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The Effect of Implementing Evaluative Feedback on Staff Nurses' Performance Regarding Documentation

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Abstract

Background: Accurate documentation of nursing care is vital to protect patient from missed or unsafe care, periodic audit of the documents is crucial for assessing staff nurses' performance with provision of feedback to improve their performance. **Aim**: This study aimed to assess the effect of implementing evaluative feedback on staff nurses' performance regarding documentation. **Research design*:*** Quasi experimental design was used. **Setting**: El Demerdash University Hospital **Subjects**: 90 staff nurses were included in the study **Data collection**: An audit checklist of various nursing records in a patient file. **Results**: More than one quarter of staff nurses had adequate total performance regarding documentation at the pre intervention phase . However, it increased markedly after the intervention to reach 86.9% at the post intervention phase, and it decreased to 74.9% at the follow up phase which significantly higher than the pre intervention phase. **Conclusion**: There is a statistically significant improvement of staff nurses' performance regarding documentation after using evaluative feedback. **Recommendations**: Evaluative feedback has to be used as a mean for improving nurses' performance in different aspects of care. Current formats of nursing records should be revised and updated and expand using of an audit technique in different patient care areas.

Key words: Documentation, Evaluative feedback, Staff nurses' performance.

Introduction

Documentation of patient care is important for improving the quality and continuity of healthcare, both in daily patient care and transitions between different healthcare services(***Sequist, 2015).*** Accurate documentation is one of the best defenses for legal claims associated with nursing care. To limit nursing liability, documentation must clearly indicate that individualized, goal directed nursing care was provided to a patient based on a nursing assessment ***(Perry, Potter & Ostenford, 2014).***

Nursing documentation is an essential function of professional nursing practice. Therefore, it is crucial that nursing assessments, care plans, implementation of interventions, and evaluation of the results should be systematically and accurately communicated through effective documentation ***(Okaisu et al., 2014).*** Conversely, substandard documentation of nursing assessments was associated with in-hospital and post discharge mortality. Current health care systems require documentation to ensure continuity of care, provide legal evidence of nursing care provided, and support evaluation of quality patient care ***(Scruth, 2014).***

Documentation is defined as any written or electronic records that describes the status of the client or the care provided to him or her ***(Lyeria & Barry, 2014)***. Nurses through documentation can communicate their assessments of patient condition, different interventions that are carried out and the results of these interventions. Also, it can promote good nursing care by encouraging nurses to assess client progress and determine which interventions are effective and which are ineffective, identify and document changes to the plan of care as needed. Meet professional and legal standards is the other benefit of documentation which considered as a valuable method for demonstrating this within the nurse-patient relationship and the nurse has applied knowledge, skills and judgment according to professional standards ***(College of Registered Nurses of British Columbia, 2013).***

The records are an important part or the communication structure of the health care organization. Accurate and complete records are required by law and must be kept by all agencies, both governmental and nongovernmental. The records provide complete information about the patient, indicate the extent and quality of the services being resolved legal issues in malpractice suits and provide information for education and research **(*Stanhope & Lancaster 2014).*** There are different forms of records to facilitate record keeping and allow quick, easy access of information. Hospital records are an important source of data used by all members of the health care team. It is a vital aspects of nursing practice over time. Types of records include nurse's progress notes, continuing records, flow sheets, kardex, flow sheet, discharge summary and family records ***(Saranto et al.,2014).***

Registered Nurses Association of the Northwest Territories and Nunavut, *(2015)* clarified that if the documentation was on paper forms, the elements for effective documentation of nursing care practices should be accurate, clear, concise, correct, avoid generalizations and vague phrases or expressions. The use of abbreviations, symbols or acronyms can be an efficient form of documentation if their meaning is well understood. All entries in a paper-based system should be written legibly using black ink, or in accordance with agency policy. There should be no black or white space in paper-based documents as this presents an opportunity for others to add information unbeknownst to the original author. Errors must be corrected according to agency policy. If an error occurs in paper-based documentation, do not make entries between lines, do not remove anything and do not erase or use correction products.

