



**DOCUMENTATION PRACTICE AND ASSOCIATED FACTORS AMONG
INTENSIVE CARE UNIT NURSES WORKING AT PUBLIC HOSPITALS IN
ADDIS ABABA, ETHIOPIA, 2022**

BY: ALEHEGN KEREIGN

**ADVISORS: AYALNESH ZEMENE (BSC, MSC, ASSISTANT
PROFESSOR)**

ZEGEYE KEBEDE (MSC, MSC/EMCCN)

**A THESIS TO BE SUBMITTED TO SCHOOL OF NURSING DEPARTMENT OF
EMERGENCY AND CRITICAL CARE NURSING SPHMMC, IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF
SCIENCE CRITICAL CARE NURSINGPRACTITIONER**

**FEBRUARY, 2022
ADDIS ABABA, ETHIOPIA**



**DOCUMENTATION PRACTICE AND ASSOCIATED FACTORS AMONG
NURSES WORKING IN INTENSIVE CARE UNITS AT PUBLIC HOSPITALS
IN ADDIS ABABA, ETHIOPIA, 2022**

BY: ALEHEGN KEREHIGN

**ADVISORS: AYALNESH ZEMENE (BSc, MSc, ASSISTANT
PROFESSOR)
ZEGEYE KEBEDE (BSC, MSC/EMCCN)**

**A THESIS TO BE SUBMITTED TO SCHOOL OF NURSING DEPARTMENT OF
EMERGENCY AND CRITICAL CARE NURSING SPHMMC, IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF
SCIENCE CRITICAL CARE NURSING PRACTITIONER**

**FEBRUARY, 2022
ADDIS ABABA, ETHIOPIA**

St. Paul's Hospital Millennium Medical College
Graduate Study Program
Department of emergency and critical care nursing

Name of the investigator	Alehegn Kerebign Missa
Full title of the research project	Documentation Practice and Associated Factors among Nurses Working in Intensive Care Units at Public Hospitals in Addis Ababa, Ethiopia, 2022
Duration of the project	December 10 to 30, 2021
Study area	Addis Ababa
Total cost of the project	25,708.00 ETB Birr
Source of funding	St. Paul's Hospital Millennium Medical College
Address of investigators	Name: Alehegn Kerebign Cell phone: +251911969987 E-mail alehegnkerebign@gmail.com
Name and address of advisers	1. Name : Ayalnesh Zemene (MRH, Assistant professor) E-mail: Ayalnesh.zemene@sphmmc.edu.et or ayuzem4@gmail.com 2. Name : Zegeye Kebede (MSC/EMCCN) E-mail : Zeg642736@gmail.com

Acknowledgement

I am eternal gratitude to God who is my strength all the time, and then my gratitude goes to SPHMMC for giving the chance and funding, and also would like to thank my advisors Ayalnesh zemene and Zegeye kebede for their amendment comments in the development of this thesis. Finally, I would also like to acknowledge all staff members of all intensive care units included in the study area and Saint Paul hospital millennium medical college library for-all their contribution to my thesis work.

Finally I would like to thank friends, family, for their patience support, encouragement and motivation.

Abstract

Background: In health care systems nursing care documentation is a vital and powerful tool that ensures continuity of care and communication between health personnel for better patient outcomes. Practice of nurses' towards nursing care documentation, affect the quality and coordination of patients' care. Hence, this study aimed to assess practice and associated factors towards nursing care documentation among nurses working at public hospitals in Addis Ababa Ethiopia.

Methods: Institutional based cross-sectional study was conducted among 358 nurses working in intensive care units at public hospitals in Addis Ababa from August 2021to January 2022.All nurses were selected by proportional allocated. Data was collected by using self-administered questionnaire and observation check list. EPI info and SPSS were used for data entry and analysis respectively. Bivariable analysis was performed to select candidate variables for multi variable logistic regression analysis. All independent variables with p-value less than 0.20 were taken as candidates for multivariable logistic regression model. The AOR estimated to measure the strength of association. In final model p-value of less than 0.05 at 95% CI was considered as statistically significant association.

Results: A 358 respondents were participated in this study with the response rate of 97.8%. Of a total nurse who took part in the study, 61.17%) of them were females. Two hundred twenty (61.45%) of the study respondents scored as having good practice, 222 (62.01%) of the study participants were scored as having good knowledge, and 221 (61.73%) of the study participants having favorable attitude. in the finale model of multivariable logistic analysis knowledge (AOR= 1.63; 95% CI: 1.04, 2.54) and attitude of nurses (AOR= 2.30; 95%CI: 1.47, 3.58) had statically significant association with nursing documentation practice.

Conclusion and Recommendation: This study revealed that good nursing documentation practice was 61.45 % among ICU nurses. The knowledge and attitude of intensive care unit nurses toward nursing documentation were the only factors associated with nursing care documentation practice. Therefore I suggest to the hospitals to improve nurse's knowledge, attitude and documentation practice by different mechanism like training, sharing experience with other hospital and give short term course.

Keywords: documentation, nursing care, practice, intensive care units,

Acronyms and Abbreviations

CNE	Comprehensive Nursing Education
EPI Info	Epidemiological Information Software
ICU	Intensive Care Unit
IRB	Institutional review board
NGO	Non-governmental organization
PPS	Probability proportion to sample size
SPSS	Statistical Package for Social Science
WHO	World Health Organization

.

Table of Contents

Acknowledgement	i
Abstract	ii
Acronyms and Abbreviations	iii
List of figures	v
List of tables	v
1 Introduction	1
Statement of the problem	3
Significance of the study	5
2 Literature review	6
2.1 Practice of nurses about documentation	6
2.2. Factors Associated with documentation practice	7
2.3. Conceptual frame work	9
3 Objectives	10
3. General objectives	10
Specific objectives	10
4 Methods	11
4.1 Study area and period	11
4.2 Study design	11
4.3 Populations	11
4.3.1 Source population	11
4.3.2 Study population	11
4.3.3 Eligibility criteria	12
4.3.3.1 Inclusion criteria	12
4.3.3.2 Exclusion criteria	12
4.4 Sample size determination	12
4.5 Sampling technique	13
4.6 Study variables	14
4.7 Operational definition	14
4.8 Data collection tools and procedures	15
4.9 Data quality control	15
4.10 Data processing and analysis	16
4.11 Ethical clearance	16
4.12 Dissemination of result	17
Annex	33

List of figures

Figure 1: Conceptual framework of documentation practice and associated factors among nurses working in intensive care units of at public hospitals in AddisAbaba, Ethiopia, 2021 by referring different litterateurs (5. 6, 22, 25, 28, 29, 30).....	9
Figure 2: Schematic presentation of hospitals and distribution of nurses for each hospital in Addis Ababa, Ethiopia, 2022.....	13
Figure 1: Practice of documentation among Nurses working in Public Hospital in Addis Ababa (n=358)	21

List of tables

Table 1: Socio demographic characteristics of intensive care unit nurses at public hospitals in Addis Ababa from December 10 th - 30 th 2021 (n=358).....	18
Table 2: : working area related characteristics of intensive care unit nurses at public hospitals in Addis Ababa from December 10 th - 30 th 2021 (n=358).....	19
Table 3: Practice of nursing documentation among nurses working at public hospitals in Addis Ababa from December 10 th - 30 th 2021 (n=358)	20
Table 4: Knowledge of nurses towards nursing documentation in public hospital, Addis Ababa (n=358).....	22
Table 5: Attitudes of nursing towards nursing documentation practices, AddisAbaba(n=358)	25
Table 6: Factors associated with nursing documentation practice among nurses working in ICU in public hospital in AddisAbaba (n=358).....	27

1 Introduction

1.1. Background of the study

Nursing documentation is the process of recording and keeping evidence to have an account of what happened and when it happened (1). It is an integral, vital, and important part of professional nursing practice, with the primary purpose of communicating patient information to the health care team. The history of nursing care documentation has been started since Nightingale defined as the record of nursing care that is planned and given to individual patients and clients by nurses (2). The quality and coordination of care depend on the communication between nurses with each other, with other members of the healthcare team for continuity of care about their patients (3).

The importance of proper documentation in nursing cannot be overstated. Failure to nursing documentation of a patient's condition, medications administered, or anything else related to patient care can result in poor outcomes for patients, and liability issues for the facility, the physician in charge, and the nurse(4). Proper nursing documentation provide many function for patients, physicians, nurses and other care providers, and families. Accurate documentation is important for communication and continuation of care to everyone (5). Accurate documentation is an important prerequisite for individual and safe nursing care. It is a severe threat for the individuality and safety of patient care if important aspects of nursing care remain undocumented.

