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Development Of Nursing Care Instruments Based On The 3s Framework (Sdki, Slki, Siki) For Inpatient Settings

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ABSTRACT

Standardized nursing documentation is essential for ensuring consistency, accountability, and quality in patient care. In Indonesia, the 3S framework—comprising the Standar Diagnosa Keperawatan Indonesia (SDKI), Standar Luaran Keperawatan Indonesia (SLKI), and Standar Intervensi Keperawatan Indonesia (SIKI) serves as a national standard. However, its application in inpatient settings remains inconsistent due to the lack of integrated, user-friendly tools. This study aimed to develop and validate a nursing care documentation instrument based on the 3S framework to improve documentation accuracy, support clinical decision-making, and promote standardization in inpatient wards. A Research and Development (R&D) approach was employed, using a modified Borg and Gall model across five stages: preliminary study, planning, product development, expert validation, and limited field testing. Data were gathered through literature reviews, chart audits, clinical interviews, and focus group discussions with nurses. The instrument was designed to address the 12 most frequently encountered nursing diagnoses in general medical-surgical wards, which were systematically mapped to appropriate SLKI outcomes and SIKI interventions. The final tool features structured diagnosis formats (PES, PR, PS), outcome targets with timelines, and categorized interventions (observation, treatment, education, collaboration), implemented in a shift-based checklist format. Validation by five expert nurses yielded strong content validity (I-CVI range: 0.833–1.000), and field testing with 15 clinical nurses demonstrated acceptable internal consistency (KR-20: 0.790–0.845). Additionally, 87% of nurses reported improvements in documentation quality and workflow efficiency. In conclusion, the 3S-based nursing care instrument is valid, reliable, and practical for clinical use, and its adoption is recommended to enhance nursing documentation standards and the quality of care in hospital settings.

INTRODUCTION

The provision of high-quality nursing care is a cornerstone of effective healthcare delivery systems globally. Nursing services not only influence patient outcomes but also serve as an indicator of the overall quality of health services in a country (Ackley, 2024). However, healthcare systems around the world are under increasing strain due to multifaceted challenges, including critical shortages of nursing staff, increasing patient acuity levels, and mounting administrative workloads. These pressures have raised significant concerns about the continuity, efficiency, and safety of nursing care, particularly in low- and middle-income countries (WHO, 2022; Alligood, 2022). In the Asian context, and more specifically in Indonesia, such systemic issues are intensified by infrastructural constraints, inadequate healthcare funding, and wide disparities in professional nursing competencies and standards across urban and rural health facilities (Ministry of Health Republic Indonesia, 2023).

To address these challenges and promote standardized clinical practice, Indonesia has adopted a national nursing framework known as the 3S framework, which consists of *Standar Diagnosa Keperawatan Indonesia (SDKI)*, *Standar Luaran Keperawatan Indonesia (SLKI)*, and *Standar Intervensi Keperawatan Indonesia (SIKI)*. This integrated system is intended to standardize nursing diagnoses, expected patient outcomes, and

intervention strategies, thereby improving care planning and documentation (Tauran & Tunny, 2023). Despite its importance, the real-world application of the 3S framework in clinical practice remains inconsistent and suboptimal. Studies have shown that a significant number of nurses experience challenges in applying these standards correctly due to limited training, low familiarity with the framework, and insufficient institutional support (Muharni, 2024; Nahak, 2023; Rendana & Muharni, 2023). These limitations often result in fragmented nursing documentation and variations in the delivery of care, which undermine the objective of standardized practice.

One of the major barriers to the effective implementation of the 3S framework is the absence of user-friendly and integrated documentation tools that align with SDKI, SLKI, and SIKI. In many clinical settings, nurses rely on outdated or unstructured documentation formats, which contribute to errors, delays in care delivery, and poor communication among interprofessional teams (Hidayat, 2021). Inadequate documentation not only impairs the ability to monitor patient progress and outcomes but also affects the legal and ethical accountability of nursing practice (Harding & Hagler, 2022). Moreover, inconsistent documentation practices compromise the use of data for quality improvement initiatives and hinder the development of evidence-based nursing interventions (Wisuda & Suraya, 2024; Potter and Perry, 2021).

