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Original Research

Improvement on the Ability of Triple Standards Nursing Documentation through Case Reflection: A Pilot Study

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ABSTRACT

Introduction: The Indonesia National Nurses Association (INNA) has issued triples national nursing documentations as a standard. Professional nurse's developments program was included set of interventions to increase the ability of nurses to implement the triple standards. Nevertheless, study on the program's evaluation was scarce. The study aims to find out the improvement of the ability of nurses to do documentation nursing by Triple standards through case reflection at a regional general hospital in Indonesia.

Methods: A pilot project consisted with series of identifications was initiated. This included problem identification, problem analysis, and preparation of a Plan of Action (POA) was conducted. The research was set at a regional general referral hospital in Indonesia on 25 nurses with a purposive sampling technique. Data collection was carried out using interview and observation techniques related to the ability of nurses to carry out triple nursing documentation, then problem-solving used a case reflection discussion approach.

Results: There is an enhancement ability of nurses in nursing diagnoses by SDKI standard by 56% after cases reflection was delivered. An increase of 28% was documented on the nurse's ability for the following sections: preparation of intervention and outcomes following the triple standards.

Conclusions: Case reflections positively impact nurses' ability to implement a standardized nursing documentation. The program helps nurses more precise and structured in carrying out documentation according to 3S standards. Better and more accurate documentation can lead to more appropriate and quality care, and facilitate better communication between members of the healthcare team.

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1. INTRODUCTION

Documentation is a measuring tool for monitoring the quality of nursing care services (Momenipour & Pennathur, 2019), with documentation of nurses being able to know and be able to assess appropriate actions for patients. Quality service in service nursing homes sick proven by arranged documentation of appropriate nursing with a standard by a nurse (Manuhutu et al., 2020). The implementation of

nursing care documentation is used as a measuring tool to realize and observe the quality of nursing care services carried out in hospitals (Adawiah et al., 2021). In providing nursing care, standardization of care is needed which includes: diagnostic standards, output standards, clear intervention standards, and terminology so that nursing care can be uniform, accurate, and clear to ensure continuity and quality of service (Nursalam et al., 2020). Without clear standardization, nurses may provide different care to

patients with the same condition (Bukoh & Siah, 2020). This can result in gaps in the quality of care (Karaca & Durna, 2019) and can compromise patient safety and medical errors (Stanley et al., 2019).

Efforts that can be made to improve the quality of nursing services are nurses must be able to carry out nursing care by predetermined standards, namely from assessment to evaluation along with documentation. Nurses are not only required to improve the quality of service but are also required to be able to document nursing care correctly (Sudaryati et al., 2022). As stated in the law of the Republic of Indonesia Number 38 of 2014 concerning Nursing Article 37th states that nurses are obliged to document nursing care according to standards (Asnawi et al., 2019). In addition, nursing care documentation has many benefits from various legal aspects, including service quality, communication, finance, education, research, and accreditation (Abbasi-Moghaddam et al., 2019). Poor nursing documentation will cause communication errors, in action planning, in taking action, and others which can lead to a decrease in the quality of nursing care and this affects the quality of health services in hospitals (Fibriansari, Astuti, et al., 2022).

Nursing documentation carried out in Indonesia based on the Decree of the Minister of Health (KMK) RI Number HK.01.07/MENKES/425/2020 concerning nursing professional standards state that the list of nursing diagnoses contains nursing diagnoses that refer to the Indonesian Nursing Diagnosis Standards (SDKI) and a list of skills. contains nursing interventions that refer to the Indonesian Nursing Intervention Standards (SIKI) and Indonesian Nursing Outcomes Standard (SLKI). Government regulations related to the use of the SDKI and SIKI books can improve the quality of nursing care provided by nurses throughout Indonesia (Awaliyani et al., 2021). The quality of health services in hospitals is influenced by documentation carried out by a nurse in treating patients (Fibriansari, Maisyaroh, et al., 2022). Poor nursing documentation will cause communication errors, in action planning, in taking action, and others that can cause a decrease in the quality of nursing care and this affects the quality of health services in hospitals. According to (Nursalam et al., 2020) a lot of documentation is incomplete and not by the 3S (SDKI, SIKI, and SLKI), in the assessment, many nurses conduct incomplete assessments, and the formulation of diagnoses is not based on the results of the assessment which have been grouped into assessment format (Fibriansari & Kurniawan, 2021).

