Research Article

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Nursing Documents and Documentation for Patients with Heart Diseases; Could Be Made Easier

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ABSTRACT

The review article on documents and documentation for heart disease patients was conceived due to the rising prevalence of heart disease among non-communicable diseases. It highlights the need for quality nursing care through effective assessment, planning, implementation, and evaluation. Proper communication among healthcare providers, facilitated by standardized documentation, is essential for documenting patient history and care effectively. The objectives aim to expose many documents for use in the care of cardiac patients, to describe standardized documents used in the care of cardiac patients, and explore difficulties faced with accurate documentation. Information has been sourced from websites, text books, journals, and institutions of health. Results show that Standardized documents ensure that all relevant information is consistently captured, thus reducing the risk of errors and omissions. These documents include, nursing assessment sheets, intake and output charts, nursing care plans, weight monitoring sheets, discharge summaries/ reports, flow sheets, patient's progress notes, heparin administration form, digitalis/digoxin monitoring charts. It has also been revealed that algorithm sheets for vital signs, weight monitoring sheets, and flow sheets for laboratory results are important. Nursing documentation is shown to be a critical component of patient care, particularly for patients with heart diseases. The recommendations are, that continuous professional training be focused on identifying the best practices for implementing standardized documents for documentation in various healthcare settings, with a particular focus on the care of patients with heart diseases.

Keywords

Patients with heart disease, Nursing documents, Standardized documents, Patient outcomes.

Introduction

Nursing documentation is essential to nursing practice as it evidences care provided, ensures follow-up, continuity, backup, and evaluation of care [1]. Austin's work aligns with Cheevakasemsook [2], stressing the importance of clear, thorough documentation for maintaining quality care, particularly for heart disease patients where accurate records of vital signs and treatments are critical. Both studies note that fragmented systems and heavy workloads can affect documentation quality, potentially compromising patient outcomes. Documentation serves as a communication tool among healthcare providers and a crucial record for ensuring continuity of care and patient safety, especially for heart disease patients [3]. Öhlén's thesis on advanced home care nurses' practice and Ammenwerth's [4] findings highlight the importance of user acceptance in digital documentation, especially in-home care, where accurate records are key to managing complex needs. These studies emphasize that system usability and user involvement in design improve acceptance and care outcomes. Langowski's [5] discussion of online systems complements Parker and Smith's [6] insights on nursing theories, emphasizing that technology can enhance healthcare quality when integrated effectively.

Despite its importance, documentation is often seen as a burden, increasing workload and reducing time for direct patient care [7]. This review explores challenges and opportunities in nursing documentation, especially for heart disease patients, and examines the benefits of standardized documents in streamlining the process, reducing workload, and improving patient outcomes. Nursing

documents vary widely, including care records, medication charts, assessment forms, medication administration sheets, various flow charts, care plans, progress notes, incident reports, fluid balance sheets, and discharge summaries [8]. Each document ensures consistent, comprehensive, and evidence-based care, particularly in heart disease, where patients require complex, multifaceted treatment [9].

Nursing documentation plays a vital role in the effective management and care of heart disease patients, ensuring follow-up through accurate recording of health history and continuous surveillance. It guarantees continuity of care, enhances communication among healthcare providers, and supports legal compliance, ultimately improving patient safety and outcomes [10-12]. Documentation also serves as evidence of service quality, accountability, and a database for research [7,12]. Guided by scientific theories, it is central to quality care in nursing practice and requires institutional support, policies, and materials whether paper or digital for its effective implementation [13-15].

Nursing care for heart disease patients mirrors that of critically ill patients, requiring close monitoring of vital signs and ECG recordings to track myocardial function. This study emphasizes the need for concise documentation profiles to improve care quality for heart disease patients. Nursing documentation is crucial for guiding care and ensuring continuity of information within healthcare teams. However, current standards often fall short of quality benchmarks, reflecting substandard care [12,13,15]. Colucci [16] and Yancy [17] stress precise documentation of treatment responses, clinical assessments, and plans to ensure evidence-based practice and improve patient outcomes in heart disease management.

The use of standardized documents in heart disease care offers multiple advantages. These documents ensure consistent capture of relevant information, reducing errors and omissions critical in heart disease management, where accurate, timely data informs clinical decisions. Standardized documents streamline the process, reducing nurses' workload and freeing up time for direct patient care, especially in overburdened settings [3,10]. Additionally, they improve communication among healthcare providers by ensuring all team members access consistent information, minimizing misunderstandings and enhancing care alignment. This ultimately leads to better patient outcomes [7,11].

