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The Influence of Nursing Care Documenting Behavior on the Completeness of Nursing Care Documentation at Hospital X

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INDEXING

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ABSTRACT

Nursing care documentation is a written evidence of nursing process given to the patient. It is very important to both the health care team, the patient and the hospital. The completeness of nursing care documentation at hospital X in February 2017 are 76.3% in assessment, 86.4% in diagnosis, 93.3% in planning, 96% in implementation and 92.2% in an evaluation. The purpose of this research is to discover the factors that influence the completeness of nursing care documentation at hospital X. This research is an analytical survey using cross-sectional study with 89 nurses as its samples. The data are analyzed using chi-square and multiple linear regression. The completeness of nursing care documentation is affected by knowledge (χ2 12.776), attitude (17.692) and supervision (14.417). The availability of nursing facilities has no influence on the completeness of nursing care documentation (3.384). Knowledge, attitude, availability of facilities and supervision has an influence on the completeness of nursing care documentation at 34.1%. The variable with the highest influence on the completeness of nursing care documentation is supervision (B 0.180). Knowledge, attitude, and supervision have an influence on the completeness of nursing care documentation. The availability of facilities has no influence on it and the one with the highest influence is supervision.

Kata kunci:
Perilaku;
Perawat;
Proses Keperawatan;
Dokumentasi Asuhan Keperawatan.

Dokumentasi asuhan keperawatan merupakan bukti tertulis dari proses keperawatan yang diberikan perawat kepada pasien, berguna bagi pasien, tim kesehatan lain dan rumah sakit. Data kelengkapan dokumentasi asuhan keperawatan di RS X bulan Februari 2017 adalah pengkajian 76,3%, diagnosa 86,14%, perencanaan 93,3%, tindakan 96% dan evaluasi 92,2%. Tujuan penelitian untuk mengetahui faktor yang berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan di RS. Jenis penelitian ini survey analatik pendekatan crosss-sectional dengan sampel sebanyak 89 perawat. Analisis data menggunakan chi-square dan regresi linear berganda. Kelengkapan dokumentasi asuhan keperawatan dipengaruhi oleh pengetahuan (χ² 12,776), sikap (17,692), dan supervisi (14,417). Ketersediaan fasilitas tidak berpengaruh terhadap kelengkapan dokumentasi keperawatan (3.3841). Pengetahuan, sikap, ketersediaan fasilitas dan supervisi secara bersama-sama berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan sebesar 34.1%. Variabel yang paling berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan adalah supervisi (B 0.180). Pengetahuan, sikap dan supervisi berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan. Ketersediaan fasilitas tidak berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan. Supervisi paling berpengaruh terhadap kelengkapan dokumentasi asuhan keperawatan.

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INTRODUCTION

Nursing care documentation is a written evidence of nursing process that has been given to patients and it is very important to both the patients, the nurses, the health team care and the hospital. Nursing care documentation must be filled completely and must be done as soon as the nurses finish giving services to patients. Nurses who do not document the nursing care can be said to have not given any services to the patients because there is no evidence of it.[1]

Nursing documentation which is filled well and appropriately can facilitate the nurses to improve quality of service to patients. Documentation of nursing care can also be used as legal evidence in court if a lawsuit is filed by the patient or family to a court.[1] According to Paans, et al (2010) generally, documenting activities is disliked by nurses because it is time-consuming and rather boring. This can be seen from the fact that many nurses document their nursing care at end of their shift, leading to inaccurate content and focus of data.[2]

The frequently-occuring problem in documenting nursing care is incompleteness of filling, leading to poor quality, accuracy, and relevance of the nursing care documentation.[3] According to Jefferies, et al (2010) this phenomenon will certainly have an adverse impact for nurses, because the success of nurse in fulfilling their function and role as nursing caregiver can be seen from the nursing documentation.[4] This incompleteness also have an impact for the hospital, because in the nursing care documentation all of nursing actions that can be used as a reference or consideration for determining nursing costs for patients are written. When the nursing documentation is incomplete, then the calculation of costs become incompatible and eventually it causes losses to the hospital.

