Documentation of Nursing Care in Majauleng Health Centre Wajo District, Indonesia

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Abstract **- Nursing documentation is a means of communication to other health teams regarding client status. Nursing documentation is very important to convey information about client status, help nurses communicate in the results of observations, decisions, actions, and results of the actions of nurses from clients. The aim of this research is to find out the description of the application of nursing care in nursing documentation at the Majauleng Community Health Center. The research method is consecutive sampling technique, with a sample of 33 respondents at Majauleng Public Health Center, Wajo Regency, with the type of research is quantitative, the research design used is descriptive. The results obtained were the application of nursing care with good categories as many as 22 respondents (66.7%), while the application of nursing care with poor categories was 11 respondents (33.3%). Conclusion: Documentation of nursing care with the 3S approach (SDKI, SLKI, SIKI) at the Majauleng Health Centre Wajo District Indonesia, has basically been done well by 66.7%, but there are still nurses who do not understand the documentation of nursing care. So it takes a case discussion reflection to all nurses to improve their skills and knowledge in documenting nursing care. This must be supported by the availability of facilities and infrastructure such as the format of nursing care and it is hoped that the support of the Health Centre leadership in monitoring nursing care documentation is expected.**

Keywords **- Nursing care, nursing documentation, Indonesian Nursing Diagnosis Standars (SDKI), Indonesian nursing output standards (SLKI), Indonesian nursing intervenstion standards (SIKI)**

I. INTRODUCTION

Nursing services as an important part of health services need to be followed by increasing knowledge and skills, dignity and ethics of the nursing profession as mandated in article 41 of the Republic of Indonesia Law No. 38 of 2014 concerning nursing.[1]

Nursing is a form of professional service that is an integral part of health services based on nursing science and tips in the form of comprehensive/holistic biological, psychological, sociological and spiritual services aimed at individuals, families and communities who are either in a healthy or sick state that includes the entire process.[2] human life that refers to nursing as the main demand in three standard of nursing care services Indonesian Nursing Diagnosis Standard, Indonesian nursing output standards, Indonesian nursing intervention standards) which consists of assessment, diagnosis, intervention, implementation, evaluation.[3]

The application of nursing care so far refers to standard international nursing care standards such as the North American Nursing Diagnosis Association (NANDA), Nursing Intervention Classification (NIC), Nursing Outcome Classification (NOC). However, it is still not enforced in Indonesia. So that the nursing care process used in health care institutions that provide nursing services in Indonesia is diverse and requires adjustments to be used within the scope of Indonesia with a diversity of cultures, beliefs, and religions.[4]

Therefore, nursing professional organizations respond to this diversity by compiling standards of nursing care based on three standard of nursing care. The three standard of nursing care also helps nurses improve their ability to help clients achieve optimal health.[4]

The achievement of nursing care based on three standard of nursing care is one of the nurses' potentials in formulating nursing care which includes nursing assessment, diagnosis, adjustment of plans and evaluation of nursing. This is in line with the Indonesian Constitution Number 38 of 2014 concerning Nursing and the Republic of Indonesia Minister of Health Regulation Number 26 of 2019 concerning Law Regulation No. 38 of 2014 concerning Nursing. So the implementation of three standard of nursing care by Indonesian National Nursing Association Central Executive Board as a development in the application of nursing care. Nursing documentation can be a reflection of the quality of service and documentation is very important starting from assessment, diagnosis, intervention, implementation and evaluation.

Based on preliminary studies related to documentation of nursing at the Majauleng Community Health Center, it was found that out of 30 nursing care documentation, the documentation only filled 26.6% and almost all of them were incomplete, 53.3% nursing diagnosis documentation, 36.6% nursing planning documentation, 46 implementation documentation, 6%, and documentation evaluation only 30%. The Public health center Majauleng does not know about the three standard of nursing care in documenting nursing care for patients visiting the Majauleng Health Center. In addition, almost all patients did not complete their nursing care documentation and there was even a status that had no documentation at all.