Nursing documentation in ICU is important for quality assurance of the information contained in patient's charts often used to evaluate the quality of service and the appropriateness of care delivered by nurses. Proper nursing documentation also establishes professional accountability, demonstrating a nurse's knowledge and judgment skills, and it can help funding and resource management. Nursing documentation is also very important for legal issues regarding patient's records that can be used as evidence in court (6). Clear, accurate, timely and accessible documentation is an essential element of safe, quality and evidence based nursing practice (7). Incomplete, inaccurate, untimely, illegible or manipulated documentation can lead a number of undesirable outcomes like;

Medication errors (5). Nursing is not complete until the care has been properly documented and the old saying "if it was not documented, it was not done" (8). Additionally, nursing documentation is important for education, research, quality assurance and for reimbursement by third party claimants (9). Several studies have been done which focus on the benefits of nursing documentation. A study done by Bjorvelleal. Suggests that the nurses perceive nursing documentation as an important element in their practice and also to ensure the safety of the patient (10).

Existing documentation system is very poor in Ethiopia especially in public hospital. However, many nurses' still experience barriers to maintaining accurate and legally prudent documentation like poor practice towards nursing documentation, time shortage and workload. This brings insufficient cooperation between health care team members and services that have a negative impact on nursing care documentation (4, 5). Even though both paper based and electronic based nursing documentation have various principles including objectivity, specificity, clearing and consistency, comprehensive, respecting confidentiality and facility, but nurses' inadequate practice to document nursing care by using these principles makes nursing records usually of low quality (6). Nursing care documentation is essential for early recognition of patients' deteriorating condition followed by effective communication and response by members of the interdisciplinary care team leads to decreased hospital mortality. Nurses should document what they see, not what they think (7). Nurses bear a large burden in both managing and implementing the interdisciplinary team's plan for documenting the care and progress towards goals since documentation is a working framework which provides a comprehensive account of care provided to a patient (8, 11). Nurses' low practice on nursing care documentation have negative impacts on the health care of patients, the health care providers and on the profession and associated with the problem, omitting of medications, improper or double medication administrations and risk of legal harm become high(5,12,13). In Ethiopia, even though it is declared that nursing care outlines; the assessment, planning and evaluation of care must be clearly documented but still now nurses' practice towards documentation is low. Therefore, this study assesses ICU nurses Practice and factors associated with nursing care documentation.

Statement of the problem

Nursing documentation is essential for early recognition of patients' deteriorating condition followed by effective communication and response by members of the interdisciplinary care team leads to decreased hospital mortality. (5, 7)

The prevalence of poor nursing documentation practice is different, country to country, and institution to institution. Study from London and Iraq having poor documentation practice shows 53% and 51.7% respectively (14, 15). South Africa reported poor practice in documentation (16) while the Ugandan study reported poor towards the practice of nursing documentation among nurses (17). In Ethiopia, inadequacy of data collection with lack of quality was found to be a problem. {28}

Poor documentation in nurses has been shown to have negative impacts on the health care of patients' and may lead to harmful consequences like exposing the care provider for medication administration error (18), quality of patient care a good documentation improves credibility of the institution, and makes the nursing profession visible and the situation may lead to the extent that can affect the reputation of the health care facilities (19).

Studies conducted on this issue of interest are very minimal. Since the care given at ICU is a prompt lifesaving, nursing documentation should have to be complete and it minimizes hindrance of communication between care givers, medical teams and the continuity of patient care. Nurses have to accept that documentation is not separate from nursing care and it is not optional. It is an integral part of any nursing activity and an important tool that nurse use to ensure high-quality client care Therefore, this research will conduct to assess the practice and associated factors towards nursing documentation at public Hospitals in Addis Ababa, Ethiopia.

Existing documentation system is very poor in Ethiopia especially in public hospital. However, many nurses' still experience barriers to maintaining accurate and legally prudent documentation like poor practice towards nursing documentation, time shortage and workload. This brings insufficient cooperation between health care team members and services that have a negative impact on nursing care documentation (4, 5). Even though both paper based and electronic based nursing documentation have various principles including objectivity, specificity, clearing and consistency, comprehensive, respecting confidentiality and

facility, but nurses' inadequate practice to document nursing care by using these principles makes nursing records usually of low quality (6). Nursing care documentation is essential for early recognition of patients' deteriorating condition followed by effective communication and response by members of the interdisciplinary care team leads to decreased hospital mortality. Nurses should document what they see, not what they think (7). Nurses bear a large burden in both managing and implementing the interdisciplinary team's plan for documenting the care and progress towards goals since documentation is a working framework which provides a comprehensive account of care provided to a patient (8, 11). Nurses' low practice on nursing care documentation have negative impacts on the health care of patients, the health care providers and on the profession and associated with the problem, omitting of medications, improper or double medication administrations and risk of legal harm become high(5,12,13).In Ethiopia, even though it is declared that nursing care outlines; the assessment, planning and evaluation of care must be clearly documented but still now nurses' practice towards documentation is low. Therefore, this study assesses ICU nurses Practice and factors associated with nursing care documentation.

Significance of the study

This study is intended primarily to assess the Practice and associated factors towards documentation practice in Intensive Care Unit among Nurses at public Hospitals in Addis Ababa. Nurses are expected to keep accurate, timely and complete records regarding patient care not only to assess client progress ,get full information when they return again, insure the cost what they expend for hospital service, but also to protect self because it may be used as evidence in legal proceedings such as lawsuits.

At the same time, it will give baseline information for different stakeholders about practice of nursing documentation working in the intensive care unit of public hospitals. Particularly hospitals to recognize factors related documentation practice of nursing staff & help them to take corrective measures in an attempt to create a conducive environment and to improve skill as well as efficiency and quality of care.

It is very crucial for every institution to know the practice of documentation in Intensive Care Unit for appropriate measures and prevention of future practice problems and also it's important to assess its determinant in order to increase the quality of care.

The result will hopefully give a base line data for any intervention to be implemented at hospitals that have ICU in Ethiopia. This study will also help to clearly picture the practice of documentation. This study can also serve as a baseline for any further study to be done

2 Literature review

2.1 Practice of nurses about documentation

As many studies indicated globally most of nurses had inadequate practice regarding documentation as well as insufficient information and their actions are either not documented or not properly documented and thus creates a great problem when it comes to evaluation of client care (6, 18).

The growing gap between the supply of health care supplies and the demand for their services is a critical issue facing governments, managers and professionals seeking to improve health and development. One of the challenges which are not improved any health institutions including intensive care unit are unable to write what they do in the work place or incomplete records. The prevalence of good nursing documentation practice is different, country to country, and institution to institution. The prevalence of good nursing documentation practice by different study shows in London and Iraq (47%) and (49.3%) respectively (14, 15).

Documentation is reported to take up to 50% of nurses' time per shift (20). It serves a number of important functions, including communication among healthcare workers for continuity of care. Poor communication, in a broader sense, is known to contribute significantly to the occurrence of adverse events in healthcare (21). Given the significance of nursing documentation and the reality of poor documentation practices, it is not surprising that there have been resolute calls and subsequent efforts to improve its quality (9). Some studies from sub Saharan Africa have identified deficiencies in various aspects of nursing documentation. One study from Yemen reported deficiency in attitudes, knowledge and practice behaviors (22) while the Ugandan study reported knowledge and attitude deficiency towards the practice of nursing documentation among nurses (23).

Poor documentation has been shown to have negative impacts on the health care outcome, the health care provider's effectiveness and on the profession in general. The research done in Jimma University Medical center shows that (51.4%) of nursing documentation practice was poor among nurses (24).

According to the research done in public hospital of Harari and DireDawa East Ethiopia revealed that almost half of the participants (47.5%) practice completed nursing documentation (25).

Nursing documentation has both practical and legal implications in patient care therefore quality documentation and correct reporting are essential to enhance efficiency in client care (26). Regardless of the format used to document, the client's health-care record is a formal, legal document that details a client's care and progress. Nurses need to understand that their documentation can be examined when there has been a complaint or incident resulting in harm (27). The ability for the nurses to document in a clear concise, legible and legally careful manner can significantly reduce the risk of misunderstanding and negative patient outcomes related to poor communication (26, 27).

According to research conducted in west Gojjam regarding documentation practice revealed that from 142 respondents 47. 5 % had good documentation practice (scored greater than or equal to the mean value 9.45 and 52.5 had poor documentation practice (scored less than or equal to the mean value 3.23) (28).

2.2. Factors Associated with documentation practice

Documentation is one of the most disputed and questioned nursing roles, variably interpreted as accurate and evidentiary nursing actions. The workplace environment can contribute to poor documentation. Heavy workloads, laborious documentation forms, fragmentary language (i.e. documentation language that is not understood beyond the local context), inadequate resources and hospital culture all impact the quality of nurses' documentation (15).

Litterateurs discusses factors of poor documentation practice are time constraints, poor workplace environment, mismatches between staff and work load, difficult documentation forms; incomplete language, inadequate resources like PC, Paper, form, color pencil marker, lack of training on documentation and bureaucratic systems and institutional policies(5,22,,28,29,30).

