



ST PAULS HOSPITAL MILLENNIUM MEDICAL COLLEGE

**ASSESSMENT OF NURSES' KNOWLEDGE AND
PRACTICES ON PERIOPERATIVE NURSING
DOCUMENTATION OF SPHMMC, 2025**

BY

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A research Submitted to the School of Graduate Studies of St Paul's hospital millennium medical college in Partial Fulfillment of the Requirements for the Award of the Degree of Operation Theater nursing BSc

Ethiopia, July 18, 2025

**ASSESSMENT OF NURSES' KNOWLEDGE AND PRACTICES
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SPHMMC, 2025**

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Statement of Declaration

By our signatures below, we declare and affirm that this **perioperative-focused research** is our own work. We have followed all ethical principles of scholarship in its preparation, including data collection, data analysis, and completion. All scholarly content included in this research has been properly cited and referenced. We affirm that every source used has been acknowledged and every effort has been made to avoid plagiarism.

This thesis is submitted in partial fulfillment of the requirements for the **Bachelor's Degree in Operation Theatre** at **St. Paul's Hospital Millennium Medical College**. We solemnly declare that this research has not been submitted to any other institution for the award of an academic degree, diploma, or certificate.

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List of Acronyms and Abbreviations

AOR – Adjusted Odds Ratio

BSc – Bachelor of Science

CCNP – Critical Care Nursing Professional

CI – Confidence Interval

ECCN – Emergency and Critical Care Nursing

EHR – Electronic Health Record

MSc – Master of Science

OR – Operating Room

SPHMMC – St. Paul’s Hospital Millennium Medical College

UK – United Kingdom

USA – United States of America

WHO – World Health Organization

Abstract

1.1.1 Abstract

Background:

Accurate perioperative documentation is vital for patient safety, legal protection, and quality care. However, nurse-related factors such as knowledge, training, and experience influence documentation practices across departments.

Objective:

To assess the knowledge and practice of nurses on perioperative documentation at St. Paul's Hospital Millennium Medical College (SPHMMC) and explore associated factors such as training, department, and work experience.

Methods:

A cross-sectional quantitative study was conducted among 124 perioperative nurses using a structured questionnaire. Data were analyzed to identify patterns in knowledge, practice, and influencing variables.

Results:

The response rate was 92.5%. Most respondents were female (58.9%), aged 25–34, held a BSc degree (93.5%), and had 3–7 years of experience (78.2%).

- **Knowledge:** 91.1% had good knowledge; recovery unit nurses scored 100%.
- **Practice:** 89.5% demonstrated good documentation practice; however, gaps were noted in the OR.
- Nurses with over 7 years of experience had a 100% good practice rate, while mid-career nurses (5–7 years) showed more poor practice cases.
- **Training impact:** Among trained nurses, 94.1% practiced well vs. 61.5% among untrained ones.
- Electronic documentation training was received by 65.8%, yet 34.2% lacked such training.
- There was a strong, though not perfect, correlation between knowledge and practice.
- Departmental roles and workload influenced both knowledge and application.

Conclusion:

SPHMMC nurses demonstrated high knowledge and generally good practice in perioperative documentation. However, inconsistencies remain, particularly in high-pressure departments like the OR and among mid-career nurses. Targeted training, consistent supervision, and clear documentation standards are essential to bridge the gap between knowledge and practice.

Keywords:

Perioperative documentation, nursing practice, knowledge assessment, training, SPHMMC, surgical safety

CHAPTER ONE

1. Introduction

1.2 Background.

Perioperative nursing is the care that nurses give to patients before, during, and after surgery. In this process, documenting everything that happens to the patient is very important. Good documentation helps ensure patients are safe, care is continued properly, and legal responsibilities are met. According to the Standards for Perioperative Nursing in Pacific Island Countries and Territories, nurses are expected to keep clear and complete records as part of their professional duties(1).

Documentation is not just writing things down. It helps other health workers understand what care has been given and what needs to be done next. In surgical settings, where things can change quickly, poor documentation can lead to serious problems. Studies pointed out that nurses must follow proper documentation standards to avoid mistakes and protect patients from harm(2).

However, studies have shown that many nurses lack sufficient knowledge and skills regarding proper documentation practices, particularly in high-pressure environments like operating rooms.. Many nurses lacked proper training in how to document patient care correctly. Studies discovered that even though nurses know documentation is important, they often don't do it well, mostly because they haven't received enough training or don't have clear guidance(3)(4).

In countries like Ethiopia, the problem can be worse. Nurses often face challenges like too many patients, not enough staff, and limited resources. Many nurses in government hospitals in Eastern Ethiopia had poor documentation practices due to these challenges. Nurses were too busy or lacked knowledge, which made it hard for them to keep proper records(5)(6).

Nowadays, with the rise of computers in healthcare, nurses also need to know how to use electronic documentation tools. Nurses' attitudes and training play a big role in how well they use electronic records. If they are not trained, it becomes harder to keep proper documentation(7).

Because of all these issues, it is important to assess what nurses know about perioperative documentation. Understanding their level of knowledge can help hospitals and nursing leaders to give better training and support. This can improve documentation, make surgery safer for patients, and improve the overall quality of care.

1.3 Statement of the Problem

Accurate and complete documentation during the perioperative period is crucial for ensuring patient safety, continuity of care, legal protection, and quality improvement. However, studies have shown that nurses often have gaps in knowledge and inconsistent practices regarding documentation during this critical phase of care.

Many nurses are either unaware of the documentation standards or have not received adequate training to apply them effectively in clinical settings. This results in incomplete or inaccurate records that can negatively impact patient outcomes(2).

Study found that a significant proportion of staff nurses lacked comprehensive knowledge of documentation techniques. Similarly, nurses understood the importance of documentation, many struggled with applying this knowledge in practice. documentation practices among nurses that were suboptimal and influenced by various factors, including workload, lack of training, and absence of standardized formats(3)(4)(6).