Based on this description, nursing documentation is very important because good and quality documentation of the nursing care process must be accurate, complete and according to standards. If nursing activities are not documented accurately and completely, it is difficult to prove that nursing actions have been carried out correctly. The quality of nursing documentation can be seen from the completeness and accuracy of writing the nursing care process provided to patients, which includes assessment, nursing diagnosis, action plans and evaluation. .[5]

II. METHODS

This type of research is quantitative and the research design used is descriptive. The samples in this study were all nurses who served in the inpatient room with a total of 33 people at Public health center Majauleng, Wajo District, Indonesia. The sampling technique used consecutive sampling technique, which means that the sample taken was all observed subjects and fulfilled the research criteria included in the study until a certain period of time, so that the number of respondents could be fulfilled [6]. Sampling was carried out by making a direct visit to the Majauleng Community Health Center, Wajo Indonesia District. The sample is first given an explanation of the purpose of this study and is asked for approval and willingness to be involved in the sample in this study, if agreed, then continued with data collection through interviews and distributing questionnaires to the sample and observing the nurse's nursing care documentation file to the patient.

III. RESULTS

In Table 1, it is found that the most respondents are female 21 (63.6%) than male 12 (36.4%). The table below also shows that the most respondents aged 31-40 years 18 (54.5%) were greater than those aged 20-30 years 9 (27.3%). This table also shows that the respondent's education is Nurse's education, which is 13 (39.4%) higher than that of Nursing 8 (24.2%). In terms of occupation, respondents are dominated by Non government employees 21 (63.6%) compared to government employees 12 respondents (36.4%).

Table 1: Distribution of respondent characteristics

Variable	n	%
Gender		
Male	12	36.4
Female	21	63.6
Age		
20-30 years	9	27.3
31-40 years	18	54.5
41-50 years	6	18.2
Occupation		
Government employees	12	36.4
Non government employees	21	63.6
Education		
Diploma III	8	24.2
Undergraduate (S1)	12	36.4
Nurses	13	39.4

In table 2, It shows that the application of three standard of nursing care From the assessment process, nursing diagnoses, nursing planning, nursing actions and nursing evaluation, data is obtained that the description of 33 respondents (100%) conducted a nursing care assessment on clients.The nursing diagnosis also showed that of the 33 respondents who carried out the assessment there were 30 (90.9%) , which determined nursing diagnoses is greater than those who did not determine nursing diagnoses 3 (9.1%) .Data related to the formulation of nursing planning found those respondents 33 (100%) formulated the nursing action plan. Data related to nursing actions obtained that 33 respondents (100%) performed nursing actions. Data related to nursing evaluation showed that 33 respondents (100%) conducted nursing evaluations that had been given.

Table 2: Distribution of the implementation of the stages of the respondent's nursing care process

Variable	n	%
Nursing Assessment		
Yes	33	100
No	0	0
Nursing diagnosis		
Yes	30	90.9
No	3	9.1
Nursing planning		
Yes	33	100
No	0	0
Nursing Intervention		
Yes	33	100
No	0	0
Nursing Evaluation		
Yes	33	100
No	0	0

In table 3. It shows that the implementation of three standard of nursing care with an average answer to good implementation is 22 respondents (66.7%) is greater than the poor implementation of 11 (33.3%).

Table 3: Distribution of the application of the respondent's nursing care process

Variable	n	%
Good	22	66.7%
Poor	11	33.3%

IV. DISCUSSION

Nursing documentation is evidence of recording and reporting that nurses have in carrying out care records that are useful for the benefit of clients, nurses, and the health team in providing health services on the basis of accurate and complete communication in writing with the nurse's responsibilities. The quality of nursing documentation can be seen from the completeness and accuracy of writing the nursing care process provided to patients, which includes assessment, nursing diagnosis, action plans and evaluation [5].

The nursing process is a systematic method for assessing, diagnosing, planning, implementing and evaluating the condition of a patient in a healthy or sick condition so that it becomes the basis for scientific breakdown. , and form the basis of nursing practice [6]. The nursing care process so far refers to standard international nursing care standards such as the North American Nursing Diagnosis Association (NANDA), Nursing Intervention Classification (NIC), Nursing Outcome Classification (NOC). However, it is still not fully implemented in Indonesia. So that the nursing care process used in health care institutions that provide nursing services in Indonesia is diverse and requires adjustments to be used within the scope of Indonesia with a diversity of cultures, beliefs, and religions.