Some factor which are influencing the poor documentation system such as- motivational factor, lack of awareness, attitude problem, inadequate knowledge and skill regarding documentation system and job accountably (5). Knowledge and attitude of nurses about documentation was independently associated with nurses' practice towards nursing documentation (23, 31).

In Ethiopia a study conducted at Harari: age, lack training, mismatches between staff and work load, nurses with lack of motivation and familiarity with documentation format were associated with documentation practice (25). Other study conducted in Mekele revealed that unfamiliar with documentation format, lack of documentation sheet, and lack of time to record were associated with poor documentation practice(6).

2.3. Conceptual frame work

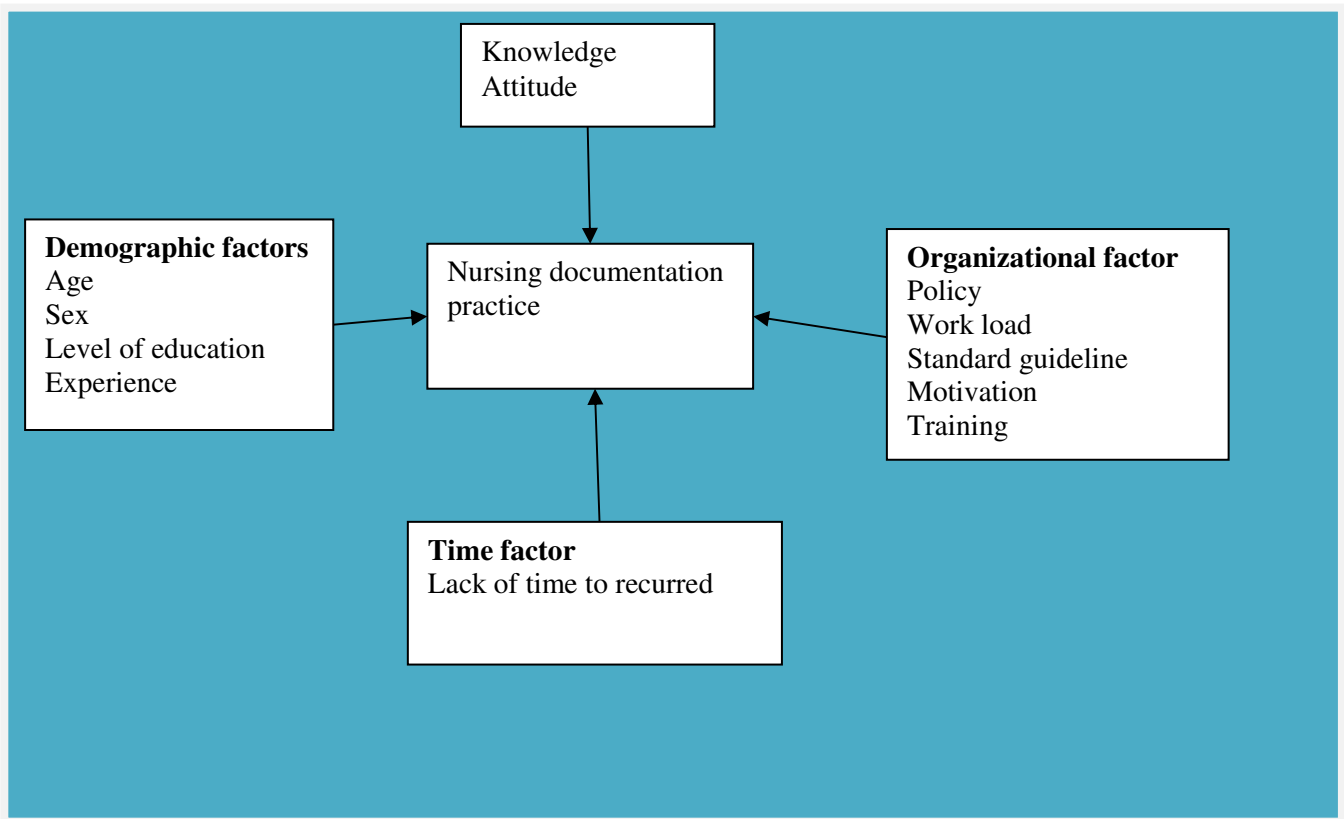


Figure 1: Conceptual framework of documentation practice and associated factors among nurses working in intensive care units of at public hospitals in AddisAbaba, Ethiopia, 2021 by referring different litterateurs (5. 6, 22, 25, 28, 29, 30).

3 Objectives

3. General objectives

- ❖ To assess documentation practice and its associated factors among ICU nurses working at public Hospitals of AddisAbaba, Ethiopia, 2022.

Specific objectives

- ❖ To assess practice of nurses towards documentation among nurses working in intensive care units at public hospitals in AddisAbaba, Ethiopia, 2022.
- ❖ To identify factors associated with practice of documentation among nurses working in intensive care units at public hospitals in AddisAbaba Ethiopia, 2022.

4 Methods

4.1 Study area and period

AddisAbaba is a capital city of Ethiopia, and seat of African Union and Economic Commission for Africa with a population of 3,384,569 according to the 2007 senses. This capital city holds 527 square kilometers of area in Ethiopia. The city comprises 11 sub-cities. The population pyramid is broad based, typically of a developing world. People from different regions of Ethiopia populate the city; the main causes of morbidity and mortality are communicable diseases that could be prevented through interaction of primary health care activities.

The city has 52 hospitals 12 public hospitals, 36 private hospitals, 3 uniform military hospitals and 2 NGO hospitals). Number of health centers are 61 of which 54 are public and 7 are NGO health centers. The city has also more than 700 clinics and 500 drug venders accountable to AddisAbaba city administration. (Data obtained from medical service directorate of the federal ministry of health, AARHB, and Addis Ababa city administration)

The Study area were at public Hospitals in AddisAbaba, those are Tikur-Anbessa specialized Hospital, St Paul's Millennium Medical Collage, St Peters' Hospital, Abate Hospital, Zewditu Memorial Hospital, Yekatit 12 Hospital, Rasdesta Damtewu Memorial Hospital, Dagemawe Menlike Hospital, and Gaudi Memorial Hospital; Tirunesh Beijing Hospitals nurses working in intensive care units at public hospitals. The data was collected from December 10th to December 30th 2021.

4.2 Study design

An institutional-based cross-sectional study was conducted to assess documentation of practice of ICU nurses working at public hospitals in Addis Ababa.

4.3 Populations

4.3.1 Source population

All nurses who are working ICU at public hospitals in Addis Ababa.

4.3.2 Study population

Nurses who are working in ICU at public hospitals

4.3.3 Eligibility criteria

4.3.3.1 Inclusion criteria

Nurses who experience of at least 6 months in each public hospital

Nurses who were available on the study time

Volunteer to participate in the study during the study period was included

4.3.3.2 Exclusion criteria

Nurses who were on annual leave maternity leaving unable to participate on the study due to illness at the time of data collection was not included.

4.4 Sample size determination

The study employed a single population proportion sample size determination formula taking the proportion as 47.5% from previous study conducted in Hariri hospital and Dire Dawa Administration Governmental Hospitals (26), 95% confidence interval (CI), and 5% margin of error.

Thus, the sample size is calculated as follows:

$$n = (Z_{\alpha/2})^2(p)(1-p) / (d)^2$$
$$n = (1.96)^2 * 0.475(1-0.475) / 0.005^2 = 383$$
$$n = (1.96)^2 * 0.468 * 0.532 / (0.05)^2 = 383$$

Where

n = minimum sample size required for the study

$Z_{\alpha/2} = 1.96$ (standard normal distribution with confidence interval of 95% and $\alpha = 0.05$)

P = 0.475 (prevalence of nursing documentation practice from previous study, 47.5%)

d = 0.05 (a tolerable margin of error);

The ultimate sample size was 422 with 10% compensation for none response according to the above formula. Even if the final sample size is 422, the total numbers of nurses working in intensive care unit at public hospitals are 366, so collected from all nurses shown below.

4.5 Sampling technique

There were a total of 12 public Hospitals in AddisAbaba, based on number of nurses; then after received lists from the institutions with each hospital and where collect the data from them.

