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Optimization of Direction and Control Functions in Improving SOAP Writing in CPPT at X Hospital

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Abstract

The provision of patient care in hospitals is carried out based on the concept of Patient-Centered Care (PCC). One of the dimensions of this PCC is the coordination and integration of care services. The integration of care services is carried out horizontally and vertically. The care provider professionals work as intra and interdisciplinary with interprofessional collaboration, assisted by an integrated patient development record written in SOAP form. As the most caregivers in hospitals, nurses must correctly record and document every patient's progress so that other professions can quickly use them. The phenomenon that occurs, doctors do not read or do not believe in the writings of nurses. Hospital X is a type a hospital, specifically in the intensive care unit; the average BOR in the last three months is 69.71%. Based on the observations, it was found that the writing of SOAP on integrated patient development records was not the same for every NurseNurse and not following the standards. So it is necessary to optimize the direction and control function of the Charge Nurse and the head of the room for writing SOAP on integrated patient development records to comply with Nursing Care Standards and SOPs for Hospital X. The method used is a pilot project, starting from data identification, problem analysis, problem priority setting, Plan Preparation of Action (POA), implementation, and evaluation. Data were collected by interview, observation, and survey methods using a google form containing questions about the knowledge and perceptions of nurses on writing SOAP on the integrated patient development record. With the direction and control/control, each level of the manager is expected to achieve organizational goals and improve the deviations found. For this reason, it is hoped that the hospital can accelerate the implementation of EMR synchronized with the nursing care standards that have been arranged and continue to carry out regular supervision in writing SOAP on the integrated patient development record.

Keywords
integrated patient development record; writing SOAP; improving; actuating; and controlling function

I. Introduction

The provision of patient care in hospitals is carried out based on patient-centered care (PCC). PCC has been used in healthcare systems (Fix et al., 2017). One of the dimensions of this PCC is the coordination and integration of care services (Araki, 2019). The integration of care services is carried out horizontally and vertically. The care provider professionals work

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as intra and interdisciplinary with interprofessional collaboration, assisted by an integrated patient development record written in SOAP form. As the most caregivers in hospitals, nurses are required to correctly record and document each patient's progress so that it can be quickly used by other professions (Hospital Accreditation Commission, 2018).

The role of medical colleagues is needed to manage evidence material for health services safely, comfortably, efficiently, effectively, and confidentially. The implementation of this medical record activity is influenced by human resources, namely medical record officers. SIMRS is a communication information technology system that processes and integrates the entire hospital service process flow in the form of a network of coordination, reporting, and administrative procedures to obtain accurate and accurate information, and is part of the Health Information System. (Andari, N. et al. 2021)

Interprofessional documentation is one way to improve interprofessional care and a key component of providing good care. So it is necessary to be aware of every nursing profession of the risks of interprofessional documentation (Adamson et al., 2020).

Nursing documentation is an essential indicator of the quality of nursing care delivery. Nursing documentation must be furnished to the highest standards to ensure the safety and quality of healthcare services (Akhu et al., 2017). Nursing documentation is essential in the health care setting and reflects various aspects, including the level of awareness of nurses in their role in providing quality health services (Alkouri et al., 2016). Nursing documentation has a positive effect on patient safety (Sulistyadi et al., 2020). Documentation is also defined as the transfer of clinical information in written form. The importance of nursing documentation is so vital that it is estimated that nurses spend 15-25% of their time doing nursing documentation (Pelletier et al., 2002).

Improving the quality of nursing documentation must be based on increasing the knowledge of nurses (Akhu et al., 2017). According to (Aihatram et al., 2020) it is necessary to conduct orientation to staff, timely audits, and continuous education. The phenomenon that occurs, doctors do not read or do not believe the writings of nurses (Pelletier et al., 2002). Research in Australia shows that 71% of respondents stated that most nursing care was never documented. This happens due to a lack of adequate understanding of hospital documentation standards and time to create documentation. Finally, the consequences of incomplete documentation are considered to be an increase in legal liability and a decrease in the quality of patient care (Wills, 1998).