Data completeness of nursing care documentation at hospital X in February 2017 is 76.3% in assessment, 86.14% in diagnosis, 93.3% in planning, 96% in implementation and 92.2% in evaluation. The incompleteness of the nursing care documentation is due to the different perceptions between nurses, the nurse's educational background, amount of workload, nurse's lack of understanding of nursing care documentation, perception that writing documentation has no effect on their income, nurse's lack of motivation, and labor changes. Many ways have been performed by the management department to respond to this problem revolving around supervision, training, and socialization about writing nursing care documentation. However, the result is still below the standards.

The results of interview on 5 October 2016 with 10 nurses at hospital X indicate that the incomplete documentation of nursing care is due to different perception between nurses, educational background, amount of workload, nurse's lack of understanding about nursing care documentation and perception that documenting nursing care process has no effect on income.

Hospital Accreditation in 2012 is an effort to improve quality of service. The hospital sets guidelines in providing services and the nurse must work in accordance with the guidelines or standard operational procedures. The implementation of nursing services by standard operating procedures in principle is a part of individual behavior to work according to their duties as a nurse.[5] Nurses at hospital X are expected to implement these standard operating procedures that have been set by the hospital and work in accordance with their duties. When they have complied with these standards, it is expected that nursing care documentation can be implemented appropriately to achieve improvement of quality of service. The purpose of this research is to discover the factors that influence the completeness of nursing care documentation at hospital X.

RESEARCH METHOD

This is an analytical survey using cross sectional approach to determine the effects of independent variables on dependent variable. The population in this study is 114 respondents and its samples are 89 nurses.

The data are collected using questionnaire and observation by checklist guides. Questionnaires are used to find out such issues as knowledge, attitude, availability of facilities and supervision. This questionnaire has previously been tested for its validity and reliability with the results of all items being valid and reliable, thus it can be used in collecting data. The data are analyzed using chi-square test and multiple linier regression test.

RESULT AND DISCUSSION

This research is conducted in July 2017 at inpatient room of hospital X with 89 nurses and nursing care documentation in the medical record.

Description of Respondents, Knowledge, Attitude, Availability of Facilities, Supervision and Nursing Care Documentation at Hospital X

Table 1. Characteristic of Respondents

	Frequency	Percentage
Age		
- 20-30 years old	41	46.1
- 31-40 years old	46	51.7
- 41-50 years old	2	2.2
Gender		
- Male	11	12.4
- Female	78	87.6
Length of Work		
- 1-3 years	27	30.3
- 4-5 years	33	37,1
- >5 years	29	32.6
Qualification		
- Diploma	68	76,4
- Ners	21	23,6

From table 1, it can be seen that most respondents (46 or 51.7%) are 31-40 years old and the least number of nurses (2 or 2.2%) is 41-50 years old. In terms of gender, most of these nurse are female (78 or 87,6%) and the remaining 11 nurses are male (12.4%). The educational qualification of these nurses is mostly Diploma (68 nurses

or 76,4%) and 21 nurses (23.6) have completed Ners degree., Finally, most respondents (33) have worked for 4-5 years and the least number of these nurses (27 or 30/3%) has worked for 1-3 years.

Table 2. Knowledge, Attitude, Availability of Facilities, and Supervision

Variable	Category	Frequency	Percentage
Knowledge	- Excellent	44	49.4
	- Good	31	34.8
	- Average	14	15.8
Attitude	- Excellent	40	44.9
	- Good	35	39.3
	- Average	13	14.7
	- Bad	1	1.1
Availability of Facilities	- Available	78	87.7
	- Moderate	11	12.3
Supervision	- Excellent	7	7.9
	- Good	49	55.1
	- Average	30	33.7
	- Bad	3	3.3

Based on table, it can be seen most respondents (44 ot 49.4%) have excellent knowledge and only 14 nurses (15.8%) have average knowledge. Most respondents (40 or 44.9) have excellent attitude and only 1 (1.1%) has bad attitude. Most of these nurses (78 or 87.7%) suggest that they have facilities available for them and only 11 nurses (12.3%) state facilities are moderately available for them. Most nurses (49 or 55.1%) receive good supervision and 3 nurses (3.3%) receive bad supervision.