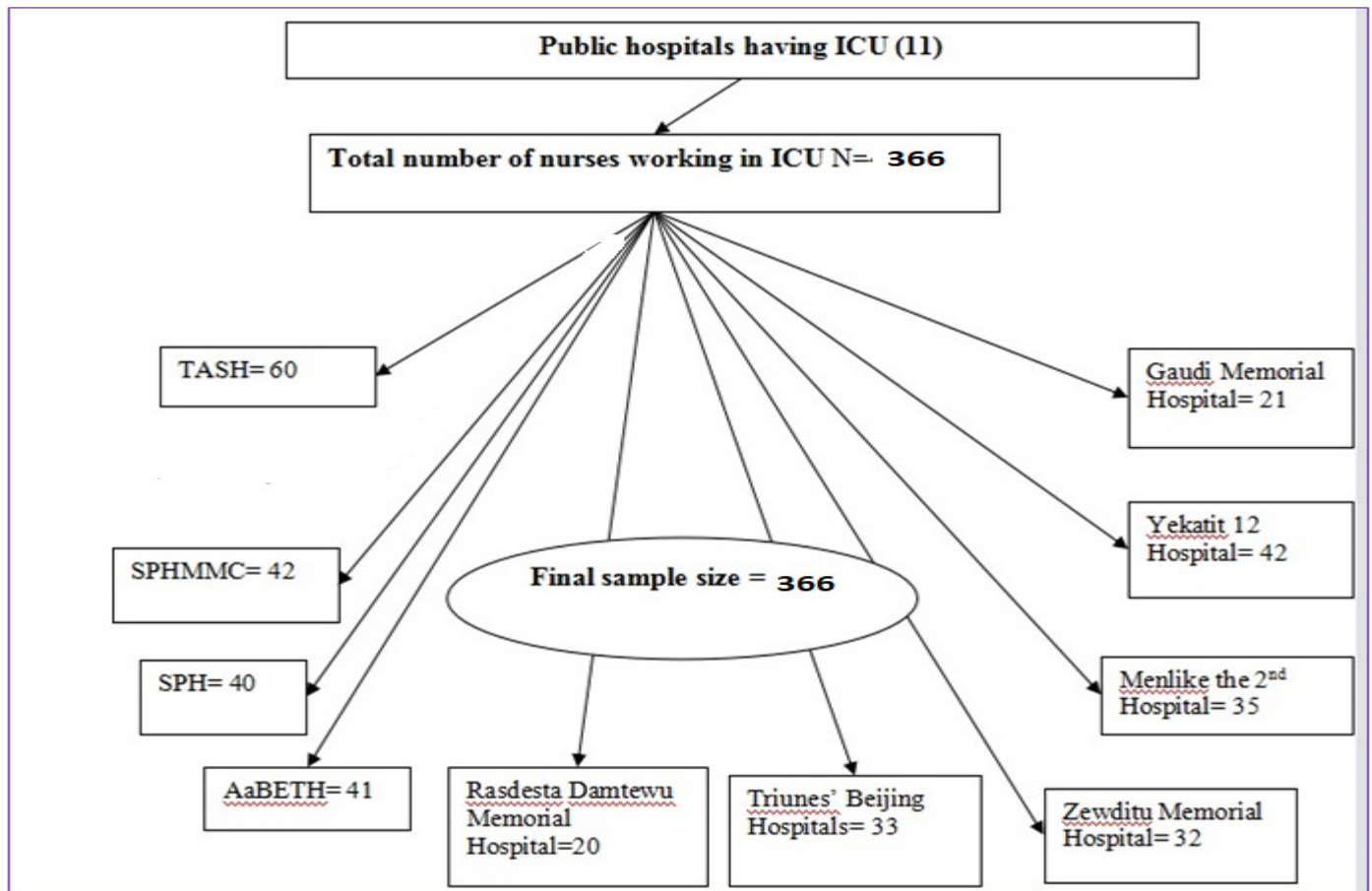


Figure 2: Schematic presentation of hospitals and distribution of nurses for each hospital in Addis Ababa, Ethiopia, 2022

4.6 Study variables

Dependent variable: documentation practice

Independent variables:

Socio demographic factors: age, sex, educational status, current working hospitals, work experience, availability of standard guide line, in-service training, recording time, motivation, knowledge and attitude towards nursing documentation .

4.7 Operational definition

Practice: In this study it refers to the actions done by the nurses on checklist regarding documentation.

Good Practice: Refers to those study participants who correctly perform documentation practice checklist through observation and score greater than mean score.

Poor Practice: Refers to those study participants who correctly perform to practice checklist through observation and less than or equal to mean score.

Good knowledge: those respondents who scored above or equal to the mean score of knowledge questions

Poor knowledge: those respondents who scored below to the mean score of knowledge questions

favorable attitude: Those respondents who scored above or equal to the mean score

Unfavorable attitude: Those respondents who scored below to the mean score of attitude questions

Nursing documentation p: record of nursing care delivered to individual clients by nurses.

4.8 Data collection tools and procedures

A structured, self administered questionnaire and practice of nurses working in intensive care units towards documentation practice were assessed by using 13 practice-related questions using an observational checklist. Both instruments was adapted from other research and modified. Structured self administered questioner was assessed after observational checklists (6, 24, 25, and 28). Based on the observation checklist, nurses who apply/ follow the recommended action were ticked as “Yes” and nurses who don’t apply/ follow the recommended action were ticked as “No”. Finally, from this aggregate score nurses who perform greater than mean score of practice related questions using checklist were categorized as having good practice whereas nurses who practiced less than or equal to mean score of practice related questions were categorized as having poor practice. The data was collected by trained data collectors and supervisors. Observation was conducted by principal investigator, two supervisors and two data collectors. Participant nurses observed for 15-30minutes, the time was selected randomly. Nurses where observed and principal investigator, supervisors and two data collectors judge them according to the prepared checklists.

A total of 9 multiple choice questions were used to measure the knowledge of respondents regarding nursing documentation adopted (32) And Participants’ attitudes was assessed via a Likert scale, with item scores ranging from strongly agree (5) to strongly disagree (32).

4.9 Data quality control

To assure the data quality data was collect by BSC nurses were not employees of the study hospitals after two days training on the techniques of data collection. The completeness the data were checked by me and supervisors. 5% (19) from the sample size were pre-test at Shashemene ICU that was not included in the final study.

4.10 Data processing and analysis

The collected data was checked visually for completeness and the responses were coded and entered into the computer using Epi info statistical package and 5% of the responses randomly selected and check for the consistency of data entry and exported to windows of Statistical Package for Social Science (SPSS) for data analysis. Results were summarized using frequencies, percentage, mean, standard deviation, and media and inter quartile range presented using figures, tables and text. Binary logistic regression was done to see the crude significant relation of each independent variable with dependent variables. Variables with P value <0.20 at 95% confidence interval during the bi variable analysis were to multi-variable logistic regression analysis by using the backward likelihood ratio method to see the relative effect of confounding variables and interaction of variables. Odd ratio with 95%CI was performed to determine the strength of association of variables at p-value less than 0.05 was taken as significant.

4.11 Ethical clearance

The research protocol was approved and ethical clearance was obtained from SPHMMC Institutional Review Board and Addis Ababa public health research and Emergency director. A formal letter of cooperation was written to Addis Ababa City Administration's Health Bureau. Consent from the city health bureau and respective public hospitals were also obtained. All nurses serving as data collectors and supervisors were informed in written form about the study.

Data collectors were give full information to the study participants about the purpose of the study and askes them to give their consent before participating in the study. Participation in the study was entirely voluntary and any involvement in the study was assured only after obtaining complete verbal informed consent. Confidentiality was strictly adhered to and identification numbers (using codes) rather than names were used during the data collection and analysis.

4.12 Dissemination of result

The result as part of the masters of Critical Care Nursing Practitioner thesis will be presented and submitted to St. Paul's Hospital Millennium Medical College. It will be also disseminated to the Addis Ababa public health research and Emergency management director, to public hospitals in Addis Ababa city and to all responsible bodies. Additionally, the findings will be presented to different scientific communities and the manuscript will be sent to reputable journal for publication.

5. RESULTS

5.1. Socio demographic characteristics of respondents

From the total of 358 respondents were participated in this study with the response rate of 97.8%. Of a total nurse who took part in the study, more than half (61.17%) of them were females. Two hundred sixty-six (74.30%) of study subjects were in the age interval of 25-30 years with the median of 28 and IQR of 3 years. Majority (91.34%) of study participants had degree educational level. More than three fourth (82.12%) of study subjects worked less or equal to three years and less than one fourth (15.08%) of them had between 4-7 years work experience (Table 1).

Table 1: Socio demographic characteristics of intensive care unit nurses at public hospitals in Addis Ababa from December 10th - 30th 2021 (n=358)

Variable's	Response	Frequency	Percent
Age in years	21-24	7	1.96
	25-30	266	74.30
	31-34	54	15.08
	≥35	31	8.66
	Median ± IQR	28 ± 3	
Sex	Male	139	38.83
	Female	219	61.17
Education	Diploma	5	1.40
	Degree	327	91.34
	MSC	26	7.26
Experience in years	≤3	294	82.12
	4-7	54	15.08
	≥8	10	2.79

5.2. Work area related characteristics of study participants

In this study, Ninety-five (26.54%) of study respondents got in service training. From a total of nurses got training, more than three fourth (88.66%) of them took in less or equal to two years. The study participants were asked about the availability of guidelines and 59(16.34%) of them reported that the availability of the guideline. More than half (66.13%) of respondents were familiar with the guideline. Three hundred fifty-five (99.16%) of study subjects were reported the 1:1 patient to nurse ratio. Majority (86.87%) of nurses were reported the presence of enough sheet and 236(65.92%) of study participants were reported that as they took motivation. One hundred seventy-three (48.32%) of the study subjects were documented the care soon after care finished (Table2).

