THE EVALUATION OF THE DOCUMENTATION OF COMMUNITY NURSING CARE

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ABSTRACT

Introduction. Community nursing care is a professional nursing service that aims to the society in improving the optimal healthy level. The characteristics of the care are very complex because it consists of individual elements, family, community, and society comprehensively. Practically, this care often faces some challenges in the process of recording and the report, especially the care done by nursing students. The research aims to evaluate community nursing care documentation including some factors: analysis, the diagnosis of nursing, act, and evaluation. **Method**. The research design is descriptive analysis by using case study approach. The data collection through the study of nursing care document was conducted by the students of Study Program of Nursing Faculty of Health Sciences Universitas Muhammadiyah Jember that is conducted in Klungkung, Sukorambi Jember from January 5th to March 14th, 2015. Data analysis of the research is a kind of narrative-qualitative research. The result of the research shows that the data resuted from accurate and empirical analysis, but not complete, and not well-organized. The process of classifying the data, determining the problems and the causes, while the diagnosis of nursing is not standardized according the diagnosis of nursing NANDA. **Result**. The identification of the problems identified does not fully represent six aggregate in the community nursing and yet, it does not show the problems happened in six primary programs of health center comprehensively. The priority determination of the problems of nursing by using MUEKE standard that consists of 12 points with 1-4 range. There was no determination of the objectives and the indicators of success, so the strategy of research design cannot confirm its relevancy with the objectives of the research. The impelemntation of the act of nursing did not confirm the systematical of cronological time, but it tend to the report based on incidental activity. The absence of the indicators of succes made the evaluation of nursing focuses on purpose of the act and it did not confirm measurement and analysis for the objectives of the research. **Conclusion**. The recommendation of the research needs to provide a guideline for the documentation of comprehensive and standarded community nursing care.

Keywords: Documentation; Care; Nursing; Community

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INTRODUCTION

The research conducetd by Rohmah, Hamid, Walid, (2013) confirmed that score of clinic study processes are: 50% poor, 31,25% enough, 18,75% good, and 0% very good. The result of the application of clinic study showed there was an improvement on the result study with the range of 4,16-10,25 points.

Beside studying in clinic area (hospital) the students of nursing also practiced in a community. The practice in the community are was used to reach the competence of community nursing., family nursing, group nursing, *gerontic* nursing, and community mental nursing. Community nursing care is a to the society in improving the optimal healthy level. The characteristics of the care are very complex because it consists of individual elements, family, community, and society comprehensively. Practically, Practically, this care often faced some challenges in the process of recording and the report, especially the care done by nursing students. The challenges were caused by some of the factors while the process of studying and teaching in the area of community, such as: (1) the minimum number of supervision, (2) the lack of 'role model' as the determination of nursing professionalism in the community, (3) the uncertainty of the competence led the role of the practice to be bias, and (4) the uncertainty of jobdesk system and the overlaps with the competence of *gerontic*/ family /mental nursing.

Recording and reporting the nursing care is a written evidence about the care that had been implemented. Although the care given to the society was considered 'good', it would not ensure the quality if it did not supported by an appropriate care documentation. The steps of nursing process approach that had been implemented, the result that had been reached, the responses of society toward the care system, and the continuing care plans could not be indicated either from the quality or the quantity objectively if the care document did not arrange based on standard of the raw nursing care.

RESEARCH METHOD

The research design used in this research was descriptive analysis by using case study approach. The population was the villagers of Klungkung, Sukorambi Jember. The sample was chosen in cluster. The data collection through document study of community nursing care was conducted by the students of Study Program of Nursing Faculty of Health Sciences Universitas Muhammadiyah Jember. Whereas the case study was applied in the form of giving community nursing care in Klungkung, Sukorambi Jember from January 5th to March 14th, 2015.

FINDING AND DISCUSSION

A. Document Analysis

The result of documentation of community nursing analysis was conducted in some dimensions, such as: 1) village dmension, 2) demographic data, 3) social-economical data, 4) environmental data, 5) health facilities, 6) pregnant woman, 7) toddlers, 8) children and teenagers, 9) elderly people.

