IMPROVING QUALITY OF NURSING CARE DOCUMENTATION IN CLINICAL PRACTICE IN COUNTY REFERRAL HOSPITALS IN KENYA

MUKUNA NJERI ANNE

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DECLARATION

I declare that this research thesis is my original work and has not been presented for a degree or any other award in any other university.

Mukuna Njeri Anne

HSM-4-3964-3/2015

Signature  Date: 10.10.2025

Supervisors

This research thesis report has been submitted for review with our approval as university supervisors.

Signature  Date …10.10.2025

Prof. Wanja Mwaura- Tenambergen

Riara University

Signature  Date …10.10.2025

Dr. Kezia Njoroge

Liverpool John Moores University

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DEDICATION

This work is dedicated to my family, for their endurance and many sacrifices throughout the course.

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I wish to recognize the effort of the following persons who made invaluable contribution to the success of this work. My supervisors, Prof. Wanja Mwaura-Tenambergen who constantly encouraged and provided guidance and Dr. Kezia Njoroge who guided and pushed me on. May God bless them.

ABBREVIATION AND ACRONYMNS

ALOS	Average length of stay
ASAL	Arid and Semi-Arid Lands
CPD	**C**ontinuous professional development
GOK	Government of Kenya
ICH	International Conference on Harmonization
ICN	International Council of Nursing
KeMU	Kenya Methodist University
KHP	Kenya Health Policy
KHSSP	Kenya Health Sector Strategic Plan
KNP	Kenya Nursing Process
LMIC	Lower and Medium Income Countries
MOH	Ministry of Health
MTPII1	Third Medium Term Plan 2018-2022
NACOSTI	National Commission for Science, Technology and Innovation
NCK	Nursing Council of Kenya
SAL	Semi-Arid Lands
SOP	Standard Operating Procedure
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization

ABSTRACT

Nursing care documentation is a core responsibility of professional nurses, spanning from patient admission to discharge and ensuring 24-hour continuity of care. Accurate documentation reflects patients' conditions, nursing interventions, and outcomes, while deficiencies compromise care quality, continuity, and safety, exposing nurses to legal risks. In Kenya, persistent challenges with documentation prompted adoption of the global nursing process, positioning documentation as its final and essential step in improving healthcare outcomes. This study addressed health systems' service delivery pillar, aiming to enhance nursing care documentation practices. Specific objectives were i) assessing the influence of individual nurse factors on the quality of nursing documentation in selected counties in Kenya; ii) establishing the influence of institutional factors on the quality of nursing documentation; iii) determining the impact of multidisciplinary collaboration on nursing documentation quality; iv) evaluating the influence of patient factors on nursing care documentation; and v) developing a framework to enhance nursing care documentation quality. The study was guided by general systems theory, McGregor's Theory Y, and Deming's theory. The study took place in Nyeri, Nyandarua, and Isiolo referral hospitals. Stratified sampling technique led to identification of three counties, census technique identified eight nurse managers, and random sampling identified 86 nurses and 158 patient case files. The study was organized into three phases. Phase one established a baseline using a descriptive research design. Phase two implemented applied research design, during which a Continuous Professional Development (CPD) module was developed, delivered at Nyeri County Referral Hospital, with a one-week follow-up. Phase three evaluated the effectiveness of the intervention using a descriptive design, with a sample size of 31 nurses and 31 patient case files. The study population included nurse managers and clinical nurses from the medical and surgical units and patient case files from those units in the three hospitals. Data collection instruments comprised questionnaires, a key informant guide, and an observation checklist, yielding both qualitative and quantitative data. Content analysis was used for the qualitative data, while quantitative data were analyzed using regression analysis with SPSS (version 26.0). Baseline results revealed that 78% of nursing care documentation was poor. Individual nurse factors, such as knowledge and attitude significantly influenced the quality of documentation. Institutional factors included standard operating procedures (SOPs), supervision, and institutional culture. Multidisciplinary factors influencing documentation quality included joint setting of clinical outcomes and collaborative clinical meetings. Patient factors affecting documentation included patient acuity, socio-economic empowerment, and inquisitive patients. Regression analysis of individual, patient and institutional factors demonstrated P values of <0.005, indicative of significant association. Post intervention, nursing documentation quality rose from 22% to 81.2%, demonstrating significant effectiveness. In summary, the findings show nursing documentation depends on many factors. Sustainable improvement requires identifying and addressing individual, institutional, and systemic influences through comprehensive, multi-faceted strategies, not singular approach. The study recommends i) adoption of systems thinking in improving nursing care documentation practice, ii) strengthening efforts for sustainability, iii) comparative study between manual versus electronic documentation, and iv) correlational study between public and private institutions.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The first nursing model was developed by Florence Nightingale in 1873. Since then, the professional responsibilities and the scope of nursing practice have evolved significantly, where they are required to take up more clinical roles and responsibilities (Grinberg & Sela, 2022). This evolution has been accompanied by a changing context in which evidence serves as the primary driver of nursing practice (Abou et al., 2020), and data for decision making is increasingly becoming important.

For effective nursing practice, comprehensive documentation of all nursing actions undertaken during patient care is essential. Nursing care documentation is defined by (Aboshaiqah et al., 2023) as a personalized record of the nursing care that a qualified nurse plans and executes for each patient. Good health is recognized as one of the sustainable development goals (United Nations, 2021). Achieving good health and well-being requires a robust health system that can meet the health needs of the population, and which embrace the health systems building blocks as outline by World Health Organization (WHO). The six pillars of health system strengthening include human resources for health, health information, medical products, vaccines and technologies, stewardship, health financing, and service delivery (Ferrinho, et al., 2023). Kenya has added Health infrastructure and Research & Development, that are key towards achieving the Kenya Health Policy 2014-2030 (Ministry of Health, 2014).

Research has linked nursing activities to patient care outcomes, with strong association between quality of nursing care documentation and the well-being of the health system as well as the patients in there (Bolado et al., 2023).

There is an increasing demand on healthcare systems to meet patients' needs and improve satisfaction, putting pressure on nurses to demonstrate that they have fulfilled patient care requirements (Friese et al., 2023). Documenting the completion of these nursing activities and patients' responses to interventions is essential. Several documents exist for nurses to record different aspects of nursing care, including the nursing kardex, fluid chart, vital signs observation chart, nursing care plan, and specialized charts. These documents should be interconnected and accurately reflect the patient's clinical condition and the nursing interventions provided. Nursing care documentation facilitates communication among nurses and between nurses and other members of the healthcare multidisciplinary team regarding their observations, decisions, interventions, and patients' responses to these interventions (Rahman et al., 2021).

ElHawary et al. (2023) emphasize that precise, comprehensive nursing documentation is fundamental to maintaining patient safety and preventing clinical errors. Such information is valuable for policymakers, researchers, and communication within the healthcare team, as well as for quality improvement. However, several studies have reported significant shortcomings in nursing care documentation, with some demonstrating a lack of thoroughness. These deficiencies hinder the benefits associated with quality nursing care documentation, such as enhanced patient safety, continuity of care, improved care quality, and reduced errors.

Recent literature emphasizes that most medical errors are less a function of individual negligence and more the result of systemic vulnerabilities, particularly weak documentation practices and flawed processes (Coelho et al., 2024). They identified common documentation errors, including illegible handwriting, the absence of dates and times, failure to properly sign medical entries, incomplete or missing documentation, late additions, subjective documentation, incomprehensible orders that are not questioned, the use of non-standard abbreviations, and correct entries in the wrong charts.

These errors can send mixed messages to the healthcare team, affecting care planning, provision, and clinical outcomes. (Saputra, & Ariyanti, 2020) asserts that detailed and comprehensive care records are vital components of effective nursing practice. Records must be timely, precise, and comprehensive. If such records do not exist, there is no evidence to support that nursing interventions were implemented, reinforcing the adage in nursing: “What is not recorded has not been done” (Brown, 2024). Hants et al. (2023) states that the quality of nursing documentation is a critical aspect of nursing, as it forms the basis for the rationale behind care decisions.

Globally, studies have demonstrated numerous gaps in nursing care documentation process. In Indonesia, errors such as illegible handwriting, late entries, the use of non-standard abbreviations, or misfiled records were reported as widespread (Saputra & Ariyanti, 2020). In Norway, gaps in care documentation were noted, with barriers identified to include technological constraints, organizational policies, social norms, and individual factors (Bjerkan et al., 2021). A similar situation was reported in

Denmark with documentation noted to be frequently incomplete or missing, posing direct risks to patient safety (Hertzum 2021).

Regionally, nursing care documentation gaps are also well documented. Suboptimal nursing care documentation was observed in Ethiopia (Kayase et al., 2022; Molla et al., 2024). A similar situation was observed in Tanzania with large gaps in the completeness of nursing care documentation. In Kenya, several studies have outlined challenges in nursing care documentation (Mbuthia et al., 2023; Muinga et al., 2023). These studies highlight gaps related to various factors in the health system. These factors can be classified as nurse-level, patient-level, organizational, and multidisciplinary-collaboration factors.

The study was anchored in the service delivery pillar, which emphasizes the provision of accessible, safe, and high-quality health services. Within this context, nursing care documentation forms a critical component, as it ensures continuity of care, facilitates communication among multidisciplinary teams, and provides evidence of the quality and effectiveness of services delivered. By anchoring the study in this pillar, the focus is placed on how accurate, timely, and comprehensive documentation directly contributes to improved patient outcomes, accountability, and overall system performance.

1.2 Statement of the Problem

Documentation is a requirement across all fields, particularly in healthcare. Effective communication among health system professionals is a critical factor in the quality of care provided by the multidisciplinary team to patients. Numerous authors highlight

nursing documentation as an essential component for ensuring patient safety and quality of care (Groot et al., 2022). Documentation enables the multidisciplinary team to deliver high-quality care.

Globally, nurses and midwives represent more than half of the professional healthcare workforce and are responsible for 80% of health indicators (Ministry of Health, Kenya, 2022). According to Patrician and Russell (2024) nurses account for 90% of interactions between health professionals and patients, making their contribution to service quality increasingly significant. In all healthcare settings, including hospitals, nurses and midwives are required to document all nursing actions using various forms, such as nursing process forms and the nursing Kardex. Unfortunately, several studies have identified deficiencies in nursing care documentation, which can severely compromise continuity of care, healthcare quality, and safety (Hertzum, 2021; Kayase et al., 2022; Molla et al., 2024).

The challenges associated with nursing care documentation led to the adaptation of the global nursing process to the local Kenyan context, incorporating documentation as the final step (Tadzong & Dufashwenayesu, 2021). Despite these efforts, nursing care documentation continues to present challenges, often resulting in scanty information that does not accurately reflect patient conditions. A study conducted in three county hospitals in the coastal region revealed scanty documentation of critical patient parameters (Mbuthia, et al., 2023). Yet, optimal nursing care documentation in county referral hospitals, that manage complex, high-acuity patients, should be real-time, objective, complete, and interoperable to ensure quality and safety and quality of care.

As we pursue universal health coverage, Kruk et al. (2024) emphasize the need to institutionalize and legislate mechanisms that ensure quality services at all levels, so healthcare is not only accessible but also safe, effective, and of high quality. Thorough nursing documentation is essential for improving the quality and completeness of patient care. As emphasized by Samani and Rattani (2023), the absence of documentation equates to the absence of proof that any care was delivered to the patient. In the nursing profession, this concept is often captured in the adage: “If it isn’t documented, it wasn’t done”. This underscores the need to bolster this element of care, thereby enhancing nursing quality and safety.

1.3 Purpose of the Study

Patient care outcomes are a primary concern for both the multidisciplinary team and health system managers. Around the world, sophisticated interventions and advancements in health technology aim to enhance healthcare outcomes. The benefits of these interventions and technologies are evident in the care documentation process. This process not only provides transparency in the delivery of care but also facilitates effective planning of healthcare services, enhances communication among team members, and improves responsiveness to patients' healthcare needs. Ultimately, accurate and timely nursing documentation enhances the quality of patient care and outcomes. Nurses remain central to achieving high-quality, safe healthcare delivery through their continuous presence and clinical coordination within the care team (Huang et al., 2024; Wei, 2023). This includes care provided by both nurses and other team members. Nurses occupy a exceptional position in the healthcare system, giving them the potential to meaningfully influence the quality of care delivered by the entire team. Accurate documentation of the care provided by nurses is vital for positively

impacting the overall quality of patient care. This study aims to identify drivers of nursing care documentation, and in the implementation phase, develop a strategy towards improving the practice, with the ultimate goal of enhancing the quality of care provided by the multidisciplinary team and, subsequently, improving healthcare outcomes.

1.4 Research Objectives

This study was be guided by the following research objectives.

1.4.1 Broad Objective

To develop a framework that enhance the quality of nursing care documentation in selected counties in Kenya.

1.4.2 Specific Objectives

i. To assess the impact of individual nurse factors on the quality of nursing care documentation in selected counties in Kenya.
ii. To investigate how institutional factors influence the quality of nursing care documentation in selected counties in Kenya.
iii. To examine the role of multidisciplinary collaboration in enhancing the quality of nursing care documentation in selected counties in Kenya.
iv. To evaluate the effect of patient factors on the documentation of nursing care in selected counties in Kenya.
v. To develop a continuous professional development module aimed at improving the quality of nursing care documentation in selected counties in Kenya.

1.5 Hypothesis

The study was be guided by the following

- $H0_1$: Individual nurse factors are not associated with documentation quality.
- H_{a1}: Individual nurse factors are significantly associated with documentation quality.
- $H0_1$: Institutional factors are not associated with documentation quality.
- H_{a1}: Institutional factors are significantly associated with documentation quality.
- $H0_1$: Patient factors are not associated with documentation quality.
- H_{a1}: Patient factors are significantly associated with documentation quality.
- $H0_1$: Multidisciplinary collaboration factors are not associated with documentation quality.
- H_{a1}: Multidisciplinary collaboration factors are significantly associated with documentation quality.
- $H0_1$: CPD module delivery was not associated with documentation quality.
- H_{a1}: CPD module delivery was significantly associated with documentation quality.

1.6 Justifications

Patients and clients accessing healthcare services in any system expect to receive high-quality care. As frontline health care workers, nurses play a significant role in contributing to the quality of care that patients receive. Unlike other members of the multidisciplinary team, nurses spend more time with patients and are uniquely positioned to understand how patients respond to the interventions provided by the team. The quality of care is reflected in nursing care documentation, which serves as a

vital channel of communication among nurses, as well as between nurses and the multidisciplinary health care team. Accurate documentation supports continuity of care and reinforces nurses' accountability for the services they deliver. This not only enhances patient safety but also protects the nurse and the health care system in the event of legal actions. County referral hospitals deliver complex, high-acuity care through multidisciplinary teams; timely, objective, and complete nursing documentation is the backbone of this collaboration, enabling safe handovers, sound decisions, and achievement of patient-care goals.

The importance of nursing care documentation is emphasized in various nursing textbooks and manuals. Despite its many benefits, research has shown significant gaps in nursing care documentation. These gaps can negatively impact the quality of care that patients receive and compromise the safety of both patients and health care providers, increasing the risk of litigation. County referral hospitals serve as the health system’s vital nexus, managing complex, high-acuity cases, and coordinating multidisciplinary care, making care documentation key towards achieving care objectives.

Organizations such as the World Health Organization (WHO), the International Council of Nurses (ICN), and the American Joint Commission on Accreditation of Healthcare Organizations strongly recommend using a nursing process for documentation and endorse its application in nursing care. The Nursing Council of Kenya underscores the importance of documentation by designating it as the final step in the Kenyan Nursing Process. This study aims to explore strategies for improving

nursing care documentation to ultimately enhance the quality and safety of healthcare delivery.

1.7 Significance of the Study

This study has system-wide implications, from individual nurses to global health actors. At the individual level, the findings enable self-assessment and professional growth: nurses can benchmark their documentation against best practice, identify gaps in timeliness, accuracy, objectivity, and completeness, and take corrective steps. Stronger documentation improves continuity of care, supports safer, faster clinical decisions, and enhances patient and provider satisfaction.

For professional bodies, the results pinpoint priority deficits that can be addressed through targeted continuing professional development (CPD). Associations and councils can design modular trainings, simulations, and audit-feedback cycles focused on core competencies (e.g., structured notes, standardized tools, lawful record-keeping). In doing so, they reinforce professional standards and cultivate a culture that treats documentation as clinical work, not paperwork.

Health facilities can translate the evidence into operational improvements. Such changes build a documentation culture that reduces errors, strengthens handovers, and raises overall care quality. At county and national management levels, the insights inform staffing, workload management, supervision policies, and quality assurance frameworks. Because documentation quality underpins medico-legal defensibility, these actions also reduce institutional risk while protecting the workforce.

In the global arena, the findings speak to challenges shared across settings; especially where resources are constrained. They can guide international agencies and partners in shaping guidelines, technical assistance, and funding priorities that elevate nursing documentation as a pillar of quality and safety.

Finally, the work advances the research agenda, highlighting questions on how documentation quality relates to patient outcomes, how technology and workflow redesign affect practice, and how leadership and team dynamics shape record-keeping. Taken together, the study equips stakeholders at every level to implement targeted interventions, inform policy, and embed high-reliability documentation practices, ultimately improving care quality locally and contributing to global learning.

1.8 Limitations of the Study

One of the primary limitations of this study lies in the potential for response bias stemming from how participants perceive the nature of the research. Specifically, some nurses may interpret the study as an audit or evaluation of their professional responsibilities and accountability, particularly concerning documentation practices. This perception may cause respondents to tailor their answers in a way that reflects positively on their own performance, rather than offering an accurate representation of their actual practices. In such instances, respondents may avoid admitting to documentation lapses, inconsistencies, or challenges that they face in their day-to-day work. This inclination to safeguard one's professional image or avoid perceived judgment can lead to social desirability bias, ultimately skewing the data toward overly favorable accounts. The result is that the research findings may not entirely reflect the

reality on the ground, potentially limiting the credibility and generalizability of the conclusions.

Moreover, institutional loyalty may also influence the accuracy of the responses collected. Nurses who feel a strong sense of allegiance to their employing institutions may consciously or unconsciously downplay shortcomings related to organizational support, resources, or infrastructure. For example, when asked about the availability of documentation tools, workload, or supervisory support, respondents may give optimistic answers that do not align with their actual experiences. This desire to portray their workplace positively may be especially pronounced in settings where respondents fear that negative feedback could harm the reputation of their facility or lead to institutional consequences. Such dynamics further challenge the objectivity of the data collected, particularly in questions concerning institutional or systemic factors.

To mitigate these potential limitations, the study design incorporates strict measures to protect participant confidentiality and reduce bias. All participants were be informed clearly and repeatedly that their participation is both voluntary and anonymous. The study emphasized that no individual responses will be traced back to specific persons or shared with supervisors, managers, or other staff. This assurance of confidentiality is crucial to fostering a safe space for honest disclosure. Furthermore, participants were be educated about the research's primary goal, which is to contribute to the improvement of nursing care documentation practices and ultimately enhance patient outcomes, rather than to evaluate individual performance or assign blame.

In addition to confidentiality, the study made efforts to foster trust and transparency by providing clear, accessible explanations about how the data will be used, who will have access to it, and how it will influence healthcare policy and practice. By framing the research as a collaborative effort aimed at institutional and professional development, rather than fault-finding, the study seeks to encourage truthful participation. Participants were also be reminded of the broader impact their input can have in shaping policies that support better working conditions, adequate documentation resources, and targeted training programs.

In conclusion, while the risk of biased responses due to personal and institutional concerns remains a limitation, the study incorporates deliberate strategies to minimize these effects. Ensuring anonymity, clarifying the intent of the study, and fostering a transparent research environment are critical to improving the accuracy and reliability of the findings. These efforts aim to encourage genuine responses that can drive meaningful improvements in nursing care documentation and, by extension, healthcare delivery.

1.9 Delimitations

The scope of this study was specifically confined to the nursing kardex as the central tool for nursing care documentation. Although nursing documentation can span multiple platforms and formats, including patient medical charts, electronic health records (EHRs), progress notes, and other communication tools, this study intentionally narrowed its focus to the kardex. The nursing kardex is a critical document used by nurses to record essential information about patient care, including the patient's current condition, vital assessments, and the nursing interventions provided during each shift.

It also includes updates on patient progress and instructions for the incoming nursing team. By focusing on this tool, the study aimed at obtaining a detailed and consistent understanding of the processes and challenges involved in one of the most widely used and practical documentation tools within many health care settings, particularly in low-resource environments.

Importantly, this narrowed scope allows for a more in-depth investigation into how nurses utilize the kardex in daily clinical practice and the extent to which it captures comprehensive, accurate, and timely information. Other forms of documentation, such as electronic health record systems or broader patient charting tools, although integral to modern health information systems, were excluded from the scope of this research. This is because these tools often involve a broader range of healthcare providers and introduce multiple variables that may dilute the study's focus. By isolating the kardex, the research can effectively explore its strengths, weaknesses, and the contextual factors that influence its use without the complexities introduced by other documentation platforms.

Additionally, this study gathered data exclusively from nurses, as they are the primary users and custodians of the nursing kardex. While other members of the multidisciplinary team such as physicians, pharmacists, and therapists, may interact with nursing documentation or contribute to it indirectly, their perspectives were not included in this study. The rationale for this delimitation is grounded in the study's objective to understand documentation practices from the viewpoint of those most intimately involved in its completion. Nurses bear the responsibility of ensuring

accurate and timely documentation, which is vital for continuity of care, communication among healthcare providers, and legal accountability.

By focusing exclusively on nurses' use of the kardex, the study maintains a clear and manageable scope, allowing for a more targeted analysis of the documentation practices, challenges, and areas for improvement. This focused approach increases the potential for meaningful, actionable findings relevant to nursing practice and healthcare policy.

1.10 Assumptions of the Study

The study makes several assumptions, which are critical to the credibility and applicability of its findings. First and foremost, it assumes that the respondents, the nurses participating in the research, were provide honest and reliable responses to the questions posed in the study tools. This assumption is vital for the integrity of the research, as the validity and reliability of the data collected depend heavily on the authenticity of participants' answers. It is expected that nurses truthfully reflected on their own practices, attitudes, and experiences related to nursing care documentation. Their willingness to provide accurate information is essential for the study to accurately capture the current state of documentation practices and to identify key areas for improvement. Without this level of honesty, the conclusions drawn may be misleading or skewed, ultimately affecting the usefulness of the study's recommendations.

Secondly, the study assumed that participants approached the research with a genuine interest in learning and improving their documentation practices. It was anticipated that nurses not only recognized the importance of accurate documentation but also appreciate the value of structured efforts aimed at enhancing it. A central component

of the study is the introduction of a framework for improving nursing care documentation, and its success hinges on the willingness of participants to engage with and adopt this framework.

This assumption is based on the belief that nurses, as healthcare professionals committed to patient well-being, are motivated to embrace practical, evidence-based strategies that can enhance both patient care and professional performance. It is further assumed that the framework will be perceived as relevant, accessible, and easy to integrate into daily routines, thereby increasing the likelihood of its application in real clinical settings. The study anticipates that once nurses understand how the framework aligns with their workflow and responsibilities, they will incorporate it consistently in their documentation practices.