Table 2: : working area related characteristics of intensive care unit nurses at public hospitals in Addis Ababa from December 10th - 30th 2021 (n=358)

Variables	Response	Frequency	Percent
In-service training	Yes	95	26.54
	No	263	73.46
When you take	≤2	86	88.66
	≥3	11	11.34
Guidelines Availability	Yes	59	16.48
	No	299	83.52
Familiar with guideline	Yes	41	66.13
	No	21	33.87
Patients to nurse ratio	1:1	355	99.16
	1:2	3	0.84
Enough sheet	Yes	311	86.87
	No	47	13.13
Took Motivation	Yes	236	65.92
	No	122	34.08
When you document	Any time when convenient	162	45.25
	soon after care finished	173	48.32
	At the end of shift hours	23	6.42

5.3. Practice of nurses towards nursing documentation practice

In this study, the study participants were assessed by 13 items of the questionnaire regarding documentation practice. Three hundred forty-six (96.65%) of the study subjects reported as they document every patients document. More than 3/4th (87.99%) of nurses were documented subjective data and 329(91.90%) of study subjects were documented objective data. Two hundred ninety-four (82.12%) of study participants were reported that they documented with the significant communication with family members. Majority (81.84%) of respondents were illustrates about the document of any advocacy that was undertaken on the patients' behalf. Three hundred twenty-two (89.94%) of study subjects were reported about the document legibly when using paper documentation forms and 307(85.75%) of nurses were reported about document advice, care or services provided to an individual within a group, communities or populations. Three hundred twenty-five (90.78%) of participants were reported complete documentation in timely manner - during, or as soon as possible after, the care or event (Table 3).

Table 3: Practice of nursing documentation among nurses working at public hospitals in Addis Ababa from December 10th - 30th 2021 (n=358)

Items	Response	Frequency	Percent
Document every patient	Yes	346	96.65
	No	12	3.35
subjective data	Yes	315	87.99
	No	43	12.01
objective data	Yes	329	91.90
	No	29	8.10
communication with family	Yes	294	82.12
	No	64	17.88
advocacy patients behalf	Yes	293	81.84
	No	65	18.16
legibly when using paper	Yes	322	89.94
	No	36	10.06
group education	Yes	307	85.75
	No	51	14.25
informed consent	Yes	319	89.11
	No	39	10.89
Complete documentation	Yes	325	90.78
	No	33	9.22
Document the date and time	Yes	326	91.06
	No	32	8.94
Never delete	Yes	305	85.20
	No	53	14.80
Document observations	Yes	314	87.71
	No	44	12.29
Co-signing entries	Yes	280	78.21
	No	78	21.79

As illustrated in Figure3, the study participants' performance was categorized into good and poor practice, with scores of 0.8756 (mean value) or above as good practice, while those below the mean score were considered to have poor practice. Two hundred twenty (61.45%) of the study respondents scored as having good practice, and the rest 138 (38.55%) of the study subjects scored below the mean as having poor practice.

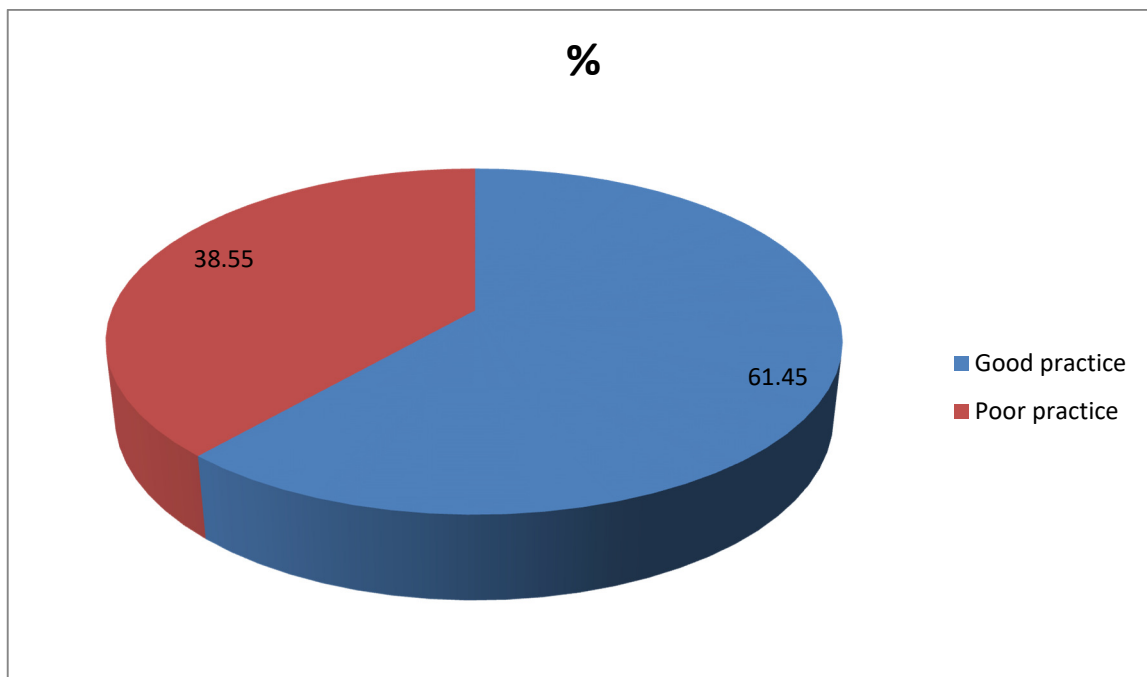


Figure 3: Practice of documentation among Nurses working in Public Hospital in Addis Ababa (n=358)

5.4. Knowledge of respondents towards nursing documentation

In this study, respondents were asked about the knowledge towards documentation by nine items of questionnaire in which more than one response for the eight items were possible. Three hundred fifteen (88.0%) of study subjects were reported nursing care should be documented according to guidelines. Concerning the principles needed to be followed while documenting, more than 3/4th (88.83%) of study participants were reported complete and 313(87.43%) of the nurses reported easily readable. Three hundred forty-one (95.25%) of respondents were reported improve quality and 330(92.18%) of study participants described about the communication with staffs regarding the advantages of patient care documentation. The study participants were asked about the main nursing activities that they were expected to document; 315(89.11%), 322(89.94%), 284(79.33%), and 295(82.40 %) of them responded assess data, progress of patients, transfer and discharge and care provided and evaluation, respectively.

Majority (91.62%) of study subjects were said poor development of the potential consequences of inadequate documentation. More than three fourth (89.39%) of study respondents were responded leads to error concerning the effects of using non-standard abbreviations while documenting patient care. Three hundred thirty-four (93.30%) of study subjects were reported document date and time about the actions of documentation that protects them from legal suit and 337(94.13%) of them gave responses about name medications of the components of documenting medication administration. Regarding responsible person to document the care provided to a patient, 289(80.73%) of study subjects were reported the same individual

who provided the care (Table 4).

Table 4: Knowledge of nurses towards nursing documentation in public hospital, Addis Ababa (n=358)

Items	Responses	Frequency	Percent
Documentation according to guidelines	Yes	315	88.0
	No	43	12.0
The principles needed to be followed while documenting			
Error-free	Yes	295	82.40
	No	63	17.60
Complete	Yes	318	88.83
	No	40	11.17
Easily readable	Yes	313	87.43
	No	45	12.57
Chronological	Yes	216	60.34
	No	142	39.66
The advantages of patient care documentation			
improve quality	Yes	341	95.25
	No	17	4.75
communication with staffs	Yes	330	92.18
	No	28	7.82
education and research	Yes	280	78.21
	No	78	21.79
Legal protection	Yes	301	84.08
	No	57	15.92
Health planning	Yes	276	77.09
	No	82	22.91
The main nursing activities that you are expected to document			
Assess data	Yes	319	89.11
	No	39	10.89
Progress of patients	Yes	322	89.94
	No	36	10.06
Transfer and discharge	Yes	284	79.33
	No	74	20.67
Care provided and evaluation	Yes	295	82.40
	No	63	17.60
The potential consequences of inadequate documentation			
Possible imprisonment	Yes	161	44.97
	No	197	55.03
Poor development	Yes	328	91.62
	No	30	8.38
Loss of salary	Yes	206	57.54
	No	152	42.46
The effects of using non-standard abbreviations while documenting patient care			
Leads to errors	Yes	320	89.39
	No	38	10.61
Wastes time	Yes	283	79.05

	No	75	20.95
Causes confusion	Yes	292	81.56
	No	66	18.44
Actions of documentation that protects you from legal suit			
Document date and time	Yes	334	93.30
	No	24	6.70
Recording what you saw	Yes	286	79.89
	No	72	20.11
Recording chronological	Yes	206	57.54
	No	152	42.46
Make corrections	Yes	193	53.91
	No	165	46.09
The components of documenting medication administration			
Name medications	Yes	337	94.13
	No	21	5.87
Date and time	Yes	337	94.13
	No	21	5.87
Routes and dosage	Yes	335	93.58
	No	23	6.42
Nurses signature	Yes	324	90.50
	No	34	9.50
Responsible person to document the care provided to a patient			
individual who has observed	Yes	227	63.41
	No	131	36.59
who assisted the care	Yes	189	52.79
	No	169	47.21
same individual who provided the care	Yes	289	80.73
	No	69	19.27

As demonstrated in figure 5, Two hundred twenty-two (62.01%) of the study participants were scored as having good knowledge, and the rest 136 (37.99%) of the study subjects scored below the mean as having poor knowledge.