The finding showed that the document analysis of community nursing was complete and well-orgaized yet. Further, Hadarani, 2012 said that the main problem of the documentation of community nurisng care is the lack of the completion of documentation itself (54,29%). The solution applied in thedocumentation of community nursing care is the use of checklist model.

Generally, the documentation should include the factors of demographic data, observation result/windshield survey, environmental data, and aggregate data. Windshield survey aimed to find out the data of general area to identify nature, and housing condition in society, road infrastructure, bridge, road lamp, the

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availabilty of the function and industry facilities, location, condition, and public area usage, the number of activities on road, noise level in all parts of society, the number nd the movement of traffic, the location and the condition of public buildings. Whereas the documentation based on aggregate data included: Fertile couples, pregnant-breastfeeding mothers, toddllers, teaangers, adult, elderly people. Each of them had specific characteristics based on the level of their development.

B. The Documentation of Community Nursing Diagnosis

The analitical process of the research included: the determination of nursing problems, the determination of correlation problems, rationa, and data. The determination of nursing diagnostic formula did not lie in specific form. Diagnostic statement is a kind of general in using one diagnostic statement (problem only), but the diagnostic redaction sis not use the statement of NANDA.

The documentation of nursing diagnosis was generaly following the stabdard problem (P) related to etiology (E) that was marked by symptoms (S). The standard of documantation can also be exemplified based on the types: actual (PES), risk/hogh rish (PE), possibility (PE), syndrome (P), healthy/prosperous (P), colaborative factor (P). Whereas the requirements are 1) based on the data analysis, and 2) comprehensive factor that met thee needs of patients (Stolte, K.M. 2004; Iyer, P W. And Camp, N. H. 2005; Rohmah, N. 2009; Rohmah, N dan Walid, S. 2009).

Based on the process of data analysis, the arrangement of the documentation of community nursing care seemed less systematic, because the process of determining the problems had been conducted before classifying supporting data. It would risk to the problems of non-based data arragement and or, the chosen data was not trusted data. The general diagnostic statement showed the lack of standardization that became the reference and particuar form that provided the diagnostic list of community nursing. These two factors could be so because the identity of nursing that showed the accuracy nurse in making decision then could not be assessed specifically. The use of diagnostic redaction in one part of the problem did not basically break the regualation, but there was some of the lack factors: uncertainty factor that was claimed to be the cause and major data marking the occurence of the problems. The impacts of the problems could be seen if there was nearly the same, e.g., ineffectiveness of health care and management that generated the students not to understand certainly the differences of both diagnosis, either on the definition, the cause, or the signs and symptoms. Thus, in order to reach the aim of the study of writing nursing diagnosis, it was still needed to use the three factors (P-E-S).

C. The Documentation of Act Plans of Community Nursing

The documentation on stage of act plans are: nursing diagnosis and the plans. The documentation was begun from the analysis of problems by using 12 considerative points MUEKE with the range of values 1-4. It was then continued by implementing the plans of community nursing without the determination of goal and the criteria of the result at first. The act of plans used active form rather than instruction ones, so it tend to the previous activities that had been done. There were two types of documented activities, health education and cooperation, monitoring activity and evaluation, monitoring activity of cross program, and undetermined referrals.

According to Iyer, P W. And Camp, N. H. 2005 ; Rohmah, N. 2009 ; Rohmah, N dan

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Walid, S. 2009, the components in the documentation of act plans of nursing are: the priority of nursing diagnosis, determining goal and result criteria, arranging plans design, and determining the ratio.

The finding showed that there were no components of the urgency of documentation on goal determination. Generally, nursing process approach is an approach based on the problems with 'problem solving' point. Any kind of the problems found during the process of caring clients are determining the goal and the indicators of success. The goal is the direction determining the things should be planned, and how are the steps? The act plans will not meet the achievement without the presence of goal. If it is seen from the use of active form, then it should be more appropriate by using instructive sentences to show the pointed strategies either from the compiler or the member of team included in the care system.