Moreover, the assumption extends to the expectation that the nurses will not only adopt the framework passively but will actively engage with it, seeking clarification, asking questions, and providing feedback. This proactive involvement is important for the long-term sustainability of improved documentation practices and for fostering a culture of accountability and continuous improvement within healthcare institutions. Ultimately, these assumptions are central to the study's goal of developing actionable recommendations that can enhance the quality, completeness, and accuracy of nursing care documentation across various healthcare settings.

1.11 Operational Definitions

Nursing care documentation is defined as the process of recording all data obtained from a patient through assessment, as well as information derived from evaluations and interventions (Bolado et al., 2023). In the context of this study, nursing care

documentation specifically refers to the entries made in the nursing kardex that detail the patient's condition and the care provided. Ang, Bautista and Sapul (2021) describe the nursing kardex as a practical reference where nurses record essential patient details such as identity, diagnosis, diet, allergies, activity levels, and care plans, and consult it throughout their shifts to organize and retrieve information efficiently. As such, the Kardex offers a consolidated source of patient information, crucial for ongoing care.

Quality nursing care documentation is defined by the Nova Scotia College of nursing (2022) as documentation that possesses several key characteristics: it should be reachable, accurate, relevant, consistent, clear, succinct, comprehensive, legible, thoughtful, timely, contemporaneous, successive, and reflective of the nursing process. Additionally, it must be retrievable for future reference. In the context of this study, quality nursing care documentation included 11 parameters that focused on entries in the nursing kardex that are complete, objective, specific, clear, and entered in a timely manner. These parameters were be designed to capture essential attributes of effective nursing care documentation that align with best practices in nursing.

Improving Quality of Nursing Care Documentation: In the context of this study, improving the quality of nursing care documentation refers to the development, implementation, and evaluation of strategies that aim to enhance the accuracy, timeliness, and completeness of nursing records. The study focuses on addressing common challenges in documentation practices, such as incomplete entries, delayed documentation, and lack of clarity or specificity in recorded information. Improving documentation quality involves training and educating nurses about the importance of thorough and accurate documentation, as well as providing tools and resources that

streamline the documentation process. This includes the introduction of electronic health records (EHR) and the implementation of standard operating procedures that emphasize documentation best practices. Improving nursing care documentation in county referral hospitals in Kenya is essential to ensure that healthcare providers can deliver safe, coordinated, and effective care to patients. High-quality documentation serves not only as a record of the patient's condition and nursing interventions but also as a communication tool across multidisciplinary teams, a source of legal evidence, and a basis for monitoring quality and accountability. In resource-constrained settings such as county referral hospitals, where patient loads are high and staff shortages are common, strengthening documentation practices is particularly critical to reduce errors, prevent fragmentation of care, and support continuity of treatment.

Nursing Kardex: The nursing kardex is a clinical tool used to document key information about a patient's condition and the care provided. This tool includes vital data such as patient assessments, ongoing nursing interventions, medication administration records, and any changes in the patient's condition. It acts as a real-time document that guides nurses in providing consistent and effective care. In this study, the nursing kardex is used as the primary source of documentation for assessing the quality and accuracy of nursing records. It is a critical tool for communication within the healthcare team, ensuring that nurses and other healthcare providers are aware of the patient's health status and the treatments being provided. By consolidating essential data in one place, the Kardex enhances efficiency, reduces omissions, and ensures that critical information is easily accessible to the entire nursing team, as well as the other members in the multidisciplinary team.

Timeliness of Documentation: Timeliness refers to the promptness with which nursing care documentation is completed after patient interventions or assessments. In the context of nursing, documentation should be entered immediately or within a reasonable time frame after each intervention or patient interaction to ensure the information is accurate and reflects the patient's current condition. Documentation that is timely ensures accuracy by reducing the risk of memory lapses or retrospective alterations, and it strengthens the reliability of the record as a basis for clinical decision-making, legal evidence, and communication among healthcare providers. Delays in documentation can result in missed details, inaccuracies, or failure to capture important changes in patient health. This study assessed the timeliness of documentation as a key component of quality nursing care documentation. Specifically, entries were considered timely if entered within 30 minutes of execution of nursing interventions. In busy or resource-constrained settings, such as the county referral hospitals, timely entries are especially critical to ensure that essential details about patient status and care provided are readily available for subsequent shifts, audits, or emergencies. Consequently, timeliness is recognized globally as a key indicator of quality nursing documentation and a safeguard for both patients and practitioners.

Comprehensive Documentation: Comprehensive documentation refers to the thoroughness of nursing care records. It encompasses detailed, clear, and complete entries that reflect all aspects of patient care, including assessments, interventions, patient responses, and outcomes. Comprehensive documentation ensures that nothing is omitted and that all aspects of the patient's care are accurately recorded for future reference. This also includes documenting any changes in the patient's condition and the rationale for interventions provided. In this study, comprehensive documentation

was assessed based on its completeness and the extent to which all relevant details are captured in the nursing kardex. Incomprehensive records create critical gaps that can lead to misinterpretation, duplication of effort, or unsafe care, as subsequent providers may not have access to the full clinical picture. Comprehensiveness is therefore a key indicator of documentation quality, as recognized in international standards and local practice audits, and is directly linked to patient safety, legal protection for nurses, and the overall effectiveness of health service delivery. It provides a holistic and reliable account of the patient's status and care trajectory.

Objective Documentation: Objective documentation involves recording information in an unbiased, factual, and measurable manner. It requires nurses to document observations, interventions, and patient responses without subjective interpretations or assumptions. For example, "temperature 38.5°C, patient reports headache" is an objective record, while "patient looks unwell" is subjective and open to interpretation. Objective documentation is important for maintaining the accuracy and reliability of the nursing record, which is used for clinical decision-making and legal purposes.

It ensures accuracy, reliability, and consistency of the health record, supports evidence-based decision-making, and provides legally defensible accounts of care. In contrast, subjective or opinion-based entries may compromise patient safety, create ambiguity during handovers, and weaken the medico-legal validity of records. Thus, objectivity is recognized globally as a core attribute of quality nursing documentation and a professional standard for safeguarding both patients and practitioners. This study emphasizes the importance of objective documentation in nursing care, particularly in ensuring that entries in the nursing kardex reflect what was directly observed or done.

Nursing Process: The nursing process is a systematic method of providing patient care that involves assessment, diagnosis, planning, implementation, and evaluation. Within this study's framework, documentation must capture every stage of the nursing process. Precisely recording assessments, nursing diagnoses, care plans, interventions, and evaluations helps ensure that the care delivered adheres to recognized protocols and reflects professional standards and best practices. This structured approach not only guides care but also ensures that documentation is complete and systematic, improving its utility for healthcare teams and supporting patient outcomes, in alignment with Lerbæk (2025), who stress that nurses need to use objective, rather than subjective language as a means of enhancing transparency and clarity.

Patient Safety and Documentation: Documentation plays a critical role in patient safety, as it provides a permanent record of the care delivered, the patient's progress, and any significant changes in their condition. Accurate documentation is a safeguard that prevents errors, facilitates timely interventions, and supports communication among healthcare professionals. In the context of this study, improving nursing care documentation is seen as an essential step in enhancing patient safety. This operational definition underscores the importance of accurate, complete, and timely documentation as a key element in reducing the risks of clinical errors and improving the quality of care delivered in county referral hospitals. Accurate documentation also supports the early detection of clinical deterioration, facilitates smooth handovers between shifts, and serves as legal evidence in the event of disputes. Globally, patient safety frameworks emphasize documentation as both a safeguard for patients and a protective mechanism for nurses, reinforcing that high-quality records are not merely

administrative tasks but essential components of safe, accountable, and patient-centered care (Musee & Wagoro, 2022).

Electronic Health Records (EHRs): Electronic Health Records (EHRs) refer to digital versions of patients' paper charts and nursing documentation. EHRs are used to streamline the documentation process, making it easier to store, retrieve, and update patient information. The use of EHRs in nursing care documentation has been associated with improved accuracy and efficiency in record-keeping (Douma et al., 2024). In this study, EHRs may be evaluated as a tool to improve the quality and timeliness of nursing care documentation, particularly in settings such as county referral hospitals where paper-based systems may still be in use. EHRs improve efficiency in documentation by enabling structured data entry and facilitating timely updates, which are essential for continuity of care. Globally, and increasingly in low- and middle-income countries, EHRs are recognized as transformative tools for strengthening health systems and advancing universal health coverage.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This study reviewed various scholarly works and organizational practices, concentrating primarily on nursing care documentation and the factors influencing this process. The review is organized according to the research objectives, with specific aspects highlighted in the conceptual framework.

2.2 Quality of Nursing Care Documentation

2.2.1 Completeness of Nursing Care Documentation

Completeness in nursing care documentation refers to the thorough and accurate recording of all essential patient information related to their condition, treatment, and the nursing interventions provided. This includes details such as patient assessments, vital signs, administered medications, nursing diagnoses, care plans, responses to interventions, and instructions for ongoing care. Ensuring comprehensive documentation is a core responsibility of nurses and is fundamental to the delivery of high-quality healthcare services.

Complete documentation plays a critical role in enhancing multidisciplinary communication by providing a clear and accurate account of patient care, which supports informed decision-making by all members of the healthcare team. It also serves as a vital tool for legal protection, offering a factual record that can be used in case of disputes or audits. Furthermore, it supports quality assurance initiatives, helps

track the effectiveness of care, and forms the foundation for continuity of care, especially during shift changes or patient transfers.

Despite its importance, studies conducted globally have consistently shown significant deficiencies in documentation practices among nurses. In many cases, nursing records are found to be incomplete, inaccurate, or lacking sufficient detail, which undermines patient safety and care outcomes (Alhammadi et al., 2022; Cheung & Yip, 2024). Addressing these gaps is critical.

This lack of proper documentation can result in fragmented care that compromises patient safety. Missing documentation has also been linked to poor healthcare outcomes and increased litigation against healthcare providers. This constitutes a major problem because medical records are the only source of reliable information regarding the patient's illness journey, the interventions that have been undertaken, and the plan of care towards resolving the issue. (Alhammadi, et al., 2022). When documentation is lacking, nurses struggle to demonstrate that they performed necessary nursing care activities, which can lead to perceptions of negligence in their duties. As a result, they could be held accountable for any negative patient outcomes.

Entries in organizational documents or health records must be accurate, valid, and complete (Nursing Council of Kenya, 2024). Yanti, et al. (2024), further support this by stating that complete and accurate clinical notes, which are up to date and contain sufficient information, facilitate more appropriate healthcare decisions. As such, the notes be perfectly written and meet stipulated standards. This benefits patients by reducing time spent on redundant tests and preventing incorrect diagnoses or

inappropriate treatments. Healthcare organizations also gain from improved decision-making, leading to better patient outcomes and allowing more focus on those in greater need.

Furthermore, insufficient healthcare documentation can significantly impact a patient's long-term health outcomes. As reported by Aiken, et al. (2021), accuracy in nursing documentation can be a crucial factor in clinical decision-making. Gassas (2021) emphasizes that approximately 72% of health record issues stem from incorrect patient information in nursing records, while Ferreira, et al. (2023) notes that inconsistent, inaccurate, and incomplete nursing notes frequently pose risks to patient safety. Hence, it is essential for nurses to maintain thorough and accurate documentation to protect their professional responsibility.

This approach reduces the risk of liability, and if care is ever questioned, robust documentation provides strong evidence to defend both the nurse and the healthcare system. Additionally, effective nursing documentation enhances the quality of care received by patients, ultimately leading to greater patient satisfaction and trust in the healthcare system. To add to this importance is that the nurse is at the center of care, and must make clear communication to the multidisciplinary team, and the patient. Completeness of the documented nursing care is one way of achieving this. Without doubt, communication is vital in nursing practice and promotes delivery of quality patient care, while nurturing trust, and developing strong relationships with the healthcare team. Nurses communicate using both verbal and nonverbal messages, and active listening, and appreciating the patient's perspectives and concerns, and passing them on to the team members rely on how well the nurse puts it down in writing. This

can have huge implication in regard to actions of other team members, and eventually the Patients journey to recovery.

2.2.2 Objectivity of Nursing Care Documentation

Objectivity in nursing care documentation refers to the practice of recording only what is directly observed, measured, or heard from the patient, while deliberately avoiding the inclusion of personal opinions, assumptions, or interpretations. The principle of objectivity is essential because personal viewpoints and subjective interpretations can vary among practitioners, potentially resulting in inconsistent representations of the clinical picture. Since 1860, Florence Nightingale urged nurses to document what they saw, heard, or measured, as opposed to views (Turkowski, et al., 2024)). Such inconsistencies can mislead other healthcare professionals, ultimately impacting patient safety and clinical decision-making. In contrast, objective documentation provides a clear, consistent, and reliable account of the patient's condition and nursing interventions, enabling seamless communication among members of the multidisciplinary team.

According to the Nursing Council of Kenya (2024), nursing documentation should strictly reflect factual observations and patient statements, without drawing conclusions or inserting opinions. For example, if a nurse observes that a patient is experiencing hemorrhage, the documentation should include the specific amount of blood lost, the appearance of the bleeding (e.g., oozing, gushing), and the precise anatomical location from which the bleeding is occurring. This factual recording enables other healthcare team members, such as physicians, surgeons, or emergency care providers, to

independently interpret the information and initiate appropriate interventions without being influenced by potentially incorrect subjective interpretations.

This emphasis on objectivity is also echoed by international nursing regulatory bodies. The Nova Scotia College of Nursing (2022) clearly outlines that nursing documentation should be free from the nurse's personal opinions or emotional responses. This includes avoiding the use of emotive or exaggerated language such as "very," "extremely," or "awfully." The University of Calgary in Qatar (2022) supports this stance, encouraging nurses to document events and patient responses using specific, descriptive, and measurable terms, rather than vague expressions or generalizations. This enhances the legal credibility of nursing records while promoting consistency and dependability in ongoing patient care.

Furthermore, Ahmed et al. (2023) provides guidance on how to appropriately include opinions or subjective statements when necessary. If a nurse needs to record something that is not a direct observation, such as a concern expressed by a family member or an interpretation from another staff member, the use of quotation marks and proper attribution is essential. For instance, a note may read: *"Patient's sister stated, 'He looks much worse than yesterday.'"* This promotes transparency and clearly identifies the source of the opinion, preventing the nurse from being misattributed as the origin of subjective information.

In addition, nurses are advised to avoid documenting any unclear medical orders. If an order is not fully understood, it is preferable to seek clarification from the prescribing clinician rather than attempting to interpret or guess. Documentation based on

assumptions increases the risk of errors and miscommunication, which can lead to inappropriate or even harmful interventions. Ensuring clarity in the nursing record not only protects the patient but also the nurse from potential legal and professional repercussions. Objectivity also extends to avoiding judgments or assumptions about the patient's behavior or condition. For example, instead of documenting that a patient was "uncooperative," it is more appropriate to state, *"Patient refused to take prescribed medication after explanation was given,"* or *"Patient turned away when nurse attempted to take vital signs."* This preserves the neutrality of the record and allows others to form their own clinical judgments based on observable facts.

In conclusion, objective nursing documentation plays a crucial role in ensuring safe, effective, and coordinated patient care. By focusing on observable facts and patient statements, and by excluding personal opinions, nurses create records that are not only legally sound but also clinically valuable. As emphasized by various professional bodies, adopting a disciplined, objective approach to documentation is vital in enhancing communication among healthcare teams, minimizing errors, and upholding professional accountability.

2.2.3 Specificity of Nursing Care Documentation

Specific nursing care documentation mean that the nurses has obtained and put down detailed information of assessment, care planned, interventions carried out, any evaluations conducted and the findings. This not only ensures continuity of care but also enhance compliance to the set standards, while observing and aligning to legal requirement. During the documentation process, nurses should avoid ambiguous statements and generalizations. For instance, saying "the patient is in fair general

condition" does not provide precise information (Bjerkan et al., 2021). In care documentation, specificity is an essential aspect that demonstrates patient-centered care. Patient centeredness aims at holistic and individualized approach to care delivery. This includes identifying and documenting contextual patient information that identify and respects them as individuals. The documentation should patient engagement sand active listening, such as referencing to their comments reflect the patient's perspective, including explicit references to their comments or quotes, which can demonstrate active listening and engagement.

Without specific patient information, it becomes challenging to create a patient-centered care plan that addresses individual patient needs. Furthermore, using vague language indicates a failure to apply the nursing process, which aims to gather specific information necessary for centered care. Nursing documentation must be legible and use standardized terminology, including acronyms and symbols (College of Registered Nurses of Manitoba, 2024). Ajibade (2021) notes that person-centered care is the result of specific documentation, as it addresses each patient's unique needs.

Rahman et al. (2021) explain that employing the nursing process enhances patient-centered care by identifying specific patient care needs and interventions. This process guides nurses to systematically recognize patients' health care challenges and their responses to illness, thereby addressing their specific needs. Ultimately, this promotes the implementation of care activities that are tailored to the patient and organized to address priority health issues. However, despite the significance of clinical records, documentation often receives low priority. It is not uncommon to encounter documents containing illegible entries, inappropriate comments, and gaps in information.

Discrepancies often occur between entries made by different health care professionals, leading to confusion, impaired decision-making, delayed interventions, and obstacles in achieving desired healthcare goals (Wang et al., 2025). Vanka, et al. (2025) provide basic guidelines on what to do and what to avoid in clinical record entries, as outlined in Table 2.1.

Table 1.1

Essential Guidelines for Making Clinical Record Entries: Do's and Don'ts

To do	Not to do
● Have timed entries ● Indicate objective statements ● Document any non-adherence ● Record all verbal communications, including phone calls and face-to-face conversations, as part of the clinical documentation process. ● Indicate informed consent ● State reservations regarding health care being offered	● Employ abbreviations ● Use of humorous, offensive or personal comments ● Use nonspecific terms ● Alter or erase clinical notes in a manner that makes the original entry untraceable

This guidance instructs nurses on the importance of quality and comprehensive care documentation. It encourages them to regularly reflect on their nursing interventions and assess the impact of these interventions, allowing for adjustments and improvements as needed.

2.3 Influence of Institutional Factors on Quality of Documentation of Nursing Care

2.3.1 Standard Operating Procedure on Documentation

Standard Operating Procedures (SOPs) are structured, written instructions designed to guide the consistent execution of specific tasks in accordance with best practices and institutional policies. According to Smith, et al. (2022), SOPs are essential frameworks that define how tasks should be performed in response to particular situations, ensuring uniformity and quality in service delivery. Their relevance spans across various sectors to include the military, religion, manufacturing, and healthcare. In all these fields, standardization is critical to achieving optimal outcomes. In clinical settings, especially in clinical trials, SOPs help maintain alignment with the principles of Good Clinical Practice (GCP), as outlined by the International Conference on Harmonization (ICH, 2025). These SOPs ensure the integrity of research processes and the safety of participants by regulating every step of the clinical trial procedures.

However, while SOPs are commonly associated with specialized and high-risk activities such as clinical trials, their value in everyday clinical practice, particularly in nursing care documentation, cannot be overstated. SOPs serve as a vital tool to ensure that all healthcare workers, including nurses, consistently follow defined standards when providing care. Tukia et al. (2024), argue that SOPs are often confined to the operational guidelines of small units or departments and are not uniformly applied across broader clinical settings. This gap is particularly concerning in nursing practice, where comprehensive and accurate documentation is fundamental to patient safety, continuity of care, and legal accountability.

In Kenya, the development and use of SOPs in nursing are increasingly emphasized by regulatory authorities such as the Nursing Council of Kenya (NCK). The NCK has endorsed the Kenya Nursing Process (KNP) as the guiding framework for professional

nursing practice. The KNP outlines the sequence of nursing actions, from assessment to evaluation, and explicitly includes documentation as its final step. According to the NCK's *Manual for Clinical Procedures for Nurses and Midwives* (2025), nursing documentation should follow hospital-specific policies and must record all relevant data for each procedure. However, in the absence of structured SOPs tailored to documentation, nurses may unknowingly omit vital information, leading to fragmented or incomplete records.

The implications of such omissions are far-reaching. Nursing documentation is not merely a bureaucratic requirement, but it is a cornerstone of safe, effective healthcare. It facilitates communication among healthcare providers, guides ongoing patient care, and serves as legal evidence of the care provided. Without SOPs, documentation practices are often inconsistent, resulting in variable record quality and gaps in critical information. Chervonenko (2023) notes that SOPs provide staff with a clear understanding of their responsibilities, ensuring that they meet professional standards and institutional expectations. These procedures offer clarity in roles, reduce confusion, and help healthcare workers navigate complex clinical environments efficiently.

Empirical studies have confirmed the benefits of SOPs in clinical practice. For example, a study by International Council for Harmonization (2025) in a London hospital examined the use of documentation forms in stoma care and found that the absence of standardized formats led to incomplete and inconsistent records. Nurses were left to decide what information was essential, resulting in variability that undermined patient care continuity and legal defensibility. Similarly, Guerrero et al.(2024) argued that a lack of standard procedures creates disorder in nursing services, impeding quality

improvement efforts. Their research highlighted the importance of routines and norms in establishing order and control, essential elements in any clinical setting.

One of the core benefits of SOPs is that they serve as a benchmark for continuous quality improvement. By standardizing the documentation process, SOPs reduce variability, ensure completeness, and minimize the risk of errors. This, in turn, enhances patient safety and increases the reliability of nursing records. Additionally, SOPs can support nursing education by serving as instructional tools during orientation and training, reinforcing the expectations for proper documentation. Nurses who are aware of and trained in using SOPs are more likely to understand the value of accurate record-keeping and integrate it into their practice.

Moreover, studies indicate that access to SOPs positively influences nurses' documentation behavior. Research by Tadese et al. (2024) found that nurses familiar with and who had access to SOPs were twice as likely to complete documentation accurately compared to those without such access. This statistic underscores the impact of institutional support and resources on clinical practice. It also suggests that improving the availability and visibility of SOPs could substantially improve nursing documentation standards.

In addition to institutional benefits, SOPs enhance accountability among nursing staff. When clear guidelines are in place, nurses are more aware of their responsibilities and can be held accountable for omissions or errors in documentation. This fosters a culture of professionalism and diligence, as nurses recognize that their records are an integral part of patient care and legal compliance. SOPs also play a critical role during audits, investigations, or legal proceedings, providing evidence that care was delivered

according to accepted standards. Developing SOPs for nursing care documentation should not be a one-size-fits-all approach. Each healthcare facility must consider its unique patient demographics, staffing levels, technological capabilities, and local challenges. SOPs must be tailored to reflect these contextual factors while aligning with national guidelines and international best practices. In Kenya, for example, the NCK provides overarching principles, but each hospital is responsible for adapting these into specific, actionable procedures suited to their environment. This localized approach ensures relevance and practicality, increasing the likelihood of successful implementation and compliance.

In conclusion, the integration of Standard Operating Procedures into routine nursing care documentation is essential for improving the quality, consistency, and safety of healthcare services. SOPs provide a structured framework that guides nurses in what, how, and when to document, reducing ambiguity and variability in clinical records. Their use ensures adherence to professional standards, facilitates communication among multidisciplinary teams, and enhances legal and professional accountability. The absence of SOPs, on the other hand, leaves room for errors, omissions, and inconsistencies that can compromise patient care and institutional credibility.