Nursing care standards play a pivotal role as quality benchmarks and serve as the foundation for validating structured documentation instruments based on the 3S framework (SDKI, SLKI, SIKI). These standards offer a practical and standardized format that enables nurses to record nursing diagnoses, expected outcomes, and interventions with greater accuracy, clarity, and efficiency. By integrating these standards into daily clinical documentation, the developed instrument aims to enhance the quality, completeness, and consistency of nursing records. This alignment not only supports more precise clinical decision-making but also promotes patient safety, strengthens accountability, and facilitates systematic quality assurance. Ultimately, the implementation of such an instrument is expected to advance evidence-based nursing practice and improve the overall standard of care across healthcare settings in Indonesia (Haugen, 2022;.Jannah, 2020).

In response to these pressing challenges, this study aims to develop and validate an integrated nursing care documentation instrument based on the 3S framework (SDKI, SLKI, SIKI). The absence of a practical, standardized tool has been a major barrier to the effective implementation of national nursing standards in daily clinical practice. Therefore, the proposed instrument is designed to bridge this gap by providing nurses with a structured, user-friendly format to document diagnoses, expected outcomes, and interventions consistently. This tool not only supports the accuracy and efficiency of nursing records but also reinforces clinical decision-making, enhances interdisciplinary communication, and upholds legal accountability. By aligning documentation practices with national standards, the instrument is expected to improve the overall quality of nursing care, promote evidence-based practice, and ensure better patient outcomes across diverse healthcare settings in Indonesia.

METHOD

Study Design

This study employed a descriptive research design with a Research and Development (R&D) approach, adapted from the Borg and Gall model. The instrument development process was carried out through five key phases: (1) preliminary study, (2) planning, (3) product development, (4) expert validation, and (5) limited field testing.

1. Preliminary Study

This stage aimed to identify the need for a 3S-based nursing care instrument within inpatient settings. Data collection was conducted through three primary methods:

a. A comprehensive literature review was carried out to examine the implementation of the Indonesian nursing standards SDKI (Standar Diagnosa Keperawatan Indonesia), SLKI (Standar Luaran Keperawatan Indonesia), and SIKI (Standar Intervensi Keperawatan Indonesia) as well as the challenges associated with nursing documentation in clinical practice.
b. In-depth interviews were conducted with 10 bedside nurses working in inpatient wards to

explore the barriers and limitations they encounter in current documentation practices.

c. The first Focus Group Discussion (FGD) was organized to gather diverse insights and validate initial findings. This FGD involved a total of 17 participants, consisting of 10 clinical nurses, 5 nursing management staff, and 2 nursing experts representing both academic and practical backgrounds.

2. Planning

Based on the findings from the preliminary phase, the researcher developed an initial draft of the nursing care instrument incorporating the three core components of the 3S framework:

a. Standar Diagnosis Keperawatan Indonesia (SDKI)
b. Standar Luaran Keperawatan Indonesia (SLKI)
c. Standar Intervensi Keperawatan Indonesia (SIKI)

The instrument was designed in the form of a structured documentation sheet, aimed at facilitating systematic recording and seamless integration into the nursing workflow within inpatient settings. The format was developed to ensure clarity, ease of use, and alignment with clinical routines, thereby supporting accurate and standardized documentation practices.

3. Product Development

The initial draft of the instrument underwent a limited review involving a team of clinical nurses and nursing management staff to assess its relevance, clarity, and applicability within the context of inpatient clinical practice. Feedback gathered from this initial evaluation was used to refine and adjust the instrument, ensuring it met practical needs and aligned with existing workflows and documentation standards.

4. Expert Validation

Content validation was conducted by a panel of five experts, comprising senior nursing academics and experienced clinical practitioners. The validation process employed the Content Validity Index (CVI) method, specifically using the Item-Level CVI (I-CVI) to assess the relevance and clarity of each item within the instrument. The results demonstrated an I-CVI score of 0.92, indicating a high level of content validity and strong agreement among the experts regarding the instrument's appropriateness for clinical application.