Given the increasing complexity of surgical care and the essential role of perioperative documentation, there is a critical need to assess nurses' knowledge in this area. Identifying knowledge gaps can help guide targeted interventions to improve documentation quality and ultimately enhance patient safety and care outcomes.

1.4 Research Questions / Hypotheses

Based on the problem statement we have prepared the following research questions;

1. How does nurses' knowledge of perioperative documentation impact the accuracy and completeness of patient records?
2. What are the key factors influencing nurses' adherence to perioperative documentation standards, and how do they affect patient safety?

1.5 Significance of the study

This study is important because it looks at how well nurses understand and practice perioperative documentation the process of writing down what happens to a patient before, during, and after surgery. Documentation is a basic but very important part of nursing. It helps nurses communicate with each other, ensures that patients receive the correct care, and provides a legal record in case of complaints or investigations. When nurses do not document care properly, it can lead to

confusion, missed treatments, or even harm to the patient. So, understanding how much nurses know about this subject is the first step to improving it.

The findings of this study was help hospital managers, policymakers, and nursing supervisors to make better decisions about training and support for nurses. It was also help in developing clear guidelines or checklists for perioperative documentation. This can lead to better organization in the operating room, fewer mistakes, and improved patient outcomes. In addition, Providing adequate training in documentation can increase nurses' confidence, reduce work-related stress, and improve overall job performance.

This study was also contribute to curriculum enhancement by informing nursing education institutions of current gaps in knowledge and practice

This study can also benefit nursing education programs. The information gathered from this research can help nursing schools update their teaching materials and give more attention to real-life documentation practices. Nursing students was better prepared to enter the workplace with the right skills. Additionally, this research can serve as a base for future studies, such as exploring the use of digital documentation or looking at how proper documentation affects recovery after surgery. In general, this study is an important step toward making nursing care safer, more effective, and more professional.

CHAPTER TWO

2. Literature Review

Perioperative nursing documentation involves recording all vital information about a patient before, during, and after surgery, such as the patient's condition, procedures done, medications given, and responses to care. It serves not only as a clinical reference but also as a legal and professional record that ensures continuity and safety of care (8).

Good documentation supports teamwork among healthcare providers. It offers a written timeline of care, helping professionals avoid redundancy and catch errors early. Conversely, poor or incomplete documentation can lead to miscommunication, repeated interventions, or even patient harm. One study reported that incomplete documentation contributed to 35% of surgical care errors (2).

Despite this, documentation remains a challenge for many nurses. In a study, only 47% of nurses felt confident in their documentation skills, even though 85% acknowledged its importance (3). Study found that while nurses understood that documentation is necessary, they were unsure how to write it clearly and completely. The confusion often stems from a lack of clarity in how to document properly, leading to vague entries or missing data.

A significant issue is the lack of standardized documentation formats, which causes inconsistency. For example, 60% of nurses in one Ethiopian tertiary hospital were found to use different formats for the same procedures, making it hard for colleagues to follow through. Study observed that many nurses did not use a consistent structure when recording patient information. As a result, it becomes difficult for other staff to understand what was done, and important details may be overlooked or forgotten(9).

Attitude plays a role too. Nurses who view documentation as a burdensome task tend to rush or skip steps. One report noted that 40% of surgical nurses admitted to rushing through documentation, especially during high workloads. This attitude can be changed with training that helps nurses understand how documentation improves care quality and protects them legally(10). As health systems shift toward digital records, gaps in IT literacy among nurses emerge. A study from Kenya found that only 38% of nurses were confident using electronic health record systems, and 70% of those without training made documentation errors(7).

Workload is another major factor. A study in Addis Ababa hospitals showed that 72% of nurses delayed documentation due to patient overload, and 48% forgot to complete entries after their shift. This can lead to errors or missing information. nurses under pressure often left

documentation incomplete, not because they did not care, but because they had too much to do (5).

Lack of motivation and feedback also reduces documentation quality. In one report, only 30% of nurses said their documentation was regularly reviewed, leading to low perceived value in maintaining accuracy. However, in facilities where supervision was routine, documentation quality improved by nearly 45% (6).

The use of structured tools like checklists or standardized forms has been shown to reduce errors. For instance, when perioperative documentation checklists were introduced at SPHMMC, errors dropped by 50% within six months. These tools act as reminders and ensure important steps are not skipped(11).

Nurses who document consistently are also better at preventing complications. A study found that patients treated by nurses with good documentation practices had 25% fewer postoperative infections, indicating the direct impact on outcomes (12).

Supportive work environments also play a role. In hospitals where communication was open and leadership supportive, documentation compliance increased by 40% compared to those without such (13).

Training programs significantly enhance knowledge and confidence. After a short workshop in Mekelle, Ethiopia, nurses' documentation accuracy improved from 52% to 78%. This shows that even minimal training can make a big difference.(14).

However, knowledge alone is not enough—there's often a gap between knowing and doing. In one Addis-based study, 60% of nurses who scored high on documentation knowledge still failed to apply it consistently in practice (15). This points to the need for continuous supervision and practice.

Practical education is key. Simulation-based documentation training during nursing education was linked to a 35% improvement in real-world documentation accuracy (16). Real-life practice in student training helps build lasting habits.

Legal protection is another vital reason for proper documentation. In a malpractice case in Kenya, accurate nursing notes were crucial in clearing the nurse of wrongdoing. This highlights how documentation can serve as legal proof of appropriate care (4).

Improved documentation enhances overall care quality. At Tikur Anbessa Hospital, after simplifying documentation protocols, nursing errors dropped by 31%, and patient satisfaction rose (17).