The problem of nursing documentation in Indonesia is caused by the lack of nurse supervision of nursing documentation, competency problems in the documentation, lack of confidence, and lack of motivation in conducting nursing documentation (Kamil et al., 2018). To optimize the writing of SOAP on the integrated patient development record, the roles and functions of nursing managers are needed. Managers motivate, direct activities, and coordinate (Robbins & Judge, 2017). Managers must monitor staff performance and compare it with the established objectives carried out through the control function. With the controlling, it is expected that managers can ensure that organizational goals are achieved and make improvements to the deviations found. The roles and management functions carried out by nursing managers are interpersonal, informational, and decisional roles and planning, organizing, staffing, actuating, and controlling functions (Robbins & Judge, 2017).

Hospital X is a type a hospital, specifically in the intensive care unit; the average BOR in the last three months is 69.71%. Based on the observations, it was found that the writing of SOAP on integrated patient development records was not the same for every NurseNurse and not following the standards. So it is necessary to optimize the writing of SOAP on integrated patient development records to improve the quality of documentation and the quality of care provided.

This study aims to optimize the function of directing and controlling the Charge Nurse and the head of the room for writing SOAP on integrated patient development records to follow Nursing Care Standards and SOPs for X Hospital.

II. Research Methods

The method used is a pilot project from September 6 to October 1, 2021, starting from data identification, data analysis, problem priority setting, preparation of Plan of Action (POA), implementation, and evaluation. Collecting data through interviews with the nursing field, nursing committee, coordinator, head of the room, Charge Nurse, and Nurse Associate and through observation and distribution of questionnaires containing perceptions and knowledge of nurse documentation on integrated patient development records. The collected data is analyzed using a computer. The results of data analysis are used to determine the problems identified using a fishbone diagram, including man, material, method, machine, money, and environment.

This pilot project uses Kurt Lewin's theory of change, which consists of 3 stages: unfreezing, movement, and refreezing (Robbins & Judge, 2017). The disbursement stage includes data collection, problem diagnosis, and a decision to make changes. The movement stage consists of compiling POA, drafting NurseNurse writing on integrated patient development records, conducting discussions and brainstorming, socialization, and the desire to improve. The refreezing stage is the stage of stabilizing the system change into the status quo.

III. Result and Discussion

Based on the results of interviews with the Charge Nurse, the head of the room, and the nursing committee, it was found that the writing of nurses in the integrated patient development record emphasized the quantity element, and the writing was not uniform between each staff. Quantitative data was obtained by distributing google forms to the coordinator, head of the room, and Charge Nurse, who filled out 13 respondents. As for the Nurse Associate who filled as many as 53 respondents.

Table 1. Demographic data of respondents (n: 13)

Variable	Category	Amount	%
Gender	Female	13	100.0
Age	36-45 years old	5	38.5
	46-55 years old	8	61.5
PK Level	PK I	1	7.7
	PK II	2	25.4
	PK III	9	69.2
	PK IV	1	7.7
Position			
	Coordinator	2	15.4
	Head of the room	5	38.5
	Charge Nurse	6	46.2
Employee Status	civil servant	12	92.3
	BLU	1	7.7
Last Education	Diploma III of Nursing	1	7.7
	Diploma IV of Midwifery	1	7.7
	Bachelor of Nursing	2	15.4

	Nurse	8	61.5
	Specialist Nurse	1	7.7
Period of work at IRI	< 6 years	7	53.8
	6-10 years	-	-
	>10 years	6	46.2

Data Primer, September 2021

The data in table 1 shows that there are still a small number of coordinators, Karu, and charge nurses with level PK I and level PK II.