Study Population and Sampling

The study population consisted of all inpatient ward nurses at RSUP Dr. Muhammad Hoesin Palembang, where the research was conducted in 2024. A purposive sampling technique was employed to select participants based on their relevance to the study's objectives. The sample included:

a. 10 nurses who participated in the initial in-depth interviews, providing valuable insights into current documentation practices and challenges.
b. 17 participants for the first Focus Group Discussion (FGD), which included a diverse group of clinical nurses, nursing management staff, and nursing experts. This group contributed to the refinement of the developed nursing care instrument.
c. 15 nurses involved in the limited field testing phase of the instrument, where their feedback helped assess the practicality and usability of the tool in real clinical settings.

Data Collection Instruments

Several instruments were used to collect data throughout the study. These included structured observation sheets to assess nursing documentation practices, interview and FGD guides to facilitate qualitative data collection, content validation forms for expert review using the Content Validity Index (CVI), and reliability assessment forms to evaluate the consistency of the instrument during field testing.

Validity and Reliability Testing

The instrument's content validity was evaluated using the Content Validity Index (CVI), specifically the Item-Level CVI (I-CVI), to assess the relevance and clarity of each component as judged by expert reviewers. Reliability was examined during a limited field implementation using the Kuder-Richardson Formula 20 (KR-20), which is appropriate for measuring the internal consistency of structured instruments with dichotomous response formats. These assessments ensured that the instrument met established standards for validity and reliability in clinical documentation tools.

Research Ethics

This study received ethical approval from the Health Research Ethics Committee of Faculty of Medicine, Sriwijaya University, with approval number 024-202. Informed consent was obtained from all participants, and data confidentiality was

maintained in accordance with standard ethical principles for human subjects research.

RESULTS AND DISCUSSION

RESULTS

The development of nursing care instruments based on the 3S framework (SDKI, SLKI, SIKI) for inpatient settings was carried out through a structured Research and Development (R&D) process, involving preliminary studies, instrument design, expert validation, and limited field trials. The aim was to create a standardized, integrated, and practical documentation tool that aligns with Indonesia's national nursing standards as determined by the Indonesian National Nurses Association (PPNI) (Sege et al., 2022).

The development focused on the 12 most common nursing diagnoses frequently encountered in inpatient wards. These were identified based on documentation audits, interviews with clinical nurses, and focus group discussions. The diagnoses were selected for inclusion due to their high prevalence and clinical relevance in general medical-surgical inpatient care.

Based on data collected from clinical documentation audits, interviews, and focus group discussions with inpatient nurses, twelve nursing diagnoses were identified as the most frequently occurring in inpatient care settings. These include *Ineffective Airway Clearance (D.0001), Impaired Gas Exchange (D.0003), Acute Pain (D.0077), Risk for Infection (D.0142), Impaired Physical Mobility (D.0054), Nutritional Deficit (D.0019), Impaired Skin Integrity (D.0129), Hyperthermia (D.0130), Sleep Pattern Disorders (D.0055), Risk for Falls (D.0143), Self-Care Deficit: Bathing/Hygiene (D.0109),* and *Anxiety (D.0080)*. These diagnoses reflect common clinical problems encountered in general medical-surgical wards and were used as the foundation for developing a standardized nursing care instrument based on the 3S framework (SDKI, SLKI, SIKI).

Each diagnosis was systematically mapped to corresponding nursing outcomes from SLKI and nursing interventions from SIKI, resulting in an integrated documentation tool. The instrument includes a diagnosis form aligned with SDKI, using structured formats such as PES (Problem, Etiology, Symptoms), PR (Problem, Risk Factors), or PS (Problem, Symptoms), depending on the type of diagnosis. Outcome components are drawn from SLKI and include clearly defined goals, target criteria, and specified time intervals to guide the evaluation of care effectiveness. Additionally, the intervention section follows SIKI guidelines and classifies actions into four main categories: observation, treatment, education, and collaboration. Together, these components form a comprehensive and standardized nursing documentation instrument designed to improve care consistency, support clinical decision-making, and enhance the quality of nursing services in inpatient settings.