Table 3. Completeness of Nursing Care Documentation

Variable	Category	frequency	Percentage
Nursing Care Documentation	- Complete	69	77.5
	- Incomplete	20	22.5

In table 3 above, it can be seen that most documentations of nursing care (69 or 77.5%) are complete and only 20 documents (22.5%) are incomplete.

Results of Chi-Square Test

Table 4. Chi-Square Test Results

Variable	χ^2 value	χ^2 table	*p*
Knowledge	12,776	5,991	0,002
Attitude	17,692	7,815	0,001
Available of facilities	3,805	3,841	0,051
Supervision	14,417	7,815	0,002

In table 4, it is known that the values of χ^2 for knowledge, attitude and supervision are greater than χ^2 table values, which means knowledge, attitude and supervision have influences on the completeness of nursing care documentation. Availability of facilities has no influence on the completeness of nursing care documentation at hospital X with χ^2 value of 3.805 (<3,841).

Results of Multiple Linier Regression Test

Table 5. Results of Multiple Linier Regression Test

Variable	**Unstandardized coefficients B**	t value	t table	*p*
Knowledge	0.161	3.141	1.660	0.002
Attitude	0.170	3.391		0.001
Available of facilities	0.154	1.351		0.180
Supervision	0.180	3.219		0.002

Based on table 5, it can be seen that value of B unstandardized coefficients is the biggest for supervision (0.180). This means supervision has the greatest influence on the completeness of nursing care documentation.

Discussion

Knowledge

Nurse's knowledge about documentation of nursing care at hospital X is mostly excellent. This means the nurse knows the meaning, purpose, benefits and method of writing documentation of nursing care process. According to Notoadmodjo, knowledge has a responsibility and main function for forming a person's behavior. Before performing any action, people should firstly analyze, perceive and interpret it and then follow it up by doing the action they think necessary.[6]

The nurses at hospital X know that nursing documentation is a document which can be used as evidence by nurses, containing all of activities on nursing process and useful for patients, nurses and other health teams. Nurses know that the nursing care documentation goal is to improve the effectiveness and efficiency of nursing. Nurses also know the benefits of nursing care documentation as a recorder of the problems associated with nursing care which has been given to the patient. The nurses know that the writing of nursing care documentation must be done once the patient is admitted until the patient is discharged. The data source for filling the nursing

documentation is the patient, the family, and other health teams. The nursing documentation must be clear, complete, and accurate in describing the services given.[1]

Attitude

The nurses mostly have excellent attitude towards documenting nursing care process at hospital X. This means most of them accept, respond to, appreciate and are responsible for their duties as a nurse. Attitude is a reaction or response to a stimulus or object yet it is still closed from someone. Attitude cannot be directly seen, that means it can only be interpreted from closed behavior. Attitude is a feeling of like or dislike or a mental condition which is always prepared, studied, and organized based on experience which gives a special influence on someone's response to people, objects and environment.[6]

The nurses in hospital X mostly show the acceptance attitude. This mean after giving services to patient, nurses must document the nursing process. The nurse mostly showed a willing attitude. This means the nurses want to completely fill the nursing care documentation. Also the nurses mostly have appreciative attitude. Appreciation is a nurse's ability to invite other nurses or discuss the issue of filling in nursing documentation. According to Huryk (2010) a person's attitude is determined by the environment that can guide or initiate a person's behavior. When the environment is good, then their attitude will be good as well.[7]

Attitudes have some basic components, which are beliefs, the concept of an object, ideas, evaluation of objects, and the tendency to act.[8] According to Siswanto, et al (2013) a nurse with a good attitude on nursing care documentation usually have a tendency to document the nursing care completely, while those with bad attitude towards documenting of nursing care usually have the tendency to documenting nursing care incompletely.[9]

Availability of Facilities

Results of this research show that supporting facilities for documenting the nursing care like formats and standards of nursing care are mostly available at each ward in hospital X and they are always available when needed for documenting the nursing care. Availability is readiness of tools like resources, goods, assets and budget to be used or operated at the time which has been determined. Facility is a tool to support the implementation.

