The Implementation of Theory of Planned Behavior in Identifying Behavioral Models of Nursing Documentation in "X" Hospital

Erna Dwi Wahyuni[1]*, Nursalam[1], Yulis Setiya Dewi[1], Amel Dawod Kamel[2]

1. Faculty of Nursing, Universitas Airlangga, Indonesia.
2. Collage of nursing, King Saud bin Abdul Aziz University for Health Science KSAU-HS-Riyad-KSA - Maternal and New Born Health, Nursing, Faculty of Nursing, Cairo University, Egypt.

Abstract

Documentation is one of the most important responsibilities of healthcare providers, including nurses. The behavior of documenting nursing care can be influenced by several factors. The objective of this study was to identify nursing care documentation behavior based on the Theory of Planned Behavior (TPB) in "X " Hospital.

This study used an explanative survey with a cross-sectional approach, at four wards of "X" Hospital. The sample was recruited using the proportional random sampling technique, consisting of 50 respondents, taken according to the inclusion criteria. Research variables were: background factors (age, sex, education, and knowledge), attitude, subjective norm, perceived behavioral control (PBC), intentions, and nursing documentation behavior. Data were collected using a structured questionnaire and observation sheet, they were analyzed using partial least squares (PLS).

The results showed that 1) attitude, subjective norm, and PBC were affected by background factors (knowledge), 2) intention was affected by PBC and attitude 3) nursing documentation behaviors were affected by the intention and PBC. The development of behavioral models of nursing documentation that originally only emphasized routine activity, attitude, and intentions.

So, in general, the development of the nursing documentation behavior model refers to the TPB.

Clinical article (J Int Dent Med Res 2021; 14(4): 1694-1700)

Keywords: Healthcare, health care quality, nursing documentation, nursing record, Theory of Planned Behavior.

Received date: 15 February 2021 **Accept date:** 06 August 2021

Introduction

Nursing documentation is an important element in nursing action because the official documentation contains all records of information about the patient, both from the results of the examination, action, and care to the treatment given to patients. Nursing documentation according to standards is still one of the problems in the nursing profession[1]. Some problems that are still found in nursing documentation are low quality, completeness, and timeliness, which have an impact on reducing the effectiveness of the documentation [2].

*Corresponding author:
Erna Dwi Wahyuni,
Faculty of Nursing-Universitas Airlangga Kampus C Mulyorejo Surabaya 60115, Indonesia.
E-mail: erna-d-w@fkp.unair.ac.id

One of these problems was found in the inpatient room at a hospital in East Java. The results of research conducted at X Hospital East Java through the observation of nursing care documents on medical records showed that the documentary action taken was still lacking. This is indicated by the incomplete documentation, especially in the section on assessment, diagnosis, intervention, and evaluation.

The factors of knowledge and motivation of nurses on the implementation of the nursing care documentation are one of the causes which the application of documentation was not perfectly done. The Nursing Unit Manager (NUM) of medical ward in "X" Hospital, in an interview conducted at the same time, said that the documentation so far has not been carried out optimally. As many as 78.6% (11 out of 14 people) nurse administrators only filled out the implementation sheet with the assumption that