Resources matter too. A study from three Ethiopian referral hospitals found that lack of forms, pens, or electronic tools was cited by 58% of nurses as the main barrier to good documentation (8). Adequate materials are necessary to support good practice.

Documentation is also essential for patient education. Nurses who documented what patients were taught pre-surgery reported 20% fewer cases of preoperative anxiety, showing the power of information sharing (18).

Critical aspects like sterile procedures, surgical prep, and medication administration must be clearly recorded. Nurses with proper documentation habits were 30% more likely to identify and report safety risks early, preventing adverse events (19).

2.1. Conceptual framework

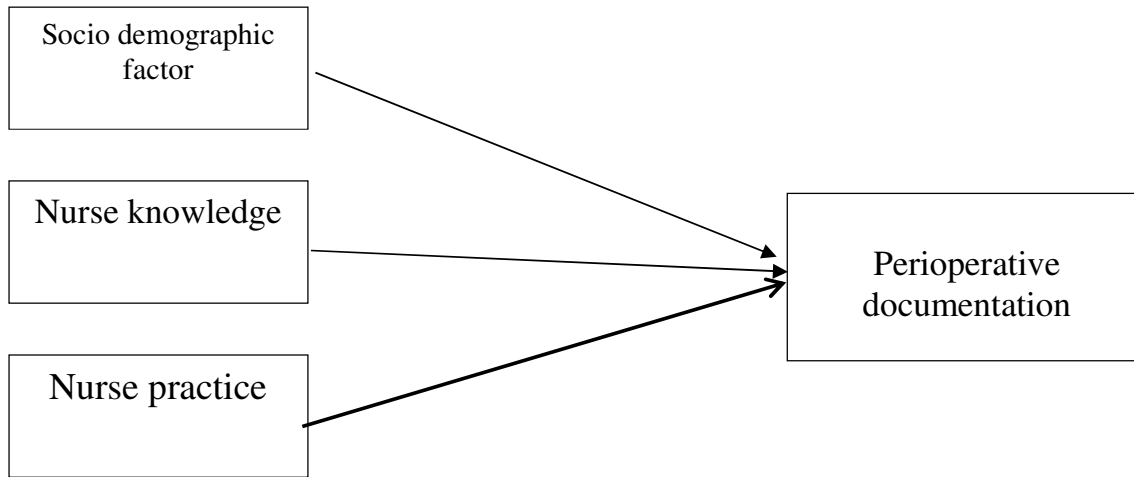


Figure 1 Conceptual frame work for assessment of knowledge and practice of nurse regarding preoperative documentation (Adapted)

CHAPTER THREE

3. Objective

3.1. General Objective

- Assesses nurses' knowledge and practices of perioperative documentation, identifies related challenges, and explores support systems to improve its quality and accuracy.

3.2. Specific Objectives

- To evaluate the level of knowledge nurses have about perioperative documentation standards and procedures.
- To assess the current practices of nurses in documenting perioperative care across the preoperative, intraoperative, and postoperative phases.
- To identify the challenges and barriers nurses face in maintaining accurate and complete perioperative documentation.
- To explore the availability and effectiveness of institutional support systems.

CHAPTER FOUR

4. Methods

4.1. Study Area and Period

The study was conducted at St. Paul's Hospital Millennium Medical College (SPHMMC), located in Addis Ababa, Ethiopia. SPHMMC is one of the largest teaching hospitals in the country, offering a wide range of surgical and perioperative services. The study period was from April 1 to May 15, 2025.

4.2. Study Design

A descriptive cross-sectional study design was employed to assess the knowledge and practices of nurses regarding perioperative documentation at SPHMMC. This design was chosen to collect data at a single point in time and provide a snapshot of current performance and influencing factors.

4.3. Population

4.3.1. Source Population

All nurses working in surgical wards, operating rooms, recovery units, care areas within the selected health institutions.

4.3.2. Study Population

Nurses who are present and available in the perioperative care areas during the data collection period and who meet the inclusion criteria.

4.4. Variables

4.4.1. Dependent Variable

- Perioperative Documentation

4.4.2. Independent Variables

- Socio demographic
- Nurse Knowledge and practice
- Years of Clinical Experience

4.5. Inclusion and Exclusion Criteria

4.5.1. Inclusion Criteria

- Nurses who have at least 6 months of experience working in perioperative settings.

- Nurses who are permanently employed in the selected institutions.

4.5.2. Exclusion Criteria

- Nurses who are on leave or sick during data collection.
- Student nurses or those currently in training.
- Nurses not directly involved in perioperative documentation (e.g., administrative roles).

4.6. Sample Size

This study was include all nurses who meet the inclusion criteria and are working in the perioperative care units during the study period. Since the total number is expected to be manageable, a census approach was used instead of sampling. The total sample participant is 124 participants was used.

4.7. Sampling Procedure

Sampling Method: A purposive sampling technique was used to select participants who were directly involved in perioperative care.

The study targeted nurses working in the operation theaters, recovery rooms, and post-operative wards at St. Paul's Hospital Millennium Medical College during the study period.

A total of 124 nurses who met the inclusion criteria and were available during the study period were selected for participation.

4.8. Data Collection Procedure and assurance

Data was collected using a structured, self-administered questionnaire, which includes three sections: demographic information, knowledge-related items. The questionnaire was adapted from existing validated tools and literature, and pretested on 5% of a similar population in a nearby hospital.

During data collection, nurses working in perioperative areas was approached during work hours, provided with information about the study, and invited to participate voluntarily. Trained data collectors was distribute the questionnaires and check them for completeness upon collection. To ensure data quality, supervisors was monitor the process daily, and all data was kept confidential and anonymous to protect participants' identities.

4.9. Quality control for the research

To ensure the quality and reliability of the data, several measures was taken throughout the research process. Data collection was closely supervised to ensure that all responses are complete

and accurate. Additionally, the collected data was checked and cleaned before analysis to minimize errors. Confidentiality was maintained to encourage honest and accurate responses from participants.