Management of facilities and infrastructure is in charge to give service professionally in the field of health infrastructure to organize process of health services effectively and efficiently.[10]

According to Nuaraeni, et al (2014) facilities of health care are a tool or place used for conducting the health service.[11] Facilities and infrastructure that are bad in documentations caused the incomplete documentation of nursing care. The research conducted by Gamrin & Joeharno (2008) based on patient's perceptions finds that the availability of facilities is related to quality of service, which means that the available facilities to support the administration of health services will lead to maximum services provided and will certainly affect patient satisfaction.[12]

Supervision

Nurse's perception of supervision of nursing care documentation by ward head is mostly good. This means the ward head makes a planning of supervision, organizing, guidance and controlling. Supervision is an activity performed by the leader or boss with direct, periodic observation to the job made by subordinates and when a problem is found, the supervisor give a direct assistance to help resolve it.[13]

Nurse's perception of planning conducted by the ward head is mostly good. It means the ward head has set the planning for supervision associated with documentation and gives an explanation in easy-to-understand sentences about the documentation of nursing care. The nurse's perception of the ward head's responsibility for organizing is mostly good. This means the ward head has given assignment to the nurses to perform nursing documentation. The ward head is willing to accept advice from nurses and answering the difficulties nurses in the filling of nursing documentation. The ward head play his role well as a coach. The ward head's role in coaching involves giving guidance to nurses about documenting, giving training and motivation to the nurses for improving their ability to filling the nursing documentation. Nurse's perception of the supervision of ward head's role in relation to control is mostly good. This means the ward head has evaluated the documentation of nursing conducted by the nurses and praises when the nurse can complete the documentation and give suggestions to those nurses who have not been able to complete the documentation.

According to Tampilang, et al (2013) supervision in professional nursing practice is a process of meeting the

resources needed by the nurses to complete the tasks to achieve the hospital's goals.[14]

Documentation of Nursing Care

Documentation of nursing care in hospital X has mostly been completed. However, some documents are still incomplete, especially the form of assessment and diagnoses. According to Siswanto, et al (2013) incomplete documentation will give harm to patients because important information about their care and health conditions are neglected.[10]

Hospital X has set the standard of completeness for nursing documentation, it is complete if it is filled 100%. The results showed that some nursing care documents are incomplete. On the assessment form, it is found that some documents have not been completed with patient identity regarding the age and mobile phone number. In the medical history sub form, incomplete filling is found in prior history of disease, in vital signs sub form, incomplete filling is also found mainly on weight, height and attitudes of patient, and in the assessment sub form some nurses are found not writing their names and fill in only their signature. Documentation of nursing care is very important because it is a key factor in supporting consistency and quality of patient care in a hospital.[10]

The Influence of Knowledge on the Completeness of Nursing Care Documentation at Hospital X

Results of data analysis indicate that knowledge has significant influence on completeness of nursing care documentation in hospital X at χ^2 value of 12.776 and p value 0.002. This means the better the knowledge that these nurses have on nursing care documentation, the more complete the filling of nursing documentation would be.