Nurses spend more time with patients than any other health care providers so the patient outcomes are affected by the quality of nursing care rendered. Thus, improvements in patient safety can be achieved by improving nurses' performance ***(Patricia, 2011)***. Performance is the actual conduction of activities to meet responsibilities according to standards. It is an indication of what is done and how well done. In recent years, it has been increasingly recognized that improving the performance of health personnel should be the core of any sustainable solution to health system performance ***(Taylor & Joseph, 2015).*** Moreover, It is very important to understand the importance and consequence of periodic evaluation of the performance which aims to give feedback to the learner or to make the decision about the degree of achievement ***(Wong, 2016).***

Audit is a systematic and critical examination to examine or verify certain records. Nursing audit means the assessment of the quality of nursing care or use of a record as an aid in evaluating the quality of patient care. A nursing care audit is an assessment of the quality of clinical nursing or audit related to the planning, delivery and evaluation of care. It is an important component of nursing care. Nursing audit is

an exercise to find out whether good nursing practice is applied **(*Clement, 2015)*.**

Auditing practice is used to assess performance and to plan quality improvement projects, meanwhile, audit is necessary, but using it only is not sufficient to improve the quality of performance ***(Hutchinson et al., 2015).*** Feedback is a part of communication. It consists of all verbal messages that a person either consciously or unconsciously sends out in response to another person's communication. Feedback is the information provided by an agent regarding aspects of one's performance or understanding. The aim of feedback session was to make nurses aware of strengths and weakness points of their performance (***Hunt, 2013)***.

There are two types of audits used in nursing peer review: concurrent and retrospective. The concurrent audit is an auditing process that evaluates the quality of ongoing care by looking at the nursing process. Concurrent audit is used to evaluate care being received by the health care team to the patient. Meanwhile the retrospective audit, or outcome audit, evaluates quality of care through examines what happened after the episode of care has been completed ***(Stanhope & Lancaster, 2014).*** Retrospective audit is easily managed as the audit team can plan and select a time to collect data from different sources. Despite retrospective audit can not change or correct any deficiency in care, but it considered as a starting point for correction and improvement ***(Hunt, 2013).***

Significance of the study:

Abd El Kader, (2014) concluded that despite the majority of staff nurses had satisfactory knowledge regarding documentation they had inadequate performance regarding documentation in various nursing records in the patient file and recommended that developing an audit system for different patient records and provide continous supervision and effective guidance to staff nurses about their performance regarding documentation. Also the researchers noticed that most of nursing records were not timed, the signature was incomplete and unclear writing format was found so many data can not be understood. A lot of missing data to be documented in patient file was clearly observed which may be due to absence or lack of feedback provided to staff nurses about their performance. All of this has negative effects on patient condition progress and quality of care rendered to the patient which can threaten patient safety.

Aim of the study

This study aimed to assess the effect of using evaluative feedback on staff nurses' performance regarding documentation.

Operational definitions in this study:

1- Documentation refers to nursing records in the patient file.

2- Rertrospective audit means reviewing patients' files after the episode of care has been completed.

Research hypothesis:

Staff nurses' performance regarding documentation will be improved after the implementation of evaluative feedback.

Subjects and methods:

Research design:

A quasi experimental design was used in this study.

Setting:

The study was conducted in surgical units at El Demerdash hospital which

affiliated to Ain Shams University Hospitals. This hospital consists of four floors contains 12 surgical departments, Surgical Intensive Care, Operating Theaters, Outpatient Clinics and Emergency Unit . The bed capacity of this hospital is 320 beds.

Subjects:

This study consisted of two study subjects, staff nurses and patient files

1- Staff nurses:

This group consisted of all staff nurses working in the before mentioned setting. Their total number was 90 staff nurses. The purpose of including all staff nurses was underlying on the importance and value of the study subject and the negative consequences of inadequate documentation on patient progress, length of stay in the hospital which accompanied with physical, psychological and monetary burden and also delaying in taking the correct decision about patient condition in correct time. The type of sample is convenient sample technique.

2- Patient files:

It represents 275 patient files which were audited retrospectively by the researchers. These files represent 10% of total admissions in the surgical units in the last six months. From 20 to 25 patient files were checked from each surgical unit. The criterion for file selection was for the patient who had hospitalized for at least one week so that the different forms of records were completed which might reflect the documentation pattern and style in all nursing records in the patient file.

