

Results of a Study of the Medical History of a Hematology and Bone Marrow Transplant Center

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ABSTRACT

Background: There is evidence that Mongolia did not maintain official nursing records to record nursing care provided to patients prior to 2013. In a review conducted by Finnish researcher Kaija S et al., 143 It is important to note that the nursing history should not only have a standard vocabulary, but also to have a common understanding of how to record information about daily activities and patient safety. Researchers B. Azjargal et al. considered that the complete implementation of the nursing history assessment using the Gordon index is moderately problematic. In addition, researchers D. Ariunaa et al. in their study evaluating the nursing history of patients with acute myocardial infarction determined that 80.5% of 36 patients with acute myocardial infarction had a nursing history. However, it is reasonable to study the nursing history recording of patients with specialized care such as hematology, blood cancer, chemotherapy, and bone marrow transplantation. Objective : Studying the characteristics of medical history taking in a hematology and bone marrow transplant center.

Methods and methodology: The study used a qualitative research document method to analyze 50 nursing records maintained by the Center for Nursing Care of the National University of Mongolia (NUM). A total of 4 records maintained by nurses were analyzed using a qualitative research document method. The analysis was conducted using an 8-question assessment form based on the nursing record keeping instructions approved by the Minister of Health's Order No. 611 of 2019.

Statistical processing: The data from the survey, which assessed the nursing history of the participating health care institutions, were processed using the statistical software for social research, SPSS-22.

Results: In the study of nursing history taking, 62% (50) of 20-30 and 38% (19) of 31-40 were found, 58% (29) of 31-40 were found, 42% (21) of 31-40 were found, 70% (35) of 31-30 were found to be male, 24% (12) of 31-40 were found to be female, 2% (1) of 31-40 were found to be male, 2% (1) of 31-40 were found to be female, 2% (1) of 31-40 were found to be male, 2% (2 % (41), #39-100% (50), #46-46% (23), #1-6% (3), #29-12% (6), #33-56% (28), #18-36% (3). The diagnosis was made according to the assessment 72% yes, no 28%, the plan was made according to the diagnosis 82% yes, no 18%, whether the most important plan was planned was yes 58% no 42%, the diagnosis choice is low when keeping the history of patients with blood disorders.

Conclusion: In monitoring the nursing history, it is concluded that 80% of the diagnosis choices are recorded on # 6, which is a complication of blood disorders.

Keywords: Vital Signs, Pain, Fluid Balance, Patient Assessment, Documentation

Introduction

A Nursing History is a Document that Documents the Assessment of a Patient's Condition, Diagnosis, Planning

and Implementation of Interventions conclusions, and professional nursing activities [1]. There are many researchers who have documented that many countries around the world are working to transfer medical records to electronic format. Finnish researcher Kaija S et al. A review conducted in 2011, which analyzed 143 research articles, noted the need for standardized

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wording in nursing histories and found that it is important to have a common understanding of how to record information about daily activities and patient safety [2].

In Mongolia, before 2013, there was no official nursing record keeping system to record nursing care provided to patients, which led to a lack of both nursing care and nursing care services [3]. The nursing history approved for the first time in the history of the sector by Order No. 450 of the Minister of Health in 2013, has become an important document for recording the actions and activities of nurses, sharing information about the patient's condition with others, and continuously providing care according to the 5 stages of nursing activities [4].

B. Azjargal et al., it was found that the complete implementation of the nursing history assessment using the Gordon index was moderately problematic. The nursing diagnosis of arterial hypertension was predominantly made by identifying pain, symptoms, risk factors, and psychosocial needs, and the diagnosis of cardiovascular changes was considered difficult to determine because the nursing assessment technique was not consistently evaluated, which made it difficult to determine the results [5]

researcher D. Ariunaa et al., when assessing the nursing history of a client with acute myocardial infarction, it was found that 80.5% of 36 clients with acute myocardial infarction had a nursing history and that out of 15 nursing diagnoses that could be made during a heart attack, 9 nursing diagnoses were recorded and nursing care was implemented [6].

We have been implementing the nursing history for 10 years, and there is a need to further evaluate the nursing history management in the field of specialized nursing, namely hematology and bone marrow transplantation [4,7,8]. Therefore, there is a need to study the current status of the nursing history management used by the Hematology and Bone Marrow Transplantation Center of the First State Central Hospital.

Purpose

To study the characteristics of the medical history keeping in a hematology and bone marrow transplant center and to identify the need for a model history in the future.