As healthcare systems become more complex and patient needs more diverse, the demand for reliable and standardized nursing documentation will continue to grow. Hospitals, nursing schools, and regulatory bodies must work collaboratively to develop, implement, and continually review SOPs that support high standards in documentation. Training programs should emphasize the importance of SOPs, and institutions must allocate resources to ensure their effective dissemination and use. By prioritizing SOPs

in nursing care documentation, healthcare providers can safeguard patient outcomes, support nursing professionalism, and strengthen the overall health system.

2.3.2 Patient Load Versus Nursing Workload

Nursing workload refers to the volume of work that nurses undertake over a shift or given period of time. Alhosani, et al. (2023) term this as the time required to undertake nursing care activities, including both physical and cognitive efforts exerted towards achieving this end. by physical and cognitive efforts to provide patient care in addition to service management tasks and professional development activities.

This may entail direct patient care activities, administrative tasks, and other responsibilities assigned to the nurse, and which they have an obligation to fulfil. While nursing care provision is complex and thus making it difficult to compute workload, methods such as number of patients that a nurse shas to take care of, the number of hours a nurse needs to put in per day, and the number of nursing tasks to be undertaken have been used to measure the workload (Ivziku, et al., 2021). In Kenya, the method used to measure workload is nurse to patient ratio, with the nursing council having provide a recommendation of number of patients per nurses in different service delivery areas (Nursing Council of Kenya, 2023). The number of patients is based on the complexity of nursing care activities expected per patient in the particular unit. Excessive workload has been shown to negatively impact nurses' motivation, ability to provide quality care, and overall well-being. In addition, omission of essential nursing care activities has been observed where the number of nurses did not meet the recommendation for the patient load (Ivziku, et al., 2021).

The quality of health care provided has been shown to be influenced by many factors, with workload being identified as one of them (Maghsoud, et al., 2022). In their study, they reported high workload as affecting emotional well-being of the nurses, with increased incidence of medication errors, and decreased quality of nursing care in other aspects to include nursing care documentation. This has the potential to lead to adverse events, with other multiple complications for the patient and the health system.

Nurses around the world commonly report heavy workloads. This stems from a reported global shortage of the nursing workforce (MacPhee, et al., 2023). The core of the nursing profession is caring. For this to occur optimally call for sufficient workload, so that the activities can be undertaken seamlessly. The ensuing high workload translates to a stretch in the time the nurse has over the various activities they have to undertake. Nursing care documentation may suffer as nurses prioritize care activities to the documentation process.

When exhausted, nurses may record information that is difficult to read, which can lead to challenges when that documentation is needed by other healthcare team members for continuity of care (Demsash et al., 2023). Furthermore, these studies indicate that nursing documentation is often scanty and incomplete due to a shortage of nurses to carry out necessary tasks. This situation increases the risk of important information being forgotten or recorded incorrectly. Bobamohamadi et al. (2023) noted that the heavy workload faced by nurses in hospitals, being responsible of a significant load of patient care, and often also get assigned other duties beyond their primary roles is a significant concern in the United States. They highlighted reduced patient length of stay as one factor that increases nurses' workloads, resulting in nurses caring for more patients who are in the acute phase of illness and therefore sicker. Additionally, the

aging population presents more healthcare needs, demanding more time for each patient and subsequently increasing the nurses' workload. They argue that these factors adversely affect patient safety. Although they do not specify the exact ways these issues impact safety, a high nurse workload can hinder documentation and communication between nurses and other healthcare providers, compromising continuity of care. Maghsoud, et al. (2022) also emphasize the necessity of having an adequate number of professional nurses on staff to facilitate effective service delivery, which would alleviate nurses' workloads and minimize adverse occurrences.

They suggest that patient information should be recorded as soon as possible after an event to avoid forgetting critical details or overlooking important issues. Certainly, documenting nursing care while managing a high patient volume call for a balancing act between the two so that none suffers at the end of the day. High patient volume can lead to less time for detailed documentation, potentially impacting the quality of records and potentially outcomes, according to medical professional.

Nicholson (2022) offers tips for documentation, such as documenting findings promptly, avoiding blank spaces, using direct quotes from patients and family members for accurate meaning, and clarifying incomplete details. The heavy workload on nursing staff increases the likelihood of extreme exhaustion and job dissatisfaction, which can subsequently result in high turnover rates (Griffiths, et al., 2020). Babamohamadi, et al. (2023) also emphasize that nursing staff is the backbone of any healthcare system, and their workload is complex and multifaceted. In Kenya, nurses report increased workload due to staff shortages and insufficient resources (Mbuthia et al., 2023). Sanchez and Romano (2023) identified understaffing as a significant

contributor to heightened stress levels, which, coupled with a heavy workload and pressure for productivity, can lead to cognitive biases.

This situation may cause staff to bypass safety measures and policies in the pursuit of efficiency. When overwhelmed by patient care activities, nurses often neglect documentation, prioritizing care over record-keeping. Trainer (2023) noted that documenting nursing care consumes more of the nurse's time than actual patient care provision. The importance of optimal nursing staffing levels in healthcare service delivery is well recognized. Studies have shown a direct relationship between better patient care outcomes and higher nursing staffing levels (Griffiths et al., 2020). Babamohamadi, et al. (2023) reported that instances of missed care correlate directly with low nursing staff numbers, which can lead to adverse healthcare outcomes.

2.3.3 Institutional Cultural Factors

Institutional factors encompass the established rules, norms, values, and structures that shape the behavior and operational patterns of individuals within an organization. These factors can be both formal, such as written policies, laws, regulations, and job descriptions, or informal, such as seen in workplace cultures, social expectations, and unspoken norms that evolve over time. Institutions, including healthcare settings, function through these mechanisms to maintain consistency, ensure accountability, and streamline operations. These institutional frameworks are particularly influential in shaping how healthcare services are delivered and how documentation is managed by nurses.

In the context of nursing care documentation, institutional factors are pivotal in either promoting or impeding proper record-keeping. Nursing documentation serves not only as a clinical communication tool but also fulfills critical professional, legal, and administrative purposes. As such, institutions must play a proactive role in creating an enabling environment where accurate, timely, and comprehensive documentation is viewed as a priority and supported by adequate resources, policies, and supervisory systems. Tadese et al. (2024), argue that documented nursing information is central to fulfilling both professional and legal obligations.

Well-maintained nursing records provide evidence of care delivered, facilitate continuity in patient care, and offer protection in the event of legal scrutiny. For institutions, failure to ensure proper documentation processes exposes them to significant liability. In the event of adverse outcomes or legal disputes, incomplete or inaccurate documentation could be interpreted as negligence, not just by the individual nurse, but by the healthcare institution as a whole. Therefore, institutions must cultivate a culture that supports high standards in nursing documentation by embedding this expectation into policy, training, and everyday clinical practice.

The structural design of health institutions can also significantly impact nurses' ability to document effectively. Many healthcare systems, particularly in low and middle-income countries, are characterized by under resourced environments and personnel shortages. This often leads to expanded roles for nurses, where they are expected to carry out non-nursing tasks that fall outside their core responsibilities. Mbuthia et al. (2023) observed that nurses in Kenyan healthcare settings frequently undertake auxiliary tasks such as housekeeping, patient transportation, stock management, and

meal distribution. These additional responsibilities not only increase workload but also reduce the time available for essential tasks like documentation. Consequently, the institutional organization of labor can be a critical barrier to maintaining high-quality nursing records.

Additionally, inadequate financial and administrative support further complicates the situation. When healthcare facilities lack sufficient funding, they are unable to invest in proper infrastructure, such as electronic health records (EHRs), documentation tools, or even basic stationary for manual records. Similarly, without administrative systems that ensure timely audits, continuous training, and feedback mechanisms, there is no way to monitor or improve the documentation practices of nurses.

This absence of institutional oversight allows poor documentation habits to persist unchecked, compromising both patient care and organizational integrity. Furthermore, institutional policies regarding staffing ratios have a direct bearing on documentation quality. When nurse-to-patient ratios are not aligned with the complexity and volume of care required, the likelihood of rushed or missed documentation increases. Nurses overwhelmed by high workloads may prioritize urgent clinical tasks over record-keeping, resulting in incomplete or delayed documentation. The Nursing Council of Kenya, the Ministry of Health, and other professional bodies have recommended optimal staffing norms; however, compliance with these guidelines is often poor due to systemic resource constraints. Institutions that fail to invest in adequate staffing indirectly contribute to documentation deficiencies.

Institutional culture also plays a crucial role in influencing nursing documentation practices. Culture, in this context, refers to the shared beliefs, values, and assumptions that guide behavior in the workplace. A culture that undervalues documentation or treats it as a mere formality fosters complacency and poor adherence to best practices. Conversely, institutions that prioritize documentation, by celebrating when it is done well, integrating it into performance appraisals, and providing continuous education, tend to have higher documentation quality. This cultural orientation towards accountability and excellence can be nurtured through leadership initiatives, mentorship, and consistent messaging from top management.

Supervision and leadership within institutions are equally important. Active managerial support, including frequent audits of nursing records, direct feedback, and the availability of clinical guidelines, has been shown to positively influence documentation habits. Nurse managers who lead by example and emphasize the importance of documentation help set the tone for what is expected. Institutions with robust supervision mechanisms are better positioned to ensure that documentation standards are met and sustained. Training and professional development are additional institutional responsibilities that affect documentation quality. Regular in-service training sessions that focus on improving documentation skills, updating staff on policy changes, and teaching the use of new tools (such as digital record systems) can significantly enhance the competence and confidence of nurses. Institutions that neglect continuous education fail to equip their staff with the skills required for effective documentation in an evolving healthcare environment.

Moreover, the presence or absence of Standard Operating Procedures (SOPs) for nursing documentation is a telling indicator of institutional commitment. SOPs provide clear, concise, and standardized guidelines for what, when, and how to document nursing care. In institutions without such protocols, documentation tends to be inconsistent, with wide variations between departments and individuals. As Tadese et al. (2024) noted, nurses who have access to documentation SOPs are twice as likely to complete their records thoroughly compared to those who do not. This suggests that SOPs not only guide practice but also instill a sense of accountability and professionalism.

Technology is another institutional factor with immense potential to transform documentation practices. When institutions invest in digital health infrastructure, such as electronic medical records (EMRs), mobile documentation applications, or automated alert systems, the process becomes more efficient, accurate, and accessible. However, the implementation of such systems requires substantial investment, training, and change management, which must be institutionally supported. Facilities that fail to adopt technology continue to rely on cumbersome and error-prone paper-based systems, limiting their ability to ensure consistent and high-quality documentation.

In conclusion, institutional factors are central to the quality of nursing care documentation. From organizational culture and staffing policies to supervision, financial support, infrastructure, and technological investment, institutions shape the environment in which nurses operate. Without deliberate and sustained efforts to address these factors, even the most dedicated nurses may struggle to maintain high standards of documentation. Healthcare institutions must therefore recognize their role

not just as service providers but as enablers of professional practice. By fostering a culture of accountability, investing in resources and infrastructure, and supporting staff through leadership and training, institutions can significantly enhance the quality of nursing documentation, and ultimately lead to better patient outcomes, improved organizational performance, and a reduction in legal and professional risks.

2.3.4 Organizational Supportive Supervision

The quality of healthcare services has long been a concern. When clients seek care from a hospital or health system, they expect to have their health restored, dysfunctions normalized, and problems solved. To ensure quality services, a health management system must be in place that acknowledges client needs and adheres to established standards. Nursing can greatly benefit from quality management, which fosters improvements in healthcare that fulfill both the healthcare team's and the patients' needs (Chance et al, 2024). This is echoed by Sergio et al. (2023), who assert that effective organizational supervision is key to enhancing nursing documentation.

As a member of the management team within the health system, the nurse manager is committed to providing quality and safe healthcare. This responsibility includes ensuring that nursing staff interventions adhere to current organizational protocols, policies, and standards. Medical records must reflect evidence of this compliance. The nurse manager is also tasked with supporting an effective and efficient documentation system.

Furthermore, the nurse manager must ensure that documentation standards are followed and that expectations are clearly set. In any clinical environment, nurse managers are

responsible for offering ongoing guidance, delivering timely feedback, and participating in the development and revision of documentation policies (Ominyi et al., 2025). They emphasize that it is advantageous for the nurse manager to fulfill these roles, as failure to do so could lead to questions about their leadership quality and risk management, especially in the event that a staff member faces accusations of professional malpractice. Questions may then arise concerning whether the staff member was adequately supported and whether they followed both organizational and regulatory accreditation standards.

2.4 Influence of Individual Factors on Quality Documentation of Nursing Care

2.4.1 Knowledge on Nursing Documentation Practice

(Bolado et al., 2023) conducted a study on nursing documentation practices and found that over half (57%) of the respondents had poor knowledge of nursing care documentation. Knowledge is crucial for nurses in their daily professional work, as it contributes to the development of the organization's evidence base and the documentation of patient services (Jarosz et al., 2025). Suwarto et al. (2025) also emphasize that professional nurses must demonstrate knowledge and competence regarding the reasons for recording information.

Despite the importance of patient care documentation for communication among nurses and other healthcare providers, Groot et al. (2022) reported a tendency among nurses to treat patient records as personal documents rather than institutional records, resulting in low priority being given to recording care. Several studies have assessed nurses' knowledge of nursing care documentation. Tadese et al. (2024) reported that 51.1 % of nurses in North Shewa Zone public hospitals in Ethiopia had good nursing

documentation practice. Bolado et al., (2023) found that in Wolaita Zone public hospitals, only 42 % of nurses demonstrated good documentation practice, and Kerebign (2025) noted that among ICU nurses, 61.45 % had good documentation practice, and knowledge and attitude were significantly associated factors. In contrast, Molla et al. (2024) found that only 30.4 % of nurses in their study exhibited "good" nursing documentation practices.

While planning and delivering patient care should be structured to address individual patients' needs, many institutions face challenges in helping nursing professionals enhance their knowledge and understanding of the nursing process. This includes nursing diagnoses, identifying patient problems, and outlining a plan for care (Toney & Thayer, 2023). Zhang et al. (2025) noted that although principles of documentation apply to both electronic and paper-based methods, nurses often lack adequate knowledge and exhibit poor attitudes towards documenting nursing care. This inadequacy results in nursing records that are of low quality, lacking objectivity, consistency, comprehensiveness, and specificity, among other important principles.

2.4.2 Nurses Attitude Towards Documentation of Nursing Care

Attitude has been defined by Gomathy, et al. (2022) as the mental or psychological status of an individual. The attitude of the nurse towards nursing care documentation is an important determinant of how successful the process is. Madugu et al. (2021), concluded that nurses had a positive attitude towards nursing care documenta, and also, identified a number of factors that can affect nurses' attitude towards nursing care documentation, to include a high workload, knowledge level, supervision, among others. Efforts to improve on the care documentation process, then require that the

factors are addressed, so that the nurse is provided with an optimal environment to accomplish care documentation. Mabunda et al. (2025) emphasize the importance of fostering positive attitudes among nurses toward documentation, arguing that high-quality nursing records are foundational to the delivery of safe, effective patient care Their study revealed that attitude is a key determinant of nursing care documentation. However, only 50% of the participants demonstrated a favorable attitude toward this practice. This finding is similar to what was reported in other studies, which found favorable attitudes among nurses among at 58.8% (Ayele et al., 2021), and 35.6% in the North Shewa Zone in Ethiopia (Tadese et al., 2024). More positive attitude may be related to nurses having factors such as the perceived time demands of documentation, the complexity of the process, and the lack of recognition for the importance of documentation in clinical practice. Nurses often face high workloads, particularly in understaffed environments, which can cause them to prioritize direct patient care over documentation.

As a result, some may view documentation as a time-consuming and less rewarding task, leading to a negative attitude toward the practice. In these instances, nurses may engage in minimal documentation or delay completing records, which can affect the quality and accuracy of patient care. Despite the differences in attitudes between regions, improving the attitude of nurses towards documentation is essential to enhancing the quality of care and ensuring that nursing practices are adequately recorded. Additionally, providing nurses with continuous professional development opportunities on the importance of documentation and its impact on patient care could foster a more positive attitude and a greater sense of responsibility toward this task. Furthermore, creating an environment that values and acknowledges the role of

documentation in improving patient outcomes can lead to greater nurse engagement with the process. When nurses understand that accurate and timely documentation contributes to better patient care, they are more likely to take the time to complete their documentation accurately. Supervisors and managers also play a critical role in shaping attitudes by providing support and encouraging a culture that prioritizes documentation as an integral aspect of nursing practice.

Improving nurses' attitudes toward documentation is essential for enhancing the quality of nursing care. While there are variations in attitudes across different regions, the findings suggest that fostering a positive attitude toward nursing documentation should be a priority for healthcare organizations. Strategies to improve attitudes should include providing training on the importance of documentation, simplifying the documentation process, and creating an environment that values and supports accurate record-keeping. By addressing the challenges that contribute to negative attitudes and providing solutions to improve the documentation process, healthcare systems can ensure better patient outcomes and more effective communication among healthcare teams.

2.4.3 Nurses' Age

The relationship between nurses' age and documentation practices remains complex. While some studies show that older nurses generally have more experience with documentation, other research suggests that younger nurses may perform better due to their familiarity with modern technologies. Regardless of age, it is essential to provide ongoing training and support for all nurses to enhance their documentation practices and ensure high-quality patient care. In their study on the factors associated with

nursing care documentation among nurses, Mabunda et al. (2025) found no correlation between age and nursing care documentation.

Their findings suggest that age does not directly impact how well nurses document patient care, indicating that other factors, such as workload, training, and workplace environment, may play a more prominent role in determining the quality of documentation practices. However, Bolado, et al. (2023) reported a positive relationship between age and documentation practices. They found that younger nurses, particularly those with one to five years of experience, tended to perform better in terms of nursing documentation in medical and surgical wards compared to their more experienced colleagues.

Younger nurses may be more accustomed to using modern technologies such as electronic health records (EHRs), which are often more intuitive and user-friendly. They might also have received more recent training on documentation standards and the importance of accuracy in maintaining patient records. This familiarity with technology and current best practices could lead to better documentation practices compared to older nurses who may have been trained on paper-based documentation systems. On the other hand, older nurses with more years of experience may be less comfortable with newer technologies and may rely more on traditional methods of documentation. This could result in challenges in adapting to the fast-paced advancements in healthcare technology, leading to inconsistent documentation practices. Additionally, older nurses might face greater time pressures or more administrative duties, which could affect their ability to dedicate time to detailed documentation.

It is also possible that older nurses, having more experience, may become more confident in their clinical judgment and prioritize direct patient care over documentation. This could be particularly true in fast-paced clinical environments, where experienced nurses might focus more on patient outcomes than on completing comprehensive documentation. Younger nurses, in contrast, may place a higher emphasis on documentation as they are still in the process of developing their clinical skills and may rely more heavily on accurate records to guide their decision-making.

2.4.4 Nurses' Education Qualification

Nurses' education qualifications play a crucial role in shaping their skills, competencies, and ability to perform essential tasks, including nursing care documentation. Nursing care documentation is a fundamental part of nursing practice, as it ensures accurate and comprehensive records of patient care, which are critical for patient safety, effective communication among healthcare teams, and the continuity of care. However, studies examining the link between nurses' education levels and their documentation practices have produced mixed results.

As an essential skill, nursing care documentation is emphasized throughout all levels of nursing education. The Nursing Council of Kenya has further embedded this in the procedure manual, to enhance meaningful care documentation (NCK, 2025). Imam et al. (2023) found no significant difference in the quality of documentation based on nurses' levels of education. In contrast, Porat, et al. (2022) indicated that there is no evidence linking higher education levels for nurses with improved patient safety. However, Schnelli et al. (2023) holds a different viewpoint, stating that the knowledge

and competencies gained during training correspond to the level of education. They believe that advanced training for nurses enhances critical thinking skills, patient case management, and other important abilities. Ultimately, the competencies of nurses and other healthcare providers are demonstrated through their actions and the documentation of the care they provide.

2.4.5 Nurses' Years of Experience

The years of experience a nurse has in the healthcare setting often play a crucial role in their overall competence and proficiency. The expectation is that nurses' competence in various areas improves with experience, particularly in the area of nursing care documentation. Experience provides nurses with the opportunity to develop their clinical skills, improve their knowledge, and become more efficient in performing various tasks, including documenting patient care. It is generally expected that as nurses gain experience in their roles, they become more adept at managing the complexities of nursing care and better at fulfilling the associated documentation requirements.

Experienced nurses are typically more confident in their clinical decisions and more thorough in their documentation practices, as they have encountered a wider range of clinical situations and developed strategies for handling them efficiently. A study by Mabunda et al. (2025) found a positive correlation between nurses' monthly salaries and their knowledge of nursing care documentation. Nurses who had poor knowledge of documentation were also found to have inadequate monthly salaries. Generally, a nurse's salary is linked to their years of experience. This is not surprising, as nurses with greater experience and competence are often expected to earn higher salaries due to their increased responsibility, skills, and ability to handle more complex cases. The

study implied that more experienced nurses who possess a greater understanding of documentation are likely to be rewarded with higher pay, reflecting the value of their expertise in nursing practice.

However, it is essential to recognize that while experience generally improves competence, it does not guarantee optimal documentation practices. In some cases, nurses with extensive experience may fall into habits of informal or incomplete documentation, especially if they feel that their knowledge and experience should be enough to ensure quality care without the need for detailed records. This could be particularly true in busy or understaffed environments where experienced nurses are focused on providing direct patient care rather than on meticulous documentation. As a result, it is crucial to provide ongoing training and support to ensure that even experienced nurses maintain high standards of documentation.

Additionally, while nurses' experience is often correlated with improved documentation practices, factors such as the work environment, workload, and organizational support can also influence documentation quality. For example, nurses in high-pressure environments or those with excessive patient loads may struggle to maintain detailed documentation, even if they have extensive experience. This highlights the importance of creating a supportive work environment that allows experienced nurses to dedicate adequate time to documentation without compromising patient care.

Nurses' years of experience are positively correlated with improvements in documentation practices, as experience allows for the development of both clinical and documentation skills. Experienced nurses are more likely to recognize the value of

accurate documentation and have the competence to manage complex cases and patient records efficiently. Furthermore, experience often leads to better compensation, which can further motivate nurses to maintain high standards in their documentation practices. However, it is important to ensure that experienced nurses receive ongoing support and training to prevent complacency in documentation and ensure that they continue to meet evolving standards in healthcare documentation.

Desai (2023) concurs with the fact that experience improves performance, as it builds on the human capital, but notes that this may not hold in all cases. Experienced nurses are however expected to be more likely to recognize the value of accurate documentation and have the competence to manage complex cases and patient records efficiently. Furthermore, experience often leads to better compensation, which can further motivate nurses to maintain high standards in their documentation practices. However, it is important to ensure that experienced nurses receive ongoing support and training to prevent complacency in documentation and ensure that they continue to meet evolving standards in healthcare documentation.

2.5 Correlation between Multidisciplinary Collaboration and Quality Documentation of Nursing Care

Healthcare practice is increasingly dynamic and complex, especially when patients present with multiple systemic pathologies (Marlikowska et al. 2024). Additionally, health care provision often involves unpredictable situations that require a team approach, as no single professional can adequately handle them (Shi et al., 2025). Consequently, health care is delivered by a team of providers with diverse skills and competencies, all aimed at helping patients restore their health. Nurses, who are with

patients 24 hours a day, play a crucial role within the multidisciplinary team. Fowler (2022) notes that other professionals, as well as patients and their relatives, often turn to nurses for support.

