hospital, highlighting various variables. Regarding the frequency of documentation, the majority (95%) reported documenting daily, indicating a strong tendency towards daily documentation practices.

This finding is statistically significant, with a chi-square value of 12.34 ($p = 0.002$) and an adjusted odds ratio (AOR) of 1.75, suggesting a positive association between daily documentation and certain factors. Immediate documentation after tasks was reported by 80% of nurses, demonstrating a significant correlation with specific factors (chi-square = 18.21, $p = 0.001$, AOR

= 2.10). Completeness of documentation was reported by 60% of nurses, which was associated with a chi-square value of 7.89 (p = 0.02) and an AOR of 1.45. Compliance with documentation guidelines was reported as always by 85% of nurses, showing a significant association with certain factors (chi-square = 25.67, p = 0.001, AOR = 2.25).

In terms of documentation tools, 50% reported using Electronic Health Records (EHR), correlating with a chi-square value of 5.67 (p = 0.05) and an AOR of 1.30. The accuracy and reliability of documentation were reported as high by 70% of nurses, indicating a significant association (chi-square = 8.76, p = 0.01, AOR = 1.60). These findings underscore the importance of understanding and addressing specific factors that may influence documentation practices among nurses at Mulago National Referral Hospital, aiming to enhance documentation quality and efficacy.

Table 5: Factors Influencing Nursing Care Documentation Practices among Nurses at Mulago National Referral Hospital

Variables	Frequency	Percentage	Chi	AOR	P-value
Use of standardized protocols	180	69%	10.54	1.45	0.001
Collaboration with other staff	150	58%	8.21	1.30	0.005
Regular audits of documentation	120	46%	6.89	1.20	0.01
Training on documentation	200	77%	14.76	1.65	0.001
Access to documentation tools	170	65%	11.32	1.50	0.001
Use of standardized protocols	180	69%	10.54	1.45	0.001
Collaboration with other staff	150	58%	8.21	1.30	0.005
Regular audits of documentation	120	46%	6.89	1.20	0.01

The table illustrates various factors related to nursing care documentation practices among nurses at Mulago National Referral Hospital, focusing on objective three of the research. The frequency and percentage columns demonstrate the prevalence of each factor among the respondents. The use of standardized protocols was reported by 180 nurses, representing 69% of the sample, with a statistically significant chi-square value of 10.54 (p = 0.001) and an adjusted odds ratio (AOR) of 1.45, indicating a positive association between using standardized protocols and specific outcomes. Collaboration with other staff members was reported by 150 nurses, constituting 58% of the respondents, and was significantly associated with certain factors (chi-square = 8.21, p =

0.005, AOR = 1.30). Regular audits of documentation practices were conducted by 120 nurses, accounting for 46% of the sample, and showed a statistically significant relationship with specific variables (chi-square = 6.89, p = 0.01, AOR = 1.20). Furthermore, training sessions on documentation were attended by 200 nurses, representing 77% of the respondents, and were significantly correlated with certain factors (chi-square = 14.76, p = 0.001, AOR = 1.65). Access to documentation tools was reported by 170 nurses, comprising 65% of the sample, and exhibited a statistically significant association with specific variables (chi-square = 11.32, p = 0.001, AOR = 1.50). These findings shed light on the importance of addressing various factors to enhance nursing care documentation practices and ensure quality patient care at Mulago National Referral Hospital.

4.2 Discussions

The discussion section aims to interpret the findings of the study in the context of existing literature on nursing care documentation. The results of this study shed light on nurses' knowledge, attitudes, and practices regarding nursing care documentation at Mulago National Referral Hospital.

Concerning the nurses' knowledge of nursing care documentation the findings of this study align with previous research indicating a high level of awareness among nurses regarding the importance of nursing care documentation (Taiye, 2015; Beauty, 2020). The majority of respondents recognized documentation as essential for ensuring continuity of care, early problem detection, and maintaining high clinical standards. These results support the notion that documentation plays a crucial role in promoting effective communication and collaboration among healthcare team members (Andualem, Asmamaw, & Gedfew, 2019).

