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# The Implementation of Nursing Diagnosis Based on Indonesian Nursing Diagnosis Standard: Retrospective Study

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## ABSTRACT

Nursing documentation provides evidence of patient care quality and facilitates efficient communication between healthcare providers. Although it has been discussed extensively in various scholarly article, there is still diversity in formulating nursing diagnoses nursing documentation in Indonesia persists as a challenge. The objective of this study is to describe the implementation of nursing documentation is being implemented following Indonesian nursing diagnosis standards in the inpatient ward. A quantitative design with a retrospective approach was used, in which 225 medical records from Banda Aceh hospitals, were obtained and assessed. The Nursing documentation were randomly selected based on hospital stay of more than 3 days. The instrument for collecting the data from the patient progress notes used an observations form. The data were analysed using univariate statistics. The results revealed that the implementation of nursing documentation following Indonesian nursing diagnosis standards in the inpatient ward was sufficient category (54.7%). The continuous direction, control, and evaluation of nursing activities and documentation should be done by a nurse manager. It is important to maintain good quality in nursing activities to enhance patient satisfaction, safety, and cost-effectiveness photoaging.

***Keywords:*** Nursing Documentation, Nursing Diagnosis, Indonesian

## INTRODUCTION

Nursing activities are crucial within the hospital and must address the issues that the patient requires. Nursing activities should result in documentation that demonstrates critical thinking. Clear and accurate nursing documents ensure optimal inter-professional communication and evaluation of nursing care [1]. One of the most significant ways nurses can demonstrate their performance is through documentation. Nursing care documentation uses a nursing process approach that consists of the stages of assessment, diagnosis, planning, implementation, and evaluation. It is a scientific method for solving nursing problems and improving the expected results for patients [2]. Effective documentation helps ensure continuity of care, saves time, and minimizes the risk of errors [3].

Nursing assessment and diagnosis are parts of the process in nursing science that allow nurses to solve patient problems. However, if the method does not work effectively, the purpose of the nursing process is not achieved. One reason is that the assessment

form and the nursing diagnosis are not integrated, which can reduce the effectiveness of the nursing intervention [4].

A nursing diagnosis is a clinical judgment about an individual, family, or community response to actual or potential health problems. [5]. Nursing diagnosis can provide the basis for the proper intervention. As a part of the nursing obligation, nurses should be competent in assessment and diagnosis procedures. The important nursing diagnosis formula used to identify a complex problem involves investigating the problem etiology and describing signs and symptoms. Nursing diagnosis encompasses actual nursing diagnosis, risk analysis, and identification of syndromes [6, 7].

Nevertheless, there is a lack of evidence showing that nursing diagnosis yield better patient or organizational outcomes [8]. If nursing diagnosis were shown to be related to a set of outcomes in different settings, their attribution and documentation may become more important for clinical and organizational purposes, and they could assume a strategic role for clinicians and administrators [9]. A study in Indonesia found that prospective nurses' knowledge about nursing documentation according to SNARS at the nursing diagnosis stage was in the poor category (65.8%) [10]. Apart from that, minimal nursing resources and lack of compliance are one of the triggers for the low quality of nursing care documentation. This has an impact on incomplete documentation at the diagnosis stage[11].

Nurses need to be evaluated for their nursing documentation due to the presence of variations and errors. The nurse's documentation abilities are influenced by their knowledge, skills, expertise, and special training or education. Nursing documents are designed to serve as a guide for nurses in carrying out nursing services and meeting legal accountability and responsibility. In addition, nurses must be granted greater autonomy in providing healthcare services, enhanced intraprofessional communication, and enhanced quality of care [12].

## METHOD

A quantitative design with a retrospective approach was used, in which 225 medical records from Banda Aceh hospitals, were obtained and assessed. The Nursing documentation were randomly selected based on hospital stay of more than 3 days. The instrument for collecting the data from the patient progress notes used an observations form. The data were analysed using univariate statistics.

## FINDINGS

A total of 225 medical records for patients who had been hospitalized for more than 3 days in the medical surgical ward were obtained and analyzed. Data were obtained from the documentation completed by nurses while providing nursing care for each patient. The demographic data showed that 107 (47.6%) respondents were ranging from 26 to 35 years old, and in most of them, 139 (61.8%) were male. The majority of patients were treated for one to five days, with 168 respondents (74.7%), according to their length of stay. The results are presented in Table 1 below.