Given this central position, nurses must maintain a comprehensive understanding of patient care, and their documented nursing assessments should facilitate other health care professionals in making informed clinical decisions. A multidisciplinary care team typically encompasses nursing, medical, and allied health professionals. Research has shown that a multidisciplinary approach can improve health care outcomes (Srinivas et al., 2023). However, this collaboration is not always realized in practice (Pradelli et al., 2025). Al Khalfan et al. (2021) highlight that effective multidisciplinary teams significantly enhance the quality of health care provided to patients in critical care units. A well-coordinated multidisciplinary team promotes patient-centered care of high quality. Nevertheless, evidence suggests that even when organizations document certain interactions or protocols, they fail to fully embed them into actual practice (Jedwab et al., 2022).Communication remains one of the leading challenges within many multidisciplinary teams, which severely compromises their success and the quality of their activities (Medakovic, 2020). Collaboration is especially critical in health care because the sector is inherently multidisciplinary. To achieve successful results, various specialties must frequently communicate and work together to conduct comprehensive assessments of patient situations, followed by effective treatment plans. This necessitates shared patient care outcomes and alignment of actions among all team members. At the turn of the 20th century, the Mayo brothers developed the concept of multidisciplinary teamwork. The Model of Care established at the Mayo Clinic outlined

principles aimed at achieving coordinated patient care through a multidisciplinary approach, focusing on treating the whole patient (Hughes, 2021).

The topic of documenting nursing care and care planning has been discussed among nurse managers and educators since the mid-1960s. Walker and Selmanoff (1964) described the behaviors and attitudes regarding the documentation and review of nurses' notes, indicating gaps in how documentation was conducted and utilized. Specifically, nurses' notes were often found to be inaccurate, rarely read, or valued, which demonstrated a lack of teamwork and resulted in silos. Recent evidence shows that physicians and nurses often emphasize different aspects of patient care, and that greater alignment or synergy between them is linked to better outcomes (Endris et al., 2022). Achieving this synergy requires seamless communication, with each professional referencing and questioning the documentation provided by others.

2.5.1 Joint Setting of Health Care Outcomes and Clinical Meetings

Patient clinical outcomes are crucial indicators for assessing the effectiveness and cost-efficiency of health care. They serve as a foundation for evaluating the quality of care provided and assist in guiding clinical decisions while identifying areas for improvement. The systematic use of patient outcomes to measure health care effectiveness dates back to the Crimean War, when Florence Nightingale documented the conditions of care for military patients and studied how those conditions affected patient outcomes (Kolagari et al., 2023). Formulating health care outcomes relies on comprehensive assessment data. Toney and Unison (2023) state that the first step of the nursing process is a thorough nursing assessment. This involves systematically and continuously gathering data to develop a patient-specific nursing care plan. The

assessment phase is crucial, as it determines the success of subsequent steps in the nursing process.

Health care teams consist of various professionals, including prescribers, caregivers who address patients' daily needs, diagnosticians, and medication experts. Each team member contributes specific expertise, fostering harmony and collective synergy that effectively meets patient needs. For harmony to exist among team members, clear role definitions are essential, while some overlap in skills is also beneficial (Baek et al., 2023). One of the most effective ways to achieve goals is through teamwork. Teams play a significant role in organizational structures (Chappell, 2022). Health care quality can be enhanced through information gathering; however, the value of quality information is lost if it is not utilized effectively. It must be applied to streamline clinical and administrative tasks, such as communication with patients and their families.

The health care team should leverage this information to provide appropriate care services, mitigate risks associated with health care, and monitor various aspects of service provision. Therefore, information alone is not valuable; its significance emerges from its impact on decision-making processes. Data that are suitable for use by consumers define information quality (Tukia et al., 2024).

Sharing health care information is vital, and this can only be accomplished through accurate, concise, and timely documentation. Multidisciplinary collaboration can be influenced by several factors, including a lack of mutual respect among team members and poor communication. Although nurses and physicians share common ethical

responsibilities, there has been a documented failure to recognize each other's complementary roles and the interdependence of their skills and knowledge. Braam et al. (2024) observe that while multidisciplinary collaboration can lead to integrated, patient-centered care, the modes of collaboration in many settings remain undefined, both for team members and for the diverse diagnoses that require input from various disciplines.

2.5.2 Communication among Care Team Members

Information plays a critical and central role in the medical field. Medakovic (2020) indicates that the process of medical care requires a continuous flow of information before and after each task or task sequence to build and maintain continuity of care. Patient goals are achieved through interconnected tasks that build on one another; none are isolated. A significant amount of a nurse's time is spent on information management, as nurses are central to the management of the interdisciplinary team and the implementation of the team's patient management plan. Additionally, nurses bear the burden of documenting the care provided and measuring its effectiveness. They must also demonstrate competence, self-esteem, and respect for others. As part of the multidisciplinary team, nurses must participate as equals.

Historically, nursing's responsibility for patient safety has focused on narrow aspects of care, such as avoiding medication errors and preventing patient falls. While these dimensions of patient safety remain important, the scope of quality improvement and measures promoting patient safety is much broader and deeper. Nurses make significant contributions as members of the multidisciplinary team, particularly in enhancing patient safety by coordinating and integrating care among various healthcare

professionals. Furthermore, nurses are crucial in maintaining communication within healthcare settings, playing a key role in avoiding lapses in communication errors (Pazar, et al., 2024).

The role of nurses extends beyond merely meeting patient care needs or following doctors' prescriptions. Nurses must actively contribute their insights regarding treatment and the responses patients exhibit (The Joint Commission, 2024). Huang et al. (2021) demonstrated that nurse notes are often underutilized in making clinical decisions about patients, despite the fact that these notes contain valuable information not found in flow charts. He observed notable differences between nurses' and physicians' notes, highlighting the need for integration to achieve a comprehensive understanding of a patient's clinical status. However, reports indicate that nurses often do not feel respected by others in the healthcare team, leading them to feel oppressed and further discouraging respect and trust from their multidisciplinary colleagues.

2.5.3 Joint Ward Rounds

Joint ward rounds are meetings that bring together multidisciplinary team for the purpose of discussing patients' illness, treatment plans and progress. Both joint ward rounds and nursing care documentation, though distinct activities, are crucial for patient care, and intermarry in the sense that they both contribute towards effective and efficient health care provision, that ensures achievement of desired health care outcomes. Joint ward rounds is one mechanism of enhancing working together of the multidisciplinary team, by allowing a more holistic approach in addressing patient needs. Yet, the education of most healthcare providers tends to be compartmentalized, with professionals primarily trained alongside others from their own discipline. As a

result, only a few groups of health professionals are taught to work effectively as part of integrated teams.

However, collaboration between healthcare professionals from different specialties is essential for delivering patient care. This collaboration enables information sharing, enables the execution of quality and safety checks, and supports patients' understanding and adherence to prescribed treatment plans (Katantha, 2025).Team spirit in healthcare involves a multidisciplinary team working cooperatively, with each member assuming complementary roles and sharing decision-making responsibilities for problem-solving and formulating care plans. Effective collaboration among nurses, physicians, and other team members fosters awareness of each other's competencies and skills, which is crucial for ongoing improvement in clinical decision-making (Tulane University, 2021).

Research has demonstrated that collaborative efforts lead to better patient care outcomes, such as reduced morbidity and mortality rates, fewer preventable adverse drug reactions, and optimized medication dosing (Agency for Healthcare Research and Quality, 2023). Additionally, effective coordination of care enhances harmony across various healthcare settings and providers, resulting in improved quality and patient outcomes. This kind of coordinated care has been shown to reduce unnecessary hospital admissions, emergency department visits, and delays stemming from repeated diagnostics or redundant patient histories (Müller et al., 2023). Sela et al. (2022) found that physicians often have a low perception of nurses' contributions to the quality of primary healthcare. This may stem from a poor understanding of nurses' roles within

the healthcare team or from nurses not asserting themselves as integral members of multidisciplinary teams.

A study in Abidjan (Ivory Coast) assessed knowledge and practices among health workers and found limited good knowledge among staff about certain clinical protocols (Braam et al., 2024). while in Kinshasa, 7.6% of doctors undervalued nursing as a profession (Bosongo et al., 2021). As a result, these doctors may overlook the significance of nurses' notes and miss opportunities to enhance the quality of written communication. This diminishes team synergy and hampers informal peer audits of nursing documentation, ultimately impacting collaboration and patient care outcomes. Furthermore, Bosongo et al. (2021) argue that the absence of role clarity perpetuates a perception that nurses are merely implementers of doctors' orders, leading to reduced interaction and collaboration within multidisciplinary teams. Consequently, this perception fosters siloed operations, wherein each team, despite caring for the same patient, develops its own goals, action plans, and evaluation strategies independently from one another.

Braam et al. (2024) indicate the critical role of an effective multidisciplinary team, as it affords a holistic health care delivery approach, with more coordinated care activities, which lead to better health outcomes. By working together, decision making process is enhanced, with efficient use of resources, and this promotes growth of the professionals in the team.

2.6 Patient Factors

2.6.1 Patient Demands

Bolado et al. (2023) identified a connection between the demands of nursing care and the rates of adverse events. As the demands for care increase, the time required to address these needs also rises. Additionally, with greater disease severity, there is an increase in technical demands, such as the number of invasive devices and procedures required. These technical requirements, along with various medical procedures and the types and quantities of medical devices, necessitate time-consuming nursing activities (Moteri et al., 2024). This can take away from the time available for nurses to document the care provided.

Furthermore, patient turnover, reflected by the number of admissions, transfers, and discharges on a unit places a significant demand on nursing time (Park et al., 2024). As healthcare systems become more complex, the demands placed on nursing professionals will only increase, leading to a growing challenge in managing both the care of patients and the necessary documentation. Given these circumstances, it is essential to find ways to alleviate the pressures on nursing staff, including improving documentation practices and leveraging technology to streamline the process. This would ensure that nurses have more time to focus on patient care without compromising the quality of documentation.

2.6.2 Patient Acuity

The level of patient acuity significantly impacts the volume and detail of nursing documentation required. Udina et al. (2020) points to the relationship that exists between acuity, and the level of nursing staffing. Additionally, patient acuity is strongly

correlated with the frequency of interventions and the complexity of care required, both of which increase the demands on nursing professionals. This should be matched by the information documented, with a call for clearer communication among the health team.

Critical patients often require immediate responses to changes in their physiological conditions, and failure to document these changes can result in missed opportunities for timely interventions. Mengli et al. (2023) referred to critical care units as "rescue colonies" due to the high volume of severe and unstable patients they accommodate. These units require more resources, including a lower nurse-to-patient ratio, which ensures that nurses are available to provide close and continuous care. However, even with a more favorable nurse-to-patient ratio, the complexity of care required still places significant pressure on nurses to balance the demands of direct patient care with the documentation process. Kim et al. (2024), observe that as patient acuity increases, the nurse plays a crucial role in surveillance to gather, synthesis, and interpret clinical information for clinical decision making. These nursing care activities can only be reflected by nursing care documentation.

The importance of communication within the multidisciplinary healthcare team cannot be overstated in high-acuity settings. Nurses must communicate effectively with doctors, respiratory therapists, and other healthcare professionals to ensure that patient status changes are documented promptly and accurately. As highlighted by Al Khalfan et al. (2021), poor communication within the healthcare team can result in fragmented care, which can increase the risk of patient harm or even mortality. Effective documentation serves as a critical tool for facilitating communication among team

members, ensuring that each healthcare professional is aware of the patient's current condition, treatment plan, and any recent changes. This also ensures that no vital information is lost or overlooked, which can help reduce errors in care.

Patient acuity refers to the severity of a patient's condition and the level of care needed. In many cases, the constant shifting of priorities due to these increased demands means that the quality of documentation may be compromised. Nurses may not keep pace in documenting the various interventions, as their attention and focus may be on meeting the most urgent aspects of patient care. As a result, these patients consistently require the presence and intervention of nurses, leading to increased documentation. Mengli et al. (2023) describe critical care units as "rescue colonies" where high-acuity patients are admitted.

These units are typically equipped with more resources, including a lower nurse-to-patient ratio based on patient needs. Additionally, the authors emphasize the importance of high professional ethics in these settings. This necessity arises from the fact that patients' physiological conditions can change rapidly; thus, close observation and communication regarding any changes can mean the difference between life and death. Effective communication within the multidisciplinary team is essential, as each team member must assess and share data from their evaluations (Al Khalfan et al., 2021) to make appropriate clinical decisions. Failure to communicate effectively can lead to fragmented care and an increased risk of mortality.

The need for communication is also necessitated by the fact that patient acuity is strongly correlated with the frequency of interventions and the complexity of care

required, both of which increase the demands on nursing professionals. In high-acuity settings, such as intensive care units (ICUs), nurses are tasked with providing continuous monitoring and performing various medical interventions. Critical patients often require immediate responses to changes in their physiological conditions, and failure to document these changes can result in missed opportunities for timely interventions.

2.6.3 Patient Age

The age of patients is a significant factor that affects the complexity of nursing care and, consequently, the volume and detail of documentation required. Given this is a significant demographic parameter, it is normally documented alongside other patient identity information such as name. This important identifier can influence treatment plans and nursing interventions, as well as patient responses to medical interventions. For example, a very young or very old patient might require specific care protocols or additional support. Old age come with declining physical and physiological functions, leading to an increased need for nursing care. The increased need of nursing care translates to increased nursing time that contribute to a higher workload.

On the other extreme, infants and young children may require more frequent and intensive nursing care due to their developmental stages and vulnerability to sudden changes in disease process. Along with this, children may not be able to communicate their health needs, and nurses must, and need to take time undertaking physical examination to elicit the needs, and to interpret behavior in to physiological changes. This demands more time that for adults' patients who can explicitly indicate how they feel. Besides, communication and trust are crucial in children care due to the triadic

relationship between the patient, parent, and healthcare provider. The nurses must also invest time towards this important aspect. This unique perspective contrite to workload and nursing time in this category of patients.

Elderly patients have been reported to present unique challenges for healthcare providers. Bjerkan et al. (2021) indicate that elderly patients require complex care, encompassing both nursing and medical support. This complexity arises from the multiple health issues associated with aging. Myrstad and Ranhoff (2020) emphasizes that managing the chronic conditions that accompany aging compounded by higher levels of disability increases healthcare costs. Moreover, elderly patients often experience cognitive impairments, such as dementia or delirium, which can complicate their care. These cognitive challenges require additional documentation to ensure that healthcare providers have a clear understanding of the patient's mental and physical condition.

Nurses must also document any changes in cognitive function, behavior, or emotional state, as this information is essential for providing appropriate care and avoiding potential harm. Furthermore, elderly patients may have more frequent hospital readmissions due to the chronic nature of their conditions, leading to repeated interactions with nursing staff and a consistent need for thorough documentation across multiple admissions. This allows for optimal care processes, and availability of evidence on which clinical decisions can be based. In general, as the aging population continues to increase, healthcare systems must adapt to the specific needs of elderly patients, to ensure that nursing care documentation is comprehensive and accurately

reflects the complexity of their care. This is essential not only for providing high-quality care but also for complying with legal and regulatory standards.

2.7 Summary

Florence Nightingale developed the first model of nursing in 1873. Since then, the nursing scope of practice and the role of the professional nurse have evolved, with a significant emphasis on evidence-based nursing. Various factors, including technology, societal values, education, demographics, and health care financing, have influenced how nursing care is delivered (Vleminckx et al., 2024).

Patient care documentation is a fundamental and critical competency utilized by nurses to communicate the clinical status of each patient's health care needs and responses to care ((Jacques et al., 2025). As a professional nurse, one is responsible for ensuring the quality and safety of patient health care. The primary way to demonstrate this responsibility is through documenting the nursing care provided. Lippincott Nursing Center (2025) emphasizes that regardless of a nurse's skills, poor documentation can significantly undermine credibility, especially in the event of a lawsuit.

The purpose of nursing documentation has continually evolved and has become increasingly important due to changes in regulatory agency requirements, professional nursing practice, and legal regulations (Hankey, 2023). Patients' health care records serve as an audit of the history of care provided and are essential for communication among nurses, enabling the ongoing provision of care (College of Registered Nurses of Manitoba, 2024). These records serve as evidence that care was administered. The quality of documented nursing care is crucial for both patients and nurses, as high-

quality documentation enhances patient care by improving communication regarding patient issues (Health professionals' routine practice documentation, 2023). Proper nursing documentation is also vital for nurses themselves. According to Samani and Rattani (2023), regardless of a nurse's experience or competence, errors or omissions in documentation can lead to serious consequences for both patients and nurses if legal issues arise related to the care provided.

Accurate documentation fosters communication that enhances the quality of care while fulfilling legal and professional requirements. It also contributes to improvements in health care and research, demonstrating professional accountability. Conversely, poor documentation can have detrimental effects on professional accountability, patient care, and organizational risk (Rahman et al., 2021). Professional liability is a critical component of nursing practice (Kearney, 2022). Numerous challenges, such as staff shortages, various documentation types, a lack of materials for documentation, and inadequate knowledge about the importance of documentation, have been identified as obstacles to effective nursing care documentation. Substandard documentation has drawn the attention of the professional community and regulatory organizations (Samani & Rattani, 2023) and can expose nurses to legal and professional liability if the care provided is questioned. Nursing documentation serves multiple purposes that benefit the patient, the nurse, the multidisciplinary team, and the healthcare system as a whole (Demsash, et al., 2023).

2.8 Theoretical Framework

This study was guided by general systems theory, the systems model, McGregor's Theory Y, and Deming's theory. General systems theory was developed by Ludwig

von Bertalanffy in 1936. This theory posits that a system is characterized by the interactions of its various components and the nonlinearity of those interactions. Von Bertalanffy asserts that the role of a system is to process or convert energy and resources into products or outputs for use either outside the system (in the environment) or within itself, or both.

The concepts and principles of general systems theory are applicable to understanding and explaining how hospitals operate. Hospitals function as open systems, interacting with their environment to acquire what they need for growth, sustained operation, and to meet their goals. A hospital can be viewed as a subsystem existing within a larger system. Hospital systems consist of a structured arrangement where various parts are interconnected in specific ways. The actions of individual healthcare workers influence and contribute to the overall wellbeing of the system and the quality of healthcare services provided. Nurses, in particular, both influence and are influenced by the healthcare system, impacting their delivery of services and the quality of nursing care documentation.

The systems model was developed by Betty Newman in 1972. In her theory, Newman posits that energy sources are surrounded by a normal line of defense, several lines of resistance, and a flexible line of defense. Energy sources represent the factors that help a patient cope with stressful life events, while the normal line of defense represents an individual's equilibrium, and the flexible line of defense reflects the dynamic nature that can change rapidly. Similarly, the nursing documentation process can be perceived to include these three elements: energy sources represent individual nurses' factors, the normal line of defense represents the established parameters set by healthcare

institutions, and the flexible line of defense represents the adaptability of both the nurse and the institution, which can affect the quality of nursing care documentation.

Douglas McGregor's Theory Y was presented in his 1960 book, "The Human Side of Enterprise." This theory suggests that the desire to work is as natural as the desire to play or rest, and that threats and controls are not the only means to achieve high-quality output. The theory asserts that individuals are often committed to providing service and that the capacity for imagination and creativity in problem-solving is widely distributed among the population. McGregor's Theory Y is the most fitting lens for this thesis because high-quality nursing care documentation depends on clinicians' discretionary effort, professional judgment, and collaboration, behaviours Theory Y explicitly assumes and seeks to unlock.

Theory Y posits that people are intrinsically motivated, capable of self-direction, and eager to accept responsibility when goals are clear and conditions are supportive. In county referral hospitals, documentation quality hinges less on mere rule-following and more on nurses' initiative to record timely, objective, and comprehensive notes, coordinate across disciplines, and continuously improve workflows, precisely the forms of engagement Theory Y predict.

Kazzaz (2023) notes that Deming's theory of variation seeks to understand why systems do not behave as predicted. He argues that while all systems exhibit variations, it is important for managers to distinguish between common and special causes of variation. Special variations can often be traced to identifiable factors, such as changes in procedures or staff shifts, while common variations typically stem from established

processes, systems, or designs that workers can recognize but only managers can change. The nursing documentation process may exhibit variations between different healthcare institutions, among hospital units, between nurses, and even with the same nurse during different shifts. As the theory suggests, it is up to managers to identify both special and common causes of variation and address them appropriately to establish best practices within their units or institutions.

These theories are particularly relevant to this study because health systems are organized in ways where care processes, healthcare structures, and care outcomes interact within a healthcare platform, forming a cohesive system. Oldland et al. (2020) identified seven domains of the professional practice framework pertaining to nurses' responsibilities for healthcare quality, which include clinical leadership and governance.

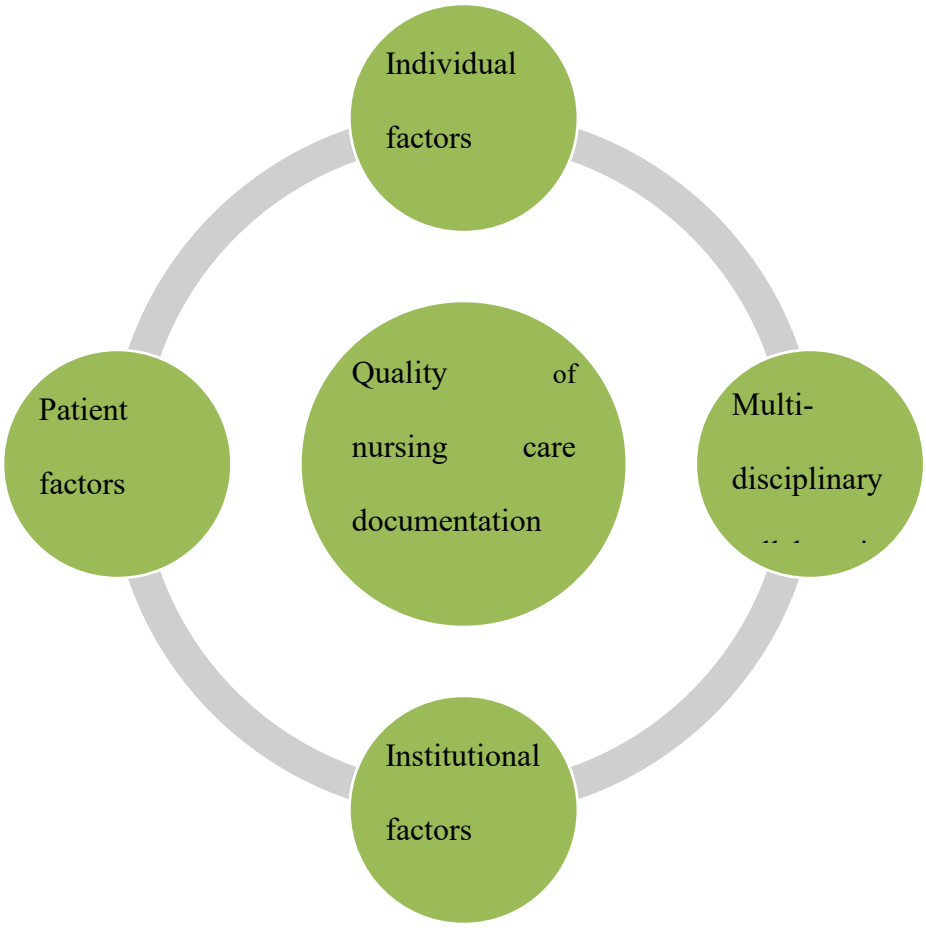
Table 2.1

Similarities Between the Seven Domains of Healthcare Quality and the Four Factors Influencing Quality Nursing Care Documentation

S No	The seven domains of healthcare quality	Similar factor that affects nursing care documentation
1.	Medical/technical competencies	Individual factors
2.	Positive interpersonal behaviors	
3.	Person centered care	Patient factors
4.	Evidence based practice	Multidisciplinary collaboration
5.	Promotion of safety	
6.	Clinical leadership	Institutional factors
7.	Management of environment	

These interact to contribute to the overall quality of nursing care documentation as depicted in figure 2.1.