The type completion of nursing act plan is still thought to be able to meet the cooperation between cross program and cross sector comprehensively, society empowerment through the improvement of their active participation in health issues, and monitoring activity and care evaluation. Perception generated by the documentation of act plans confirmed that the strategies to overcome the problems of community nursing aimed to the community education incidentally and minamally. The strategies of reconstructing the documentation was still superficial, so the society change tend to be impermanent and the continuing behavior change became a habit that would be hard to do.

D. The Impelementation of the Act of Community Nursing

Report activity of the implementation of the act of community nursing was recorded from the analitical activities until the evaluation. It did not only record the activities based on the plans result, but also record other avtivities: *Musyawarah Masyarakat Desa (MMD) I* for getting the whole data from every single family, the profile of Klungkung, and the health issues happened in every urban. Further, MMD II functioned to determine the priority of problems and act plans of nursing, then it was formed into a group based on the issue that relate to it. MMD III and MMD IV had been implemented, but they were not supported by strong documentation.

The components of the implementable documentation included: ethic, competence, fulfillling the needs of patients, and fulfilling family advocacy (Rohmah, 2014). Aziz (2011) found the fact about the implementable documentation of the recording process of nursing care that is inaccurate toward the recorded data in the documentation of nursing care and it is found that there is a lack of documentation that has not arranged after the implementation of the act of nursing. Some factors influencing the nurse to record the process of implemenataion of nursing care are in the form of not systematic documenatation, the lack of exercise, not optimal supervision, the lack of motivation, knowledge and competence of the nurse, high level of jobdesk, limited time, and the lack of reward or achievement, clear punishment, and the lack of firm leader in the implementation of recording nursing care.

The finding also showed the different fact from that of Aziz's that the documentation of the implementation was arranged in detail that related to time, place, person, activity and result. However, not all the things written in the implementation was not fully in the form of the application of act plans, the overlaps between the activity of data collection, nursing diagnosis, plans, implementation and evaluation was also found. Problem

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solving activity was arranged into one with other activities. The implementation of community nursing act should be the application of plans design of nursing act and reflect: 1) promotive and preventive strategies; 2) cross program and cross sectoral cooperation; 3) improvement of active participation of the society in terms of health issue; 4) monitoring and the evalution of activities, and 5) referrals to health centers as the techinical executive unit to implement goverment's program in terms of health issues.

E. The Documentation of the Evaluation of Community Nursing Care

The documentation of evaluation was based on team work. It did not tend to clear goal and indicators, but rather to report the chronological activities that was then ended up with evaluation of place, participants, tools and materials.
The finding showed that the documentation of the evaluation was bias, because it was not able to confirm the comparison between the current data and the indicators of reaching the goal. Also, it was not able to confirm the goal and the overcome of the problems of nursing. Azis (2011) said that the completion in filling the documentation form of nursing care is 49,07%. Nursing record arranged by the nurse is not fully able to record the actual condition and act of nursing to the patients, so the function of nursing record cannot be used optimally.
The documentation of the evaluation of nursing is a measurable document that become the indicator of successful care and the information of the change of community behavior. The strategies needs to do is to arrange the evaluation based on the standard of documentation. Also, the evaluation of documentation process toward the change of community behavior for each activity needs to be implemented in order to reach the goal optimally.

CONCLUSION AND SUGGESTION

A. CONCLUSION

1. The documentation of the accurate and empirical analysis, but not complete and not well-organized.
2. The documentation of the process of data classification, the determination of the problems and the existing cause, while the nursing diagnosis did not meet the standard and not raw based on the nursing diagnosis NANDA. The identification of the problems sis not fully represent six aggregate in community nursing and it also did not confirm the problems happened in 6 primary program at health center generally.
3. The documentation of determining the priority problems of community nursing used MUEKE standard that consist of 12 points with the range value 1-4. The was no determination of goal and indicator of success, so the strategy of plans design was not able to confirm the relevancy and the goal optimally.
4. The documentation of the implementation of community nursing act did not confirm the chronological and systematical time, but it tend to report the incidental activity.
5. The documentation of the evaluation of nursing oriented in reaching the act goal and it did not describe the measurement and assessment of the goal because there was no certain indicator of success.

B. SUGGESTION

It is expected to provide a comprehensive and standard documentation guidelines of community nursing.

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