Tool of data collection:

-An audit Checklist of patients' records:

It was aimed to check staff nurses' actual performance regarding documentation in different nursing records in the patient files. It was developed by the researchers based on review of related literature ***(Afify, 2003, Ali, 2013, Abd Elkader, 2014 and Perry, et al., 2014).*** This checklist consisted of 40 items. It contains three parts; the first part contains data such as the name of the department, date and time of the audit .The second part consists of 6 items covered patient identification which should be written in each record as patient full name, gender, hospital number, admission date, diagnosis and surgeon's name. The second part consisted of 34 items covering the characteristics of effective documentation in different nursing records in a patient file. It divided under four certain dimensions as accuracy (16 items), timing (6items), signature (6 items) and confidentiality (6 items).

Attached sheet was used for collecting pertaining data about study subjects such as, age, gender, nursing qualification, years of experience and attending training courses about documentation.

Scoring system:

Each item checked to be documented was scored 1 and zero if not documented. The total score for each dimension and for the total audit were calculated by summing up the scores attained. These scores were converted into percent scores. The staff nurses' performance was considered adequate if the total score was 60% or more and inadequate if less than 60%. (***Abd El Kader, 2014)***

Tool Validity and Reliability:

Study tool was validated by a jury group consisted of 7 professors in Nursing Administration and Medical –Surgical Nursing from Ain Shams and Cairo Universities. This group judge the clarity, comprehensiveness and accuracy of the tool, based on their opinions, necessary modifications was done as rephrasing of

some statements and /or rearranging of some items. Assessing the reliability of the tool was performed through measuring its internal consistency. It proved to be high as revealed by a Cronbach alpha coefficient which was 0. 946.

Pilot study:

A pilot study was conducted on 30 patient files representing 10% of the main study sample. It served to assess the clarity, feasibility and applicability of the tool. These files were included in the main study sample.

Field work:

The actual field work included four main phases, assessment, planning, implementation and evaluation.

Assessment phase:

The researchers met the staff nurses at their work units to explain the purpose of the study and its benefits and ask their participation. After gaining their approval, the researchers used the audit checklist. The researchers visited the studied units two days per week and revised the filled records. The process of audit was done retrospectively in each surgical unit, it took about 10-15 minutes for each patient file. This phase took two months from June 2015 till end of July 2015.

Planning phase*:*

After completing the data collection in the assessment phase, analysis was done in order to identify the strengths and weakness points of staff nurses' performance regarding documentation as detected from the auditing of patients' records. Then the researchers wrote these remarkes in a list . Each list was specifying the common mistakes and pitfalls of staff nurses' performance in each unit. The researchers prepared written guidelines about effective documentation based on the information obtained in the assessment phase in addition to related literature.

The researchers also bring copies of some filled forms of current official nursing records which presented in patient file as nursing notes and medication charts to be as an example or model which presented to staff nurses during evaluative feedback sessions. This phase took two months from Augest to September 2015.

Implementation phase:

The evaluative feedback was given by the researchers to participated staff nurses in groups by using an interview technique. Each group represents staff nurses working together in the same unit. The researchers met them three times and discussed with them the common strengths and weakness points regarding their performance without specifying names or personnel. Positive points were highlighted about adequate performance items which got high marks, while items which got low score were explained with identification of the possible causes through the discussion with staff nurses, and suggest methods for corrections and improvements. During evaluative feedback sessions, the researchers provide positive, supportive environment and encouraged and support staff in a positive way. At the end of each session, the researchers summarize the main discussion points and topics. Each group interview took about 10 to 20 minutes, and then the researchers distributed leaflets contains the guidelines of effective documentation. Some staff nurses asked to discuss their performance and its' quality individually, the researchers respond to their requests and implemented interview for each staff nurse separtly. This phase took three months from October to December2015.

Evaluation phase:

After the completion of evaluative feedback sessions, the researchers evaluated the effect of the intervention on the staff nurses' performance through auditing of different records which filled by the participants. This was done by using the same data collection tool and procedure as in the assessment phase.

In the follow-up phase, the same process was repeated three months after the intervention using the same data collection tool and procedures.