Figure 2.1: Interconnectedness of Factors Influencing Nursing Care Documentation



Source: Oldland et al., (2020)

The issue of nursing documentation and care planning has been discussed by nurse educators and administrators since the mid-1960s, when Walker & Selmanoff (1964) described attitudes and behaviour regarding writing and reading nurses' notes. They revealed that the notes were neither valued nor accurate and that they were seldom read. The principles and concepts of organizational theories can be applied to understand hospitals and their processes, particularly regarding nursing care documentation and its impact on patient care. Various internal and external factors influence both nursing

practices and institutional procedures. Additionally, there are strategies that hospitals can implement to achieve optimal performance in nursing care documentation.

Organizational charts and structures visually represent these relationships, which are regulated by hospital rules, guidelines, procedures, and policies. The quality of nursing care documentation relies on interactions within the healthcare system. Thus, these theories can enhance our understanding of how healthcare institutions operate. They enable us to visualize, assess, analyze, and comprehend the processes, arrangements, and feedback loops that characterize these institutions, as well as how these elements interrelate and affect nursing care documentation.

2.9 Conceptual Framework

The conceptual framework guiding this study was developed by the researcher. The model focuses on independent variables that can affect the quality of nursing care documentation, which serves as the dependent variable, in hospitals located in selected counties. This framework is linked to the guiding theories: systems theory, McGregor's Theory Y, and Deming's Theory. To achieve high-quality nursing care documentation, a systemic approach is necessary, as outlined in systems theory. This approach includes individual nurse factors, institutional factors, and patient factors. The individual nurse's ability to engage in and complete the nursing documentation process can be influenced by both their personal motivations and potential barriers.

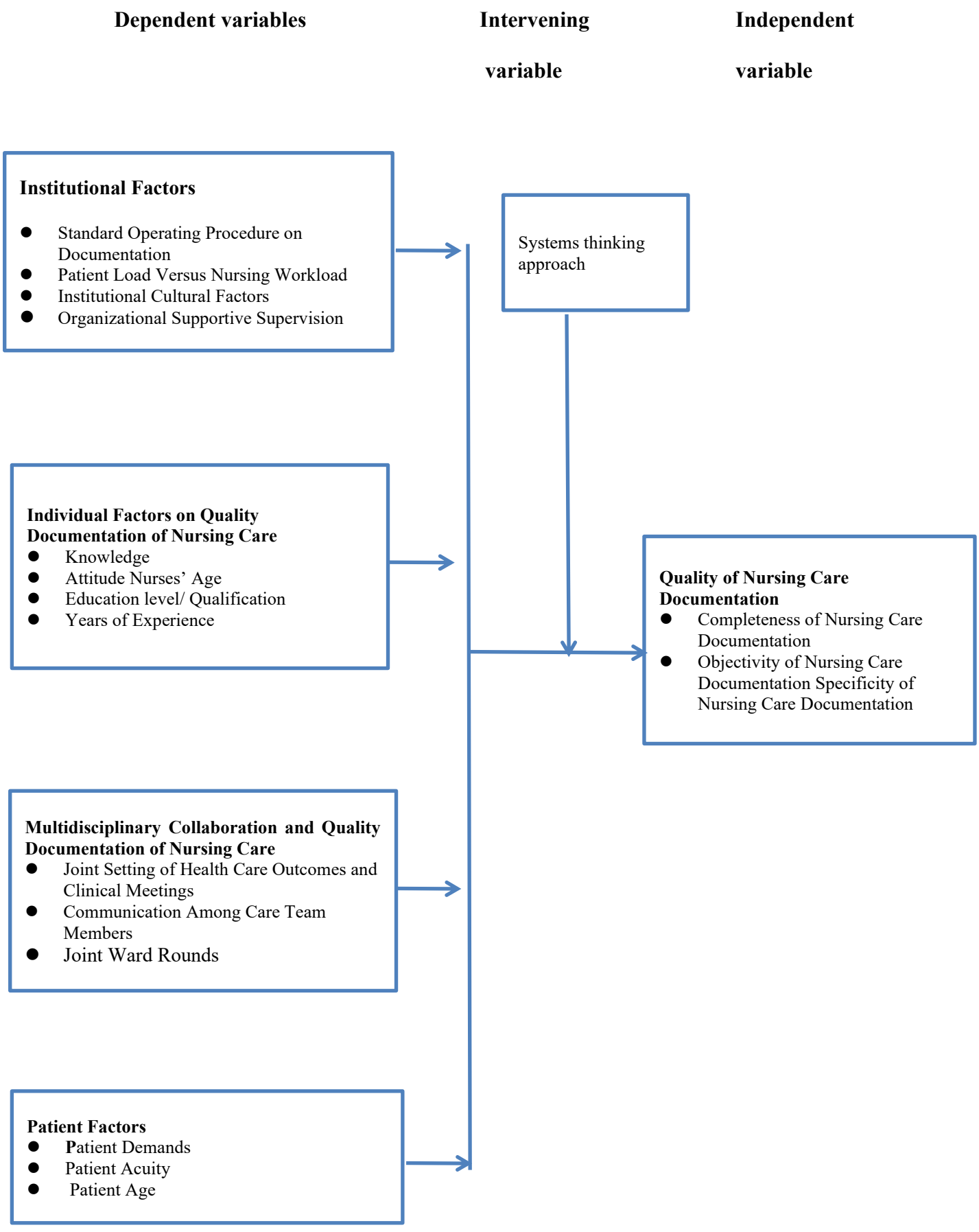
Institutions define their goals and expected outcomes, and the overall culture within the institution plays a significant role in determining performance across various areas. The institutional environment provides values and guidance regarding various aspects of

care, which in turn shapes staff behavior. Therefore, institutions can manipulate these factors to achieve desired performance levels in different areas of care. Additionally, various patient factors influence the interactions between patients and healthcare providers, impacting the extent to which nursing care is documented. McGregor's Theory Y describes a mindset that institutions can adopt to enhance their processes. The core idea of this theory is that management should maintain a positive attitude toward their staff. To implement this effectively, management needs to clearly articulate the goals to be achieved, engage staff in the journey toward those goals, and allow them the freedom to be creative and leverage their unique potential to advance the team's objectives. It is crucial to involve the entire multidisciplinary team in efforts to improve the nursing documentation process.

According to the systems model, the nursing documentation process can be understood to have three components: energy sources representing the individual factors of nurses, a normal line of defense symbolizing the parameters established by the healthcare institution, and a flexible line of defense that reflects the adaptability of both the nurses and the institution. All three components can influence the quality of nursing care documentation. Efforts to enhance the quality of care documented by nurses can target these three elements, adjusting them to favor positive change. Using Deming's Theory, both nurses and managers can analyze the nursing documentation process to identify variations from the desired standards. Management will then work to address these identified issues to achieve optimal documentation standards within the unit or institution.

The conceptual framework highlights the dynamic interaction between individual nurse factors, institutional support, patient-related elements, and multidisciplinary collaboration in shaping the quality of nursing care documentation. It suggests that no single factor operates in isolation; rather, it is the synergy among these components that significantly influences documentation practices. The framework underscores that for improvements in nursing documentation to be meaningful and sustainable, all these domains must be considered and addressed collectively. By recognizing this interconnectedness, the framework provides a comprehensive approach to understanding and enhancing nursing documentation, promoting not only individual accountability but also systemic and collaborative responsibility for improved care outcomes.

Figure 2.2: Conceptual framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, the specific procedures used in the study are outlined. These procedures included the adopted design, the target population, the sampling technique and sample size, the study tools and instrumentation, pre-testing, data collection processes, and data analysis procedures. The study adopted a positivist philosophical approach, which postulated that reality is constant and can be described from an unbiased perspective (Creswell & Creswell, 2023). The study assessed and impartially described nursing care documentation and the factors that influence this process.

3.2 Research design

This study employed two designs; descriptive survey and applied research. The design was selected according to the study phase. The phases, and the respective designs are outlined below.

3.2.1 Phase 1 – The Baseline

This phase employed a descriptive survey research design to gather data regarding nursing care documentation at a specific point in time. According to McCombes (2023), descriptive research is defined as an account of phenomena as they currently exist, with researchers having no control over the variables. The goal of this approach was to provide insight into current issues. In this phase, the design enabled an assessment of the existing situation concerning nursing care documentation.

3.2.2 Phase 2 – The Intervention

Phase 2 of the study utilized an applied research design. According to Kothari (2014), applied research aims to find solutions to immediate problems faced by society or organizations. This type of research contributes to the expansion of knowledge by generating practical solutions to societal issues. In this phase, the primary focus was on improving the quality of nursing care documentation as a critical component of professional nursing practice. To address the identified gaps, a framework for enhancing documentation practices was developed and operationalized through a Continuing Professional Development (CPD) module entitled *"Training Guide for Nurses and Nurse Managers."* The module was designed to strengthen nurses' competencies in accurate, comprehensive, and timely documentation by applying a systematic thinking approach. This approach encouraged participants to view documentation not as a routine clerical task, but as an integral part of the nursing process that supports continuity, accountability, and quality of patient care.

The baseline study findings revealed significant deficiencies in existing documentation practices, including incomplete records, lack of standardization, and limited awareness of the broader implications of poor documentation. Such shortcomings were shown to compromise effective communication, hinder clinical decision-making, and affect the coordination of care among members of the multidisciplinary healthcare team. Consequently, the CPD module aimed to bridge these gaps by promoting best practices, establishing clear standards, and fostering a culture of professional responsibility in nursing documentation, ultimately contributing to improved patient outcomes and strengthened healthcare delivery systems.

3.2.3 Phase 3 – The evaluation

This phase adopted descriptive survey research design. In this phase, the design was used to establish the status of nursing care documented after intervention. This was undertaken in one of the study sites, Nyeri County Referral Hospital, where the intervention was undertaken. To determine if the training had impacted on the nursing care documentation process.

3.3 Location of the Study

The study was conducted in three county referral hospitals in Kenya. The selected counties, where Isiolo, Nyeri, and Nyandarua were chosen to provide geographical diversity as well as differences in social and cultural practices and economic conditions. The decision to focus on these three counties was also influenced by resource constraints, as the target population is widely distributed and would require a budget larger than what the researcher could afford.

Isiolo County is classified as arid and is located in the upper eastern region of Kenya. It covers an area of 25,350.6 km² and has a population of 268,002 according to the 2019 census, resulting in a density of 11 persons per square kilometer. The county is divided into three sub-counties: Isiolo, Merti, and Galbatulla. It is home to individuals from multiple cultures and ethnicities, including the Turkana, Borana, Meru, and Somali communities. The county referral hospital is located in Isiolo town, with a bed capacity of 202 and an occupancy rate exceeding 90%. There are 149 nurses providing care across various service areas in the hospital.

Nyeri County is situated in the central region of Kenya. It occupies an area of 3,325 km² and has a population of 759,164, resulting in an average density of 228 persons per square kilometer. The county referral hospital is located in Nyeri town, with a bed capacity of 329 and an occupancy rate of over 90%. The hospital employs 215 nurses to deliver nursing services across various departments. Nyandarua County, also located in the central region, covers an area of 3,286 km². It has a population of 638,289, leading to an average density of 194 persons per square kilometer. The county referral hospital, JM Kariuki Hospital, is situated about 1 kilometer from Ol Kalou town along the Nairobi-Nyahururu Road. This facility has a bed capacity of 200 and an occupancy rate exceeding 95%. There are 110 nurses working in the hospital, distributed across different service areas.

3.4 Target Population

According to Willie (2024), a target population is defined as a group composed of all members of a real or hypothetical set of individuals, events, or items that share observable common features, which a researcher aims to generalize results from a study. In this particular study, the target population included three counties: Nyandarua, Nyeri, and Isiolo. These counties represent non-arid, semi-arid, and arid regions, respectively. The selection of these counties was intended to provide geographical diversity, as well as variations in social, cultural practices, and economic conditions. The study focused on the County Referral Hospitals in these counties, which include Nyeri County Teaching and Referral Hospital, J.M. Kariuki Teaching and Referral Hospital, and Isiolo County Teaching and Referral Hospital. In recent years, hospitals in Kenya have been reorganized under the devolved health system policy to strengthen referral pathways between facilities as envisioned in the Kenya Health Sector Referral

Strategy (2014–2018). The impact of enforcing national referral guidelines has been evaluated, showing reductions in direct hospital walk-ins and shifts toward formal referral use (Omondi et al., 2024). The strategy provides a framework for a functional referral system across all 47 counties to enhance health service delivery at various levels. It seeks to ensure streamlined referral services, thereby reducing overcrowding at National Referral Hospitals.

Healthcare services should not solely rely on the services available at each facility; rather, they should be determined by the country's comprehensive health care offerings. In Kenya, the public sector remains the primary source of healthcare, with the majority of facilities being government-owned. Furthermore, approximately 75% of the population lacks health insurance, resulting in out-of-pocket payments for healthcare services (Africa Health Business, 2021). Therefore, it is crucial to deliver healthcare efficiently, while promoting quality and safety. Optimal nursing care documentation is one strategy to achieve this, as it reduces healthcare costs and enhances patient satisfaction and trust in health institutions. Strengthening health systems is essential for improving health outcomes and achieving health-related goals, both nationally and globally. In particular, Kenya has committed to achieving Universal Health Coverage by 2030 (Nyawira et al., 2021), and the nursing profession, through various roles including nursing care documentation has the potential to make significant contributions to this goal.

In this study, the nurse manager from each county hospital, along with two nursing managers from the medical and surgical units, were selected using a census technique. Nurse managers are responsible for maintaining patient care standards by overseeing

nursing care delivery and ensuring a multidisciplinary approach. Their insights were invaluable in identifying the current status, challenges, and opportunities for enhancing the quality of care associated with nursing care documentation. Additionally, nurses, who directly deliver nursing care to patients, were included in the study to help understand the barriers and facilitators of nursing care documentation. Nurses were randomly selected from each hospital as detailed in the study.

Patient case files from the three hospitals provided documented evidence of care and served as a means for verifying the quality of nursing care documentation. The medical-surgical units in Nyeri County Teaching and Referral Hospital have a bed capacity of 70, with an average occupancy of 63 (90%). Isiolo County Hospital has a medical-surgical unit with a bed capacity of 48 and an average occupancy of 46 (95%), while J.M. Kariuki Hospital has a bed capacity of 56 with an average occupancy of 48 (80%) in its medical-surgical units. The average length of stay (ALOS) in the medical units across the three hospitals was 4 days, and in the surgical units was 9 days. This results in approximately 7,209 patients annually in the medical wards and 3,204 in the surgical units. Patient case files were selected proportionally from each facility using a random sampling technique, as outlined in the study. In total, there were 150 nurses in the medical-surgical units across the three hospitals (42 at J.M. Kariuki Hospital, 60 at Nyeri County Teaching and Referral Hospital, and 48 at Isiolo County Hospital). The Cochran formula (1963) was utilized to randomly sample nurses from the three hospitals in proportion to their numbers. A summary of the sample size for the different categories of the target population is presented in the Table 3.1.

Table 3.1

Sample Size Per Category Per Hospital

Category	J.M. Kariuki Hospital	Nyeri County Referral Hospital	Isiolo County Referral Hospital
Baseline			
Nurse managers	1	1	1
Nurse managers of medical surgical units	2	2	2
Nurses	25	34	27
Patient case files	49	63	46
Post implementation			
Patient case files	0	32	0

3.5 Sample Size Determination and Sampling Procedure

3.5.1 Sample Size Determination

Counties- Three counties; Nyeri, Nyandarua and Isiolo were sampled using stratified sampling techniques to ensure representation of arid, semiarid and non-arid counties.

Hospitals- The referral hospital in each county was sampled.

Nurse managers- Three key informants, the three nurse managers in the county referral hospitals were targeted in this study.

Nurses in medical and surgical wards- Yamane (1967) formula was used to derive the sample size of the nurses, 25 from J.M Kariuki Hospital, 34 from Nyeri County Referral Hospital, and 27 from Isiolo County Referral Hospital. The medical and surgical wards were selected since these are the areas where the largest proportion of in-patients are cared for in the county referral hospitals (Barasa et al., 2020), and as such, improvement in these units would yield greatest impact. There were a total of 108 nurses working in the medical and surgical wards of the three hospitals. Yamane (1967) formula (1967) was applied as follows;

$n= N/1+N(e)^2$

Where;

n= desired population size

N= population size

e= level of precision

Population size = 28+41+33= 102

n=108/1 + 108(0.05x0.05) = 86.04 (rounded off to 86)

The sample was drawn proportionally from the three hospitals.

Two nurse managers were sampled form each hospital. One of these was the hospital nurse manager, and the other two were the in charges in the medical and surgical wards.

Patient case files- The patient case file was chosen as the unit of analysis because it is the authoritative, complete record of care across an admission, capturing nursing assessments, plans, interventions, evaluations, handovers, and outcomes over multiple shifts. This choice aligns with the study outcome that focused on quality of nursing documentation. Yamane (1967) formula was used to determine the sample size for nurses and patient case files. This formula assumes a 95% confidence level and a proportion (P) of 0.5. In Nyeri County Teaching and Referral Hospital, the medical-surgical units have a bed capacity of 70, with an average occupancy rate of 63 beds (90%). Isiolo County Hospital has medical-surgical units with a bed capacity of 48 and an average occupancy of 46 beds (95%). J.M. Kariuki Hospital has a bed capacity of 56 in its medical-surgical units, with an average occupancy of 48 beds (80%).

$n= N/1+N(e)^2$

Where;

n= desired population size

N= population size

e= level of precision

Population size = 63+47+48= 157

n=158/1 + 158(0.05x0.05) = 158 + 0.39.

158 + 0.39= 158.4

This was rounded off to the nearest 10, giving 158 patient case files.

3.5.2 Sampling Procedure

i) The Counties

The purposeful sampling technique was used to select three counties. These counties were categorized into three groups: Arid Lands, Semi-Arid Lands (SAL), and Non-ASAL counties. The classification aimed to create diversity in nursing staff density, which may influence nursing care documentation. The Arid and Semiarid lands were considered hardship areas, facing unique geographical challenges and a low rate of attracting and retaining healthcare professionals (Otundo ,2024).). There are nine counties categorized as arid, 14 as semiarid, and 24 as non-ASAL (National Drought Management Authority, 2023).

Arid counties are defined as those located in dry regions and are characterized by frequent droughts, which are linked to various health challenges. Additionally, these areas often face insecurity, making it difficult to retain healthcare workers. Poor retention of nurses may negatively impact the nurse-to-patient ratio and, consequently, the implementation and documentation of nursing care. The counties fitting this description are outlined in Table 3.2.

Table 3.2

List of All Counties in Kenya by Climatic Conditions

No	**Arid Counties**	**Semi-Arid counties**	**Non ASAL counties**

1.	Baringo	Embu	Nyandarua
2.	Garissa	Kajiado	Kiambu
3.	Isiolo	Kilifi	Nairobi
4.	Mandera	Kitui	Mombasa
5.	Marsabit	Kwale	Nyamira
6.	Samburu	Laikipia	Kisumu
7.	Tana River	Narok	Busia
8.	Turkana	Nyeri	Kirinyaga
9.	Wajir	Taita Taveta	Kisii
10.		Tharaka Nithi	Machakos
11.		West Pocket	Murangá
12.		Lamu	Trans Nzoia
13.		Makueni	Uasin Gishu
14.		Meru	Nandi
15.			Elgeyo Marakwet
16.			Nakuru
17.			Kericho
18.			Bomet
19.			Vihiga
20.			Kakamega
21.			Bungoma
22.			Siaya
23.			Homa Bay
24.			Migori

The Semi-Arid counties, similar to arid counties, experience predominantly dry climatic conditions, which support a combination of agricultural and pastoral activities. However, some areas within these counties are affected by drought and insecurity. Retaining healthcare workers in these regions can be difficult, particularly in remote and insecure locations. This challenge can impact the nurse-to-patient ratio and the implementation and documentation of nursing care activities. A list of these counties can be found in Table 3.2. In contrast, the non-ASAL counties (also detailed in Table 3.2) benefit from a more favorable climate and face fewer challenges related to the employment and retention of healthcare workers. This positive environment contributes to better nurse-to-patient ratios and overall improvements in nursing care conditions.

ii) Health Facilities

The county referral hospital from each county was picked. From the hospital, the sample consists of key informants, nurses in medical surgical wards and patient case files. Key informants consisted of nurse managers, who were responsible for maintaining the quality nursing care services through supervision and directing all aspects to include nursing care documentation. The census technique was used to pick the hospital nursing services managers and the medical surgical unit managers.

Nurses in medical surgical units who were confronted by varying patient conditions, situations and demands in their day-to-day work, posing different demands in regard to nursing care documentation were included. Random sampling technique was applied to get the sample. Patients' case files were included to check evidence of nursing care documentation. Simple random technique was used to pick the study files.

3.6 Inclusion and Exclusion Criteria

3.6.1 Inclusion Criteria

The study included nurse managers and nurses working in the medical and surgical units of county referral hospitals in Nyeri, Nyandarua, and Isiolo. Patient case files considered for the study were those of patients who were admitted and discharged from the medical and surgical units of these hospitals within the last 30 days.

3.6.2 Exclusion Criteria

Healthcare providers who are not nurses were not included in the study. Additionally, any nurse managers or nurses from the medical and surgical units of the three referral hospitals who are on annual leave, maternity leave, or unable to participate due to

illness at the time of data collection were excluded. Patient case files of individuals who were discharged more than 30 days ago were also excluded.

3.7 Data Collecting Instruments

Three sets of tools were used in data collection, one for nurses, one for the nurse managers and one for the patient case files. The development of the tools was guided by the objectives to ensure consistency of content, and that the tools speak to each other.

3.7.1 Questionnaire

This was structured into four sections. Section one addressed individual nurse factors that influence nursing care documentation. Factors under consideration in this section included age, gender, qualification, and knowledge on nursing care documentation. In addition, a 5-point Likert scale was used to measure nurses' opinion on various issues of nursing care documentation. Section two addressed institutional factors that influence nursing care documentation. A 5-point Likert scale was used to measure factors under consideration to include availability and utilization of standard operating procedures, patient load per nurse per shift, institutional culture in regard to nursing care documentation, and supervision in relation to nursing care documentation, Section three interrogated multidisciplinary collaboration and its influence on nursing care documentation using a 5-point Likert scale.