Methods and techniques

The study used a qualitative research document method to analyze 50 nursing records maintained by the Center for Nursing Care of the National University of Mongolia (NUM). A total of 4 records maintained by nurses were analyzed using a qualitative research document method. The analysis was conducted using an 8-question assessment form based on the nursing record keeping instructions approved by the Minister of Health's Order No. 611 of 2019.

Statistical processing

The data from the study, which assessed the nursing history of the participating health care institutions, were processed using the statistical software for social research, SPSS-22. Results : In the study of nursing history taking, 62% (50) of 20-30 and 38% (19) of 31-40 were found, 58% (29) of 31-40 were found,

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Conclusion

In monitoring the nursing history, it is concluded that 80% of the diagnosis choices are recorded on # 6, which is a complication of blood disorders.

In our study, 50 histories were analyzed using 4 checklists in the nursing history of the UNTE and TSECHSCHS centers using a document research method.

According to the Order No. 203 of the Minister of Health of the Republic of Mongolia dated August 19, 2005, the independent legal documents for reporting and reporting on the provision of professional nursing care were limited to three types of registration forms: fever sheet, patient medication sheet, and intensive care card, and there was no registration form for information on the provision of professional nursing care. However, the Order No. 136 of May 28, 2004 approved a model for maintaining nursing documents for home nursing care, which became the first approved document model for professional nursing care [9].

The document for recording nursing care by nurses in inpatient units was approved by the Order of the Minister of Health No. 450 of 2013 [4]. In 2019, the nursing history was re-approved by the Order of the Minister of Health No. 611, and there were no changes to the document for recording the nursing care of adults in inpatient units by nurses. Indonesian researcher Mira A (Mira Asmirajint) and others (2017) A study conducted in 2011 found that nursing care delivery was inadequate , including nursing assessment (20.8%), biological assessment (0.4%), nursing diagnosis (20.8%), and determining the patient's home nursing needs (41.3%) . Our study identified that the nursing history needs to be updated in terms of content [10].

Researcher Ayele S (Ael Simachiv et al . ,) conducted a study of 338 nursing documents from 3 hospitals in Ethiopia , and 264 (78.1%) were conducted according to the standard of nursing process of the patient , 107 (31.7%) were without nursing diagnosis, and 185 (54.7%) based their nursing care plan. 173 (51.2%) of the nurses did not document the care provided according to the plan , and 179 (53.0%) did not evaluate the participation of the nurses . The implementation of nursing care among the 3 hospitals surveyed was 49.12 % , 68.18 % and 69.42% . Nursing professionals should improve the documentation required for the implementation of the nursing process. The nursing manager should monitor the overall implementation of the nursing process and organize activities to make nurses aware of the need to pay attention to the improvement of nursing documentation and nursing process [11].

American researcher Darinda E. S (Darinda Sutton) et al. found that creating predefined clinical packages in electronic health records is essential to reduce the paperwork burden ON HEALTHCARE providers. This reduced the amount of documentation by 48.5% and reduced the time spent on each page of care history by more than 2 minutes [12].

In a study conducted by D. Sarantuya et al. in at the Dornod aimag's Health and Social Care Center, nursing diagnosis #39 was given to 96.6% of patients with kidney and urinary tract disorders, but the pain intensity was not assessed using the Wong Baker method, and the implementation was not recorded as a result. Also, the nursing history of the patient was recorded in 90.7% of cases, and 10.3% were not recorded. The nursing diagnosis made by the nurse using the patient's physical condition assessment form was 17.3% consistent with the genitourinary system questionnaire of the disease history, and 82.7% were underdiagnosed [13].

Research conducted in Ethiopia in 2019 Hagos T (Hagos Taseu) found that nurses have poor experience in documenting nursing care. Lack of time, lack of knowledge of nursing documentation standards, and lack of knowledge of nursing documentation practices are factors contributing to inadequate documentation [14].

In a 2019 study in Brazil by researcher Oswalcir Almeida de A, et al. , of 416 nurses surveyed, 89.9% documented one step; 56.0% documented four steps; 4.3% documented only nursing notes; and 5.8% did not document any steps . Nursing notes were also kept the least in outpatient departments, diagnostic units, and surgical departments, while the most documented were in intensive care units, emergency rooms, and inpatient departments. Data collection and diagnosis were the least documented steps in the surveyed departments, with 78.8% of the surveyed departments [15].

Conclusion

In the nursing history review, it is concluded that 80% of the diagnostic options for circulatory failure or #6 in complications of blood disorders are recorded, which suggests that it is appropriate to provide a model history for the department.

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