Table 1. Development of the 3S-Based Nursing Care Instrument Components for Inpatient Settings

Component	Previous Documentation Practice	3S-Based Instrument Development Approach
Nursing Diagnosis	Diagnoses often lacked standardized format or supporting data	Refers to SDKI; uses PES/PR/PS structure; checklist format with causes, signs, and symptoms
Nursing Outcomes	Often omitted or vague outcome criteria	Refers to SLKI; includes outcome name, target level, and time interval
Nursing Interventions	Interventions not consistently labeled or categorized	Refers to SIKI; labeled and categorized as observation, treatment, education, collaboration
Implementation	Lacked standard formatting and often separated from interventions	Based on planned SIKI interventions; checklist format; recorded over 3×8 hours
Evaluation	Evaluation forms were separate and lacked process indicators	Evaluation includes timing, reassessment, and outcome tracking over 3 days

Validity and Reliability Testing

The developed instrument was validated by a panel of 5 experts using the I-CVI (Item Content Validity Index), and tested for reliability in a field trial involving 15 nurses. Each nurse applied the instrument to one real inpatient case, selecting 3 of the 12 common diagnoses.

Table 2. Validity and Reliability Results of the 12 Most Frequent Nursing Diagnoses in Inpatient Settings Based on the 3S Framework (SDKI, SLKI, SIKI)

Nursing Diagnosis	I-CVI Range	KR-20 Value	Interpretation
Ineffective Airway Clearance	0.916 – 1.000	0.833	Valid and Reliable
Impaired Gas Exchange	0.833 – 1.000	0.830	Valid and Reliable
Acute Pain	0.917 – 1.000	0.845	Valid and Reliable
Risk for Infection	0.900 – 1.000	0.812	Valid and Reliable
Impaired Physical Mobility	0.875 – 1.000	0.822	Valid and Reliable
Nutritional Deficit	0.917 – 1.000	0.796	Valid and Reliable
Impaired Skin Integrity	0.850 – 1.000	0.805	Valid and Reliable
Hyperthermia	0.875 – 1.000	0.790	Valid and Reliable
Sleep Pattern Disorders	0.900 – 1.000	0.808	Valid and Reliable
Risk for Falls	0.850 – 1.000	0.803	Valid and Reliable
Self-Care Deficit (Bathing)	0.917 – 1.000	0.819	Valid and Reliable
Anxiety	0.875 – 1.000	0.826	Valid and Reliable

The table 2 demonstrates that all twelve of the most frequent nursing diagnoses in inpatient settings developed based on the 3S framework (SDKI, SLKI, SIKI) achieved strong content validity (I-CVI: 0.833–1.000) and acceptable reliability (KR-20: 0.790–0.845), confirming their consistency and suitability for clinical documentation.

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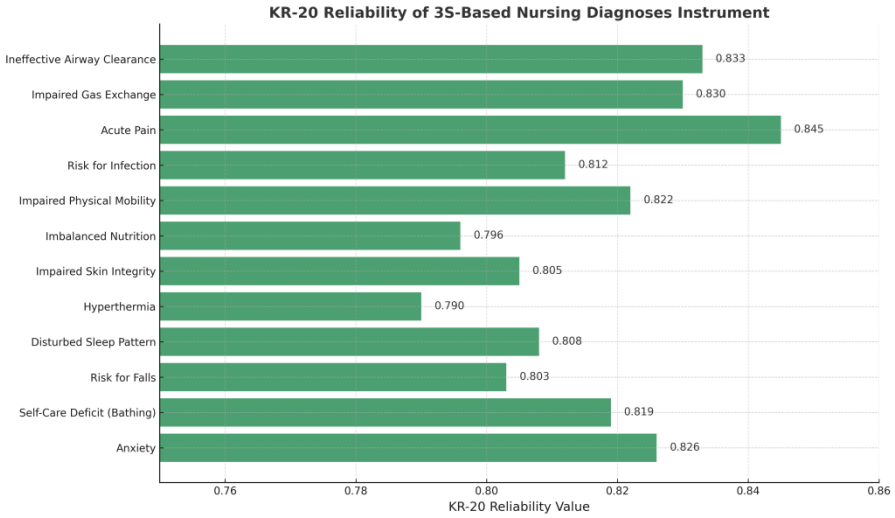