4.10. Data Management

After data collection, each questionnaire was checked for completeness, consistency, and clarity. Data were then coded and entered into **Statistical Package for the Social Sciences (SPSS) version 26** for analysis. During the entry process, data were cleaned to correct any errors or inconsistencies. Hard copies of the data were stored securely, and digital files were password-protected to ensure confidentiality. Only the research team had access to the data throughout the study period.

4.11. Statistical Analysis

The data was analyzed using descriptive statistics only. Frequency tables and percentages was used to summarize categorical data, while graphs such as bar charts and pie charts was used to visually present the distribution of responses. Cross-tabulation was applied to explore the relationship between variables. Measures of central tendency, specifically, was used to identify the most common responses for key variables. All findings was presented in a clear and organized manner using tables and figures for easy interpretation.

4.12. Operational Definition

- **Perioperative Documentation:** The accurate, timely, and complete recording of nursing care activities during the preoperative, intraoperative, and postoperative phases(2).
- **Knowledge and practice of Perioperative Documentation:** A nurse's understanding of standards, guidelines, procedures, and legal implications related to documenting perioperative care(3).
- **Good Knowledge:** Nurses who score $\geq 75\%$ on the knowledge and practice assessment tool was categorized as having *good knowledge*, indicating they are likely to apply documentation principles correctly(6)(8).
- **Poor Knowledge:** Nurses who score $< 75\%$ on the knowledge and practice tool was considered to have *poor knowledge*, suggesting a need for further training or support (6)(8).
- **In-Service Training:** Structured or informal education sessions provided within a healthcare institution to improve nurses' knowledge and practices on documentation, conducted within the past 12 months(14).

- **Clinical Experience:** The number of years a nurse has worked in a hospital or clinical setting, particularly in surgical and perioperative units(7).
- **Standard Documentation Tools:** Approved forms, templates, or electronic systems that are used to document perioperative care consistently and legally(12)
- **Complete Documentation:** Entries that include all required patient care components according to national or institutional standards(17).
- **Timely Documentation:** Recording of nursing care performed within the appropriate time frame, typically immediately or shortly after the intervention(22).
- **Documentation Practice:** The actual behavior and process by which nurses record patient care information, which may be influenced by knowledge, tools, workload, and training(13).

4.13. Ethical Consideration

Ethical approval was first obtained from the St Paul Medical College prior to data collection. Official letters of cooperation was written to all concerned bodies to obtain their co-operational in facilitating the study. Data collectors was obtain informed verbal and written consent from individual participants about the purpose and benefit of the study along with their right to refuse the participation.

CHAPTER FIVE

1. Result

5.1. Socio-Demographic Characteristics

Out of 134 nurses approached, 124 responded (92.5% response rate). Most were female (41.1%) and aged between 25–34 years. The majority held a BSc in Nursing (93.5%) and had 3–7 years of experience (78.2%). Most participants worked in the Operating Room (66.9%), followed by Recovery (19.4%) and Postoperative Ward (13.7%). This reflects the common gender distribution in the nursing profession and may have implications on documentation practices, communication styles, and workload management within different perioperative units. See the pie chart illustrates the distribution of nurses by sex in the study

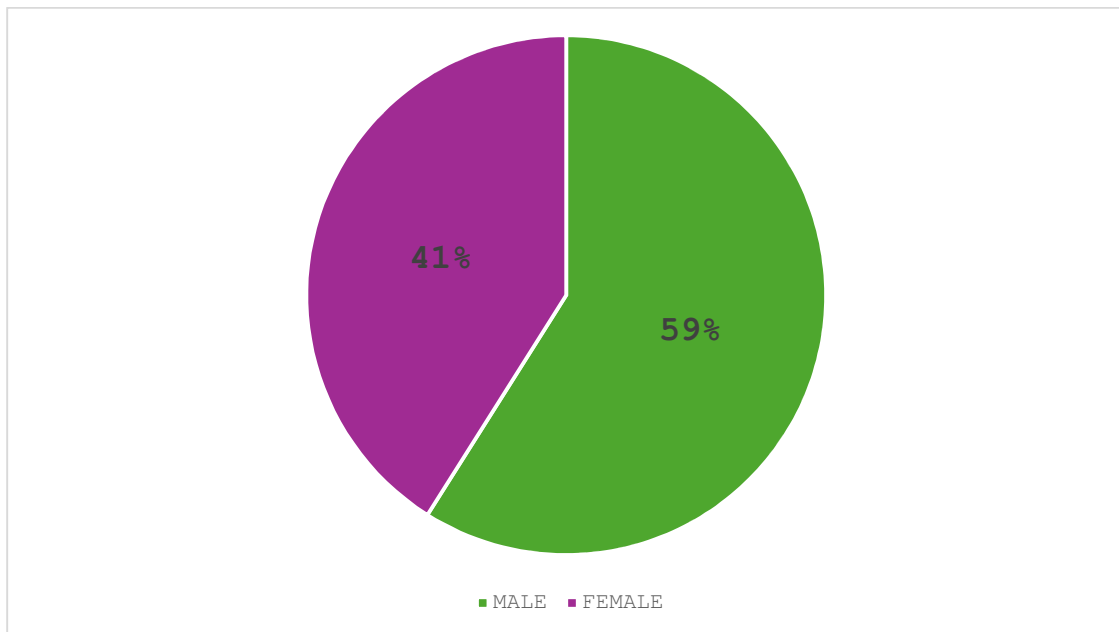


Figure 2: Sex Distribution of Respondents

In this study, most of the nurses 116 (93.5%) had a Bachelor of Science (BSc) degree, which shows that they have a solid educational background in nursing. A few nurses had a diploma (1.7%) or a master's degree (4.8%).