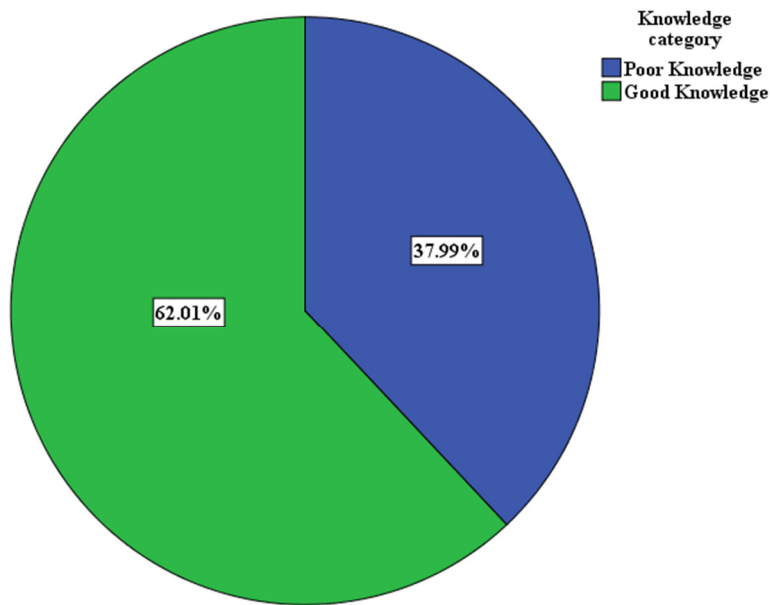


Figure 4: Knowledge of nurses towards nursing documentation in public hospital, Addis Ababa

5.5. Attitudes of nursing towards nursing documentation practices

As shown in Table 5, the study respondents were asked about the attitude towards documentation by twelve items. One hundred eighty-nine (52.79%) of study subjects were strongly agree with the item of “Nursing documentation is equally important as any.” Similarly, 206(57.54%) of study participants were strongly agreed with documentations ensures continuity of care. One hundred thirty-six (37.99%) of nurses were agreed with the item” Documentation importance to other health care.” More than half (58.66%) of the study subjects were strongly agreed about the idea of “Documentation serves to show the workload and tasks performed.” Regarding the item of” many benefits can be derived from the use of documentation”, 120(33.52%) of nurses were reported agree (Table 5).

Table 5: Attitudes of nursing towards nursing documentation practices, AddisAbaba(n=358)

Items	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	N	%	N	%	N	%	N	%	N	%
Nursing documentation is equally important as any	10	2.79	7	1.96	17	4.75	135	37.71	189	52.79
Documentation s ensures continuity of care	6	1.68	9	2.51	8	2.23	129	36.03	206	57.54
Documentation importance to other health care	8	2.23	4	1.12	8	2.23	136	37.99	202	56.42
Nursing documentation enhances the exchange of information	7	1.96	8	2.23	6	1.68	110	30.73	227	63.41
Nursing documentation improves the interaction between medical	8	2.23	6	1.68	11	3.07	119	33.24	214	59.78
Documentation serves to show the workload and tasks performed	9	2.51	11	3.07	15	4.19	113	31.56	210	58.66
Nursing documentation has a positive impact on patient safety	2	0.56	8	2.23	13	3.63	115	32.12	220	61.45
A well-written report can replace an oral shift report	5	1.40	12	3.35	13	3.63	113	31.56	215	60.06
Documentation makes nurses work visible	7	1.96	7	1.96	7	1.96	129	36.03	208	58.10
Nursing documentation helps nurses gain sufficient knowledge	5	1.40	8	2.23	11	3.07	118	32.96	216	60.34
Nursing documentation makes patients hospital discharge go	8	2.23	5	1.40	11	3.07	126	35.20	208	58.10
Many benefits can be derived from the use of documentation	8	2.23	7	1.96	11	3.07	120	33.52	212	59.22

As displayed in figure 6, One hundred thirty-seven (38.27%) of the study subjects were scored as having unfavorable attitude, and the rest 221 (61.73%) of the study participants having favorable attitude.

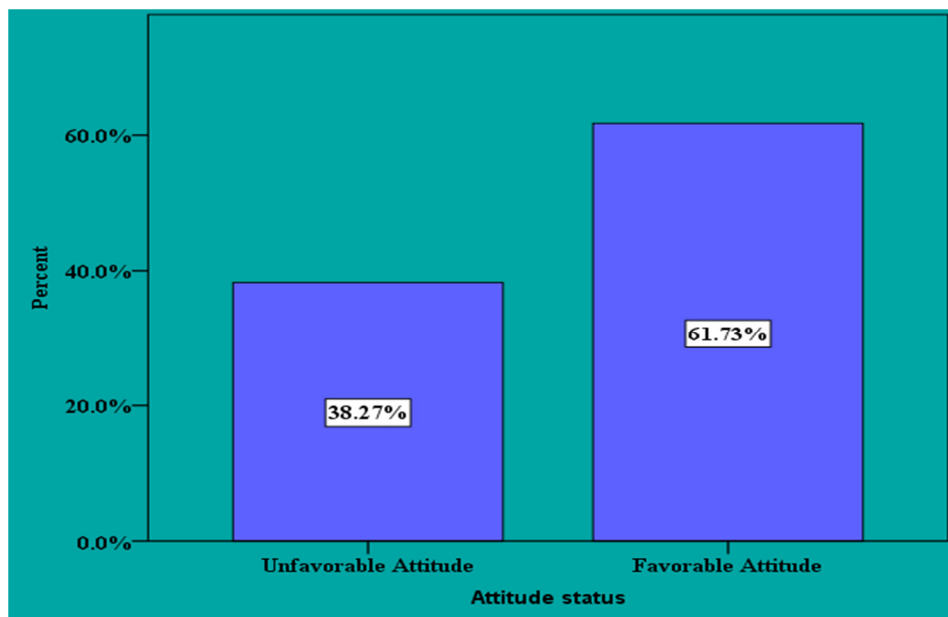


Figure 5: Attitudes of nurses towards nursing documentation in public hospital, Addis Ababa

5.6. Associated factors

Bi variable analysis was carried out to correlate the nurse documentation practice to independent variables. At first, each variable was separately entered in a binary logistic regression model then, variables that had a $p < 0.20$ were selected for multivariate logistic regression analysis.

In *bi variate* analysis, variables which were found to have an association with documentation practice were Age in years, educational background, work experience, guidelines availability, documentation time, knowledge, and attitude.

Multi-variable logistic regression was also carried out to detect the independent effect of the variables by controlling the confounding effect of other variables. In view of that, two variables were found to have association with documentation practice at p value less than 0.05. These variables were knowledge and attitude of nurses.

Intensive care unit nurses who had good knowledge were 1.63 times more likely to develop good practice compared to nurses who had poor knowledge (AOR= 1.63;95%CI: 1.04, 2.54).

Similarly, the odds of having good practice among intensive care unit nurses who had favorable attitude was 2.30 times the odds of nurses with unfavorable attitude (AOR= 2.30;95%CI: 1.47, 3.58).