Administrative design and ethical considerations:

Official permissions to conduct the study were obtained from pertinent authorities. The reserchers gain the approval about study from the research and ethics committee at the Faculty of Nursing, Ain-Shams University. The reserchers explained the aim of the study and its' implications to the hospital medical and nursing directors to get their approval and seek their support before the conduction of the study.The participants were reassured about the confidentiality and anonymity of any obtained information and that it would be used only for the purpose of scientific research. Also the participant has the right to withdraw from the study at any time. The study could not have any harm for the participants.

Statistical Analysis

The collected data were revised, coded, tabulated and introduced to PC using statistical package for social sciences (IBM SPSS 20.0). Data was presented and suitable analysis was done according to the type of data obtained for each parameter. Frequency and percentage for non-numerical data .Means and standard deviations and range for parametric numerical data while Median and Inter quartile range (IQR) for non parametric data. McNemar test was used to determine if there are differences on a dichotomous dependent variable between two related groups. It can be considered to be similar to the paired-samples t-test, but for a dichotomous rather than a continuous dependent variable. The McNemar test is used to analyze pretest-posttest study designs. In the present study Mcnemar test was used to test for statistically significant performance improvement concerning staff nurses' documentation in post intervention phase as compared to pre intervention and in follow up phase as compared to pre intervention phase. Statistical significance was considered high at P – value <0.001.

Results

Table (1): Demographic characteristics of the studied staff nurses (n=90).

Variables		No.	%
Age (years):	Less than 30 years	42	46.7%
	30-40 years	34	37.8%
	More than 40 years	14	15.6%
	Mean±SD	32.98± 4.10	
	Range	21.0-40.0	
Gender:	Male	18	20.0%
	Female	72	80.0%
Nursing Qualification:	Diploma	68	75.6%
	High average diploma	13	14.4%
	Bachelor degree	9	10.0%
Years of experience:	Less than 10 years	33	36.7%
	10-20 years	26	28.9%
	More than 20 years	31	34.4%
	Mean±SD	13.79± 5.56	
	Range	2-20	
Attending training courses in documentation	Yes	38	42.2%
	No	52	57.8%

Table (1) shows that less than half of the studied staff nurses (46.7%) had aged less than 30 years; the mean age is 32.98 + 4.10, the majority of them were females. Slightly more than three quarters (75.6%) had nursing diploma. Regarding years of experience, more than one third (36.7%) had less than 10 years. In addition less than half of staff nurses were attended training courses in documentation

Table (2): Audit of staff nurses' performance concering patient identification throughout intervention phases (n=275)

Auidt of patient identification	Intervention phases						Mcnemar Pre-Post	Mcnemar Post-Follow up
	Pre		Post		Follow up			
	No.	%	No.	%	No.	%		
Inadequate (<60%)	69	25.1	8	2.9	28	10.2	<0.001**	<0.001**
Adequate (60%+)	206	74.9%	267	97.1%	247	89.8%		

(**) Highly statistically significant at P<0.001

Table (2) shows that there is a highly statistically significant improvement in staff nurses' performance regarding recording of patient identification in post intervention and follow up phases as compared to pre intervenion phase (P<0.001).

Table (3): Audit of staff nurses' performance regarding documentation throughout intervention phases (n=275)

Documentation Dimensions		Intervention phases						Mcnemar Pre-Post	Mcnemar Post-Follow up
		Pre		Post		Follow up			
		No.	%	No.	%	No.	%		
Accuracy	Inadequate (<60%)	188	68.4%	16	5.8%	37	13.5%	<0.001**	<0.001**
	Adequate (60%+)	87	31.6%	259	94.2%	238	86.5%		
Timing	Inadequate (<60%)	201	73.1%	34	12.4%	69	25.1%	<0.001**	<0.001**
	Adequate (60%+)	74	26.9%	241	87.6%	206	74.9%		
Signature	Inadequate (<60%)	177	64.4%	17	6.2%	43	15.6%	<0.001**	<0.001**
	Adequate (60%+)	98	35.6%	258	93.8%	232	84.4%		
Confidentiality	Inadequate (<60%)	128	46.5%	36	13.1%	62	22.5%	<0.001**	<0.001**
	Adequate (60%+)	147	53.5%	239	86.9%	213	77.5%		

(**) Highly statistically significant at P<0.001

As regards the audit of the staff nurses' performance regarding documentation dimensions, Table (3) illustrates that less than one third of nursing records had an adequate audit in accuracy and timing dimensions at the pre intervention phase. The post intervention phase revealed highly statistically significant improvement in all dimensions (P<0.001). At the follow up phase, there were some declines in staff nurses performance regarding all dimensions. but, it remained signficantly higher when compared with the pre intervention phase (P<0.001).