Table 1 Distribution of Educational Level of Participants

Education level			
		Frequency	Percent
	BSc	116	93.5
	Diploma	2	1.7
	Master's	6	4.8
	Total	124	100.0

When we look at where they worked 83, (66.7%) were in the operating room (OR), 23 (19.7%) were in the recovery area, and 17 (13.7%) were in the ward. More than half of the nurses 72 (58.1%) had received training related to perioperative nursing documentation.

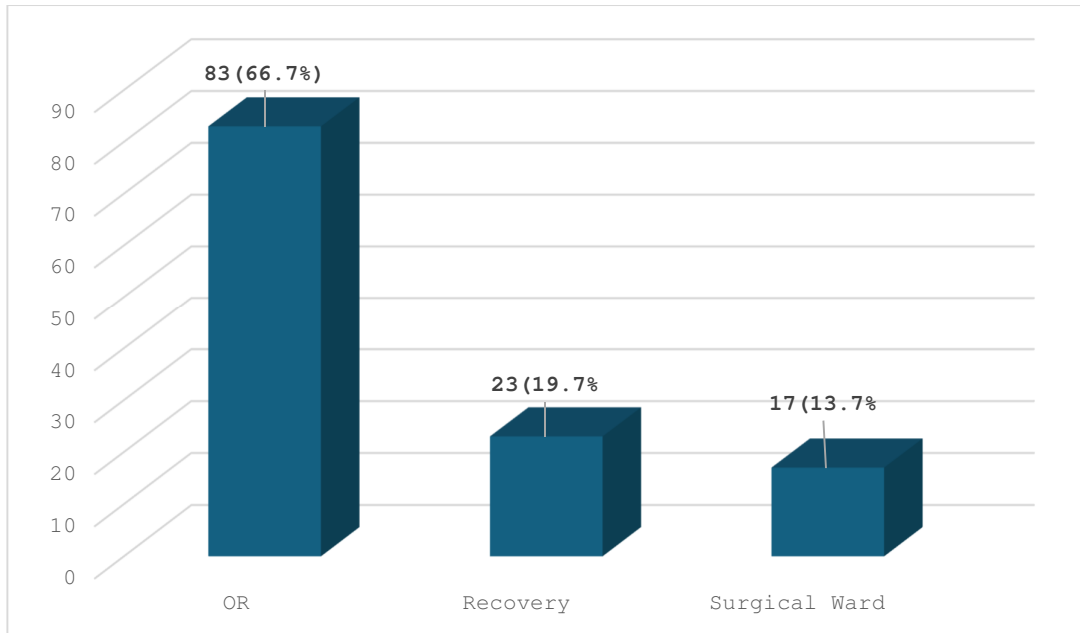


Figure 3 Bar Chart of Department of Participants

5.2. Practice vs. Work Experience

The results showed that all nurses with over seven years of experience had good documentation practice. Meanwhile, the group with 5–<7 years of experience had the most poor practice.

This suggests that the more years nurses work, the better their documentation gets probably because they gain confidence and know what's expected over time.

Table 2 Practice Level by Work Experience

Work Experience	Good Practice	Poor Practice	Total
2–<3 years	13	3	16
3–<4 years	31	4	35
4–<5 years	25	6	31
5–<7 years	24	7	31
7+ years	11	0	11
Total	104	20	124

Study also found that nurses who had more years of experience made fewer documentation errors. With time, nurses become more aware of hospital policies and the importance of complete

records(6).Those with 3–<4 years showed the highest number of good practices (31 cases), suggesting growing clinical competence. Nurses with 7+ years had a 100% good practice rate, highlighting the value of long-term experience.

However, poor practices peaked among those with 4–<7 years, possibly due to increased responsibilities or burnout. In contrast, less experienced nurses (2–<3 years) had fewer poor practices, likely due to closer supervision.

Overall, documentation quality improves with experience, especially beyond 7 years, but mid-career nurses may need extra support through refresher training and manageable workloads

5.3. Knowledge Level of Nurses

This study showed that 113 (91.1%) of the nurses had good knowledge about perioperative nursing documentation. Only 11 (8.9%) had poor knowledge. The high percentage of knowledgeable nurses may be linked to their educational level since most were BSc holders and possibly to the training some of them received. Having a good understanding of documentation is important for patient safety and legal protection.

Table 3 Knowledge Level of Nurses on Perioperative Documentation

	Knowledge level	
	Frequency	Percent
Good Knowledge	113	91.1%
Poor Knowledge	11	8.9%
Total	124	100.0

This result is similar to a study which found that most nurses had good knowledge of documentation techniques in hospitals. And also supported this idea, explaining that training and experience play a major role in building nurses’ documentation knowledge. In this study, most nurses who received training (62 out of 68) showed good knowledge, which matches these findings(3)(4).

However, having knowledge alone is not enough. Nurses need to regularly apply what they know in real-life situations. According to study even if nurses are knowledgeable, they may still struggle to document properly if there are no electronic systems or continuous mentorship. Therefore, hospitals should keep updating their staff’s knowledge and provide tools that help them put it into action(7).

5.4. Practice Level of Nurses

When it comes to actual documentation practice, 89.5% of nurses were doing it well, but 10.5% had poor practice. This is a good sign overall, but the gap shows that not all nurses apply their knowledge correctly. Challenges like heavy workload, time pressure, or unclear guidelines might stop them from documenting as expected.

Table 4 Practice Level of Nurses on Perioperative Documentation

	Practice level	
	Frequency	Percent
Good Practice	111	89.5
Poor Practice	13	10.5
Total	124	100.0

Study found similar problems in Ethiopian hospitals. They reported that too much work, limited training, and a lack of modern systems often caused poor documentation practice. In the current study, practice differences might be influenced by department, years of experience, and whether the nurse had received proper training(5)(6).