Table 6: Factors associated with nursing documentation practice among nurses working in ICU in public hospital in AddisAbaba (n=358)

Variables	Category	COR(95%CI)	AOR(95%CI)	P-value
Age in years	21-24	1.00		
	25-30	4.36(0.83, 22.88)	3.80(.61, 23.86)	0.154
	31-34	3.37(0.60, 18.94)	3.20(.47, 21.71)	0.233
	≥35	3.46(0.58, 20.70)	4.03(.55, 29.71)	0.172
Education	Diploma	5.45(0.53, 55.80)	4.40(.34, 56.21)	0.255
	Degree	2.29(1.02, 5.15)	1.63(.61, 4.35)	0.329
	MSC	1.00		
Experience	≤3	1.00		
	4-7	0.56(0.31, 1.01)	.77(.39, 1.53)	0.456
	≥8	0.56(0.16, 1.99)	.84(.19, 3.67)	0.813
Guidelines Availability	Yes	0.50(0.29, 0.88)	.72(.38, 1.40)	0.335
	No	1.00		
When you document	Any time when convenient	2.10(0.87, 5.07)	1.48(.58, 3.80)	0.411
	Soon after care finished	2.27(0.94, 5.48)	1.43(.56, 3.68)	0.453
	At the end of shift hours	1.00		
Knowledge	Poor	1.00		
	Good	1.69(1.09, 2.62)	1.63(1.04, 2.54)	0.033*
Attitude	Unfavorable	1.00		
	Favorable	2.35(1.51, 3.65)	2.30(1.47, 3.58)	<0.001*

Keys: 1.00 indicates reference category; * significance at p-value < 0.05

6. DISCUSSION

The main purpose of this cross-sectional study was to investigate nursing documentation practice and associated factors among intensive care unit nurses in public hospitals of Addis Ababa, Ethiopia.

The findings of this study showed that 61.45% of the study respondents had good practice. This finding is higher than a study conducted in the United Kingdom (47.3%) (14) and Iraq (49.3%) (15), the reason might be the study area and the study design. The result of this study agrees with the study conducted in Jimma, Ethiopia, demonstrating that 51.4% of nursing documentation practice was poor among nurses (24) and a study conducted in Harari and Dire Dawa indicates nursing documentation practice was (47.5%) (25). Similarly, our study finding is higher than that of a study finding by West Gojjam, which reveals that 47.5% of nurses had good documentation practice (28).the discrepancies might be arise due to study design, the study population, the study area and time.

The result of this study shows that knowledge of intensive care towards practice nursing care documentation was good (62.01%). In the current study, nurses who had good knowledge regarding documentation are 1.63 times more likely to have good nursing documentation practice as compared to those who have poor knowledge. This finding is in line with the studies from Uganda (23) and the United States (5). This can possibly be explained with the following: good knowledge of nursing care documentation improves familiarity with documentation guidelines and manuals and enhances the adherence to standardized nursing practice, and nursing professionalism.

Regarding Attitude, 61.73% of the intensive care unit nurse having favorable attitude. Nurses who had a good attitude towards nursing care documentation were also 2.30 times more likely to have good documentation practice compared to those who had a poor attitude. This observation is consistent with study results from Sweden (33). This could be due to the fact that good attitude towards nursing care documentation enhances motivation of nurses to document nursing care. Additionally, nurses may learn to appreciate the value of documentation in the care process of patients.

7. Conclusion and Recommendations

7.1. Conclusion

This study revealed that nursing care documentation practice was good (61.45%) among intensive care unit nurses. The knowledge and attitude of intensive care unit nurses toward nursing documentation were the only factors associated with nursing care documentation practice.

7.2. Recommendation

Nursing documentation is a very important aspect of professional practice to nurses. Based on the finding of this study, the following recommendations are forwarded for:

The researcher suggests to the hospitals or health facilities to improve nurse's knowledge, attitude and documentation practice skill by different mechanism like training, sharing experience with other hospital and give short term course.

Strength

In this study pre-tested questionnaire was used

8. Limitation of the stud

The study design for this study was cross-sectional which did not illustrate the case and effect relationship between independent and dependant variable.

This study was done in Addis Ababa public hospital which might be not Represent entire hospital in Ethiopia.

Structural self-administer questionnaire it is always subjected to respondents response bias.

Reference

1. Kebede M, Endris Y, Zegeye DT. Nursing care documentation practice: The unfinished task of nursing care in the University of Gondar Hospital. *Inform Health Soc Care*. 2017 Sep; 42(3):290-302. doi: 10.1080/17538157.2016.1252766. Epub 2016 Dec 5. PMID:27918228.
2. Wang N, Hailey D, Yu P. Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review. *J Adv Nurs*. 2011 Sep;67(9):1858-75. doi: 10.1111/j.1365-2648.2011.05634.x. Epub 2011 Apr 6. PMID:21466578.
3. MACHUDO, Sabo Y; MOHIDIN, Sharifah. Nursing Documentation Project at Teaching Hospital in KSA. *International Journal of Research in Science*, [S.l.], v. 1, n. 1, p. 4-7, june 2015. ISSN 2412-4389.
4. Avoka Asamani J, Delasi Amenorpe F, Babanawo F, Maria Ansah Ofei A. Nursing documentation of inpatient care in eastern Ghana. *Br J Nurs*. 2014 Jan 9-22; 23(1):48-54. doi: 10.12968/bjon.2014.23.1.48. PMID:24406496.
5. The American Nurses Association (ANA) is a national professional association Nursing: Scope and Standards of Practice, Third Edition, guides nurses in the application of their professional knowledge, skills, and responsibilities. 2009
6. H Tasew · 2019 · Cited by 16 — 2014;4(1):137–44. Google Scholar. 17. Nakate G, et al. Knowledge and Attitudes of Select Ugandan Nurses towards Documentation of Patient Care.
7. 2017 American Nurses Association. Committee on Nursing Practice Standards 2017. Patricia Bowe, DNP, MS, RN. Danette Culver, MSN, APRN, ACNS-BC, CCRN.
8. Oliver JM. record keeping : self reported attitudes , knowledge and practice behaviors of nurses in selected cape town hospitals 2021
9. Elisha M. Okaisu; Florence Kalikwani; Grace Wanyana; Minette Coetzee Improving the quality of nursing documentation: An action research project scinlo south Africa vol.37 n.2 Pretoria 2014
10. Björvell, Catrin & Wredling, R & Thorell-Ekstrand, Ingrid. (2002). Long-term increase in quality of nursing documentation: Effects of a comprehensive intervention. *Scandinavian journal of caring sciences*. 16. 34-42. doi:10.1046/j.1471-6712.2002.00049.x.
11. The American Nurses Association (ANA) is a national professional association Nursing: Scope and Standards of Practice, Third Edition, guides nurses in the application of their professional knowledge, skills, and responsibilities. 2010
12. Chebor, Alex. (2013). Chelagat D, Sum T, Obel M, Chebor A, Kiptoo R and Bundotich B,

Documentation: Historical Perspectives, Purposes, Benefits and Challenges as Faced by Nurses, International Journal of Humanities and Social Science Vol. 3 No. 16 [Special Issue –August 2013] P 236-240. ISSN 2220-8488 (print) 221-0989 (online).International Journal of Humanities and Social Science. 3.236-240.

13. Taylor, Helen. (2003). an exploration of the factors that affect nurses' record keeping. British journal of nursing (Mark Allen Publishing). 12. 751-4, 756.10.12968/bjon.2003.12.12.11338.
14. Law L, Akroyd K, Burke L. Improving nurse documentation and record keeping in stoma care. Br J Nurs. 2010 Nov 25-Dec 8; 19(21):1328-32. doi: 10.12968/bjon.2010.19.21.80002. PMID:21355356
15. Jebur HG, Mohammed W. Evaluation of Nursing Staffs' Documentation Standard Related to Nursing Procedures at Medical Wards in Al-Najaf Al-Ashraf Governorate. J Kufa Nurs Sci.2017;
16. Taiye BH. Knowledge and practice of documentation in Ahmadu Bella University Teaching hospital9Abth) Zaria, Kaduna State. IOSR Journal of Nursing and Health Science.2015;4(6):1-6.
17. Vital Wave Consulting. Health information systems in developing countries, in a landscape analysis; 2009. P.69–70.
18. admasu. Documentation_Practice_and_associated_factors_amongNurses_Working_at_JUMC
19. Mutshatshi, T. E., Mothiba, T. M., Mamogobo, P. M., & Mbombi, M. O. (2018). Record-keeping: Challenges experienced by nurses in selected public hospitals. Curationis, 41(1),e1–e6.
20. Gugerty, Brian & Maranda, Michael & Beachley, Mary & Navarro, VB & Newbold, Susan & Hawk, W & Karp, J & Koszalka, M & Morrison, S & Poe, Stephanie & Wilhelm, D. (2007). Challenges and Opportunities in Documentation of Nursing Care ofPatients.
21. Joint Commission Center for Transforming Healthcare releases targeted solutions tool for hand-off communications. Jt Comm Perspect. 2012 Aug; 32(8):1, 3. PMID:22928243.
22. Alhawri, Fouad & Rampal, Krishna Gopal & Abdulla, Abdelkodose. (2021). Knowledge, Attitude, Performance, and Associated Factors Towards Nursing Documentation Among Nurses in Public Hospitals, Sana'a City, Yemen.
23. Nakate, G. & Dahl, D. & Drake, K.B. & Petrucka, Pammla. (2015). Knowledge and Attitudes of Select Ugandan Nurses towards Documentation of Patient Care. African Journal of Nursing and Midwifery. 2.56-65.
24. Gizaw, Admasu. (2018). Documentation Practice and associated factors among Nurses Working at JUMC
25. TamirT,GedaB,MengistieB.DocumentationPracticeandAssociatedFactorsAmongNursesin