Figure 1. KR-20 Reliability Scores of the 12 Most Frequent Nursing Diagnoses in Inpatient Settings (3S Framework-Based Instrument)

Figure 1 shows the KR-20 reliability values for the 12 most frequent nursing diagnoses documented using the 3S-based instrument in inpatient settings. All reliability scores range from 0.790 to 0.845, indicating good to high internal consistency. The highest reliability was found in the "Acute Pain" diagnosis (0.845), followed by "Ineffective Airway Clearance" (0.833) and "Impaired Gas Exchange" (0.830). The lowest score, though still acceptable, was seen in "Hyperthermia" (0.790). These results confirm that the instrument is reliable and consistent for use in clinical nursing documentation.

DISCUSSION

This study developed and validated a standardized nursing care documentation instrument grounded in the 3S framework comprising the Indonesian Nursing Diagnosis Standard (SDKI), Nursing Outcome Standard (SLKI), and Nursing Intervention Standard (SIKI) to enhance clinical nursing practice in inpatient settings. The motivation

for this development emerged from the need for integrated, evidence-based nursing documentation that aligns with national regulatory expectations set by the Indonesian National Nurses Association (PPNI). Proper documentation is not only essential for ensuring continuity and quality of care but also serves as a legal record and a metric for nursing accountability (Muharni, 2024; Kartini & Eka Ratnawati, 2022).

The instrument was developed using a structured Research and Development (R&D) approach, which encompassed stages of needs assessment, instrument design, expert validation, and field testing. Focus was placed on the twelve most frequently documented nursing diagnoses within general medical-surgical wards. These diagnoses were identified through retrospective chart audits, semi-structured interviews with clinical nurses, and expert-led focus group discussions. Diagnoses such as Ineffective Airway Clearance, Acute Pain, Risk for Infection, and Anxiety were selected due to their clinical significance, prevalence, and frequent documentation errors noted in routine care (Purnamasari et al., 2023; Sulistyawati & Susmiati, 2020).

Each nursing diagnosis was systematically linked with corresponding expected outcomes (SLKI) and evidence-based interventions (SIKI), forming a closed-loop documentation system consistent with the nursing process model: assessment, diagnosis, planning, implementation, and evaluation. The diagnosis entries utilized the SDKI's standardized PES, PR, or PS format to ensure diagnostic clarity and consistency. Outcomes were operationalized through measurable indicators, goal targets, and specified evaluation timeframes. Interventions were classified into observation, treatment, education, and collaboration categories per the SIKI taxonomy, allowing for detailed planning, delegation, and evaluation (Cuda & Censani, 2022; Berman et al., 2021).

Comparative analysis against previous documentation systems revealed substantial improvements in structure, completeness, and clinical relevance. Earlier records were often fragmented, non-standardized, and lacking measurable outcomes. In contrast, the new instrument incorporates all documentation components—diagnosis, outcomes, and interventions into an integrated, shift-based checklist. This enhances continuity across nursing shifts and facilitates timely evaluation and decision-making (Nahak, 2023; Abd El Rahman et al., 2021; Kamil et al., 2020). Moreover, the checklist format promotes user-friendliness and supports compliance with institutional audits and accreditation metrics.

Content validation by five expert nurses yielded Item-Content Validity Index (I-CVI) scores ranging from 0.833 to 1.000, exceeding the widely accepted threshold of 0.78, thereby affirming strong content validity (Polit & Beck, 2019). Additionally, internal consistency was confirmed through a limited field test involving 15 clinical nurses, with Kuder-Richardson 20 (KR-20) reliability values ranging from 0.790 to 0.845. These results indicate a high degree of reliability and practical usability. The findings are consistent with earlier literature emphasizing the role of structured nursing documentation in improving quality of care and ensuring professional accountability (Sari et al., 2021; Doengoes & Moorhouse, 2019).