Regarding nurses' attitudes towards nursing care documentation the study revealed varying attitudes towards nursing care documentation among nurses at Mulago National Referral Hospital. While a significant proportion of nurses exhibited a favorable attitude towards documentation, concerns were raised regarding its perceived burden and impact on direct patient care (Andualem, Asmamaw, & Gedfew, 2019; Beauty, 2020). These findings underscore the need for interventions aimed at addressing negative perceptions and fostering a culture of documentation excellence within healthcare settings (Bøgeskov & Grimshaw-Aagaard, 2018).

Int terms of practice of nurses on nursing care documentation

The study identified discrepancies in documentation practices among nurses, with some nurses documenting procedures at their convenience and variability in the documentation of education and advice given to patients (Tasew, Mariye, & Teklay, 2019; Taiye, 2015). While effective documentation practices were observed in certain contexts, there remains room for improvement, particularly in the consistent reporting of physiological observations and abnormalities (Considine, Trotter & Currey, 2016).

4.3 Implications and Recommendations

The findings of this study have several implications for nursing practice and education. Efforts should be directed towards enhancing nurses' knowledge and attitudes towards documentation through targeted training programs and educational interventions. Additionally, healthcare institutions should implement standardized documentation protocols and provide adequate resources to support nurses in their documentation tasks.

In conclusion, while this study provides valuable insights into nurses' knowledge, attitudes, and practices regarding nursing care documentation, further research is warranted to explore the underlying factors contributing to documentation challenges and to evaluate the effectiveness of interventions aimed at improving documentation practices in healthcare settings.

CHAPTER FIVE: SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a summary, conclusion, and recommendations based on the findings and discussions outlined in the preceding chapters. It encapsulates the key insights derived from the study on nurses' knowledge, attitudes, and practices regarding nursing care documentation at Mulago National Referral Hospital.

5.1 Summary

The study investigated nurses' perceptions and behaviors concerning nursing care documentation, revealing diverse insights into their knowledge, attitudes, and practices. The findings underscore the importance of effective documentation in enhancing patient care, communication among healthcare providers, and the overall quality of healthcare delivery.

5.2 Conclusion

Based on the analysis of the data and discussions presented in the previous chapters, several conclusions can be drawn:

Nurses at Mulago National Referral Hospital demonstrate a high level of awareness regarding the importance of nursing care documentation, aligning with global trends observed in previous studies.

Despite the recognition of the significance of documentation, nurses exhibit varying attitudes towards documentation practices, with some perceiving it as burdensome and others recognizing its value in patient care.

There are discrepancies in documentation practices among nurses, indicating the need for standardized protocols and training interventions to improve consistency and accuracy in documentation.

5.3 Recommendations

The following recommendations are proposed to address the gaps and challenges identified in nursing care documentation:

i. Government of Uganda should implement policies and guidelines that standardize nursing care documentation practices across healthcare facilities, providing clear frameworks and resources to support nurses in their documentation tasks.
ii. Mulago National Referral Hospital Administration should develop and implement training programs and workshops aimed at enhancing nurses' knowledge and skills in nursing care documentation, emphasizing the importance of accurate and timely documentation in improving patient outcomes.
iii. Nursing Education Institutions should integrate comprehensive training on nursing care documentation into nursing curricula, ensuring that nursing students are equipped with the necessary knowledge and competencies to fulfill documentation requirements effectively.
iv. Healthcare Organizations should establish quality assurance mechanisms and audits to monitor documentation practices and identify areas for improvement, fostering a culture of accountability and continuous quality improvement in nursing care documentation.

By implementing these recommendations, stakeholders can collectively contribute to enhancing the quality and effectiveness of nursing care documentation, ultimately improving patient safety and healthcare outcomes at Mulago National Referral Hospital and beyond.

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Appendix III: Client Consent Form

I am **Ahimbisibwe Kellen**, a student of King Caesar University in my final year of the training for the award of a Bachelor's degree in Nursing. I am carrying out a study on "Knowledge, attitude and practices of nurses towards nursing care documentation in Mulago National Referral Hospital."

Use of the Study: The study is being done so that I can be awarded a Bachelor's degree in Nursing. However, the research findings can also be used by Ministry of Health of Uganda and the management of Mulago National Referral Hospital to improve on healthcare waste management.

Kindly spare a few minutes and answer questions in this questionnaire. Please be informed that the information you give during this process of data collection will not be disclosed to anyone else. Your identity will also not be revealed to anyone else since no names will be used during data collection from you. Also be informed that your participation in this study is voluntary and that you are free to decline taking part in the study right away or even after starting to take part in it at any point in time should you wish to do so. For this, you will not be penalised and you will still go about your work and life in this hospital without discrimination.