The application of three standard of nursing care is a benchmark that can be used as a guide in preparing nursing diagnoses, nursing outcomes and nursing interventions in providing safe, effective, and ethical nursing care. [4]

Based on the results of research on the application of the stages of the nursing care assessment process the results obtained by 33 respondents (100%) conducted an assessment of patients, this is in line with the research results obtained by Armawati Abidin (2018),[7] that nursing assessment is one of the nursing care. which contributed to a good quality of service to 88% patients. This was also confirmed by Husnul and Muhammad (2016) that in this study 33 respondents (67.2%) were obtained, indicating that nurses carried out nursing assessments to patients according to nursing care standards that could improve the quality of nursing care services.[8] However, the results of filling out the questionnaire differ from the results of the observations made, where it was found that in the Majauleng Community Health Center there was no nursing care assessment format that was filled in by the nurse, only medical resumes and the course of the disease were filled in by the doctor. The nurse took notes in the nurse's note column, but in the results of the observation of the note, the researcher did not find any notes on nursing care based on client complaints. The records of the nurses in the Majauleng Community Health Center only document the client's medication and diet. So that there is a mismatch between the results of filling out the respondent's questionnaire with the results of the researchers' observations. In addition, it was also found that there were still respondents who did not record the results of the assessment and only carried out the assessment when the client first entered the Public health center, respondents considered that the assessment was only carried out when the patient entered and did not need to carry out the assessment until he returned home.

Assessment is the basis for providing nursing care services to clients and families. The nurse conducts the assessment by recording the assessment result data in accordance with the respective assessment guidelines. The process of recording the assessment results data must be carried out by all nurses who are in charge of providing services to clients. Nurses' ignorance regarding the documentation of nursing assessment results is due to several factors, namely nurses having multiple burdens at work, lack of reward, monitoring from the leadership regarding nursing care documentation. So that this is what can lead to the unsuccessfulness of nursing care carried out.

Based on the results of research on the application of the stages of the nursing care diagnosis process, 30 respondents (90.1%) also obtained the results of determining nursing diagnoses to clients, this is in line with the research results obtained by Armawati Abidin (2018), that nursing diagnosis is one of the aspects that provides quality service. good for patients, namely 22 respondents (88.0%). [7] However, there were 3 (9.1%) respondents who did not determine a nursing diagnosis. This is in line with the results of observations made, where it was found that in the Majauleng Public Health Center there was no nursing diagnosis format that was filled in by nurses, only medical diagnoses that were filled in by doctors. The nurse only documents the client's medication and diet without establishing a nursing diagnosis based on the results of the assessment performed. This is evidence that nursing care is an inseparable cycle between the stages of the nursing care process with one another and is interrelated between assessment, nursing diagnosis, action planning, implementation and nursing evaluation. Respondents in this study, most of them know the theory related to the process of determining nursing diagnosis based on the Indonesian Nursing Diagnosis Standard, respondents know the Indonesian Nursing Diagnosis Standard of professional organizations that socialize the use of 3S (SDKI, SIKI, SLKI), but there are also respondents who do not know it. The determination of nursing diagnosis at the Majauleng Community Health Center refers to the SDKI, but there are still 9.1% who do not refer to the SDKI but refer to the experiences of their respective respondents based on the education taken by the respondent. In addition, other factors that influence include the busyness of nurses, work experience (length of work), discipline and education level of nurses or nurses' perceptions of the importance of writing nursing care documentation. The stages of the nursing care diagnosis process are formulated based on the results of an assessment of client complaints.

Based on the results of research on the application of the stages of the nursing care planning process, the results

obtained by 33 respondents (100%) made plans to clients, this is in line with the results of research conducted by the Husnul & Muhammad, that nurses planning nursing care to patients according to nursing care standards can improve the quality of nursing care services.[7] Planning is the basis for providing nursing care services to patients and families. The nurse performs an action plan that is based on nursing diagnoses. However, the results of filling out the questionnaire were not in line with the results of observations, where it was found that in the Majauleng Community Health Center there was no nursing planning format that was filled in by the nurse. The nurse made notes in the nurse's note column, but in the results of the observation of the note, the researcher did not find any nursing care planning records based on client complaints. The nurse only documents the client's medication and diet without establishing a nursing plan based on the formulated nursing diagnoses.

Basically, respondents have made a nursing plan that refers to the Indonesian nursing output standards, by 33 (100%) but the documentation of nursing planning is not optimal, due toas factors suchnurses 'busyness, work experience (length of work), discipline or level of education of nurses or nurses' perceptions of the importance of writing nursing care documentation.