Statement of Problem

Studies worldwide have identified documentation as a major challenge in nursing practice, significantly impacting healthcare delivery. Junttila [7] notes that nurses often view documentation as burdensome, contributing to workload, burnout, and decreased job satisfaction. Simplifying and standardizing documents could alleviate this pressure, allowing more time for direct patient care. Gimenes [11] emphasizes documentation's critical role in outpatient care for heart disease patients, where incomplete records can lead to gaps in care and hinder early interventions [9]. Poor communication among healthcare professionals, a leading cause of medical errors according to the WHO [10], and inadequate documentation practices contribute to care discontinuity, delayed diagnoses, and adverse outcomes. Collins et al. [11] link documentation quality to patient mortality, with studies showing that staff shortages, heavy workloads, and poor leadership in South Africa, Uganda, Kenya, and Ghana exacerbate documentation issues [18-20]. The WHO reports that poor documentation significantly contributes to the 98,000 annual deaths from medical errors in the U.S. and the 60% death rate from poor-quality care in low- and middle-income countries [21,22]. Hence, this write up addresses the objectives as shown below:

Objectives

To explore nursing documents in the care of patients with heart disease.

To outline the process of documentation in patients with heart diseases.

To explore difficulties with documentation on patients with heart disease.

Nursing Documents

This discussion will focus on nursing documents, examining both their various types and their significance in clinical practice. Nursing documents, which include care plans, progress notes, medication records, and patient assessments, flow sheets, incidence reports, shift change reports, fluid balance charts, are standardized documents which play a crucial role in ensuring accurate communication, continuity of care, and legal accountability.

Process of Documentation on Patients with Heart Diseases

Nursing documentation has to be streamlined for coherence and comprehensive for effective communication among healthcare team members. Various documentation formats enable nurses to capture all necessary health information for identifying patient problems and meeting their needs. Parker and Smith [6] stress the importance of integrating user-friendly systems aligned with nursing practices, ensuring digital tools enhance rather than detract from nursing roles. Proper training is crucial for successful implementation. Different charting methods are essential for effective documentation:

- Narrative Notes.
- Charting By Exception (CBE)
- SOAP (IER) for subjective, objective, assessment, plan, intervention, evaluation, revision.
- PIE for problems, interventions, evaluations.
- Focus (DAR) for data, action, response [18].

Nursing frameworks like SOAPIE and ADPIE provide organized formats for documenting healthcare information, crucial for quality improvement and risk management [9,15,18]. Cardiovascular diseases (CVDs) are chronic conditions that significantly impact global mortality and disability rates [35,36]. Proper documentation of nursing interventions is essential for safe care and facilitates communication within multidisciplinary teams.

Nursing Document	Description of function
Nursing discharge summaries/reports	These are completed when a patient takes his card and is transferred to another health institution or home, where a visit from a community nurse may be required. Many institutions provide prepared summary forms. Some documentation plans combine the discharge note with care instructions and the final progress note, while others include control lists to facilitate element registration [23].
Flow sheets	Flow leaves give nurses the opportunity to register nursing data quickly and comprehensively, ensuring legible documentation of the patient's condition over time. They include diagrams for vital signs, intake/output, medication, and skin integrity, as well as charts for mobility and daily activities [24,25].
Patient's progress Notes	Progress notes written by nurses provide information regarding the progress of a patient towards desirable outcomes. They detail patient problems, nursing interventions, and vary by the institution's documentation system [26].
Shift Change Reports	Shift change reports are given to all nurses of the next shift to ensure continuous patient care, providing a summary of patient needs and care instructions. Reports can be delivered orally, in writing, or via recording, with personal communication allowing for questions. Written and recorded reports are concise, saving time and aiding in rapid identification of patient changes [27].
Incident report sheet	Joanna Briggs Institute [28] discusses nurse-led interventions to reduce cardiac risk factors in adults, emphasizing the need for accurate documentation and monitoring of patient outcomes. This underscores the broader role of documentation, including incident reports, which are crucial for identifying and analyzing adverse events, ensuring safety, and improving clinical practices [26].
Vital signs form	Björvell [29] emphasizes the significance of comprehensive nursing documentation, focusing on effective instruments for documentation. Specifically, the nursing vital sign form is crucial for tracking blood pressure, heart rate, and respiratory status in cardiovascular disease. Accurate forms aid early detection of changes, timely interventions, and enhance patient safety and treatment monitoring.
Fluid balance sheet	Johnson et al. [30] emphasize the integral role of structured nursing documentation in managing cardiovascular disease, highlighting the nursing fluid balance sheet as crucial for monitoring fluid status. Proper tracking of intake and output helps detect imbalances, supports timely interventions, and enhances patient outcomes by preventing complications and ensuring effective fluid management.
Nursing care plan	Bates' [31] guide to physical examination and history-taking emphasizes the importance of developing a detailed nursing care plan for cardiovascular disease. Such plans are crucial for assessing cardiovascular health, identifying risk factors, and implementing targeted interventions. Bates highlights the need for comprehensive patient assessments, including history taking and physical examination, to create individualized care plans. For cardiovascular disease, these plans help prioritize patient needs, monitor blood pressure, manage symptoms like chest pain, and prevent complications. They also serve as a roadmap for nursing staff and multidisciplinary teams, promoting continuity of care and improved patient outcomes.
Heparin administration form	The "Selected Skills Sheets" from Kettering College of Medical Arts [32] emphasizes the importance of accurate and detailed documentation when administering Heparin, particularly for patients with cardiovascular disease. The Heparin administration form is crucial for tracking dosage, timing, and patient response, ensuring safe and effective anticoagulant therapy. Proper completion of this form helps prevent dosing errors, monitors coagulation status, and reduces risks of complications like bleeding or thrombosis. This documentation is vital for continuity of care, supporting clinical decision-making, and enhancing patient safety in cardiovascular disease management.
Digitalis/digoxin monitoring chat	Underwood's [33] article "Demystifying Documentation" emphasizes the importance of clear and consistent documentation in long-term care settings, particularly for cardiovascular disease management. The digitalis/digoxin monitoring chart is highlighted as crucial for tracking therapeutic levels and ensuring patient safety. Given digoxin's narrow therapeutic range, careful monitoring of symptoms, serum levels, and side effects is essential to prevent toxicity. Proper use of the chart aids in documenting dosage, patient response, and adverse reactions, supporting timely treatment adjustments, enhancing provider communication, and improving patient outcomes.
Weight monitory sheet	Woodruff's [34] "Heart Sounds Tutor" underscores the importance of weight monitoring in managing cardiovascular disease, as weight fluctuations can signal fluid retention or worsening heart failure. The weight monitoring sheet is a critical tool for tracking daily or periodic weight changes in patients with cardiovascular conditions. Accurate documentation helps nurses detect early signs of fluid imbalance, guiding interventions such as adjusting diuretics or modifying diet. Woodruff highlights that consistent use of this tool supports proactive care, reduces complications, and improves patient outcomes by ensuring timely responses to changes in cardiovascular health.