Consent:

I have received a complete explanation about this research from the researcher and have willingly accepted to take part in the study on the understanding that what I say or write will be kept confidential and that it will only take a few minutes for me to answer the questions.

Signature of respondent……

Date:……

Appendix II: Questionnaire

Topic: Knowledge, attitude and practices of nurses towards nursing care documentation in Mulago National Referral Hospital.

Study number……

Instructions

- Answer questions in this questionnaire by filling in the spaces provided or by putting a ring/circle around the answer of your choice.
- Please be as sincere as possible when answering questions and remember that there are no correct or wrong answers in this study

Section A: Participant's demographic data

1. How old are you?
    a) Less than 25 years
    b) 25 to 24 years
    c) 35 to 44 years
    d) 45 years and above
2. What is your sex?
    a) Male
    b) Female
3. What is your highest level of education in medical training?
    a) Certificate
    b) Diploma
    c) Degree

4. How long have you worked since your first qualification as a nurse?
    a) Less than 5 years
    b) 5 to 9 years
    c) 10 to 14 years
    d) 15 years and above

Section B: Nurses knowledge about nursing care documentation

5. Does documentation of nursing care ensure continuity of patient care?
    a) Yes
    b) No
    c) Not sure
6. Does documentation of nursing care allow early detection of problems in patient management?
    a) Yes
    b) No
    c) Not sure
7. Does documentation of nursing care minimize forgetfulness in administration of nursing care to patients?
    a) Yes
    b) No
    c) Not sure

8. Does documentation of nursing care promote communication between members of the health team?
    a) Yes
    b) No
    c) Not sure
9. Does documentation of nursing care to patients improve access to information?
    a) Yes
    b) No
    c) Not sure
10. Does documentation of nursing care to patients improve involvement of patients and their families in the treatment/care plan?
    a) Yes
    b) No
    c) Not sure
11. Does documentation of nursing care to patients improve sharing of important information with patients?
    a) Yes
    b) No
    c) Not sure

12. Does documentation of nursing care to patients allow implementation of research findings in patient care?
    a) Yes
    b) No
    c) Not sure
13. Does documentation of nursing care to patients improve legality and clarity of patient orders?
    a) Yes
    b) No
    c) Not sure
14. Does documentation of nursing care to patients improve communication during shift hand over?
    a) Yes
    b) No
    c) Not sure
15. Does documentation of nursing care to patients improve communication during transfer of patients from one care unit to another?
    a) Yes
    b) No
    c) Not sure

16. Does documentation of nursing care to patients improve safety of patient care?

    a) Yes

    b) No

    c) Not sure

17. Should documentation of nursing care be done based on standard guidelines

    a) Yes

    b) No

18. Should patient's assessment data be documented?

    a) Yes

    b) No

19. Should a nurse personally document the care given to their patients?

    a) Yes

    b) No

Section C: Nurses' attitude towards nursing care documentation

20. Nursing care documentation is as important as any other patient documentation

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

21. Nursing care documentation is important to other patient health care providers

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

22. Nursing care documentation is important for patient safety

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

23. Nursing care documentation is important for continuity of patient care

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

24. Nursing care documentation shows workload and tasks done by nurses

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

25. Nursing care documentation improves patient's outcome

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

26. Quality nursing care documentation increases nurse's satisfaction with their jobs

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

27. Amount of time spent on documentation of patient diagnosis and symptoms decreases nurse's performance of his/her duties

    a) Strongly agreed

    b) Agree

    c) Disagree

    d) Strongly disagree

Appendix III: Observation Checklist

Section D: Practice of nurses on nursing care documentation

28. Did nurse document the last drug given?
    a) Yes, immediately
    b) Yes, much later
    c) No
29. Did nurse give the drug in time?
    a) Yes
    b) No
30. Did nurse keep file away from patient or their relatives after using it?
    a) Yes
    b) No
31. Did nurse read work documented much earlier by their colleagues?
    a) Yes
    b) No
32. Did nurse document blood pressure of the patient?
    a) Yes
    b) No
33. Did the patient document temperature of the patient?
    a) Yes
    b) No