Table 2. Perceptions of respondents (Coordinator, Karu, and Charge Nurse) about nurse documentation at CPPT (n: 13)

Statement	Answer Options	
	Yes (%)	No (%)
The documentation carried out by the staff at the integrated patient development record is good	69.2	30.8
Staff always carry out assessments before documenting care	92.3	7.7
Writing documentation on the integrated patient development record is the same for every staff	76.9	23.1
The staff has documented care at integrated patient development record according to applicable policies	92.3	7.7
Always supervise the documentation of care at the integrated patient development record	84.6	15.4

Primary Data, September 2021

The data in Table 2 shows that almost all respondents stated that the staff had documented care at integrated patient development record according to applicable policies (92.3%). A small number of respondents stated that the staff had not adequately documented the integrated patient development record (30.8%), writing documentation the integrated patient development record is not the same for every staff (23.1 %). The care documentation is not always carried out on the integrated patient development record (15.4%). Respondents' statements regarding documentation of care at integrated patient development records that follow this policy (SOP) need to be reviewed because, based on observations, the writing is not following the standards set by the hospital.

53 respondents filled out the questionnaires addressed to Charge Nurses and Nurse Associates, with the following results:

Tabel 3. Data Demografi Respondent (Charge Nurses and Nurse Associates) (n: 53)

Variable	Category	Amounts	%
Gender	Female	50	94.3
	Male	3	5.7
Age	26-35 years old	24	45.3
	36-45 years old	18	34.0
	46-55 years old	11	20.8
PK Level	Non-PK	4	7.5
	PK I	20	37.7
	PK II	13	24.5
	PK III	16	30.2
Employee Status	Civil Servant	33	62.3
	BLU	6	11.3

	Contract	14	26.4
Last Education	Diploma III of Nursing	37	69.8
	Diploma III of Midwifery	1	1.9
	Bachelor of Nursing	3	5.7
	Nurse	12	22.6
Period of Work at IRI	< 6 years	34	64.2
	6-10 years	9	17.0
	>10 years	10	18.9
Attend intensive training	Already	32	60.4
	Not yet	21	39.6

Primary Data, September 2021

Based on table 3, it is found that most (64.2%) of respondents have a working period of fewer than six years, and almost half of respondents (39.6%) have not attended intensive training.