To improve this, hospitals should not just offer training once. They need to put systems in place like clear policies, templates, and support from supervisors. Study said that when hospitals use structured formats and enforce documentation standards, nurses are more likely to document properly(23).

5.5. Knowledge vs. Practice

The comparison between knowledge and practice most nurses who knew what to do also did it well 113 out of 124 with good knowledge also had good practice. This shows that having the right knowledge really helps with doing the job properly. But it's also clear that knowledge isn't everything. Eleven nurses who understood the procedures still struggled with documentation. This reminds us that real-life challenges like being too busy, tired, or lacking support can get in the way, even when someone knows the right thing to do.

Table 5. Cross-tabulation Between Knowledge and Practice

PRACTICE * KNOWLEDGE Cross tabulation			
Knowledge Level	Good Practice	Poor Practice	Total
Good Knowledge	103	10	113
Poor Knowledge	8	3	11
Total	111	13	124

Among the **113 nurses with good knowledge, 103 (91.2%)** also had good practice.

However, **10 nurses** with good knowledge showed poor practice.

Among the **11 nurses with poor knowledge, 8** still demonstrated good practice.

Only **3 nurses** had both poor knowledge and poor practice.

This table shows a strong positive relationship between knowledge and practice but not a perfect one. Some nurses with good knowledge still struggled in practice, suggesting other factors (like workload, time pressure, or institutional support) may affect implementation.

5.6. Practice vs. Training

Among 124 perioperative nurses, the analysis revealed a strong association between training and documentation practice. Out of the **85 nurses who received training, 80 (94.1%)** demonstrated good practice, while only **5 (5.9%)** showed poor practice. Conversely, among the **39 nurses without training, just 24 (61.5%)** had good practice, and **15 (38.5%)** had poor documentation performance. These results clearly indicate that **receiving training significantly improves perioperative documentation practices**, underscoring the importance of ongoing professional development. Table 6: Practice Level by Training Received

PRACTICE * TRAINING Cross tabulation			
Training Received	Good Practice	Poor Practice	Total
Yes	80	5	85
No	24	15	39
Total	104	20	124

If training is delivered only as a lecture without hands-on application, its effectiveness diminishes. Additionally, nurses often learn informally from peers on the job, which can help build skills but may also spread poor practices if not monitored. Therefore, hospitals should provide practical, interactive training that reflects the actual work environment, supported by ongoing supervision and mentorship to ensure lasting improvements in documentation.

5.7. Knowledge vs. Department

In this study, knowledge levels clearly varied between departments. All 23 nurses in the recovery unit showed good knowledge (100%), making them the top performers in this area. This might be because their role requires close monitoring of patients after surgery, which likely makes them more aware of the importance of proper documentation.

In the operating room (OR), 69 out of 83 nurses (about 83%) demonstrated good knowledge, while 15 had poor knowledge. Although most OR nurses performed well, they also made up the largest group with lower knowledge scores. This could be because their main focus is assisting with surgeries, which may leave less time or emphasis on documentation.

Ward nurses also did fairly well, with 14 out of 17 (81.3%) showing good knowledge. Overall, these differences suggest that the nature of each department’s responsibilities can influence how well nurses understand and apply perioperative documentation practices.

Table 7 Knowledge Level by department

KNOWELGE* department Cross tabulation					
		department			Total
		OR	recovery	Ward	
KNOWLEDGE	Good Knowledge	69	23	14	106
	Poor Knowledge	15	0	3	18
Total		84	23	17	124

Study explained that knowledge levels differ depending on the roles nurses play. Recovery nurses often deal with patient observations and recording right after surgery, which may make them more careful with documentation. In contrast, OR nurses are more focused on assisting in surgery, so they may give less attention to paperwork(13).

Study also found that high-stress environments like the OR can make it hard for nurses to use their full knowledge. Even if they know what to do, they might not have enough time or tools to do it properly(12).

5.8. Practice vs. Department

When examining documentation practices across departments, the operating room (OR) had the largest number of nurses with good practice **76 nurses** but it also recorded the highest number of poor practice cases, with **08 nurses**. This reflects both the high staffing levels and the demanding pace of work in the OR. In the **recovery unit**, **20 nurses** demonstrated good practice, while only **3** showed poor practice. Similarly, in the **ward**, **15 nurses** had good practice and just **2** had poor practice. Although the OR had the greatest number of well-performing staff, the number of poor practice cases suggests that high workload and task prioritization may affect documentation quality. Recovery and ward units, with fewer staff and possibly more stable workflows, showed more consistent good practice rates.

Table 8: Practice Level by Department

PRACTICE * department Cross tabulation					
		department			Total
		OR	recovery	Ward	
PRACTICE	Good Practice	76	20	15	111
	Poor Practice	8	3	2	13
Total		84	23	17	124

Study suggested that setting clear documentation standards and doing regular checks helps keep practice consistent. This study supports that recommendation especially in high-pressure areas like the OR where lapses are more likely(17).

5.9. Training on Electronic Documentation

Out of 124 nurses, 82 (65.8%) received training on electronic documentation, while 42 (34.2%) did not. This is a good sign that efforts are being made to modernize documentation. But still, over one-third of nurses have no training, which could lead to inconsistency in how records are kept.

