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Nursing Documentation of Patients' Information at Selected Primary Health Care Facilities in Limpopo Province, South Africa: Implications for Professional Practice

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Abstract : Background: Patients' information must be complete and accurately documented in order to foster quality and continuity of care. The multidisciplinary health care members use patients' documentation to communicate about health status, preventive health services, treatment, planning and delivery of care. The purpose of this study was to determine the practice of nursing documentation of patients' information at selected Primary Health Care (PHC) facilities in Vhembe District, Limpopo Province, South Africa. Methods: The research approach adopted was qualitative while exploratory and descriptive design was used. The study was conducted at selected PHC facilities. Population included twelve professional nurses. Non-probability purposive sampling method was used to sample professional nurses who were willing to participate in the study. The criteria included participants' whose daily work and activities, involved creating, keeping and updating nursing documentation of patients' information. Qualitative data collection was through unstructured in-depth interviews until no new information emerged. Data were analysed through open–coding of, Tesch's eight steps method. Results: Following data analysis, it was found that professional nurses' had knowledge deficit related to insufficient training on updates and rendering multiple services daily had negative impact on accurate documentation of patients' information. Conclusion: The study recommended standardization of registers, books and forms used at PHC facilities, and reorganization of PHC services into open day system.

Keywords : documentation, knowledge, patient care, patient's information, training
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