Headroom as a manager responsible for a nursing answer on management service nursing in a unit at home sick, have function direction that has not quite enough answer in give direction, guidance, and transfer of knowledge. Activity is an activity reflection case (Oktaviani & Rofii, 2019). Reflection case is something method or activity that reflects the experience clinical nurse in To do care (Kurniasih et al., 2020). Application reflection case could help in

enhancing the ability of a nurse To do good and effective planning to increase quality nursing (Resiyanthi et al., 2021). Activity discussion reflection case among headroom and nurse to documentation with 3S implementation is implemented aims to increase quality documentation in service nursing. Reflection case has the destination minimize the gap between knowledge and practice nursing, developing learning nursing sustainability, and improving the competence nurse to do care to nurse (Amir et al., 2019) so that nurse in operating as role and function based on applicable guidelines, guidelines, and policies. So that creation enhancement satisfaction and safety of the patient. Activity reflection cases can also increase nurses' ability to solve a problem in service nursing.

Based on studies preliminary that the source of information for nurses comes from manuals that have been issued by PPNI by 52%, while no nurses have attended 3S nursing documentation training. The information obtained by nurses in the application of nursing documentation is very instrumental in improving the ability of nurses in the application of 3S in hospitals. In the aspect of planning and nursing actions, nurses tend to be based on routines and do not refer to nursing problems that are made, revision of actions based on response evaluation is also rarely done. The interview with Headroom states this incomplete recording of actions is motivated by a lack of understanding of the things that are necessarily written in the available medical record format. Based on a problem it is to improve the ability of nurses to do documentation nursing needed effort to handle the problem to happen. Optimization reflection case related documentation nursing with the application of 3S is design expected innovation will increase the ability of nurses to do documentation nursing by the 3S standard so that becomes consideration researchers to use development innovation. Based on the background above, it is necessary to conduct a study to find out the increase in the ability of nurses to document nursing according to the 3S standards (SDKI, SIKI, SLKI) with the case of reflection at RSUD Dr. Haryoto Lumajang.

2. METHODS

2.1 Design

Method research on the study used the pilot project method, analysis results, and implementation moment discussion based on the analysis problem. Activities carried out in this pilot project started with identification problems, analysis problems, and the preparation of a Plan of Action (POA).

2.2 Population, Sample, and Sampling

Respondent in the study is headroom, committee nursing, manager nursing, and nurse 25 people who were audited.



Figure. 1 Identification and Analysis Problem

2.3 Variable

Variables in a study this is the ability of a nurse to do documentation nursing according to 3S.

2.4 Instruments

Data retrieval with method interview and observation using the sheet instrument observations that contain related to nurse mapping.

2.5 Procedure

Results of data analysis are later used to determine identified problems using problem diagrams, including man, material, method, machine, money, and marketing. After the problem is identified next conducted determination of priority problems, preparation of a Plan of Action (POA), and plans act continued.

2.6 Data Analysis

Analysis and settlement problem by way case's reflection.

2.7 Ethical Clearance

This research has been declared eligible by the Health Research Ethics Committee of RSUD Dr. Haryoto Lumajang with letter number 070/423/427.75/2022 on March 14, 2022.

3. RESULTS

Results obtained through assessment with use sheet observations, interviews, and questionnaires show not yet optimal documentation nursing with an application of 3S (SDKI, SIKI, and SIKI) at RSUD Dr. Haryoto Lumajang. The result from data analysis in

the analysis problem includes man, material, method, machine, money, and marketing.