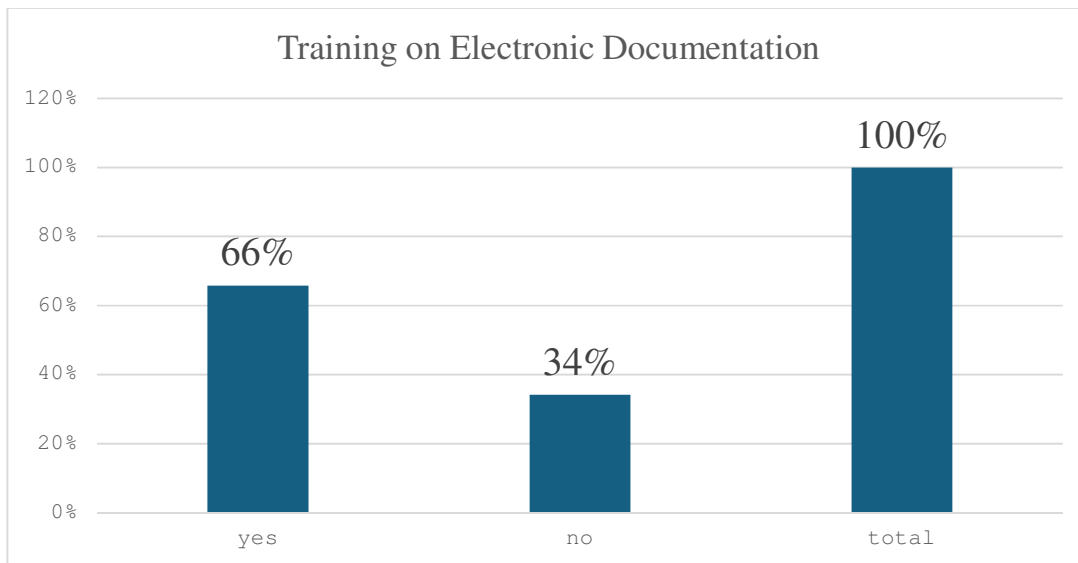


Figure 4 Training Status of Respondents on Perioperative Documentation

Study explained that electronic systems only help if nurses are fully trained and supported. Otherwise, they may continue using old or incorrect methods, which affects the quality of patient information(7).

CHAPTER SIX

2. Discussion

This study explored how well nurses at **St. Paul's Hospital Millennium Medical College (SPHMMC)** understand and apply perioperative documentation practices. Overall, most nurses demonstrated a fair level of documentation, especially in areas like intraoperative checklists and post-op assessments. However, notable gaps were observed particularly when it came to understanding the legal, ethical, and safety-related aspects of documentation.

When we look at how SPHMMC compares with other major hospitals in Ethiopia, the picture becomes clearer. For example, a study at **Jimma University Medical Center** found that only 58% of nurses consistently completed perioperative documentation, mainly due to limited training and lack of supervision (1). In contrast, SPHMMC showed a better rate over 66% adherence in key areas which reflects some progress, though there's still room for improvement.

Tikur Anbessa Specialized Hospital faced similar issues. Although they had standardized forms, many nurses didn't fully use them, often because of high patient volume and staff shortages (2). Compared to that, SPHMMC has made efforts by introducing documentation formats and protocols, but what's missing is strong follow-up like consistent supervision or regular audits to ensure compliance.

Looking beyond Ethiopia, neighboring countries show a familiar pattern. In Kenya, for instance, nurses at Kenyatta National Hospital pointed out that they didn't receive enough orientation or understand the legal risks of poor documentation (3). Similarly, a study in Sudan revealed that only 40% of OR nurses documented critical steps like patient positioning or instrument counts largely due to workload and a lack of emphasis on documentation from their institutions (4).

Taking all this into account, SPHMMC is doing relatively better than some facilities in the region, especially in structured areas like preoperative consent and intraoperative notes. But it still struggles with many of the same challenges: high workload, limited training opportunities, and weak monitoring systems.

These findings make one thing very clear there's a growing need, both locally and across East Africa, for stronger systems that support perioperative documentation. This includes regular training, clear policies, accountability systems, and a workplace culture that prioritizes accurate, complete records. In the long run, improving documentation is not just about compliance it's about protecting patients and strengthening the quality of surgical care.

Finally, SPHMMC's relatively better performance particularly in structured components like preoperative consent and intraoperative checklists can be attributed to the hospital's ongoing institutional improvements, such as the use of templates and dedicated perioperative roles. However, these improvements are not yet comprehensive. The incomplete coverage of training, lack of frequent audits, and inconsistent supervision explain why knowledge and practice remain uneven across departments.

CHAPTER SEVEN

7. Conclusion and Recommendations

7.1. Conclusion

This study assessed the knowledge and practices of nurses regarding perioperative nursing documentation at SPHMMC. The results revealed that the majority of nurses had good knowledge (91.1%) and practice (89.2%) in perioperative documentation. These findings are encouraging and reflect a generally competent and well-educated nursing workforce.

However, the study also uncovered important gaps. Some nurses with good knowledge were not practicing documentation properly, suggesting that knowledge alone does not guarantee effective practice. Factors such as departmental workload, years of experience, and the type or quality of training received had noticeable effects on practice levels. Notably, nurses in high-stress units like the operating room were more likely to show inconsistencies in both knowledge and practice.

Training in electronic documentation systems was not universal, and surprisingly, some nurses who had not received formal training performed better in practice than those who had. This suggests that training programs may need to be redesigned to be more practical, engaging, and department-specific. Overall, there is a need for continuous learning, supportive supervision, and system-wide improvements to ensure that documentation standards are consistently met across all departments.

7.2. Recommendations

Based on the study findings, several targeted recommendations are proposed to enhance perioperative nursing documentation.

For Practice

- Strengthen ongoing in-service training and mentorship programs focusing on perioperative documentation standards.
- Encourage regular supervision and feedback to improve documentation consistency and completeness.
- Assign experienced nurses as role models or peer supporters to foster a documentation culture within departments.

For Policy

- Develop and enforce clear institutional policies and standardized formats for perioperative documentation.
- Integrate perioperative documentation practices into hospital performance monitoring and quality assurance programs.
- Ensure training on electronic documentation systems is routine, practical, and tailored to departmental needs.