This result is in line with the research conducted by Polapa, et al (2014) which concludes that knowledge has significant influence on the implementation of nursing care documentation at Otanaha Hospital Gorontalo. Respondents with good knowledge can document the nursing care appropriately.[15]

Nurse's knowledge is highly related to the level of completeness of nursing care documentation. The greater the knowledge that nurses have about documentation, the more complete the filling of nursing care documentation would be, either for current time or for the future.[16] Knowledge is closely related to the application of nursing care documentation, therefore nurses should be required to continue develop their knowledge about nursing care documentation to improve the quality of service in hospital.[15]

The Influence of Attitude on The Completeness of Nursing Care Documentation at Hospital X

Based on the data analysis, it is found that nurse's attitude has significant effect on the completeness of nursing care documentation at hospital X at χ^2 value of 17.692 (> 7,815) and p value of 0.001. This means the better the nurse's attitude the more complete the filling of nursing care documentation would be.

This result of research is in line with Mastini (2013) which finds that attitude has significant relation to the completeness of nursing care documentation at Sanglah Hospital Denpasar Bali. The better the nurse's attitude toward nursing care documentation, the more likely the documentation would be appropriate.[10]

A person's attitude is determined by the environment that can guide or initiate a person's behavior. When the environment is good then their attitude will be good as well.[7] Attitude is a nurse's perception or desire to complete the documentation of nursing care. Attitudes are divided into 4 stages that is receiving, responding, appreciating and being responsible.[17]

The Influence of Availability of Facilities on the Completeness of Nursing Care Documentation at Hospital X

The results show that facilities to support the documentation of nursing care in the form and format of nursing care documentation are mostly available. Its χ^2 value is 3.805 and its p value is 0.051 (3.805 <3.841). This means availability of facility of nursing care documentation has no effect on the completeness of nursing care documentation at hospital X.

This result is not in line with research by Martini (2007) which finds that the availability of facilities for documenting nursing care has some influence on the effectiveness of nursing care documentation. Also, good quality of work is determined by availability of facilities.[18]

Facilities for documenting nursing care in the form and format of nursing care documentation is available in inpatient room and they are always available when needed. It actually can improve the completeness of filling nursing care documentation at hospital X, however, the result of data analysis indicates the absence of influence of

availability of facility on the completeness of nursing care documentation. According to nurses at the inpatient room of hospital X, this is caused by many factors such as great amount of workload, perception that filling the documentation of nursing care has no effect on salary, the fact that nurses often fill in documentation of nursing care at the end of shift, leading to limited time available for filling the form, and nurse's lack of commitment in maintaining and using the support facilities which are already provided by the hospital.[19] The management of facilities and infrastructure in hospital X has prepared the format and standards of nursing care, but this nursing care documentation has not been filled completely. This is caused by gender, age, length of work, qualification, salary, nurse knowledge and workload.

The completeness of infrastructure and facilities of nursing care documentation is most important to support the implementation of documentation.[20] Thus when facilities are sufficient, it would increase the nurse's performance. Many factors inhibits the implementation of nursing care documentation, although basically the nursing process has been applied.[21]

The influence of supervision on the Completeness of Nursing Care Documentation at Hospital X

From the results of data analysis, it is found that supervision has significant influence on the completeness of nursing care documentation in hospital X at χ^2 value of 14.417 and value of p of 0.002. This means the better the supervision by the ward head the more complete the filling of nursing care documentation conducted by nurses would be.

This result is in line with the research conducted by Yanti & Warsito (2013) which explains that there is significant influence of supervision by the ward head on documentation quality.[21]

The ward head need to maintain, coach, motivate, guide and appreciate the work of the nurse. This, eventually, will have an impact on the nurse's job satisfaction.[16] The ward head should be able to be a good supervisor to nurses, so as to improve the quality of nursing care given to patients and ultimately can improve the nurse's performance. Supervision of the ward head is an important factor in nursing care documentation; supervision is a planned activity from a manager which include planning, organizing, coaching and controlling.[22]

According to Tampilang, et al (2013) the nursing manager is required to have the ability in determining the activity plan according to the purpose, organizing staff and work, lead and evaluate each activity related to nursing care.[14] Related to the efforts to improve the completeness of filling nursing documentation. Supervision of nursing care documentation is an activity that needs to be done by the ward head. This ward head needs to maintain, develop, and provide motivation, guidance and respect for the work of nurses which will have an impact on the nurse's job satisfaction.[23]