The 3S framework facilitates clinical reasoning and critical thinking by establishing a clear link between assessment, diagnosis, goals, and interventions. This supports the development of clinical judgment, especially among novice and early-career nurses. This approach is congruent with Benner's Novice to Expert theory, which posits that structured frameworks enhance cognitive development and decision-making confidence across five stages of clinical expertise (Mayenti et al., 2024; Murtiningsih et al., 2021). As such, the 3S-based instrument not only serves as a documentation guide but also as an educational scaffold. The use of standardized documentation instruments fosters inter-nurse communication, consistency, and compliance with hospital quality standards and accreditation requirements. It provides a shared language for documenting nursing care, which is crucial for reducing errors and enhancing patient safety. In institutional contexts, standardization also contributes to improved workflow efficiency and documentation accuracy (Widyastuti, 2024; Amir & Kaseger, 2023; Wisuda, 2020).

The results demonstrate that the instrument is both valid and reliable, with high potential for clinical adoption without the need for extensive retraining

assuming nurses are already familiar with the 3S framework. The practicality of the tool, especially its shift-friendly checklist design and alignment with PPNI standards, supports its scalability across various hospital units. Moreover, its integration into clinical workflows has the potential to elevate nursing documentation from a perfunctory task to a core aspect of professional practice (Wahyuliati, 2024; Harding & Hagler, 2022). In conclusion, the 3S-based nursing care documentation instrument is not only theoretically sound and empirically validated but also highly applicable in inpatient clinical settings. By enhancing the standardization, clarity, and usability of nursing records, it contributes to quality improvement, clinical accountability, and patient safety. Hospitals particularly those operating medical-surgical wards are encouraged to adopt this tool to streamline documentation practices, support professional development, and align with national standards (Muzaenah et al., 2023; (Hockendberry, 2020).

Strengths and Limitations

The nursing care instrument developed based on the 3S framework (SDKI, SLKI, SIKI) aligns with Indonesia's national standards, ensuring regulatory consistency and facilitating integration into local healthcare settings. It provides a structured, evidence-based approach to documentation, linking diagnoses, outcomes, and interventions to enhance continuity of care, decision-making, and communication among nurses. The shift-based checklist format improves clinical efficiency and inter-professional collaboration. Demonstrating strong content validity and internal consistency, the instrument supports both novice and expert nurses in making clinically sound decisions. However, its implementation may face challenges, such as varied nurse familiarity and resource demands for training. While primarily designed for medical-surgical wards, its applicability in other settings requires customization. The limited field testing sample and potential for oversimplification in complex cases are additional limitations. Moreover, the instrument’s focus on diagnosis and interventions may reduce attention to holistic aspects of care, and its widespread adoption may be resource-intensive for smaller institutions.

Implications for Practice

The development of a nursing care instrument based on the 3S framework (SDKI, SLKI, SIKI) has significant implications for clinical practice, particularly in inpatient settings. By standardizing documentation practices, this tool promotes consistent, evidence-based care, ensuring that nurses systematically assess, plan, implement, and evaluate patient care. It enhances communication among nursing staff, supports clinical decision-making, and fosters continuity of care across shifts, which is crucial for patient safety in busy hospital environments. The instrument's structured approach also provides a valuable educational resource for nurses, guiding less experienced staff in developing clinical reasoning skills. However, successful implementation will require training and adaptation to various clinical contexts, as well as ongoing support to ensure its integration into existing care workflows. Ultimately, the tool has the potential to improve nursing care quality, accountability, and patient outcomes in inpatient settings.

CONCLUSION

In conclusion, the development and validation of the 3S-based nursing care documentation instrument represents a significant advancement in inpatient nursing practice. Grounded in the Indonesian National Nursing Standards (SDKI, SLKI, SIKI), the instrument enhances the quality, consistency, and reliability of nursing documentation. Its structured approach ensures comprehensive integration of assessment, diagnosis, outcomes, and interventions, thereby improving continuity of care and clinical decision-making across shifts. The instrument’s strong content validity and internal consistency, confirmed through expert validation and field testing, make it a reliable tool for nursing practice. Additionally, its user-friendly checklist format supports efficient documentation, promotes compliance with institutional standards, and facilitates improved inter-nurse communication. This tool not only improves documentation quality but also serves as a valuable educational resource, supporting the development of clinical reasoning and judgment, particularly among novice nurses. The instrument’s adoption can streamline nursing workflows, enhance

patient safety, and elevate the professional standards of care, particularly in medical-surgical wards.

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