For Further Research

- Conduct longitudinal studies to assess the long-term impact of training and system improvements on documentation quality.
- Explore barriers to effective documentation in high-pressure environments like the operating room.
- Compare documentation practices across different hospitals or regions to identify best practices and gaps.

7.3. Strengths of the study

- ♣ Focused on a critical but often overlooked area perioperative nursing documentation.
- ♣ Included a relatively large and diverse sample of nurses from multiple perioperative units.
- ♣ Used a structured, pre-tested questionnaire to ensure data quality and reliability.

7.4. Limitation of the study

- ♣ The study was conducted in a single institution, limiting generalizability to other settings.
- ♣ Self-reported data may be affected by response bias.
- ♣ Budget Constraints: Limited funding (only 9000 ETB) affected the scope of data collection and the ability to provide incentives.
- ♣ Shortage of Stationery Materials: Scarcity of printing paper and data organization tools delayed data processing and analysis.

7.5. Dissemination of result

- ♣ The findings will be presented to St. Paul's Hospital Millennium Medical College (SPHMMC) nursing and surgical departments.
- ♣ A copy of the report will be submitted to the nursing research coordinator and library.
- ♣ Results may be shared at professional conferences and published in peer-reviewed journals if possible.

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Annex

CONSENT FORM FOR QUESTIONNAIRES

The following informed consent must be mandatorily obtained from any person invited to participate in a research study in the form of a survey or questionnaire.

This study has been approved by the University Ethics Committee

1. **TITLE OF RESEARCH: ASSESSMENT OF NURSES' KNOWLEDGE AND PRACTICE ON PERIOPERATIVE NURSING DOCUMENTATION OF SPHMMC, 2025**
2. **For this study, you was completing a short survey** about nurses' knowledge and practices related to perioperative documentation. The aim is to assess how experience, and knowledge influence the accuracy and completeness of documentation in surgical care settings. **If you have any questions before you complete this survey, please contact us**
3. **All responses you provide for this study was completely confidential. When the results of the study are reported, you was not be identified by name or any other information that could be used to infer your identity.**
4. **By clicking "Yes" below, you acknowledge that you have read and understood that:**
 - Your participation in this survey is voluntary. You may withdraw your consent and discontinue participation in the project at any time. Your refusal to participate was not in any way adversely impact upon you.
 - You have given consent to be a subject of this research and respond to the survey / questionnaire(s) as truly as possible
 - You do not waive any legal rights or release the University or the investigator from liability for negligence or misconduct.
5. **Do you wish to participate in this study?**

Yes, I am consenting to participate

No, I am NOT consenting to participate

SECTION A: SOCIO DEMOGRAPHIC FACTORS

1. Age: _____
2. Gender: Male Female
3. Work experience in perioperative care: _____

4. Educational level (in Nursing): Diploma Bachelor's Degree Master's Degree or higher
5. Current work unit: ward recovery OR
6. Have you received formal training in documentation in the past 2 years? Yes No

SECTION B: KNOWLEDGE AND PRACTICE BASED QUESTIONNAIRES

NOTE: Choose the most relevant response from your understanding perspective.

No.	Question	Options
1	What is the primary purpose of perioperative documentation?	a) Reduce nurses' workload b) Ensure patient safety, continuity of care, and legal protection c) Eliminate need for communication d) Record for admin purposes only
2	Most common challenge nurses face in maintaining documentation?	a) Lack of interest b) Limited resources & high workload c) Excessive training d) Overuse of electronic tools
3	How does inadequate training affect documentation?	a) Excessive documentation b) Incomplete or inaccurate records c) Eliminates need for documentation d) Improves efficiency
4	Role of institutional policies in documentation?	a) Reduces nurse workload b) Ensures compliance with standards c) Eliminates documentation d) Focuses only on electronic records
5	Impact of high workload on documentation?	a) Improves efficiency b) Leads to incomplete/rushed documentation c) Eliminates need d) Ensures better communication
6	Major barrier to proper documentation?	a) Excess free time b) Lack of standardized formats/guidelines c) Overuse of verbal communication d) Too many electronic tools

Electronic Documentation Awareness & Training

No.	Question	Options
7	Are you aware of any electronic perioperative documentation system at SPHMMC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
8	Have you received training on electronic documentation systems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Knowledge, Practices, and Perceptions

No.	Question	Options
9	Why do nurses struggle despite understanding importance of documentation?	a) Lack of training/guidance b) Prefer verbal communication c) Not involved in care d) Excess free time
10	Expected outcome of improving documentation?	a) Confusion b) Improved patient safety and outcomes c) Reduced communication d) Eliminate standards
11	Role of training in improving practices?	a) Reduces need b) Equips with skills & knowledge c) Eliminates policies d) Focus on electronic tools
12	Benefit of proper documentation for education programs?	a) Reduces clinical practice b) Updates teaching materials c) Eliminates theoretical learning d) Avoids periop settings
13	Main objective of the study?	a) Reduce nurses b) Assess knowledge, challenges, support systems c) Eliminate documentation d) Focus only on electronic tools
14	Benefit of institutional support systems?	a) Eliminates documentation b) Provides resources/training c) Reduce nurse numbers d) Focus on e-records only

Practice-Based Questions

No.	Question	Options
15	How often do you complete intraoperative documentation after surgery?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
16	Which phase is most difficult to document?	<input type="checkbox"/> Preoperative <input type="checkbox"/> Intraoperative <input type="checkbox"/> <input type="checkbox"/> Postoperative <input type="checkbox"/> All phases <input type="checkbox"/> No challenge
17	Have you received feedback/audit on documentation?	<input type="checkbox"/> Yes, regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
18	How often is your documentation reviewed by supervisor/quality team?	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never <input type="checkbox"/> I don't know