Table 4. Respondents' Perceptions of Documentation on CPPT

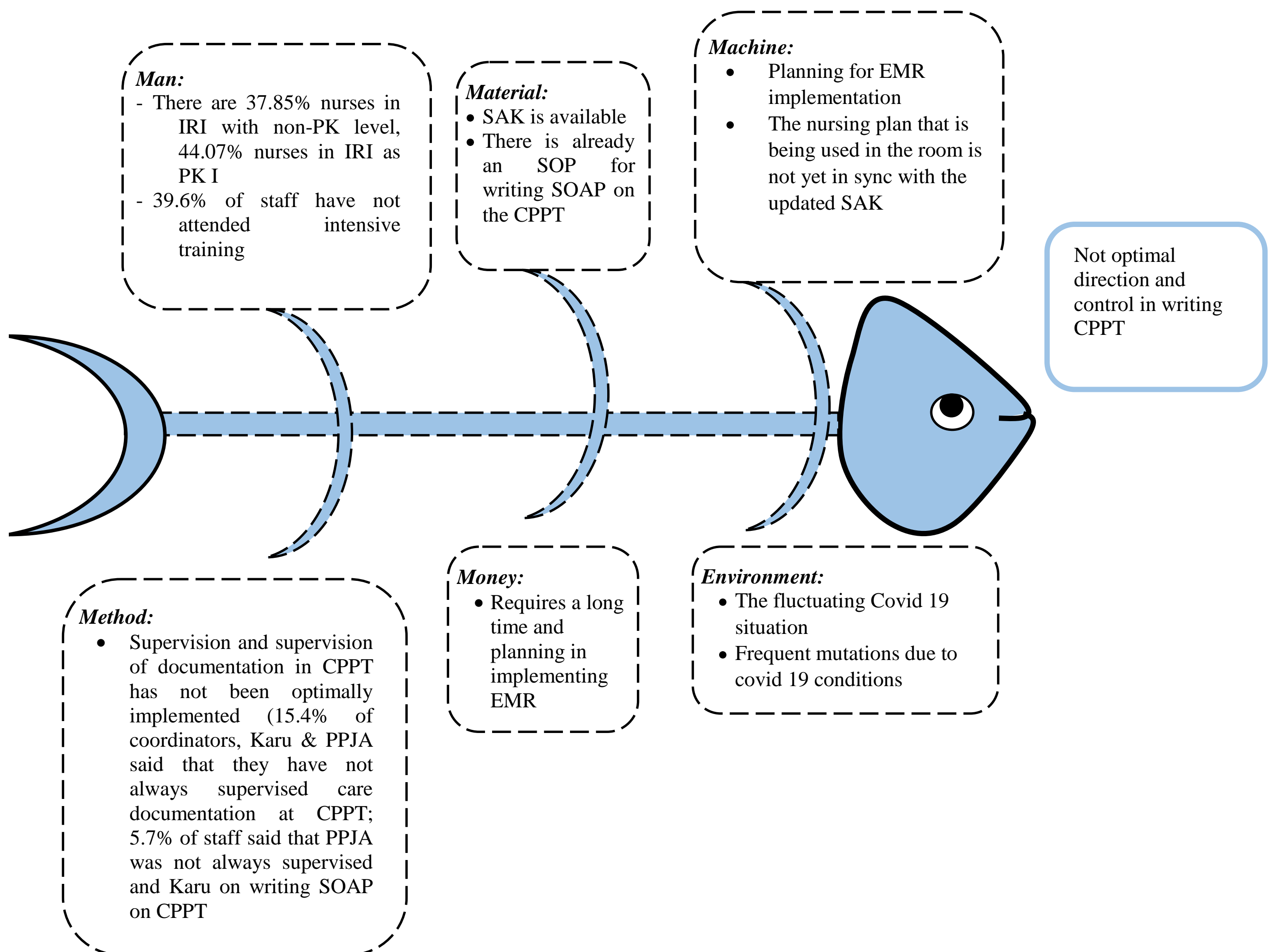
Statement	Answer Options	
	Yes (%)	No (%)
Have written correctly on the integrated patient development record on the medical record	98.1	1.9
Has been socialized about how to write on the integrated patient development record	94.3	5.7
Nursing care writing in IRI is the same for every Nurse	86.5	13.5
Have carried out nursing/midwifery documentation to the maximum	100	-
Have written nursing/midwifery documentation on integrated patient development record according to hospital policy	100	-
The hospital already has guidelines on how to write nursing documentation on the integrated patient development record	92.5	7.5
The Nurse'sNurse's writing on the integrated patient development record is always supervised by the head of the room	94.3	5.7

Primary Data, September 2021

Table 4 shows that all respondents stated that they had written nursing documentation on the integrated patient development record following hospital policies and had been maximally carried out. However, based on observations, it was found that some were not optimal and not following hospital policies.

3.1. Problem Analysis

Using fishbone diagrams, problem analysis with a causal analysis approach shows that direction and control are not optimal in writing integrated patient development records.



3.2. Implementation

The implementation uses a management function approach from planning, organizing, staffing, actuating, and controlling (POSAC) Planning: Implementation of the planning function is to review SOPs, identify the most common nursing diagnoses found with Charge Nurse, review and revise Financial Accounting Standards and draft writing SOAP on the integrated patient development record with the nursing committee and the nursing field. The implementation of activities is carried out by conducting discussions and brainstorming offline.

Organizing dan Staffing: The organizing and staffing functions are carried out by the SOP that has been prepared by the hospital, namely the writing of SOAP on the integrated patient development record is carried out by the Nurse Associate and Charge NurseNurse, or by the Nurse Associate which will be verified by Charge Nurse. Supervision and evaluation will be carried out by the Charge Nurse and the head of the room in stages and the field of nursing services, and the nursing committee.

Actuating: The implementation of the directive function is conducting discussions and brainstorming and socialization for optimizing integrated patient development record writing on SOAP which is attended by the nursing service sector, nursing committee, installation coordinator, head of the room, and Charge Nurse. During the discussion, brainstorming, and socialization, it was also agreed that the SOP for writing nurses in integrated patient development recordS should be clarified. Expectations from the nursing field, nursing committee, and installation coordinator to write SOAP on integrated patient development recordS could be improved for quality nursing services.