Table (4): Total audit of staff nurses' performance regarding documentation throughout intervention phases (n=275)

Total audit	Intervention phases						Mcnemar Pre-Post	Mcnemar Post-Follow up
	Pre		Post		Follow up			
	No.	%	No.	%	No.	%		
Inadequate (<60%)	201	73.1%	36	13.1%	69	25.1%	<0.001**	<0.001**
Adequate (60%+)	74	26.9%	239	86.9%	206	74.9%		

(**) Highly statistically significant at P<0.001

Table (4) shows that slight more than one quarter of staff nurses had an adequate total audit at pre intervention phase. It increased to 86.9% at post intervention phase (P<0.001).

Although at the follow up phase, it decreased to 74.9%, but still significantly higher than the pre intervention phase (P<0.001).

Discussion

There are different educational actions focused on improving the quality of nursing records .Therefore, a continuous development of researchs and interventions is important in order to promote continuous improvement of the practice. Thus, the present study was designed to measure the effectiveness of evaluative feedback on staff nurses' performance regarding documentation.

The present study findings clarified that staff nurses' performance regarding documentation in patient records which audited by the researchers was significantly improved after the implementation of the evaluative feedback in both the post intervention and follow up phases when compared with pre intervention phase. This finding confirmed the study hypothesis.

This improvement after the implementation of evaluative feedback may be attributed to this method of intervention was attractive to studied staff nurses and novice way for training which met the staff nurses' training needs, The researchers discussed with them the positive and weakness points regarding their performance without specifying names or personnel. This manner encourages them to correct their malpractice areas and initiate them to be good performers.

Moreover, Another possible reason for the improvement of the present study intervention was the feedback interview based on the assessment of actual performance of staff nurses which documented by themselves. Also the evaluative feedback ended by brief summary highligheted on the main interview points and the reserchers provide some words of encouragement and support.In agreement with this, ***Leavitt and Mueller, (2015)*** emphasized that evaluative feedback makes meaningful, precise communication between two parties and it enables people to evaluate the effectiveness of their messages.

Moreover, the leaflets which contains the guidelines of effective documentation and distributed by the researchers at the end of the session may have a contribution to the success of the intervention and the improvement in the performance.The importance of such guidelines has been demonstrated by many studies ***(Dehghan et al., 2013, Abd Elwahab& Elsayed,2014,Saad,2014;Scruth,2014)***

Similar finding was reported by ***Leonard & Kyriacos, (2015)*** who found that very low level of nurse performance related to documentation, in the pre-intervention period and there is highly statistically significant improvement as a result of application of training program compared to pre-intervention. However, in disagreement with this finding ***Ali, (2013)*** reported that there was no statistically significant difference of quality of recording among nursing personal after the implementation of an internal quality system .

Regarding Audit of staff nurses documentation of patient identification, there is a highly statistically significant improvement in post intervention and follow up phases as compared to pre intervention phase, this finding may be attributed to the importance of writing patient identification data in all hospital records and requests. This result agreed with ***Berman et al., (2015)*** who assured that patient demographic characteristics and diagnosis are among the key components of structured information which needs to be included in clinical records.

Concerning audit of Staff nurses' performance regarding accuracy dimension, there is a statistically significant improvement of this dimension in post intervention and follow up phases as compared to pre intervention phases. This result could be attributed to the magnitude of accurate recording and its' effect on decision making and plans of care.Also the intervention consists of planned learning experiences which promote the development of nurses' knowledge and skills for the enhancement of their practice regarding related aspects. On the same line, ***Saad, (2014)*** noted that there was statistically significant improvement of nurses performance after implementation of the training program for using correct, approved abbreviation and entry each shift. Moreover, ***Saranto et al. (2014)*** highlighted that all entries on the patient's record are made in black ink so that the record is permanent and changes can be identified. Also black ink reproduces well in the duplication process.