This section focused on whether there is joint planning and evaluation of the patient care outcomes, as well as utility and critique of the nurses' documents by other team members in the multidisciplinary team. Section four focused on patient factors that affect nursing care documentation. They include patients' knowledge and demand to

know about the care they were receiving, as well as the nurses' practice of informing and explaining interventions and procedures to patients using a 5-point Likert scale.

3.7.2 Key Informant Interview Guide

This document was designed to collect data from key informants responsible for supervising nursing care activities. It focused on areas such as nursing care documentation, the development of standard operating procedures, challenges related to nursing care documentation within the facility, the existence of measures to improve documentation practices, and oversight of other multidisciplinary issues that impact nursing care documentation. The tool was to generate qualitative data through a guide that includes specific questions addressing various objectives. This approach allowed respondents to provide detailed insights into the study's phenomena.

3.7.3 Checklist

The checklist was used to audit patient case files of patients who were in the ward at the time of data collection. It consists of indicators of quality nursing care documentation, and was used to extract data from the patients' files. These include presence of patients' details in each sheet of nursing kardex used, initial nursing assessment, and focused assessment per shift, nursing interventions documentation and responses to the interventions, instructions for next shift, clear signage for ownership as well as timeliness of entries into the files.

3.8 Pretesting of Data Collection Tools

The study pretesting of data collection tools was done in Laikipia County Referral and Teaching Hospital- Nanyuki. This was to ensure that items are clear in the instruments developed. In addition, the pretest was to ensure that suitable and relevant information was sought. The sample consists of the nurse manager of this facility, one nursing officer in charge of the medical unit, and one nursing officer in charge of the surgical unit. 10 patient case files of patients who had been discharged from the medical surgical units over the last 30 days were reviewed in accordance with the case file review checklist.

3.9 Validity and Reliability of Instruments

Data collection instruments need to give the type of data that can be able to suitably answer the questions of the researcher. Mugenda and Mugenda (2003) accentuate that data collected must be relevant to the research hypothesis by ensuring reliability and validity. These are the issues that the researcher addressed.

3.9.1 Reliability

Reliability denotes capacity of the study instrument to give similar results after repeated use (Mugenda & Mugenda, 2003). The need for this is important in every study, as without reliability the results would not be valid (Hair et al., 2021). Study tools that are reliable produce consistent outcomes to the extent that independent persons administering the instrument yield related results (Kline, 2023). To ensure reliability, research assistants who assisted in data collection were trained to ensure that there would be consistency in the way data was collected. Explanation was given to

participants regarding the significance of the study to ensure corporation and provision of truthful information.

3.9.2 Validity

Mugenda & Mugenda (2003) describes validity as the ability of an instrument to be able to measure that which it constructed and intended to measure. Kline (2023;) explain that validity is that quality in the tool that enables it to measure what it is meant to measure. It is concerned with whether one is measuring appropriate pointers of the concept, precision of the results to the degree of what is meant to be measured. This was appraised by presenting the instrument to the experts at Kenya Methodist University for critiquing and advice. Content validity that entails assurance that items in the measuring instrument are true representation of the field which they intend to serve, on the other hand, validity was ensured by developing items in line with the objectives. Criterion validity was tested by comparing results with those of similar studies.

3.10 Data Collection Procedure

A three-day training was held for research assistants who assisted in the data collection process, one per each of the three sites. The data collection procedures were as follows:

3.10.1 Key Informants

An interview guide was utilized to gather data from key informants. This involved a face-to-face meeting between the research assistant and the nurse managers at their respective facilities or at another mutually agreed-upon location. The interview was recorded to minimize errors during analysis, and the research assistant also took notes

to supplement the recording. The interview was structured around the research objectives and focused on nursing care documentation, specifically regarding the guidance and supervision aspects related to this topic. The interview sessions lasted between 45 minutes and 1 hour, based on the volume of information that the respondent provided.

3.10.2 The questionnaire

The questionnaires were issued by the research assistants to the nurses over a one-week period for each of the hospitals. These were self-administered, whereby they were issued, and collected after they have been filled. The questionnaires were checked for completeness and legibility before collection. The content of the questionnaire was guided by the objectives, and reflected areas of nursing care documented under the control of the nurse.

3.10.3 Patient Case Files Checklist

The 158 selected files were audited by the research assistants to determine the quality and completeness of nursing care documented. The audit was done within the respective health facilities. A checklist was developed consisting of parameters that are indicators of quality nursing care documentation. The sampled patient case files were perused in line with the checklist to determine the quality of nursing care documentation per day.

3.11 Ethical Consideration

The researcher obtained an introductory letter from Kenya Methodist University (KeMU), specifically from the Department of Health System Management and Medical Education. Ethical approval was sought from the KeMU Scientific, Ethical, and Research Committee. Additionally, a research permit was acquired from the National Commission for Science, Technology, and Innovation (NACOSTI). Authority was also sought from the research units at both the county and hospital levels. Throughout the research process, ethical standards were upheld during all interactions between the researcher and participants.

Participants were informed that their involvement in the study was important but entirely voluntary. The researcher organized discussions with groups of nurses in the medical-surgical units of the hospitals to thoroughly describe the nature of the study. These discussions covered the study tools, its purpose, and the anticipated benefits for the healthcare system, the nursing profession, and each individual nurse. Each participant signed a consent form to indicate their voluntary participation in the study. Participants were informed that they would retain the right to withdraw from the study at any time. Confidentiality and anonymity were upheld throughout the research. All completed study tools will be destroyed by the researcher upon acceptance of the research report. The consent form is provided in Appendix IV.

3.12 Data Analysis

Data analysis was undertaken in both the baseline and the evaluation phases of the study. For quantitative data, SPSS, version 26.0 was used to analyze the data. Validation to ascertain if data collection was done as per the pre-set standards was done.

Editing was done to detect errors and omissions. Completed questionnaires were coded and rechecked at the end of each day. Descriptive statistics was used to determine patterns and summarize data, while inferential statistics such as correlation and regression analysis were used to further reveal relationships between different sets of data, and to allow generalization of the results. Classification of qualitative data was done to generate homogenous groups/thematic areas. Content analysis was further used to explain responses. The data analysis approach per objective was tabulated in Table 3.3.

Table 3.3

Data Analysis Method Per Objective

Objective	Indicators and information needed	Methods for data collection	Data analysis method
To evaluate the quality of nursing care documentation in selected counties in Kenya.	● Describes indicators of patients' current clinical status ● Outlines status of previous clinical indicators ● Indicates specific nursing interventions implemented ● Outcomes of the nursing interventions when due for evaluation ● Status at handing over ● Any pending interventions	Review of patients' case files	● Thematic areas ● Content analysis ● Regression analysis
To assess the influence of individual factors on quality documentation of	● Age ● Education level/qualification	Questionnaire	● Thematic areas

nursing care in selected counties in Kenya	● Knowledge on documentation ● Attitude ● Experience		● Content analysis ● Regression analysis
To assess the influence of institutional factors on quality documentation of nursing care in selected counties in Kenya	● Standard operating procedures ● Patient load interventions ● Institutional culture ● Supervision	● Questionnaire ● In-depth interview with key informers	● Thematic areas ● Content analysis ● Regression analysis
To assess the influence of multidisciplinary collaboration on quality of nursing care documentation in selected counties in Kenya.	● Joint setting of health care outcomes ● Clinical meetings ● Joint ward rounds	● Questionnaires ● In-depth interview with key informers.	● Thematic areas ● Content analysis ● Regression analysis
To assess the effect of the intervention on the quality of nursing care documentation.	● Completeness ● Objectivity ● Specificity	● Questionnaires ● In-depth interview with key informers. ● Review of patients' case files	● Thematic area ● Content analysis ● Regression analysis

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the analysis, interpretation, and description of the collected data. The data was initially entered using EpiData software and subsequently exported to SPSS version 26.0 for analysis. Validation and editing were performed to identify and correct any errors or omissions. The findings are presented in three parts: baseline, intervention and post-intervention data, aligned with the study's design.

Phase One of the study focused on the baseline assessment conducted in Nyeri, Nyandarua, and Isiolo County Referral Hospitals. The objective of this phase was to determine the factors influencing the quality of nursing documentation. Four key categories were assessed: socio-demographic characteristics, institutional factors, patient-related factors, and multidisciplinary collaboration. This phase revealed critical gaps in nursing documentation practices within the study settings. The baseline statistical information is based on 86 completed questionnaires distributed to nurses across the three hospitals. The results are organized in accordance with the study objectives and are discussed under each thematic area.

Phase Two of the study involved a targeted intervention specifically, delivering a continuous development module to multidisciplinary team at Nyeri County Referral Hospital. This was followed by a five-day mentorship of 34 nurses in the medical ward at to improve the quality of nursing documentation. The post-intervention results from this phase are presented in the subsequent section. The effect of the intervention was evaluated in phase three, where the quality of nursing care documentation was assessed,

as well as the individual nurse factors affecting nursing care documentation. These were evaluated using the tool that had been used in the baseline phase.

4.2 Reliability Test Results

The pretest was conducted at Laikipia County Referral and Teaching Hospital in Nanyuki, with a total of 30 respondents participating. This process was essential for evaluating the consistency and reliability of the measurement tool prior to the main study or intervention. The pretest helped ensure that the tool would yield stable, dependable, and interpretable results. The findings from the pretest are summarized in the table below.

Table 4.1

Reliability Test Results

Factors	Number of items	Cronbach's Alpha
Institutional factors	11	0.708
Multidisciplinary collaboration	10	0.732
Patient factors	7	0.804
Individual factors	16	0.728
Quality of documentation	11	0.738

Barbera, Naibet, Komperda and Pentecost (2020), explain Cronbach Alpha as a measure of the extent of relatedness of items in a test. A Cronbach's alpha value of 0.70 or higher is generally considered acceptable for reliability, 0.80 or higher indicates good reliability, and 0.90 or higher reflects excellent internal consistency (Taber, 2023). This is in alignment to what Izah, et al. (2024) report, that the higher the value of the Cronbach's alpha, the higher the internal consistency of the test. The results above were thus acceptable as proof of the consistency of the questionnaire items.

4.3 Phase 1: Baseline Results

4.3.1 Response rate

In the baseline phase, all 86 questionnaires were completed and returned, giving a response rate of 100 percent.

4.3.2 Respondents' socio-demographic characteristics

The socio-demographic profile of the study participants is presented in Table 4.2.

Table 4.2

Summary of Social Demographic Characteristics of the Respondents (n=86)

Variable	Frequency	Percent
Gender		
Male	33	38.4
Female	53	61.6
Age of respondents in years		
<25	5	5.7
25-30	32	37.5
31-35	8	9.1
36-40	18	21.6
41-45	12	13.6
>45	11	12.5
Mean ±SD	35 ±8.43 (Range = 23 to 59)	
Years of experience		
≤ 5	32	37.5
6-10	17	19.3
11-15	18	20.5
16-20	10	12.5
21-25	3	3.4
>25	6	6.8
Mean ±SD	10.34 ±7.87 (Range = 1 to 32)	
Nursing education level/qualification		
Certificate	1	1.2
Diploma	56	65.1
Higher Diploma	16	18.6
Bachelor's Degree	12	14
Master's Degree	1	1.2

Of the 86 nurses involved in the study, 53 (61.6%) were female and 33 (38.4%) were male. This aligns with findings by Okoroafor et al. (2022), who noted the predominance of females in the nursing profession. The trend is often attributed to the perception of

nursing as a nurturing and caring role, traditionally associated with women (Teresa et al., 2022). Supporting this, the World Health Organization (2020) reported that nine out of ten nurses globally are female. Interestingly, Mao et al. (2021) observed that male nurses often emphasize professionalism as a strategy to earn trust and respect from patients and interdisciplinary teams. Consequently, they may demonstrate a stronger commitment to professional responsibilities such as accurate nursing care documentation, potentially surpassing their female counterparts in this aspect. These gender-related dynamics are key to understanding workforce behavior.

Of the 86 participants, 5(5.7%) were aged 25 years and less, 32(37.5%) fell within the ranges of 25–30 years age group, 18(21.6%) were within the 36-40 age group and only eleven 11(12.5%) over the age of 45 years. The ages of the participants ranged from 23 years to 59 years with a mean age of 35 years (SD of 8.43). One third of the participants had worked as a nurse for 5 years or less while 17 (19.3%) and 18 (20.5%) of them worked for 6-10 years and 11-15 years respectively. Only 9(10.2%) had worked for more than 20 years. On average, the participants have an experience of 10.34 years (SD=7.87) ranging from one year to 32 years.

Nursing care documentation is a critical aspect of the nursing profession that is taught from the first year of nursing school. However, professional experience has shown that a nurse's ability to perform nursing interventions is influenced by their professional development and accumulated experience (Oliveria et al., 2022).

The complexity of patients utilizing hospital services is increasing, primarily due to significant advancements in diagnostic tools and patient care equipment. Contributing factors include an aging population and a rising number of cases involving chronic

illnesses and trauma (Martins et al., 2021). Consequently, there is a heightened demand for nursing activities, which necessitates a proportional increase in the nursing workforce. Ominyi and Agom (2020) indicate that factors such as age, educational qualifications, experience, attitudes, and knowledge of evidence-based practice among nurses influence their competence and application of these skills in patient care.

In the study, 56(65.1%) respondents held diploma nursing qualifications, while 16(18.6%) participants had higher diplomas, and only 12(14%) held bachelor's degrees; one participant had a master's degree. These findings regarding age, experience, and education levels may be related to the emigration of nurses to other countries as they gain experience. Some nurses, as reported by Abdelhadi and Kershaw (2025) to pursue career advancement and often find limited opportunities in clinical settings, leading them to explore management roles instead, where they perceive better chances for growth. The role of advanced nursing practice was noted to be at development stage by Kruth (2022), and was facing challenges such as lack of adequate regulation and recognition.

Furthermore, while there are opportunities for diploma nurses to upgrade to degrees, Kamau and Mwangi (2021) note numerous challenges associated with this process, which hinder their progression. Despite recognizing the importance of higher qualifications for career development, many nurses face obstacles in pursuing further education. The results revealed a statistically significant association between age and knowledge of nursing care documentation. Nurses aged 25 years and below demonstrated the highest proportion of good knowledge (77.8%), while only 16.7% of those aged above 44 years had good knowledge. This decline in knowledge with increasing age was statistically significant ($\chi^2 = 8.268$, $p = 0.041$), suggesting that

younger nurses may have received more current training or be more familiar with evolving documentation standards. However, age was not significantly associated with attitude toward documentation ($\chi^2 = 0.424$, $p = 0.935$), implying that nurses' perceptions and outlook toward documentation are generally consistent across age groups.

Regarding education level, the analysis did not establish a statistically significant association with either knowledge ($p = 0.157$) or attitude ($p = 0.342$). While diploma holders showed a relatively balanced distribution between good and less knowledge (53.7% and 46.3%, respectively), higher academic qualifications such as bachelor's and master's degrees did not correspond to significantly better knowledge or more favorable attitudes. This finding indicates that the level of formal education alone may not be a strong determinant of competence or positivity toward nursing documentation.

Years of professional experience emerged as another significant factor influencing knowledge. Nurses with five years or less experience had the highest proportion of good knowledge (62.5%), whereas those with over 20 years of experience recorded lower levels (22.2%). This association was statistically significant ($\chi^2 = 11.349$, $p = 0.023$), which may reflect that newer nurses are more attuned to updated documentation protocols taught during recent training. Conversely, years of experience did not significantly influence attitude ($\chi^2 = 0.787$, $p = 0.940$), suggesting that regardless of how long they have been in the profession, nurses generally held similar views toward the importance and practice of documentation. The nurse managers concurred with these findings, noting that the long serving nurses portrayed the attitude of *"I have done it long enough, what do you want to show me".* To address this, the managers outlined

being firm and continuous monitoring as mechanisms that they use, and that have been fruitful in addressing the issue.

Further analysis was done, to determine whether there was a significant association between age and the quality of nursing care documentation. The results are presented in the Table 4.3.

Table 4.3

Association Between Gender and the Quality of Nursing Care Documentation

Gender	Quality nursing care documentation N=86		Chi-square value	P-value
	Good	Poor		
Male	11(33.3%)	22(66.7%)	0.28	0.60
Female	22(41.5%)	31(58.5%)		

From the analysis, 11(33.3%) of male nurses had good documentation compared to 22(41.5%) of female nurses. Conversely, a slightly higher proportion of male nurses 22(66.7%) had poor documentation compared to female nurses 31(58.5%). However, the association between gender and the quality of nursing documentation was not statistically significant (X=0.28; P=0.60). Therefore, gender does not have a significant influence on the quality of nursing care documentation in this study population.

4.4 Responses on Individual nurses' factors on quality of documentation of nursing care

The first research objective sought to determine how individual nurse factors affect nursing care documentation. The findings are summarized in the Table 4.4.

Table 4.4

Responses on Individual Factors and Nursing Care Documentation

Nursing care documentation (n=86)		Agree	Disagree	Chi square	P-value
		n(%)	n(%)		
i.	I always believe that nursing care documentation is just as important as other patient's records.	84(97.7)	2(2.3)	78.19	0.00
ii.	I am convinced that nursing care documentation is a tedious process	41(47.7)	45(52.3)	0.19	0.19
iii.	Nursing care documentation process always takes a lot of time and effort	62(72.1)	24(27.9)	16.79	0.01
iv.	I know that nursing notes are often useful to other members in the multidisciplinary team	76(88.4)	10(11.6)	50.65	0.00
v.	The quality of nursing notes always positively influences patients care outcomes	77(89.5)	9(10.5)	53.77	0.00
vi.	I make entries in to the nursing kardex in a timely manner	68(79.1)	18(20.1)	29.07	0.00
vii.	I always refer to what the nurse in the previous shift indicated in the nursing kardex.	78(90.7)	8(9.3)	56.98	0.00
viii.	I always expect the nurse taking over from me to refer to my nursing kardex notes	74(86.1)	12(13.9)	44.70	0.00
ix.	My experience in nursing often influences the way I document nursing care	82(95.3)	4(4.7)	70.74	0.00
x.	I always make documentation of the care I have provided priority	76(88.4)	10(11.6)	50.65	0.00
xi.	I have ever been questioned before by my colleagues and supervisors about my nursing care documentation	58(67.4)	28(32.6)	10.47	0.03
xii.	I have ever questioned the documentation of nursing care by my colleagues	68(79.1)	18(20.1)	29.07	0.00
xiii.	Litigations often arise from the documentation of care they provided	62(72.1)	24(27.9)	16.79	0.01
xiv.	I often have the opportunity to learn about nursing care documentation	76(88.4)	10(11.6)	50.65	0.00
xv.	I well understand the key aspects I should include in the documentation of the care I provide	84(97.7)	2(2.3)	78.19	0.00

xvi.	I always ensure that I include the key aspects that should be included as I document care	80(93)	6(7)	63.67	0.00

The data was transformed from 5-point to 2-point data, where strongly agreed and agreed were categorized as agreed, and neutral, disagreed and strongly disagreed were categorized as disagreed. The findings revealed that 84(97.7%) of the nurses indicated that nursing care documentation is just as important as other patient records. This indicates the value and understanding that nurses place on care documentation, and the appreciation of this process as a key component of their practice. All medical records are critical and created with purpose, as the multidisciplinary team cannot solely rely on their memories for recalling interactions with patients, and neither is it practically possible for every member to verbally communicate their interactions with the patients to all other team members. A lot of effort and time is also invested in this important exercise. Moreover, there is a need to communicate this information to other members who were not part of the consultation, yet who need to be aware of the same information for decision making.

Roundrunner Health Services (2022) recognizes this fact and highlights that medical records facilitate smooth operations within a healthcare system and enhance the delivery of appropriate health interventions. According to Demsah et al. (2022) and the Nursing Council of Kenya (2023), documented healthcare is key for several reasons, including serving as a basis for continuity of care, enabling insurance reimbursement, and facilitating communication among healthcare providers for better outcomes, among others. Well-kept medical records ensure that healthcare interventions are responsive to patient needs, allowing for patient-centered care that yields positive outcomes.

Despite the importance of documentation, many clinicians are aware that their clinical entries often do not meet standards (Demsash et al., 2023), and as such constitute a gap in the continuum of health care, and overall quality of care provided. This was evident in the study, where various gaps in nursing care documentation were observed. The absence of optimal care documentation denies patients the associated benefits and can lead to poor care outcomes, which may sometimes be fatal. Tamir et al. (2021) explain that documented care is just the tip of the iceberg concerning various issues that could result in litigations and disciplinary actions within a healthcare setup.

Demonstrating an understanding of the importance of documented care among nurses is key and represents a first step toward improving the process. Dunham et al. (2020) noted that understanding professional expectations and their implications is critical to following instructions. Therefore, nurses need to appreciate not only the value of nursing care documentation but also recognize that maintaining it is a professional obligation. Azevedo and Cruz (2021) assert that nursing care documentation is a key indicator of the quality of nursing care. Without documenting the care provided, nurses cannot demonstrate the quality or lack thereof of their care, or proof that care was derived. Additionally, appropriate care documentation promotes the safety of both the patient and the provider. Demsash et al. (2023) notes that concise and clear nursing records reflect a nurse's standard of professional practice and the quality of care they provide.

This implies that a nurse who maintains clear and organized patient care documentation is likely to demonstrate a similar standard in the care they provide. Nursing care documentation has also been cited as an opportunity for nurses to reflect on the care they are providing and the results of that care (Groot et al., 2022). This reflection allows

nurses to critique the care they deliver in relation to the patient's health status and to determine if any changes are needed in the care plan. Consequently, this leads to more effective care, and nurses can operate more efficiently. Patt (2024) adds that documented nursing care guides all team members in providing the appropriate care for each patient. Additionally, nursing care documentation is essential as a tool for quality care improvement, legal protection, and regulatory compliance, among other factors. Recognizing the importance and critical role of documented nursing care is a step toward enhancing and maintaining quality in this area.

Among the respondents, 41(47.1%) agreed that they felt nursing care documentation is a tedious process. Additionally, 62(72.1%) agreed that the nursing care documentation process always takes considerable time and effort. Stites (2023) observed that approximately 40% of nurses' time is spent on documentation, leaving only 60% for implementing nursing care activities. This can lead to nurses feeling overwhelmed and may contribute to burnout. The U.S. Surgeon General's advisory on building a thriving health workforce (2022) reported that 35% to 45% of nurses experience signs of burnout.

They noted that adverse events, which can have serious repercussions for both patients and the health system, can result from healthcare worker burnout. This emphasizes the need for nurses to be attentive to the principles of conciseness and completeness in documentation. Stites (2023) advocates for the identification and elimination of repetitive information, focusing instead on key elements that enhance patient care. This ensures that the information entered into patients' care records is both purposeful and useful.

In the same study, Stites (2023) found only 47.8% of respondents as having good nursing practice. This suggests a strong relationship between attitude and actions, as our attitudes significantly influence our behavior with regression analysis yielding P value of less than 0.01). Similarly, Molla et al. (2024) found that nurses who had a positive attitude towards nursing care documentation were three times more likely to maintain proper documentation compared to those who did not share this positive attitude. These findings align with Ayele et al. (2021) and Groot et al. (2022), who indicate that nursing care documentation is often perceived as burdensome.

