ABSTRACT

Background: Nursing documentation is part of the systematic nursing approach which is summarized in the nursing process. Documentation of patient's information among nurses and midwives in Pallisa hospital still remains a big challenge. Its general objective was to assess knowledge, attitudes and practices of nurses and midwives towards documentation of patient's information in Pallisa hospital, Pallisa District.

Methods: A descriptive cross sectional design was used employing quantitative data collection methods. Data was obtained using a semi structured questionnaire written in English and the 90 respondents were randomly selected to participate in the study.

Results: 72.2% of the Nurses and midwives had adequate knowledge about documentation of patients' information. 64.4% of these were getting it through continuous professional development, 48.9% were accessing this information at the nurses' station. 86.7% had a good practice, 86.7% showed that documentation was associated with barriers, 80% showed that documentation was beneficial to both, the health facility, nurses and midwives, and to the patients themselves. 43% showed that the benefit was for referential purposes, 72.2% showed that paper system was the method used for documenting the patients' information. 48.9% accessed the information about patients at the bedside and 57.8% showed that the barrier to documentation of patients' information was finance.

Conclusion: The knowledge level of nurses and midwives was adequate 72.2%.this was because of continuous professional education and the attitude was good 80.0%. However, there are barriers that have hindered their practice 86.7% which include stationary, and work overload.