The Variable with Most Significant Influence onthe Completeness of Nursing Care Documentation at Hospital X

Supervision of the ward head is the variable wth greatest influence on the completeness of nursing care documentation in hospital X with its value of B unstandardized coefficients being 0.180 and p value 0.002. Supervision is conducted by the ward head in hospital X at the stage of planning, organizing and coaching. Most of the time, it has been going well. While at the stage of control the role of the ward head is relatively good enough, This means the ward head has evaluated the results of documentation conducted by the nurse and has done improvements when he finds error or something not in accordance with the goal, yet the ward head rarely give praise to those nurses capable of filling the documentation nurse care completely.

According to Tampilang, et al (2013) supervision in professional nursing practice is a process of meeting the resources needed by the nurse to complete the tasks in the effort of achieving the goal of the hospital. The nursing manager is required to have the ability in the role he plays in determining the activity plan based on the purpose, organizing staff and work. The ward head should lead and evaluate each activity related to nursing care. It is related to the efforts to improve the completeness of filling nursing documentation.[14]

CONCLUSION

Most of the nurses in hospital X know and understand nursing care documentation. The nurses' attitudes are mostly good toward nursing care documentation. The format and standard of nursing care documentation in each ward is mostly available. Supervision of the ward head is mostly good and the documentation of nursing care is mostly complete. Knowledge has influence onthe completeness of nursing care documentation at hospital X.

Attitude has influence on the completeness of nursing care documentation at hospital X. The Availability of facilities has no influence on the completeness of nursing care documentation at hospital X. The Supervision has some influence on the completeness of nursing care documentation at hospital X. This supervision most significantly influence the completeness of nursing care documentation at hospital X.