Controlling: The implementation of the control function is carried out through direct observation of residency students on writing progress notes in the form of SOAP on integrated patient development recordS on 50 medical record files in the ICU, NICU, and surgical HCU rooms, by seeing whether this writing has been carried out according to SOP both in quality and quantity. This control function is also carried out by Charge Nurse by verifying the writing of the Nurse Associate and providing motivation and guidance to staff. Motivation, guidance, and supervision are also carried out by the head of the room, the coordinator, the field of nursing services, and the nursing committee.

3.3. Evaluation

Evaluation is carried out on writing SOAP at integrated patient development record by the associate NurseNurse or Charge Nurse whose writing is verified by Charge Nurse. The evaluation results showed an increase in the range of 6-48% improvement from each aspect that was assessed according to the items from the observation sheet that had been provided. Furthermore, the evaluation will continue to be carried out by Charge Nurse through the verification process of writing SOAP on the integrated patient development record, as well as evaluation and monitoring by the head of the room, coordinator, the field of nursing services, and the nursing committee through filling out google forms and direct audits of medical record files.

Table 5. The results of the evaluation of writing SOAP on the integrated patient development record (n: 50 medical record files, % improvement)

No.	Evaluation Statement	%
1	Subjective data are written following identified nursing problems	6
2	Objective data are written following identified nursing problems	38
3	Nursing diagnoses are written following the data	28
4	Writing a nursing plan that will be carried out following Nursing Care Standards	22
5	The writing of instructions that will be carried out has fulfilled the OTEC elements (Observation, Therapeutics, Education, Collaboration)	42
6	Charge Nurse verifies SOAP written by Nurse Associate	48

Based on table 5, it was found that a small portion (6%) of subjective data was improved according to the identified nursing problems. For improvement in this subjective data, there is not much visible change because this subjective data cannot be studied in unconscious patients in the intensive care unit. Each small part of the improvement has occurred in the writing of nursing care plans according to nursing care standards, and nursing

diagnoses have been written according to the data. Furthermore, almost half of each there has been a change in the objective data written following the identified nursing problems, the writing of instructions to be carried out has fulfilled the elements of observation, therapeutic, educational and collaboration as well as writing SOAP on the integrated patient development record has been verified by Charge Nurse.

Integrated patient progress notes written in SOAP form are handy in providing quality service to patients starting from the process of identifying subjective and objective data to writing subjective and objective data, analyzing problems in determining assessments, and developing plans to overcome or improve client health problems (Hospital Accreditation Commission, 2018).

This pilot project was implemented based on the theory of change from Kurt Lewin. A manager must identify the changes required by the organization (Marquis & Huston, 2017). Based on the stages of planned change, the stages of change carried out by the author are unfreezing (thawing the status quo), movement (movement), and refreezing (freezing new changes to make them permanent) (Robbins & Judge, 2017). For effective change to occur at the unfreezing stage, the authors thoroughly and accurately identify the level and interest in change, motivation, and the environment in which the change will occur (Marquis & Huston, 2017). The author's stages of unfreezing are collecting data, diagnosing problems, and making decisions about the need to make changes, namely optimizing the function of direction and control in improving SOAP writing on integrated patient development recordS with nursing managers at X Hospital. At the movement stage, the authors identify, define, plan, and establish appropriate strategies with related parties to X Hospital by compiling POA, drafting Nurse writing on integrated patient development records, conducting discussions and brainstorming, and socialization. The movement stages carried out involve the managers of X Hospital, following the theory of (Marquis & Huston, 2017) namely. A leader must show flexibility in setting goals, recognizing the need for change, and providing support to staff. The pilot project implementation at Hospital X was carried out well, thanks to the chair of the nursing committee, the field of nursing services, the coordinator of the inpatient room, and several heads of rooms that could be invited to accept changes. The nursing management of X Hospital has also supported and strengthened staff efforts during the change process and provided adequate information to staff. This is also following the research results from (Hussain et al., 2018) that the leader's efforts in staff involvement and the motivation given to staff by sharing knowledge both individually and in organizations will support the change process. Coaching is carried out by the head of the nursing committee in guiding the head of the room and Charge Nurse on how to write SOAP on integrated patient development recordS according to SOP and SAK. Based on the theory from (Stefanick et al., 2013) that with coaching, a nursing manager can provide guidance, facilitate, inspire, support, and influence staff in the change process. In carrying out the pilot project at this movement stage, the author uses a strategy of providing information and communication, participation, building support and commitment, and selecting people who accept change (Robbins & Judge, 2017).