The Agency for Healthcare Research and Quality (2024) noted an increasing documentation burden, which affects healthcare professionals' work experience. Ahmed et al. (2023) echoes this sentiment, arguing that even though documentation may seem burdensome, it serves as a way for nurses and other healthcare professionals to validate that they have fulfilled their moral and legal responsibilities. Ahmed et al. (2023) further emphasizes the importance of communication among the healthcare team and with patients, asserting that documentation of care and its outcomes is a critical catalyst for achieving positive clinical results.

Despite its burdensome nature, care documentation remains the primary evidence of care provided and thus serves as a performance measure against established standards. Moreover, Groot et al. (2022) observed variations in the time nurses spend on documentation and suggested that these variations relate to a lack of clarity regarding what should be documented. It is essential to establish clear understanding and standard operating procedures to help nurses discern what is appropriate to include in documentation, ensuring that notes are comprehensive but free from unnecessary information. Additionally, when nurses evaluate the time spent on documentation, it is

crucial to differentiate between time devoted to direct patient care activities and time spent documenting non-patient care activities.

Regardless of the time constraints and competing tasks, completing care documentation is vital, as it serves as an indicator that other essential tasks were accomplished. Regarding the perceived usefulness of nursing care documentation, 76(88.4%) of the respondents agreed that documentation benefited other members of the multidisciplinary team. This aligns with findings by Rohmani et al. (2024)), who highlight the significance of nursing care documentation as an effective communication tool among various healthcare professionals. Hankey (2023) pointed out that it is practically impossible to remember everything that occurs during a shift, making documentation essential for sharing care and patient responses to interventions within the team.

In healthcare, clear and concise documentation of interventions is crucial. Nursing care documentation acts as a vital communication tool among multidisciplinary team members. Given the extensive interactions nurses have with patients, nursing notes are expected to provide a chronological outline of events related to healthcare, facilitating both care continuity and the identification of critical moments when changes to the care plan may be necessary.

With an increasing focus on improving patient care outcomes, effective communication within the multidisciplinary team is becoming more important (Sharkiya et al., 2023). Thus, nursing notes serve as a crucial basis for updates to other team members, guiding further clinical decisions about the patient. Inadequate or unclear nursing notes can lead to gaps in information, which may result in misaligned healthcare decisions and interventions, primarily when the healthcare team lacks complete information. At least

68(79.1%) of the respondents reported making timely entries in the nursing kardex. While this indicates a quality standard for nursing care documentation, it contrasts with Hankey's (2023) report that nurses often view documentation as an interruption to patient care activities.

This perspective can lead to delayed entries and, consequently, delays in leaving duty at the end of a shift. Emergencies during shifts and the increasing demands on nurses' time can exacerbate this issue. Moreover, delayed entries may result in nurses forgetting to document specific care activities or patient responses observed during the shift. Incomplete or missing documentation can lead to gaps in patient information and may contribute to erroneous patient care decisions by the care team. The necessity for timely entries is emphasized by NCK (2023), as it is a fundamental principle of effective nursing practice.

Tamata and Mohammadnezhad (2020) report that the nursing shortage is a significant issue within the healthcare system. The World Health Organization (2024) reaffirms this concern and projects that the shortage could reach 4.5 million by 2023. The International Council of Nurses (2023) has labeled the nursing shortage as a global emergency, urging immediate action to address this situation. An adequate number of nurses is essential for providing safe and quality healthcare (NCK 2023), as having enough nurses allows for division of labor, enabling each nurse to dedicate the necessary time to essential care activities, including documentation. Despite the reported prioritization of nursing roles, 58(67.4%) of respondents reported instances where their documented care was questioned. This questioning highlights an existing gap in care documentation.

Meri et al. (2022) emphasize that care documentation is a legal requirement for healthcare providers and serves as evidence that care activities have been carried out. Missing entries in nursing documentation can be interpreted as omissions in nursing care, leading to concerns about the healthcare provider's accountability and potential litigations against the healthcare system, in addition to negatively impacting patient outcomes. Inaccurate entries in the nursing kardex may result in discrepancies between documented and actual nursing care activities.

Other healthcare providers, aiming for better health outcomes, may unintentionally replicate the same activities, which can adversely affect patients, possibly resulting in issues like drug overdoses. Furthermore, repeated activities may delay patient care, increase costs, and hinder the efficiency of the healthcare team. Over half of the respondents, 77(89.5%), agreed that high-quality nursing notes positively influence patient care outcomes. This sentiment is supported by Huang et al. (2021), who assert that information from all members of the multidisciplinary team is crucial for predicting risks.

The ability to predict risks allows the team to implement preventative measures and improve healthcare outcomes. Quality nursing care documentation plays a central role in informing clinical decisions. Clinical decisions are influenced by patient responses to healthcare interventions, and nurses are uniquely positioned to gather patient information that other team members can use when making decisions. Oldland et al. (2020) highlight the critical role of nurses within the healthcare system. To perform their duties optimally, nurses must be aware of their responsibilities and expectations within the health system. Recognizing the connection between the quality of nursing notes and patient outcomes is an essential step toward enhancing both. Regarding

nurses referring to the documentation from their colleagues, 78(90.7%) of respondents agreed, that they consulted the previous shift's documentation in the nursing kardex.

Additionally, 74(86.1%), agreed that they expected nurses taking over from them to review their documentation. This illustrates the significance of documented care as a communication tool. Ahmed et al. (2023) stresses that nursing documentation should provide sufficient information so that when incoming nurses step in, they can continue care based on what has been recorded. Clear and concise nursing documentation is vital for enabling others to grasp the patient care journey and the responses patients have to healthcare interventions. These findings correlate with the fact that 58(67.4%) agreed that they had been questioned about their documented care.

This indicates that nurses refer to their colleagues' documentation when making care decisions and developing plans. Although this process is informal, it is crucial for maintaining the quality of nursing documentation. However, this practice should be supported by a Standard Operating Procedure (SOP) for documentation to ensure that all nurses have a consistent reference point. Without proper guidance, nurses may apply their standards for auditing documentation, which could result in low-quality records. Moreover, the existence of an SOP empowers questioning nurses to demand corrections in documented care to align with established expectations.

In terms of litigation and care documentation, 62(72.1%) of the respondents agreed that litigations often arise from care that is provided and documented. This is despite the fact that litigations typically concern the quality of care, which can only be verified through careful review of documentation. Almubarak and Alshatti (2023) noted an increasing trend in reported litigation cases against healthcare providers, a finding that aligns with a report from the Nursing Council of Kenya (2022).

This rise may be attributed to the influence of social media, where individuals share their healthcare experiences more widely, leading to increased reporting of cases. Therefore, healthcare providers must remain vigilant and understand the risks associated with medical litigations in order to mitigate these risks. Furthermore, White (2023) points out that even when care meets expected standards, healthcare providers may struggle to defend themselves if adequate documentation is lacking. Documented care serves as a crucial basis for determining the outcome of medical negligence cases. The 2018 lawsuit of Schaetzel vs. Mercy Health Services in Iowa highlighted the importance of professional conduct and documentation in litigation (Brent 2018).

Support for this perspective is echoed by Ghaith et al. (2022) which states that good documentation is the best defense for nurses facing lawsuits. Therefore, it is vital for nurses to understand the link between their documented care and potential litigations, enabling them to exercise caution in their practice.

Additionally, nurses should familiarize themselves with the legal consequences of litigations against the care they provide, as outlined in the Nurses Act, section 18. Staying updated on industry trends and changes in litigation patterns allows nurses to be responsive and take proactive measures to avoid actions and omissions that could lead to legal issues. This, in turn, enables nurses to advise the healthcare systems they work within, facilitating the implementation of preventive measures, as medical litigations can be costly and draining for both the nurses and the healthcare system. Regarding nursing experience, 82(95.3%) agreed that their experience influenced their documentation practices.

As nurses advance in their careers, their skills and competencies, including documentation, are expected to improve. Yadav and Dhar (2021) define experience as the total time spent performing a specific task. Rivaldo and Nabella (2023) observe that organizations tend to favor individuals with experience, as they are often perceived as better equipped to perform their assigned tasks. Although Wang et al. (2022) found no correlation between performance and experience, while a study by Bolado et al. (2023) noted that nurses with at least one year of experience were four to five times more likely, respectively, to demonstrate good documentation practice than those with <2 years' experience. Enhancing one's knowledge in their field is essential for remaining relevant and developing skills (Kiarabinu, 2022).

Learning opportunities can improve an individual's ability to complete assigned tasks and the quality of their performance. Rivaldo and Nabella (2023) agree, noting that supporting employees in developing their skills is crucial for improving performance. In light of this, 84(97.7%) of the respondents agreed that they had opportunities to learn about nursing care documentation from time to time. This indicates that nursing care documentation is recognized as a critical area within the institution, potentially highlighting gaps that drive initiatives for improvement. Consequently, 84(97.7%) of the respondents agreed that they understood and could apply the key aspects of their documentation. However, this contrasted with the managers' observations, who reported numerous gaps in the documented care, indicating that crucial aspects of documentation were frequently overlooked.

This finding was further confirmed through case file reviews, which revealed widespread deficiencies in nursing care documentation. The results of the chi-square analysis offer significant insights into nurses' beliefs and practices about nursing

documentation. The research indicates a robust and statistically significant agreement on most aspects of documentation, underscoring its acknowledged significance in nursing practice.

4.5 Influence of Institutional Factors on Quality of Documentation of Nursing Care

The second research objective sought to find out the institutional factors that affect nursing care documentation. A hospital has been described by Kartika et al. (2021) as an institution that works towards promoting the wellness and health status of the persons seeking care therein, and ensuring quality of the documented care is one way of achieving this objective. As such, it is to the best interest of the health facility to create an environment that can promote optimum care documentation practices. In addition to promoting quality of care, optimum care documentation is one way of mitigating against litigations related to healthcare provided. The findings are tabulated in Table 4.5.

Table 4.5

Institutional Factors That Influence the Quality Documentation of Nursing Kardex

Statement	Agree n(%)	Disagree n(%)	Chi square	P-value
1. My institution has adequate SOPs on nursing care documentation	67(77.9)	19(22.1)	14.53	0.0001
2. The SOPs offers sufficient guideline on nursing care documentation	64(74.4)	22(25.6)	2.81	0.0939
3. The patient load per shift is per the nursing Council of Kenya recommendations	29(33.7)	57(66.3)	4.68	0.0305
4. The patient load per shift positively affects my ability to document nursing care	69(80.2)	17(19.8)	17.30	0.0000
5. The institutional culture on nursing care documentation is appropriate	69(80.2)	17(19.8)	17.30	0.0000

6.	The institutional culture affects nursing care documentation	61(70.9)	25(29.1)	7.88	0.0050
7.	The quality of nursing notes positively influences patients care outcomes	78(90.7)	8(9.3)	34.14	0.0000
8.	My supervisor offers guidance frequently on nursing care documentation	72(83.7)	14(16.3)	22.07	0.0000
9.	The institution has a system in place to audit nursing care documentation	59(68.6)	27(31.4)	6.17	0.0130
10.	My supervisor often audits the quality of nursing care documentation	56(65.1)	30(34.9)	4.02	0.0449
11.	My supervisor often raises concerns regarding nursing care documentation in the unit	74(86)	12(14)	25.69	0.0000

The data was transformed from 5-point to 2-point data, where strongly agreed and agreed were categorized as agreed, and neutral, disagreed and strongly disagreed were categorized as disagreed. From the study results, 67(77.9%) respondents agreed that their institution has Standard Operating Procedures (SOPs) in place for nursing care documentation, while the rest 19(22.1%) disagreed to this. SOPs serve as step-by-step instructions for performing specific procedures (Credevo, 2023) and reflect the agreed-upon conditions that must be met throughout a particular process. Rusconi (2024) adds that SOPs guide work processes; without them, organizations risk inconsistency in how procedures are performed, leading to varying results.

Omoit (2021) reported that poor communication among healthcare providers contributes to medical errors, which can stem from a lack of or insufficient SOPs guiding documentation procedures. SOPs in care documentation promote standardization, aiming to minimize gaps in recorded information and ultimately improve health outcomes. Furthermore, SOPs serve as benchmarks for measuring performance. Thus, having SOPs for documentation is essential for achieving quality care and enhancing healthcare outcomes. Regarding the content of SOPs, 64(74.4%) of

the respondents agreed that the SOPs provided sufficient guidance, indicating that they were effective and met their intended purpose. This finding was collaborated by nurse managers who reported existence of SOPs. However, the managers pointed to the need to make the SOPs more accessible to the nurses, and to have regular reminders on the same.

Positive healthcare outcomes are closely related to the availability of nursing staff to provide care in clinical settings (Adamuz, et al., 2025). In this context, 69(80.2%) respondents agreed that their patient caseload impacted their ability to document care effectively. Nyawira et al. (2022) reported an inadequate number of healthcare workers with suboptimal skill mix, resulting in improper task shifting.

This situation forces nurses to assume advanced roles with more patients than recommended, thereby reducing the time available for documentation. Given that nurses often perceive nursing care documentation as a tedious process, they may prioritize patient care over documentation. Consequently, evaluations of documented care could lead to judgments that nurses failed to meet patients' needs. This could undermine the acknowledgment of the nurses' roles within the healthcare team. As a result, employers may not recognize the true value of their nurses and might not feel obligated to meet the recommended nurse-to-patient ratios.

In relation to the nurse-to-patient ratio, 57(66.3%) of the respondents disagreed that the patient load per shift in their institution aligned with the Nursing Council of Kenya's recommendations. While the nurse-to-patient ratio is just one factor affecting patient safety, it is strongly linked to patient care outcomes (Phillips et al., 2021). The ratio is a key determinant of the time nurses can spend with patients during which they perform

nursing care activities. If the ratio fails to meet recommendations, contact time is reduced, causing nurses to be spread thin across many patients.

This could result in some nursing care activities being left undone or executed late, potentially leading to negative impacts on healthcare outcomes. Additionally, Phillips et al. (2021) observe that nurses play vital roles beyond providing direct patient care. They continuously evaluate patients for early detection of deterioration, identify errors and near misses, remain vigilant regarding systemic weaknesses, and appropriately communicate changes in patient conditions. All these activities must be documented for reference by both the nursing team and other members of the multidisciplinary team. For nurses to perform these roles effectively, the working environment must support manageable patient caseloads.

Although the nurse-to-patient ratio may vary from shift to shift due to changes in patient acuity and turnover, the Nursing Council of Kenya (2022) has established standards to guide this, ensuring efficient utilization of available nurses while promoting their well-being and capacity to act within their scope of practice. These human resource standards outline the necessary inputs in terms of numbers and skill mix for each service area, allowing for effective and efficient service delivery. This ensures that nurses have the time to provide direct care and document it promptly.

A high patient load compromises nurses' ability to carry out nursing care activities and document what they have done. Indeed, an increasing number of patients per nurse correlates with a higher risk of adverse patient safety events and mortality (Phillips et al., 2021), which may affect the quality of care provided. The quality of care provided may be influenced by the lack of individualized patient care plans, which can lead to nurse burnout and disruptive behavior, ultimately resulting in job dissatisfaction and

psychological distress due to unmet healthcare goals for patients. Nursing shortage was reported by the nurse managers as a persistent problem in the three facilities. This was reported to affect many aspects of care, nursing care documentation included.

As far as institutional culture surrounding documentation was concerned, 69(80.2%) of the respondents agreed that this was appropriate. Additionally, 61(70.9%) of respondents agreed that institutional culture impacts the documentation of nursing care. These findings align with Alodhialah and AlMoteri(2025), who suggest that various subcultures exist within healthcare systems and are connected to the quality of care provided. The culture within a care system reflects the values, beliefs, and ideas of the individuals in the organization, helping to establish distinctions between right and wrong (Tietschert, & Jung, 2024). Consequently, a positive culture regarding documentation is essential for ensuring high-quality care documentation within the organization. Moreover, 78(90.7%) respondents agreed that the quality of nursing notes positively influences patient care outcomes.

This is largely because notes serve as a vital communication tool among the multidisciplinary team, which is critical for continuity of care. Interprofessional communication by junior nurses and doctors (2025) reinforce this idea by stating that the documentation by nurses should accurately reflect critical thinking; without it, communication within the interprofessional team can be hindered. They also emphasize that nursing managers should be proactive in evaluating, controlling, and directing care documentation. Further survey results indicated that 72(83.7%) of respondents noted that their supervisors frequently provide guidance on nursing care documentation.

Additionally, 59(68.6%) agreed and agreed that the institution has a system in place to audit nursing care documentation. Furthermore, 56(65.1%) of respondents agreed that

their supervisors often audit the quality of nursing care documentation. These findings suggest a commitment from health facilities and managers to support nursing care documentation and ensure its effective implementation. However, with 27(31.4%) of respondents disagreeing on their supervisors engaging to audit their notes, pointed out to a gap in supervision of this important activity. The nurse managers reported that audits were conducted irregularly, due to shortage of nurses. This was reported to affect the practice negatively since there

Concern was reported to have been raised regarding the quality of nursing notes by 74(86%) of respondents, an indication that this was a frequently occurring issue. This indicates a gap in the content of nursing notes, despite the respondents demonstrating an understanding of the importance of accurate documentation and the existing mechanism such as standard operating procedures (SOPs) and supervision to support this task. Poorly documented nursing notes have been highlighted in several studies (Tadese et al., 2024; Ahmed & Mulugeta, 2024). Such deficiencies can interfere with communication among nurses and other healthcare providers, compromising continuity and quality of care. Further analysis was done to establish the relationship between, institutional factors and nursing care documentation practice.

The chi-square test results highlight several statistically significant institutional factors that influence nurses' documentation practices as outlined in the table below.

Table 4.6

Relationship Between Institutional Factors and Nursing Care Documentation Practice

Variable	Quality of nursing documentation (n=86)		Bivariate Logistic Regression	
	Poor	Good	COR	P-value
	N	N		
Standard operating procedures				
Unavailable	28	14	1	
Available	26	18	1.335	0.521
Patient load interventions				
Heavy workload	27	17	1	
Recommended	28	15	1.133	0.779
Institutional culture				
Negative	28	16	1	
Positive	27	17	1.026	0.956

Most nurses affirmed the existence of Standard Operating Procedures (SOPs) for documentation ($\chi^2 = 14.53$, $p < 0.0001$), though their practical usefulness was less clear ($\chi^2 = 2.81$, $p = 0.0939$). While many nurses disagreed that their patient loads matched national recommendations ($\chi^2 = 4.68$, $p = 0.0305$), those who experienced manageable loads felt it improved their documentation quality ($\chi^2 = 17.30$, $p = 0.0000$). Institutional culture and supervision emerged as powerful influence, with nurses feeling supported by a culture that valued documentation ($\chi^2 = 17.30$, $p = 0.0000$) and appreciated supervisory guidance ($\chi^2 = 22.07$, $p = 0.0000$) and feedback on documentation ($\chi^2 = 25.69$, $p = 0.0000$). Regular audits and clear institutional procedures were also seen as important ($\chi^2 = 6.17$, $p = 0.0130$). These findings suggest that strong leadership, supportive culture, realistic workloads, and active quality assurance significantly impact documentation practices.

4.6 Influence of Multidisciplinary Collaboration on Quality of Documentation

The third study objective investigated the influence of multidisciplinary collaboration on the quality of nursing care documentation. The data was transformed from 5 points to 2 points data, where strongly agreed and agreed was categorized as agreed, and neutral, disagreed and strongly disagreed was categorized as disagreed. The findings are outlined in Table 4.7.

Table 4.7

Influence of Multidisciplinary Collaboration on Nursing Care Documentation

No	Statement (n=86)	Agree n (%)	Disagree n (%)	Chi square	P-value
i.	We often set health care outcomes for the patients jointly with the multidisciplinary team	56(65.1)	30(34.9)	4.02	0.0449
ii.	The multidisciplinary team often jointly evaluate patients' progress	61(70.1)	25(29.1)	7.88	0.0050
iii.	I often receive consultations from the multidisciplinary team regarding care and progress of the patients	52(60.5)	34(39.5)	.901	0.1676
iv.	We often conduct nursing rounds in my unit	77(89.5)	9(10.5)	31.86	0.0000
v.	We often hold clinical meetings in my unit	66(76.7)	20(23.3)	13.25	0.0003
vi.	We often carry out joint ward rounds with the multidisciplinary team in my unit	60(69.8)	26(30.2)	6.99	0.0082
vii.	The nurse contributes towards patient's management during the joint ward rounds	76(88.4)	10(11.6)	29.70	0.0000
viii.	There are set out parameters to check out for while receiving report at the commencement of a shift	76(88.4)	10(11.6)	29.70	0.0000
ix.	I often encounter situations where nursing kardex is not inappropriately documented	70(81.4)	16(18.7)	18.81	0.0000

x. I always act when I encounter nursing kardex that has not inappropriately documented	78(90.7)	8(9.3)	34.14	0.0000

Jepkosgei et al. (2022) define multidisciplinary collaboration as a dynamic process in which two or more healthcare professionals, with varied backgrounds and skills, come together to achieve common health goals. Undoubtedly, nurses do not work in isolation; team collaboration is essential for fulfilling the requirements of the healthcare team and the unit in which they operate (Griffiths et al., 2020). Consequently, a team effort is necessary for the successful implementation of healthcare activities. Proper documentation of these activities and their outcomes is a vital component of the multidisciplinary effort. Regarding the influence of multidisciplinary collaboration on nursing care documentation, 56(65.1%) of the respondents agreed that they often set health care outcomes for the patients jointly with the multidisciplinary team. In contrast, the remaining 30(34.9%) disagreed with this aspect.

From the nurse managers perspective, multidisciplinary collaboration exists in the sense that the team shares the same goal, of assisting the patients towards recovery. However, room for improvement in terms of holding structured clinical meetings, and documenting clearly the multidisciplinary team health care outcomes. The managers observed that this collaboration contributes greatly towards enhancing care quality, but expressed little input of this process towards nursing care documentation.

The significance of teamwork in healthcare provision cannot be overstated. Meneses, et al. (2025) noted that collaboration enhances team members' motivation, reduces treatment errors, and strengthens professional performance, ultimately leading to improved effectiveness. This assertion is supported by Reese et al. (2021), who stated that the healthcare team shares the common goal of providing high-quality and safe

patient care, and that collaboration is the means through which this goal can be achieved. Schot et al. (2020) emphasized that the effectiveness of a multidisciplinary team is contingent upon the contributions of each member, as they bring complementary roles, strengths, expertise, and experience to achieve the overall goal. Various factors, such as communication dynamics and the perceptions team members have of each other's contributions, can enhance or hinder multidisciplinary collaboration (Doornebosch et al., 2025). However, research shows that collaboration within healthcare teams has often been rated below expectations (Lerbæk et al., 2025).

This is concerning as it impedes the attainment of healthcare goals. Şahin et al. (2025) note that effective collaboration, characterized by communication and mutual respect among team members, contributes to nurses' job satisfaction and retention. Addressing professional weaknesses is essential, extending to how each discipline documents its care. Despite its importance, this remains a challenge (Lerbæk et al., 2025), as professional boundaries frequently dominate the healthcare landscape, even though all team members share the goal of restoring patients' health. Khumalo and Kane (2022) added that the diverse expertise and knowledge within the multidisciplinary team, combined with relevant patient information, lead to better patient management and outcomes.