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REFERENCE

1. Nursalam. (2013). Proses dan Dokumentasi Keperawatan: Konsep dan Praktik. Ed 2. Jakarta: Salemba Medika.
2. Paans, W., Sermeus, W., Nieweg, R., & Van Der Schans, C. (2010). Prevalence of Accurate Nursing Documentation in Patient Records. *Journal of Advanced Nursing,* 66(11), 2481-2489.
3. Zakiyah, A. (2012). Hubungan Sikap dan Karakteristik Perawat Dengan Pendokumentasian Asuhan Keperawatan di Rumah Sakit Umum Sidoarjo. Jurnal Keperawatan Sehat, 5(01).
4. Jefferies, D., Johnson, M., & Griffiths, R. (2010). A Meta‐Study of The Essentials of Quality Nursing Documentation. *International Journal of Nursing Practice,* 16(2), 112-124.
5. Sutoto, M. K. (2012). Instrumen Akreditasi Rumah Sakit: Standar Akreditasi Versi 2012. Jakarta: Komisi Akreditasi Rumah Sakit Ed 1.
6. Notoadmodjo. (2014). Promosi Kesehatan dan Perilaku Kesehatan. Jakarta: Reinka Cipta.
7. Huryk, L. A. (2010). Factors Influencing Nurses' Attitudes Towards Healthcare Information Technology. *Journal of Nursing Management,* 18(5), 606-612.
8. Nurman, M. (2017). Faktor–Faktor Yang Berhubungan Dengan Pendokumentasian Keperawatan di Ruang Rawat Inap RSUD Bangkinang. *Jurnal Ners,* 6(1), 45-58.
9. Siswanto, H., Hariyati, S., & Sukihananto, S. (2013). Faktor - Faktor Yang Berhubungan Dengan Kelengkapan Pendokumentasian Asuhan Keperawatan. *Jurnal Keperawatan Indonesia*, 16(2), 77-84.
10. Mastini, I. (2013). Hubungan Pengetahuan, Sikap dan Beban Kerja Dengan Kelengkapan Pendokumentasian Asuhan Keperawatan Irna di Rumah Sakit Umum Pusat Sanglah Denpasar. *Jurnal Keperawatan,* 3(2).
11. Nuraeni, A., Solihah, I., & Suharyanto, T. (2014). Determinan Faktor Yang Berhubungan Dengan Pendokumentasian Asuhan Keperawatan di Rumah Sakit Umum Daerah (RSUD) Pasar Rebo, Jakarta Timur, Tahun 2014. *Jurnal keperawatan,* 1(1), 21-23.
12. Gamrin, B., & Joeharno, M. (2008). Faktor-Faktor Yang Mempengaruhi Mutu Pelayanan Kesehatan di Rumah Sakit. *Jurnal Ilmiah Kesehatan Keperawatan,* 7(2), 91-100.
13. Suarli, S & Bachtiar. (2009). Manajemen Keperawatan Dengan Pendekatan Praktik. Jakarta: Erlanggga.
14. Tampilang, R. M., Tuda, J. S. B. & Warouw, H. (2013). Hubungan Supervisi Kepala Ruangan Dengan Kepuasan Perawat Pelaksana Di RSUD Liunkendage Tahuna. *E-Ners,* 1(1).
15. Polapa, Y., Hiola, R., & Pakaya, A. W. (2014). Analisis Faktor - Faktor Yang Berhubungan Dengan Pelaksanaan Pendokumentasian Proses Asuhan Keperawatan di RSUD Otanaha Kota Gorontalo. *Kim Fakultas Ilmu - Ilmu Kesehatan Dan Keolahragaan,* 2(3).
16. Putra, A., Rejeki, S., & Kristina, N. (2016). Hubungan Persepsi Perawat Tentang Karakteristik Pekerjaan Dengan Kepatuhan Dalam Pendokumentasian Asuhan Keperawatan. *Jurnal Keperawatan Notokusumo,* 4(1), 1-11.
17. Wang, N., Hailey, D. & Yu, P. (2011). Quality of Nursing Documentation And Approaches To Its Evaluation: A Mixed‐Method Systematic Review. *Journal of Advanced Nursing,* 67(9), Pp.1858-1875.
18. Martini, M. (2007). Hubungan Karakteristik Perawat, Sikap, Beban Kerja, Ketersediaan Fasilitas Dengan Pendokumentasian Asuhan Keperawatan di Rawat Inap BPRSUD Kota Salatiga. *Jurnal Manajemen Keperawatan,* 1(1).
19. Menteri Kesehatan Republik Indonesia. (2010). Tentang Izin dan Penyelenggaraan Praktik Perawat. Jakarta.

20. Mandagi, F. M., Umboh, J. M., & Rattu, J. A. (2015). Analisis Faktor–Faktor Yang Berhubungan Dengan Kinerja Perawat Dalam Menerapkan Asuhan Keperawatan di Rumah Sakit Umum Bethesda Gmim. *Jurnal E-Biomedik,* 3(3).
21. Yanti, R. I., & Warsito, B. E. (2013). Hubungan Karakteristik Perawat, Motivasi, dan Supervisi Dengan Kualitas Dokumentasi Proses Asuhan Keperawatan. *Jurnal Manajemen Keperawatan,* 1(2).
22. Haryanti, T., Pujianto, I., & Adinatha, N. (2013). Analisis Pengaruh Persepsi Perawat Pelaksana Tentang Fungsi Manajerial Kepala Ruang Terhadap Pendokumentasian Asuhan Keperawatan di Ruang Rawat Inap Rumah Sakit Swasta Di Semarang. *Jurnal Manajemen Keperawatan,* 1(2).
23. Mangole, J. E., Rompas, S., & Ismanto, A. Y. (2015). Hubungan Perilaku Perawat Dengan Pendokumentasian Asuhan Keperawatan di Cardiovaskular and Brain Center RSUP Prof. Dr. RD Kandou Manado. *Jurnal Keperawatan,* 3(2).