After optimizing the writing of SOAP on the integrated patient development record by optimizing the function of directing and controlling the Charge Nurse, the head of the room, and the coordinator, there was an improvement in writing in the range of 6% to 48%. The Charge Nurse optimizes the direction and control function by verifying the writing of SOAP on the integrated patient development record by the associate NurseNurse following the SOP, which has not previously been implemented by the Charge Nurse. Optimization of the head of the room and the coordinator of the inpatient room was carried out at the pre-conference

by discussing with the nurses and continuing to provide motivation and direction to the nurses to document the writing of SOAP on the integrated patient development record according to the SOP. This is done by a manager in implementing the actuating function with a directive focus, namely the manager guiding and increasing staff motivation (Robbins & Judge, 2017). In line with research from (Dwi et al., 2019), which concluded that the competence of staff to document patient progress records was increased through empowering the head of the room by conducting supervision, evaluation, and monitoring.

According to (Aihatram et al., 2020) to enable nurses to do proper documentation, it is necessary to carry out audits and orientate nurses. This has been carried out at X Hospital by the nursing committee. An audit of writing SOAP on the integrated patient development record was carried out by Charge Nurse to determine whether or not SOAP on the integrated patient development record was written by the Nurse Associate. At the same time, the audit of the suitability of subjective and objective data with nursing diagnoses is carried out by the nursing committee. The implementation of the audit carried out is following the controlling function that must be carried out by the nursing manager, namely continuing to carry out a continuous process to improve the quality of nursing services, namely by conducting nursing audits and determining the improvement efforts that will be carried out (Robbins & Judge, 2017).

Optimize SOAP writing on the integrated patient development record; discussions, outreach, and brainstorming were also carried out with nurses and related parties. This is following (Aihatram et al., 2020) that continuing education will improve the quality of nursing documentation.

The third stage of refreezing (refreezing stage) is stabilizing the system change into the status quo (Robbins & Judge, 2017). Ideally, changes take 3-6 months to be implemented properly (Marquis & Huston, 2017). For this reason, to maintain the status quo, efforts to optimize SOAP writing on this integrated patient development record will be carried out further by the Charge Nurse, head of the room, coordinator, nursing committee, and nursing service division according to the need to their respective roles and functions.

IV. Conclusion

The optimization of SOAP writing on the integrated patient development record can be carried out following the planning in the Plan Of Action, with full support from the field of nursing services, nursing committees, coordinators, heads of rooms, Charge Nurse, and Nurse Associate in Intensive Inpatient X Hospital.

Writing standardized SOAP on integrated patient development records will provide good quality documentation, which will also affect the quality of care provided. The output of this pilot project is a draft of writing SOAP on integrated patient development record which can be used as a reference for nurses in writing SOAP on integrated patient development records. With the control / controlling, each level of the manager is expected to achieve organizational goals and improve the deviations found.

Recommendation

It is hoped that the Charge Nurse, the head of the room, and the coordinator will continue to carry out discussions, monitoring, and evaluation on an ongoing basis. To the field of nursing services, when revising the SOP, writing SOAP on the integrated patient development record later so that it can be clarified how the verification process is when Charge Nurse is not on duty, whether it is permissible to verify by the person in charge of the shift and clarify when to write SOAP because it is an obstacle for Charge Nurse when

verifying when SOAP written in a short period during the hand over process. As well as for the nursing committee, in order to carry out a reward program for individual nurses or rooms with the best SOAP writing on the integrated patient development record and proposing the ratification of the SOAP writing a draft on the integrated patient development record. The hospital is also expected to accelerate the use of electronic medical records that are synchronized with the nursing care standards that have been prepared.

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