Man, analysis source power man obtained nurse agrees with a mentoring program for nurse new and supervise nursing in accordance schedule. Based on the results of a preliminary study, 44% of nurses have not documented nursing according to 3S standards. A total of 52% understand nurse-related low 3S applicability. Study results from side source power man that could be concluded improvement program will be understanding to documentation nursing in accordance standard is needed a nurse.

Materials, and support materials in enhancement documentation nursing are the existence of SOP guidelines (Standard Operational Procedure) and guides in to do documentation nursing using 3S. Standard Care Nursing is used in the process of documentation nursing as well as in support of the documentation process nursing.

Money, not yet available allocation of funds to improve the documentation process Becomes a problem that arises from side finance in its implementation.

Method, analysis on service nursing method used method chairman team with comparison one nurse have patient management as many as 6 to 8 people. Method supervision has not been optimally carried out in improvement documentation nursing.

Machine, not yet availability of electronic medical records or documentation nursing by computerized results in the not yet optimal system documentation.

Marketing, burden work high nurse at RSUD Dr. Haryoto Lumajang. Nurse work non-documentation work like fulfillment needs base people and actions collaboration other. Patients who go out to enter also be constrained in writing documentation nursing by

Table 1. Difference Ability 3S compiled with Case Reflection

Category	Pre		Post	
	In accordance	Not suitable	In accordance	Not suitable
SDKI	4 (16%)	21 (84%)	18 (72%)	7 (28%)
SIKI and SLKI	5 (20%)	20 (80%)	12 (48%)	13 (52%)

the standard. Based on problem analysis could conclude problems that arise in optimization documentation nursing by the 3S standard.

Solution problems that arise from analysis problems are solved through approach function management head space. Activity identification is a planning process in preparing SAK and materials as ingredient case reflection at RSUD Dr. Haryoto Lumajang. This process involves headroom, committee nursing, manager nursing, and nurse in to do coordination in the improvement of discussion program case reflection documentation nursing by the 3S standard. Through method case reflection to increase the ability of nurses to do documentation with 3S implementation. Evaluation end evaluated the ability of nurses in composing documentation nursing by the 3S standard. Before and after with use method sheet observation of 25 samples nurse with criteria inclusion patient new at RSUD Dr. Haryoto Lumajang. The table 1 was the results evaluation end at RSUD Dr. Haryoto Lumajang.

Implementation results obtained results 25 (100%) nurses as audit sample, happened enhancement ability by 56% in making a proper diagnosis Indonesian Nursing Diagnosis Standards before and after conducted case reflection. In the category of ability composing intervention according to SIKI (Standard Intervention Indonesian Nursing) and preparation outside in accordance, SLKI standard (Standard Outcome Indonesian Nursing) happened enhancement conformity 28% before and after conducted case reflection. The result obtained is there is a significant influence among the use method discussion case reflection to enhancement ability preparation of diagnoses, interventions, and outcomes by 3S standards (SDKI, SIKI, and SLKI).

4. DISCUSSION

Method discussion case reflection is one method used in function supervision nurses in operating function briefing headroom. The destination method is to improve competence, knowledge, and improved understanding of documentation with 3S implementation. Discussion process case reflection is a process of discussion, guidance, direction, and practice of direct composing documentation nursing. Plan nursing with an application of 3S in the process there are many constraints that as a lack of understanding nurses dominate or develop nursing diagnoses, interventions, and outcomes by the standard. That thing becomes a challenge alone in increasing the knowledge-related application of 3S in documentation nursing. With the existence of a rule, government-related use of the SDKI, SLKI, and SIKI

can increase the quality of care given to nurses throughout Indonesia (Kusumaningrum, 2022). SDKI is a diagnostic standard that can be used in the taking decisions of clinical nursing goods based on convenience usage, clarity of diagnostic reasoning, and completeness types of diagnosis available as well as standard language (Nurhesti et al., 2020). Case reflection discussions can help nurses to develop better analytical, planning, and decision-making skills. This supports improving the quality of nursing care provided to patients and encourages a more structured and evidence-based practice. Case reflection discussions assist nurses in maintaining the quality of nursing documentation according to standards so this facilitates better communication, a deeper understanding of the patient's condition, and more targeted and appropriate treatment planning and execution. By discussing with colleagues, nurses can ensure that diagnoses and interventions have been implemented appropriately.