**Table 1. Distribution of Demographic Data**

| Characteristics | f | % |
|---|---|---|
| Gender | | |
| Male | 139 | 61.8 |
| Female | 86 | 38.2 |
| Age (years) | | |
| < 17 | 38 | 16.9 |
| 17-25 | 35 | 15.5 |
| 26-35 | 107 | 47.6 |
| 36-45 | 31 | 13.8 |
| 46-55 | 14 | 6.2 |
| Length of Stay (days) | | |
| 1-5 | 168 | 74.7 |
| 6-10 | 57 | 25.3 |

Table 2 shows that Physiological Category diagnoses were the most prevalent, with 139 diagnoses (61.8%). Furthermore, the majority of diagnoses that appeared were 127 actual diagnoses (56.6%).

**Tabel 2. Categories and Types of Diagnoses**

| Diagnosis Category | f | % |
|---|---|---|
| Physiological | 139 | 61,8 |
| Psychological | 86 | 38,2 |
| **Types of Diagnosis** | | |
| Actual | 127 | 56,4 |
| Risk | 98 | 43,6 |

Table 3 showed that the implementation of nursing care documentation based on the Indonesian Nursing Diagnosis Standard was categorized as sufficient, with 123 nursing care documentation (54.7%).

**Tabel 3. Implementation of Nursing Documentation Based on Indonesian Nursing Diagnosis Standard**

| Implementation of Nursing Documentation | f | % |
|---|---|---|
| Good | 102 | 45,3 |
| Sufficient | 123 | 54,7 |

## DISCUSSION

Nursing professionals must employ a professional problem-solving approach, creativity, critical thinking skills, and a humanistic approach to describe scientifically-based nursing interventions [13]. Clinical nurses' leaders are accountable for helping nurses understand the significance of the nursing process during nursing care. Nurses are responsible for documenting all nursing process activities completed or planned in a fully documented document under supervision [1].

The research findings revealed that nursing activities to solve problems and meet patient needs during nursing care delivery were not conducted systematically, and critical thinking was not utilized in the process. Previous studies have demonstrated that the nursing process involves assessment, nursing diagnosis, planning, implementation, evaluation, and documentation [14]. The nursing process is a continuous cycle that is interconnected between its phases. The steps of this process are interconnected, interactive, and cannot be left alone.

Nursing diagnosis is established through a systematic process that involves data analysis, problem identification, and diagnosis formulation. Experienced nurses have the ability to perform this process simultaneously. In order to formulate a good nursing diagnosis, it is essential to include the problem's components, etiology, symptoms, and signs and to consider the gap between the normal health status and the patient's functional needs. However, in its implementation, it has been found that the diagnosis formulation still needs to be improved. In order to formulate a nursing diagnosis, good analytical skills are essential.

Nursing diagnoses do not involve the equipment used to implement medical therapy or the problems faced by the nurse while caring for the patient. Their focus is on health problems that can be resolved through independent nursing intervention, whether they are actual or potential. The nursing diagnosis is succinctly stated in relation to the patient's specific problems and guides the nurse in developing the nursing care plan [15]. Nursing diagnoses must be documented in clear terms with diagnostic labels. Nursing documentation encompasses etiology or related factors, signs and symptoms, or defining characteristics that will ultimately lead to the nursing intervention [6].

The results of this study also found that most nurses did not use existing nursing diagnosis standards, they made nursing diagnoses based on their assumptions and used language according to the language they understood. The use of non-standard terminology will result in disagreement in the diagnosis label which will ultimately lead to discontinuity in nursing care performed by nurses. This is even consistent with what is stated in the reference where the use of accurate labels will also increase the accuracy of nursing care [16]. Standard language will make it easier for nurses to be able to make treatment goals and intervention plans that must be done by nurses to overcome patient problems [17].

The Indonesian National Nurses Association (INNA) has developed nursing service standards that are tailored to the cultural differences and distinct aspects of nursing

services in Indonesia. The Indonesian nursing diagnosis standards that were prepared require that nursing diagnoses be determined in nursing care services in all hospitals. Indonesian nursing diagnosis standards for nurses can be implemented to enhance consistency in language use for diagnosis and nursing interventions [18]. Improving nurses' knowledge and skills is essential, and it will affect the preparation of nursing Diagnoses.

## CONCLUSION

The results of the study showed that there were many ways for nurses to gain knowledge in terms of applying nursing diagnoses. In fact, most nurses in Indonesia made nursing diagnoses that were not standard. There needs to be an effort to increase Nurses' knowledge. It obtained results where there is a relationship between the levels of education and the ability of nurses to apply nursing diagnoses, where the higher the education of nurses, the higher the ability to apply nursing diagnoses in documentation. This study recommends policies to increase the level of nurse education by every nursing manager. The improvement of the nursing curriculum that initially focused on medical diagnosis should now make the nursing diagnosis the basis for the delivery of material and develop standardization for nursing language as part of an evaluation of nurses for competency achievement.

### *Declaration by Authors*

**Ethical Approval:** Not Applicable

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