The present study finding On the same line, ***Saranto et al. (2014)*** highlighted that all entries on the patient's record are made in black ink so that the record is permanent and changes can be identified. Also black ink reproduces well in the duplication process. furthermore is congrount with ***Schuster, (2016)*** who stressed on the patient record entries must be brief and clear and eliminate words that don't change the intended meaning of the entry including articles such as "a" and "the" and also the subject of the sentence. Use standard abbreviations which approved by the health –care agency. Nurses must put quotes around the actual words the patient spoke.

Regarding audit of staff nurses' performance concerning timing dimension,the present study finding detected a statistically significant improvement of staff nurses' performance of this dimension in post intervention and follow up phases as compared to pre intervention phases. This result might be attributed to the majority of participated staff nurses do not know that they should timing each entry to document in the records. According to the audit, they record only the start time of working shift at pre intervention phase, the researchers during evaluative feedback clarifying this weakness point and discussed its' reasons with the staff nurses and the reserchers concentrate on the importance of timing each entery for documentation in records and its' benfits for patient safety and nurses protection. So the staff nurses' performance of this dimension was improved significantly in the post and the follow up phases when compared with the pre intervention phase.

The findings of the study related to writing new data for each entry supported by ***Ali, (2013)*** who detected that there was statistically significant improvement in timing of each entery after the implementation of internal quality system. However, in disagreement with this result, ***Abd El wahab & El Sayed, (2014)*** who assessed the quality of nursing documentation system and continuity of patient care in the Medicine University Hospital identified that the studied nurses were wrote time only once at sthe beginig of the working shift. In this regard ***Cooper & Gosnell, (2015)*** highlighted that, the record has to describe exactly what happened to a patient attached with the occurrence time which can easily achieved when document immediately after providing care.

Regarding audit of staff nurses' performance of signature dimension. The present study findings illustrate that majority of staff nurses had inadequate performance regarding this dimension before the implementation of evaluative feedback, while there was highly statistically significant improvement in the post and the follow up phase. This improvement might be due to the concern of the researchers during evaluative feed back interview to clarify the staff nurses responsibility to sign each documented datum to easily figure out the responsible person and asked him /her if needed. On the same line, the study carried out by ***Elsayed, (2013)*** reported that, there were statistically significant differences between two phases of the program post and follow up regarding the signature. In disagreement with the foregoing present study finding ***Berman et al. (2015)*** emphasized that each recording should signed by the nurse making it. The signature should include the name and title, some agencies have a signature sheet and after signing this signature sheet nurses can use their initials.

Regarding to audit of staff nurses' performance of confidentiality dimension, there was a highly statistically significant improvement of staff nurses' performance regarding this dimension in the post and the follow up intervention phases when compared with pre intervention phase. This result could be attributed to the evaluative feed back focusing on the consequences of following ethical and legal aspects when dealing with paper work especially patient file and the responsibilities of the staff nurses when following confidentiality items during recording and maintenance of patient medical file and its contents.

The present study finding is in agreement with ***Abd El Kader, (2014)*** who stressed on the staff nurses'causious attitude,and adequate performance of confidentiality items when dealing with patients information and keeping these files in safe place.

Conclusion and Recommendations

The study findings concluded that an evaluative feedback intervention improved the audited performance of staff nurses regarding documentation. **Therefore, the following recommendations are suggested:**

-Evaluative feedback has to be used as a mean for improving nurses' performance in different aspects of care.

-Current formats of nursing records should be revised and updated

- Encourage using of an audit techique for different patient care areas.

- Continuing education programs must be initiated to nurses to be acquainted with the principles and skills needed to apply evaluative feedback.

-Establish an electronic system for nursing documentation.

-Using Barcode system is recommended.

-Provide continuous supervision and guidance from head nurses to their staff about appropriate documentation.

-Documentation must be covered completely in nursing curricula in different nursing educational levels.

Further studies suggest:

-Effect of developing an Electronic medical record system on staff nurse performance and patient satisfaction.

-The effect of application of evaluative feedback on organizational effectiveness.

Implications of the study:

This study can be considerd a start point to develop the nursing staff skills in different patient care areas that affect patient safety. As well it can be a gate to effective use of audit system of all documents in hospital either related to the patient or organization which can the first step in the correction and improvement plans of the hospital staff performance and its' repound on hospital productivity and efficiency.

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