Harari Regional State and Dire Dawa Administration Governmental Hospitals, Eastern Ethiopia. *Adv Med Educ Pract.*2021;12:453-462

26. Blair W, Smith B. Nursing documentation: frameworks and barriers. *Contemp Nurse.* 2012 Jun;41(2):160-8. doi: 10.5172/conu.2012.41.2.160. PMID:22800381.
27. Collins SA, Cato K, Albers D, Scott K, Stetson PD, Bakken S, Vawdrey DK. Relationship between nursing documentation and patients' mortality. *Am J Crit Care.* 2013 Jul;22(4):306-13. doi: 10.4037/ajcc2013426. PMID: 23817819; PMCID:PMC3771321.
28. Atsedemariam A., Tarekegn A., Mezinew S., Tiliksew L., Afework E., Bekalu B.and Mihretie G.: Knowledge, attitude, practice and associated factors towards nursing care documentation among nurses in West Gojjam Zone public hospitals, Amhara Ethiopia, *Clinical Journal of Nursing Care and Practice*:2018
29. Yeung MS, Lapinsky SE, Granton JT, Doran DM, Cafazzo JA. Examining nursing vital signs documentation workflow: barriers and opportunities in general internal medicine units. *J Clin Nurs.* 2012 Apr;21(7-8):975-82. doi: 10.1111/j.1365-2702.2011.03937.x. Epub 2012 Jan 14. PMID: 22243491.
30. Prideaux, Antony. (2011). Issues in nursing documentation and record-keeping practice. *British journal of nursing* (Mark Allen Publishing). 20. 1450-4.10.12968/bjon.2011.20.22.1450.
31. Petkovšek-Gregorin R, Skela-Savič B. Nurses' perceptions and attitudes towards documentation in nursing. *Obzornik zdravstvene nege.* 2015 Jun27;49(2).
32. AyeleS,GobenaT,BirhanuS,YadetaTA.AttitudeTowardsDocumentation and Its Associated Factors Among Nurses Working in Public Hospitalsof Hawassa CityAdministration,SouthernEthiopia.SAGEOpenNurs.
33. Ehnfors M. Nursing documentation practice on 153 hospital wards in Sweden as described by nurses. *Scand J Caring Sci.* 1993;7(4):201-7. doi: 10.1111/j.1471-6712.1993.tb00204.x. PMID: 8108624.

Annex

Consent form

In signing this document, I am giving my consent to participate in the study entitled documentation practice and associated factors among nurses working in intensive care unit of at public hospitals in Addis Ababa". I have been informed that the purpose of this study is to assess documentation practice and associated factors among nurses working in intensive care units I have understood that participation in this study is entirely voluntarily and my participation or refusal to answer the questions will have no effect on me. I have been told that my answers to the questions or reports of this study will never identify me in any way. I understood that Alehegn kerebign is the contact person if I have questions about the study or about my rights as a study participant. I also know that the address of the principal investigator is: Alehegn kerebign mobile number + 251 911969987(Email:Alehegnkerebign@mail

I here approve my consent to take part in the study with my

signature. Signature.....

Date.....

Questioners

Part I: Socio demographic characteristics of ICU nurses about nursing documentation practice

Instruction- Please read the following statements carefully and put a check mark on the option if you

Socio-demographic characteristics

1. Age A.21-24 B.25-30 C.31-34 D. ≥ 35
2. Sex A. Male B. Female
3. Educational level A. diploma B. degree C.msc
4. Work experience in ICU A. ≤ 3 B. 4-7 C. ≥ 8
5. Current working ICU hospital _____

Part II: Associated factors

1. Have you taken In-service training regarding on documentation
A. Yes B.No
2. If say yes when you take the training _____
3. Average number of patients to nurse ratio in the unit _____
4. Is there guidelines Availability regarding to documentation
A. Yes (should be seen by the data collector)
B. No
5. If say yes on question No 4 Have you familiar with the standards of the guidelines
A. Yes B.No
6. Is there enough Documenting sheet in the unit
A. Yes B.No
7. Have you took Motivation from head nurse to the documentation
A. Yes B.No
8. When you document
A. Any time when convenient
B. soon after care finished
C. At the end of shift hours

Data collection sheet III.
Observational checklist for nurse's practices on documentation practice

Instruction- Please read the following statements carefully. If you see perform the given tasks on the table by the observed nurse put a check mark using (√) or (x) on the option.

S.N	Activity	Response		
		Yes	No	Remark
1.	Document Nursing documentation for every patient?			
2.	Document subjective data			
3.	Document objective data			
4.	Document significant communication with family members /significant others, substitute decision makers			
5.	Document any advocacy that was undertaken on the patients' behalf			
6.	Document legibly when using paper documentation forms			
7.	Document advice, care or services provided to an individual within a group, communities or populations (for example, group education sessions)			
8.	Document informed consent for treatments or interventions performed			
9.	Complete documentation in timely manner - during, or as soon as possible after, the care or event			
10.	Document the date and time that care was provided and when it was recorded			
11.	Never delete, alter or modify anyone else's documentation			
12.	Document her/ his own observations and actions			
13.	Refrain from co-signing entries unless agency policy clearly dictates the reason for the cosignatories			
	Total score			

Question to assess Knowledge of nursing Documentation among Nurses working intensive care unit in Public Hospitals of AddisAbaba

1. Nursing care should be documented according to guidelines
 - A. Yes
 - B. No
2. The principles needed to be followed while documenting. (more than one answer is possible)
 - A. Error-free
 - B. Complete
 - C. Easily readable
 - D. Chronological
3. The advantages of patient care documentation (more than one answer is possible)
 - A. To improve the quality of care
 - B. For better communication with staffs
 - C. For education and research
 - D. For legal protection
 - E. For Health planning
4. The main nursing activities that you are expected to document. (more than one answer is possible)
 - A. Assessment data
 - B. Progress of patients
 - C. Transfer and discharge of Patients
 - D. Care provided and evaluation
5. The potential consequences of inadequate documentation. (more than one answer is possible).
 - A. Possible imprisonment.
 - B. Poor development of the nursing profession
 - B. Loss of salary increment(demotion)
6. The effects of using non-standard abbreviations while documenting patient care. (more than one answer is possible)
 - A. Leads to errors
 - B. Wastes time
 - C. Causes confusion

7. Actions of documentation that protects you from legal suit. (more than one answer is possible)
 - A. Documenting the date and time of care
 - B. Recording only what you saw or did
 - C. Recording in a chronological order
 - D. Make any corrections clearly
8. The components of documenting medication administration. (more than one answer is possible)
 - A. Name of medications
 - B. Date and time of medications
 - C. Routes and dosage of medications
 - D. Nurses name and signature
9. Responsible person to document the care provided to a patient
 - A. An individual who has observed the care.
 - B. A colleague who has assisted the care.
 - C. The same individual who provided the care.

Question to assess attitude of nursing Documentation among Nurses working ICU in public hospital
Strongly agree (5), Agree (4), Neutral (3), Disagree (2), strongly disagree (1)

Please read the following statements carefully and check mark using (√) or (x) on the option.

Son	Questioner	Response				
		1	2	3	4	5
1.	Nursing documentation of patient care is equally important as any other patient documentation					
2.	Documentation of nursing activities ensures the continuity of care.					
3.	Documentation may be of importance to other health care providers					
4.	Nursing documentation enhances the exchange of information between nurses during their change of shift					
5.	Nursing documentation improves the interaction between medical Team members.					
6.	Documentation serves to show the workload and tasks performed by nurses					
7.	Nursing documentation has a positive impact on patient safety					
8.	A well-written report can replace an oral shift report					
9.	Documentation makes nurses' work visible					
10.	Nursing documentation helps nurses gain sufficient knowledge about patients					
11.	Nursing documentation makes patients' hospital discharge go Smoothly.					
12.	Many benefits can be derived from the use of documentation in the everyday work of nurses					

Approval Sheet

This is to certify that the proposal entitled: - documentation practice and associated factors among nurses working in intensive care units of at public hospitals in Addis Ababa, Ethiopia, **2022**, is submitted in partial fulfillment of the MSc with specialization in Critical care nursing practitioner to Saint Paul's hospital millennium medical college, Graduate Program of the nursing directorate department of critical care nursing, and has done by Alehegn kerebign ID No: GSR/4123/12 under our supervision. Therefore, we recommend that the student has fulfilled the requirements and hence hereby can submit the thesis to the Department.

1. Name of the student: - Alehegn Kerebign

Signature:- _____

Date:- _____

2. Name of primary Advisor: - Ayalnesh Zemene

Signature:- _____

Date:- _____

3. Name of co- advisor: - Zegeye Kebede

Signature:- _____

Date:- _____

4. Thesis invigilator: Rahel Nega

Signature: - _____

Date:- _____