Based on the results of research on the application of the stages of the nursing care Intervention process, the results obtained by 33 respondents (100%) carried out nursing intervention to clients, this is in line with the results of research obtained by Armawati Abidin (2018), that nursing planning is one of the nursing care that contributes to intervention quality good service to patients (88.0%). The process of recording data on the results of these actions must be carried out by all nurses who are in charge of providing services to patients. However, this is different from the results of the action which show that there is still 1 respondent (3.0%) out of 33 respondents who did not take action referring to the nursing plan that had been made because the officer did not know the nursing care procedure. In addition, there are many factors that cause nurses to not pay attention to client nursing care, including the officers having multiple burdens at work, monitoring from the leadership regarding nursing care documentation.

Nursing evaluation is a continuous process that is important to ensure the quality and consistency of nursing actions taken and the effectiveness of the nursing plan in meeting the client's wholeness. There are three important components in nursing evaluation, namely, review, modification of nursing plans and termination of services[10].

Based on the results of research on the application of the stages of the nursing care evaluation process, the results obtained by 33 respondents (100%) conducted evaluations to clients, this is in line with the results of research obtained by Armawati Abidin (2018), that nursing evaluation is one of the nursing services that contributes to service quality good for patients (88.0%). This was also confirmed by Husnul and Muhammad (2016) that in the study, 33 respondents (77.6%) showed that nurses carried out nursing evaluations to patients in accordance with nursing care standards that could improve the quality of nursing care well. Evaluation is the basis for describing nursing care services for patients and families. The nurse evaluates by recording the outcome data in accordance with the guidelines. The process of recording the results of the evaluation must be carried out by all nurses who are in charge of providing services to patient nurses. However, this is different from the results of the evaluation which show that there is still 1 respondent (3.0%) out of 33 respondents who did not make observations to clients, because the nurses did not know the nursing care procedures. In addition, there are many factors that cause nurses to not pay attention to patient nursing care, including the nurses having multiple burdens at work, the absence of reward, monitoring from the leadership who is related to documenting nursing care.

In the aspect assessed in the evaluation, the results obtained from the data were reviewed by nurses observing client responds to formative nursing actions as many as 32 respondents (97.0%), while those who did not observe client responds to formative nursing actions were 1 respondent (3.0%).

From the results of these observations, the researcher stated that in the Majauleng Community Health Center there was no nursing care evaluation format that was filled in by nurses, only medical resumes and disease courses that were filled in by doctors. The nurse recorded in the nurse's note column, but in the results of the observation of the note, the researcher did not find any nursing care evaluation records. The records of nurses at the Majauleng Health Center only document the patient's medication and diet, all of which show a lack of motivation and knowledge of nurses in carrying out nursing care for various reasons.

Based on the stages of the nursing care process starting from assessment, nursing diagnosis, action planning, intervention to evaluation, the implementation of nursing care at Majauleng health centers was 21 (66.7%) good and 11 (33.3%) less good according to Distribution of the application of the respondent's nursing care process. This is because the implementation of the respondent has carried out the stages of the nursing care process properly but it is not quite right because it is not supported by the nursing care format. The implementation of nursing care based on the three standard of nursing care (Indonesian Nursing Diagnosis Standard, Indonesian nursing output standards, Indonesian nursing intervention standards) has been known and implemented but the documentation of the stages of the nursing process is not optimal. This requires leadership support and monitoring for nurses so that they are motivated to carry out the duties of nurses appropriately and correctly. There are several factors that cause the implementation of nursing care to be poor, including nurses 'busyness, work experience (length of work), discipline and

education level of nurses or nurses' perceptions of the importance of writing nursing care documentation.

V. CONCLUSION

Documentation of nursing care with the 3S approach (SDKI, SLKI, SIKI) at the Majauleng Health Centre Wajo District Indonesia has basically been done well by 66.7%, but there are still nurses who do not understand the documentation of nursing care. So it takes a case discussion reflection to all nurses to improve their skills and knowledge in documenting nursing care. This must be supported by the availability of facilities and infrastructure such as the format of nursing care and it is hoped that the support of the puskesmas leadership in monitoring nursing care documentation is expected. The hope is that nurses can document nursing care to clients and families in a comprehensive and holistic manner as a form of implementation of the main duties and functions of a nurse in providing nursing services.

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