The results obtained in the implementation case reflection occur a 56% increase in the ability of a nurse to make nursing diagnoses according to SDKI and happened 28% increase in the ability of a nurse to arrange interventions and outcomes to suit SIKI and SLKI standards. Application method case reflection already conducted many research related cause benefit positive. Research (Resiyanthi et al., 2021) shows the existence significant relationship between application discussion cases reflection and the existence upgrade in the ability of a nurse to think critically. Implementation case reflection direct could make it easy to carry out development strategy knowledge for nurses especially in To do documentation nursing (Kurniasih et al., 2020). Discussion of case reflection with 3S is a very useful approach to improve the ability of nurses to analyze patient health problems, plan appropriate care, and develop better clinical decisions. IDHS requires nurses to identify patient health problems in detail by analyzing subjective and objective data in more depth and understanding symptoms and causal factors. With SIKI and SLKI, nurses will plan appropriate interventions to address identified problems and encourage nurses to choose actions that are supported by evidence, based on theory, and relevant to the patient's condition.

Enhancement of quality service nursing with method increase quality documentation nursing by applying diagnostic standards, standard interventions, and standards outside of the 3S standard is one of the efforts to increase quality service nursing. Effort enhancement of other quality-related enhancement quality documentation nursing

that can be conducted house sick with the use of application or system information documentation nursing. Research conducted by (Atmanto et al., 2020) results obtained that there is enhancement quality documentation nursing before and after its use of application documentation nursing. The application of 3S in nursing documentation is an important step to ensure that nursing diagnoses, interventions, and outcomes are made accurate, relevant, and by applicable standards. Nurses can perform documentation on nurse records by standard operating procedures in the medical record. Nursing diagnoses can be written after the nurse conducts an assessment on the patient's assessment form. The action plan is selected according to the nursing problem in the existing nursing care standard form to be further implemented on the patient and recorded in the integrated note.

Function management, headroom in operating function is applied function direction. Implementation from function briefing in service nursing is one is activity supervision. Activity supervision carried out could increase the quality of service nursing at home pain, especially in the safety of the patient as well as activity could strengthen cooperation between nurses one thing that can add to and strengthen cooperation between nurses is the implementation of supervision nursing (Wati et al., 2019). Supervision nursing has the benefits to improve support and case reflection as well as increasing the connection between manager nursing and nurses (Tambun et al., 2020). So that connection between manager and nurse becomes harmonized and enhances satisfaction among nurses. Efforts the conducted with method increase the understanding of nurses through optimization function briefing through activity supervision headroom with the use of method case reflection. Accordingly, nursing documentation audits by the quality committee and head of the room can also assist in monitoring the quality of documentation regularly. Evaluation of nursing care standards with the implementation of 3S as well as regular implementation of 3S evaluations by the head of space and PPJA will assist in ensuring that standards continue to be met.

5. CONCLUSION

Organizing case reflection discussions has had a positive impact in helping nurses to be more precise and structured in carrying out documentation according to 3S standards. The results of increasing the ability of nurses in documenting with 3S standards provide broader implications, which are expected to achieve optimal quality of nursing services. Better and more accurate documentation can lead to more appropriate and quality care, and facilitate better communication between members of the healthcare team.

Case reflection discussion activities can be scheduled regularly so that the learning experience is continuously updated and improved. Nursing

documentation audits by the quality committee and head of the room can also assist in monitoring the quality of documentation regularly. Evaluation of SAK with the implementation of 3S as well as regular implementation of 3S evaluations by the head of space and PPJA will assist in ensuring that standards continue to be met.

In addition, the use of Electronic Medical Records (EMR) can be a very useful alternative in ensuring the application of 3S in nursing documentation. EMR can assist in the automation of the documentation process, reduce the risk of errors, and provide easier access to patient medical records.

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