Standardized documents are proposed to address documentation challenges, improving accuracy and consistency while enhancing patient outcomes. Studies from Saudi Arabia and Canada show that standardized documentation improves patient outcomes and communication among providers, despite implementation challenges [10,11,18].

Difficulties Faced with Documentation on Patients with Heart Disease

Documentation challenges in heart disease care often stem from issues like lack of standardization, insufficient training, and high workloads, which affect the accuracy and timeliness of records. Incomplete documentation can disrupt care continuity and impact patient outcomes. Improved documentation practices are crucial for enhancing care quality, tracking complex interventions, and

Difficulties	Description of difficulties
Lack of standardization Insufficient training High workloads	Mahmoud and Bayoumy's [41] exploration of nursing documentation challenges in heart disease care mirrors Gimenes et al.'s [18] analysis of outpatient units. Both studies identify issues such as lack of standardization, insufficient training, and high workloads that impede accurate documentation. These challenges affect heart disease management by disrupting care continuity and impacting patient outcomes, underscoring the need for improved documentation practices to enhance care quality.
Poor documentation	Naylor's [42] emphasis on accurate documentation in nursing interventions for chronic conditions aligns with Al-Kandari and Thomas' [18] study on Saudi nurses' perspectives. Both highlight that poor documentation impedes tracking complex interventions and patient progress, affecting care coordination in heart disease. Improved documentation practices are deemed crucial for better communication and enhanced care quality.
Incomplete and fragmented records	Jefferies et al.'s [43] meta-study on quality nursing documentation parallels Jasemi et al.'s [23] assessment of medical-surgical units. Both highlight incomplete, fragmented records as risks to patient safety, especially in heart disease care. Standardized documentation is deemed essential for improving communication, minimizing errors, and enhancing patient outcomes.
IN accurate documentation	Adamsen and Tewes [44] discussed discrepancies between patients' perspectives and staff documentation in basic nursing care, particularly in heart disease. Their study revealed under-documented symptoms and concerns, resulting in care plans misaligned with patient needs. They advocate for more patient-centered documentation that includes the patient's voice.

ensuring patient safety. A patient-centered approach that accurately reflects their experiences is essential for effective care planning and coordination.

Conclusion

Nursing documentation is a critical component of patient care, particularly for patients with heart diseases. However, the complexity and time-consuming nature of documentation can contribute to increased workloads for nurses, potentially leading to burnout and decreased job satisfaction. The use of standardized documents offers a potential solution to these challenges, providing a consistent framework for recording patient information, reducing the risk of errors, and improving communication among healthcare providers. While there are challenges associated with implementing standardized documentation, the benefits in terms of improved patient care and reduced workload for nurses are clear.

Recommendation

- Training should be carried out among nurses on the use of standardized documents for better communication among healthcare providers and continuity of care.
- Research should focus on identifying the best practices for implementing standardized documentation in various healthcare settings, with a particular focus on the care of patients with heart diseases.
- Seminars should be organized to uncover difficulties and fill the gaps.

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