This implies that the team needs accurate information, which relates to both the documentation of patient information and the value that team members place on each other's notes and how this influences individual documentation practices. The findings were aligned to this with 61(70.1%) respondents agreeing that they participate in joint ward rounds in their units. Additionally, 76(88.4%) respondents agreed that nurses contribute to patient management during these joint ward rounds. Merriman and Freeth

(2022) describe ward rounds as complex social processes wherein discussions and decisions occur that contribute to effective, safe, timely, and progressive patient care. Joint ward rounds are documented as essential for improving interprofessional communication and collaboration (Arpagaus et al., 2025; Bonacaro, 2025).

During joint ward rounds, crucial exchanges of information among healthcare providers and shared decision-making for patient safety take place (Kallen et al., 2021). The ward round serves as a pivotal vehicle for coordinating patient care (Moleyar et al., 2020). Joint evaluations of the effectiveness of healthcare outcomes are vital, as they facilitate a collective review of care plans. This coordination is crucial, especially as lack of information and resource sharing has been identified as a global issue, resulting in siloed practices among different healthcare cadres (Berndt et al., 2023). Joint decisions are typically made during ward rounds (Zamanzadeh et al., 2021).

Despite evidence that nurses are integral to patient care, research shows they are sometimes marginalized during ward rounds. For example, Arpagaus et al. (2025) found that nurses report lower satisfaction and efficiency in interprofessional rounds and limited opportunities for meaningful contribution. Perceptions of their role vary, some observe that nurses' participation is minimal or undervalued (Berndt et al., 2023). Despite these challenges, studies indicate that multidisciplinary collaboration is enhanced when nurses are involved in ward rounds (Kallen et al., 2021). Nurses provide a broad health perspective on the patient, facilitating discussions on issues that may impact the achievement of healthcare goals.

Being present with the patient around the clock allows nurses to share important observations with the rest of the healthcare team. Therefore, nurses must know their patients well, understand their needs, and advocate for them during ward rounds.

Failing to do so denies the healthcare team and the patient the opportunity for informed decision-making, potentially delaying the achievement of patient care goals. To effectively contribute, nurses must be well-prepared, systematically document the care provided, and present this information confidently and from a value-added perspective. A problematic relationship within the multidisciplinary team has been reported, which may stem from a lack of understanding between different roles (Walton et al., 2020).

The feeling of being undervalued among nurses may relate to their perceived competence and the value they add to the multidisciplinary team. Nurses must demonstrate confidence and knowledge in patient management to speak with authority on these matters. However, this may lead to nurses hesitating to voice their opinions or observations regarding patient care. Dongen et al. (2024) found that nurses often struggle to speak up during rounds, with their input not well-received by physicians. This observation is echoed by Arpagaus et al. (2025), who noted that ward rounds were often undervalued, resulting in low engagement from some healthcare providers.

Moreover, nurses expressed frustration that physicians frequently overlooked the issues they raised regarding patients' conditions, further discouraging them from contributing to patient care goals and management. They emphasized that strong communication both verbal and documented is foundational for effective collaboration. When collaboration is impaired, each team member tends to focus solely on their respective plans and activities, leaving little room for mutual support and improvement. This professional barrier can hinder the achievement of patient care goals, negatively affect team cohesion, and potentially lead to medical errors (Costello et al., 2021). Additionally, Lee et al. (2023) highlight that nurses' continuous clinical assessments are vital to patient safety and the early identification of patient deterioration.

The findings from these assessments are only valuable if they are communicated effectively to other healthcare providers, allowing for appropriate contributions from each discipline. Optimal documentation is the first step in this communication process. Costello et al. (2021) reported that although nurses and physicians work closely together, the quality of their communication is often suboptimal. Nurses have noted that their input on patient management is frequently disregarded, which can lead to healthcare teams missing critical information that could impact clinical decisions about the patient.

When nurses feel their contributions are not valued, they may become passive, and fail to exercise caution in what and how they document, believing that other healthcare providers will not reference their notes. Unfortunately, this creates a vicious cycle where nursing notes become less informative and communicative regarding the patient's clinical status. Consequently, other members of the multidisciplinary team may find these notes devoid of value in managing the patient. Given that ward rounds consume a significant amount of healthcare professionals' time and resources (Arpagaus, et al., 2025), observed the need to ensure they are conducted in a manner that fulfills their intended purpose.

Bringing together diverse expertise in healthcare effectively can enhance patient care outcomes. Kenya has adopted a task-sharing policy that systematically delegates clinical tasks from more highly skilled professionals to less specialized staff, with the aim of enhancing efficiency by maximizing the use of existing human resources (Kinuthia, et al., 2022).

This policy requires strong collaboration among healthcare teams and emphasizes the importance of close communication among team members. According to Carrier Guide

(2023), three core values essential for effective multidisciplinary team functioning are trust, transparency, and excellent communication. Nurses have been identified as playing a critical role in the multidisciplinary team, as they ensure patient safety while providing direct care (Bakerjian, 2021). They are present with patients at all times and can make observations on a minute-to-minute basis. Bakerjian (2021) notes that nurses are adept at detecting errors and near misses, while also understanding care processes and system weaknesses. These observations will contribute to patient care only if they are properly documented and referenced by other members of the multidisciplinary team.

Effective communication will be achieved through thorough documentation, as well as discussions about clinical objectives and outcomes. Without clear communication, it becomes challenging for more skilled team members to provide supervision and verify the quality of care delivered. Rahman et al. (2021) suggest that quality nursing documentation enhances continuity of care and patient safety. Nurses and physicians work closely together, necessitating integrated professional collaboration. This collaboration requires that every caregiver contribute to patient care. Comprehensive nursing assessments should be conducted and discussed with physicians (Franco et al., 2025).

These authors observed that physicians often depend on nurses' observations to make clinical decisions. If these observations are not documented correctly, crucial information can be lost, which undermines the continuity, quality, and safety of care delivered. However, Thate et al. (2022) noted that members of the multidisciplinary team favored oral communication over written documentation, believing that written information often lacked updates and details included in verbal exchanges. This

reliance on verbal communication can create breakdowns in communication, potentially harming patient care outcomes.

Healthcare is frequently likened to a “team sport,” where coordinated collaboration is essential, even when patients present with single or multiple diagnoses (Trepanier, 2024). However, the effectiveness of such teamwork is not guaranteed; optimal collaboration demands active, respectful engagement from all team members, including meaningful interaction with patients (Dib et al., 2025). Each member should set aside their ego to appreciate each other's contributions toward achieving care goals and a shared vision of helping the patient regain their health. Consultations among the multidisciplinary team can enhance clinical care and improve patient outcomes.

From the results, 52(60.5%) of the respondents agreed that they receive consultations from the multidisciplinary team regarding the care and progress of their patients. Other team members may seek consultation because the nurse is present with the patient around the clock, from admission to discharge (Baek et al., 2023). As a result, nurses possess most of the patient information. Zamanzadeh et al. (2021) highlight that teamwork is a critical component of patient care. Effective teamwork relies on communication and consultation within the multidisciplinary team. While patient information is expected to be documented, there are situations that may require discussion or clarification beyond what's recorded.

A lack of consultation among team members could lead to missing critical details about the patient. The rest of the respondents were either neutral or disagreed on receiving consultations from the multidisciplinary team. This represents a significant communication gap that can impact patient care. The nurse's continuous presence allows for observations on the effects of various therapies the patient is receiving, which

is essential for decision-making by the multidisciplinary team. However, effective communication is key to ensuring this information is utilized appropriately. The failure to consult may be linked to the quality of nursing documentation, as the majority of the respondents indicated that their supervisors often raise concerns regarding the nursing notes.

Consequently, the healthcare team might underestimate the nurse's contributions to patient care based on these records, resulting in minimal value placed on consulting the nurse. As Engen et al. (2023) states, consultations are only likely to occur if they contribute value. As Mayo and Myers (2023) argue, it’s critical to integrate the distinct knowledge, skills, and roles of all team members through structured coordination and communication to ensure effective teamwork in healthcare.

Furthermore, approximately 70 to 80% of serious medical errors arise from poor communication within the multidisciplinary team, leading to significant morbidity and mortality that could be avoided with clearer communication. Enhancing how each team member documents their care is the first step toward improvement, urging the team to collaboratively enhance documentation practices to convey information about patients' conditions.

Regarding nursing ward rounds 77(89.5%) of the respondents agreed that these rounds often take place in their units. Nursing rounds are crucial for identifying and addressing unsatisfactory patient conditions (Suleiman, 2021), thereby enhancing patient experience and quality of care (Azhari & Sukartini, 2021). This aligns with the views of Allari and Hamdan, who emphasize that nursing, as a caring profession, focuses on meeting patients' needs holistically. However, despite reports of nursing rounds occurring, there is no documented evidence of their implementation.

This suggests that the rounds may lack intention or structure, with no defined objectives guiding the process. Consequently, the benefits associated with nursing rounds, such as promoting patient comfort and increasing interactions that lead to enhanced satisfaction, may go unfulfilled. Mulugeta et al. (2020) observed that in Ethiopian hospitals, there is a strong emphasis on physician rounds, while nursing rounds lack structure or a standardized format. This lack of a structured approach can diminish the effectiveness of these rounds, even though they have the potential to improve patient satisfaction, healthcare outcomes, and provider satisfaction through timely identification of clinical issues.

Regarding clinical meetings, 66(76.7%) of the respondents agreed that such meetings frequently occur in their unit. Clinical meetings are gatherings of the healthcare team intended to address clinical issues affecting patients and to identify opportunities for system improvement. As noted by Keel et al. (2025), such interprofessional meetings support real-time decision-making and shared responsibility among team members. These meetings provide an opportunity for multidisciplinary team cooperation and foster a shared understanding of patients' clinical status. They are noted to improve quality of care and teamwork within the multidisciplinary team (Keel et al., 2025), thereby promoting satisfaction among patients and care providers.

However, 20(23.3%) of the respondents disagreed on this issue, indicating a lack of engagement or awareness regarding the importance of clinical meetings. Given the importance of clinical meetings, their absence can compromise the quality of care and limit opportunities for sharing ideas on improving patient care. These meetings provide a chance for professionals from different disciplines to understand each other’s perspectives (Kyte et al., 2020).

Diverse approaches and viewpoints can lead to different conclusions about various aspects of patient care (Borges et al., 2021), fostering a deeper understanding of the patient and their care journey. Additionally, clinical meetings serve as a platform to identify weaknesses and promote desired improvements in the system. They encourage the review of care documentation, allowing for the identification of gaps and areas needing enhancement.

Developing a common way of working is essential because it standardizes how activities are carried out. According to NordCheck (2022), establishing standards is necessary to promote the quality and safety of products. Regarding the existence of set parameters for receiving reports at the start of a shift, 76(88.4%) of the respondents agreed that such parameters were in place. This handover is a critical time for transferring both responsibility and accountability for patient care from one nurse to another (Pun, 2021).

However, Pun also noted the unstructured nature of communication during this process, which can create serious barriers that negatively affect patient care. Important patient information is sometimes communicated orally without proper documentation, making it prone to misinterpretation and inaction. Therefore, having established parameters is crucial not only for ensuring standardized handovers but also for incorporating critical details. Documenting these critical details is a vital first step toward promoting the quality and safety of patient care. Furthermore, having colleagues review each other's behavior has been documented as beneficial (Dunham et al., 2020). Established

standards provide a basis for the receiving nurse to question what has been documented, thus holding them accountable for their actions. Without these standards, nurses may not feel compelled to critique each other's documentation, which can lead to dire consequences.

Nursing managers reported encountering documentation that did not meet expected standards on many occasions. This, they reported was a perennial problem that they perceived to compromise the image of the nurse, and the contribution of the nurses towards achieving healthcare goals. Further, they noted this gap as a compromise to the achievement of healthcare goals. Similarly, 70(81.4%) of the respondents agreed that they often find instances where nursing kardexes are poorly documented. This finding highlights a gap in nursing documentation practices and suggests that although nurses may informally audit each other's work, there is significant room for improvement. As Abu-Jeyyab (2024)) pointed out, every nurse has a responsibility to enhance the quality of care within their system. Such audits not only provide opportunities for improvement but also contribute to the overall quality of care delivered.

A gap in one nurse's documentation can lead to issues for the entire healthcare system, as inadequate documentation can result in miscommunication among the multidisciplinary team regarding a patient's status, ultimately hindering timely clinical decisions. This documentation gap is consistent with findings from Masresha et al. (2023), which revealed a 47.8% inadequacy rate in nursing documentation. Since proper documentation is essential for safe, quality, and ethical care, lapses in this area can have significant repercussions on the entire healthcare system. Masresha et al. (2023) concluded that nursing care delivery was deemed insufficient based on the documentation provided by nurses.

On a positive note, 78(90.7%) of the respondents indicated that they take action upon discovering a kardex with inadequate documentation. This demonstrates a willingness to improve and avoid potential scrutiny regarding nursing notes going forward. The University of Washington (2023) describes the purpose of corrective action as resolving identified performance gaps within an employee's work.

Achieving this requires sustained, structured efforts; a one-time correction is unlikely to yield lasting outcomes. Tralengco (2024) guide on achieving desired performance standards, which includes training employees based on a root cause analysis of the identified gaps. Institutions must invest in addressing the nursing documentation gap to ensure sustained change. Plans should also emphasize the supervisor's role, not only in fostering improvements but also in supporting employees throughout the process. Engaging other members of the healthcare team is also crucial, as teamwork enhances synergy, and the success of the team relies on the strengths of its diverse members.

Regression analysis findings clearly show that multidisciplinary teamwork significantly enhances the quality of nursing care documentation. Nurses who engaged in collaborative goal-setting, joint patient assessments ($\chi^2 = 7.88$, $p = 0.0050$), and structured ward rounds ($\chi^2 = 31.86$, $p = 0.0000$) reported better documentation practices. Frequent clinical meetings ($\chi^2 = 13.25$, $p = 0.0003$) and participation in multidisciplinary ward rounds ($\chi^2 = 6.99$, $p = 0.0082$) were also strongly associated with improved documentation.

Active nurse involvement in these collaborative activities correlated with increased accuracy and accountability in record-keeping. Structured handover procedures at the start of shifts ($\chi^2 = 29.70$, $p = 0.0000$) further promoted consistent documentation. Additionally, nurses who identified and corrected incomplete kardex entries showed

strong professional responsibility (χ^2 = 18.81 and χ^2 = 34.14). However, regular interdisciplinary consultations did not show statistical significance (χ^2 = 1.90, p = 0.1676), suggesting room for improvement. Overall, collaborative structures, accountability, and communication are vital for strengthening documentation quality.

4.7 Influence of Patient Factors on Nursing Care Documentation

The fourth study objective sought to find out the influence of patient factors on nursing care documentation. A number of patient variables can affect the interactions between a patient and the healthcare providers. Similarly, the extent to which a nurse documents patient care activity can be influenced by patient variables, and the interactions that the patient has had with the health system. The data was transformed from 5-points to 2-points data, where strongly agreed and agreed were categorized as agreed, and neutral, disagreed and strongly disagreed were categorized as disagreed. The findings are outlined in Table 4.8.

Table 4.8

Patient Factors that Influence Quality Documentation of Nursing Kardex

No	Statement	Agree	Disagree	Chi square	P-value
		n(%)	n(%)		
	I would more careful to document the nursing kardex when				
i.	I am dealing with patients who ask for an explanation of the care they are receiving	76(88.4)	10(11.6)	29.70	0.00
ii.	I am dealing with pediatric clients	65(75.6)	21(24.4)	12.04	0.00
iii.	Caring for patients who know their rights	65(75.6)	21(24.4)	12.04	0.00
iv.	Caring for patients with acute life-threatening conditions	78(90.7)	8(9.3)	34.14	0.00
v.	Handling clients in the end-of-life stage	71(82.6)	15(17.4)	20.39	0.00
vi.	Caring for severely ill patients	80(93)	6(7)	39.07	0.00
vii.	Handling social-economically stable patients	57(66.3)	29(33.7)	4.68	0.03

Pertaining to patient factors that influence quality documentation in the nursing Kardex, 76(88.4) of the respondents agreed that they pay more attention to documentation when dealing with patients who ask for explanations about the care they are receiving. Giakoumidakis et al. (2024) found that patients sometimes have inadequate knowledge about their disease, which is essential for their meaningful participation in care and adherence to therapy. Furthermore, there is significant variation among patients regarding their need to understand their illness. Patients seeking explanations about their care may be perceived as potentially litigious, which could lead nurses to pay more attention to the documentation of their care. Kwame and Petrucka (2021) recognize the importance of engaging patients in the care delivery process as a critical element of patient-centered care.

This engagement ensures that the care provided is responsive to patients' needs and aligned with their preferences and values. Patients are likely to question care interventions and processes when healthcare providers do not offer explanations voluntarily. Patients expect personalized healthcare experiences, where the provider focuses on them as the central subject of interest (Oster et al., 2024). This expectation emphasizes the importance of constant communication and discussion regarding the illness and progress between the patient and healthcare provider. In addition to fulfilling patient expectations, explaining interventions and progress has been shown to lead to better care outcomes, as it reduces misunderstandings during the care process and decreases the likelihood of misdiagnosis (Haddad et al., 2020).

Recognizing patient expectations is essential, as it fosters healthcare providers' understanding of patients who question care and the overall care process. This awareness encourages providers to be proactive in sharing information rather than

waiting for the patient to ask. The World Health Organization (2024) emphasizes in its Patient Safety Charter that the right to information is a powerful tool for empowering patients to make informed decisions regarding their care. Inkeroinen et al., (2022) note that the presence of an illness can render patients vulnerable due to deficits that impact their lives, a situation exacerbated by the power imbalance between healthcare providers and patients. Providing patients with information and encouraging their participation in healthcare decision-making helps address this imbalance and make patients less vulnerable.

The WHO (2024) developed the Patient Safety Rights Charter to promote patient safety, outlining essential concepts that, when adhered to, can enhance patient safety and quality of care. Many healthcare institutions have policies to address patients' rights. Dessalegn et al. (2021) found that patients aware of their rights experience multiple benefits, including increased safety and quality of healthcare, reduced healthcare costs, and lower risks associated with care provision.

However, there is limited awareness of patient rights among patients, which may lead healthcare providers to inadvertently neglect to observe these rights during care delivery. Notably, 65(75.6) of the respondents agreed that they exercise greater care in documenting the care of patients who are knowledgeable about their rights. A well-defined set of patient rights is a crucial tool for standardizing healthcare and ensures uniformity in patients' expectations while receiving care (Olejarczyk & Young, 2022). Consequently, a patient who understands their rights is better positioned to advocate for their expectations, prompting nurses to be more cautious in documentation.

Economic status can also influence access and the quality of care. Wang et al. (2022) and Mensah et al. (2024) observed significant disparities in healthcare that favor

economically stable populations, which may be better informed about their rights. Dessalegn et al. (2021) noted a positive relationship between patients' awareness of their rights and their education level, as well as their area of residence, with those living in urban areas generally being more informed. This awareness may stem from the degree of exposure and confidence instilled in individuals through education, along with the increased opportunities provided by urban environments.

The majority of respondents 65(75.6%) agreed that they pay more attention to documenting the care of pediatric patients. This heightened focus may be attributed to the differences between pediatric and adult care, particularly given the limited communication capacity of pediatric patients. In addition, children physiologically differ from adults in their response to illness because they bear a greater capacity of compensatory mechanisms that may make it more difficult for healthcare providers to identify changes in their health conditions (Jesen et al., 2021).

The Custom Group of Companies (2024) note that the facility of a sick child is at the center of care provision. This may entail the family expressing their emotions, that calls for clear communication by the nurse, and this can influence the documentation practice by the nurses as well. This is however contrary to the findings of Cercone et al. (2023), who noted more complete documentation of adult than children care.

In regard to patients with acute life-threatening conditions, 78(90.7%) agreed that they would pay more attention to documenting care provided. This category of patients is considered physiologically unstable, and their conditions may change from minute to minute, perhaps prompting the nurse to want to be keener in what they communicate to other health care providers. This precise documentation, as Akter, Anowar and Latif

(2020) says would promotes patient's safety, and perhaps chances of survival. Creed and Christine (2020) document the necessity of continuous assessment, interpretation and escalation of observations of the acutely ill patient.

Proper documentation of the assessment and action taken is key, not only for reference, but also as evidence that optimal care was provided. Many hospitals have developed protocols in terms of care interventions for various categories of patients with acute life-threatening health conditions. The existence of the protocols may positively influence the documentation process too. Kuyler and Johnson (2023) observe the fact that acutely ill patients may be vulnerable secondary to the effects of their illness. To address this vulnerability, nurses may concentrate more on the care activities, with more documentation too.

Nacak and Erden (2022) emphasize the critical role of nurses at the end-of-life stage. Nurses not only provide direct care but also coordinate the involvement of family members and other caregivers in the care process. A majority of respondents 71(82.6%) agreed that they would be more attentive if the patient were in the end-of-life stage. This period is marked by apprehension and anxiety for the nurse, the patient, and the family members. The knowledge that a patient's life may end at any moment likely heightens the nurse's alertness, making them more diligent in documentation and attentive to prevent any missed nursing care. Şener et al. (2020) further state that it is the responsibility of nurses to create a protective environment for patients that promotes their dignity without hastening or prolonging the dying process. This significant responsibility can lead to more thorough documentation of the care interventions provided.

Caring for patients with severe illnesses poses clinical challenges (Olorunfemi et al., 2024) and often requires multiple nursing interventions along with continuous monitoring. The complexity of these situations may enhance nursing care documentation, as evidenced by 80(93%) agreeing that they would pay more attention to documented care when caring for severely ill patients. This commitment to thorough documentation persists despite the fact that caring for severely ill patients often involves advanced technologies (Mbunge et al. 2022), which can increase the burden of care. Nurses may feel compelled to document more comprehensively, understanding the vulnerability of severely ill patients and recognizing that their lives heavily depend on the healthcare team's interventions. The finding aligns to Bolado et al. (2023) who point out that good documentation practices not only ensure continuity of care but also serve as a communication tool among healthcare providers, helping to identify and respond to deteriorating conditions promptly.

Regression analysis results show that several patient-related factors significantly influence the quality of nursing documentation. Nurses reported being more meticulous when patients actively ask questions or are aware of their rights ($\chi^2 = 29.70$ and $\chi^2 = 12.04$, $p = 0.0000$ and 0.0005), suggesting that patient engagement promotes accountability in recordkeeping. Caring for pediatric patients also improved documentation ($\chi^2 = 12.04$), likely due to the detailed monitoring required.

Critically ill patients, to include those in acute, end-of-life, or severe conditions, elicited the highest documentation accuracy, supported by strong statistical evidence ($\chi^2 = 34.14$, 20.39, and 39.07). Additionally, socio-economically stable patients influenced better documentation ($\chi^2 = 4.68$), possibly because nurses anticipate greater scrutiny from these patients or families. These findings imply that nurses adjust documentation

habits based on patient characteristics. While this can enhance quality in high-risk situations, it raises concerns about equity. Nurse managers highlighted observing better quality of nursing care documentation in specialized areas, where critically ill patients are taken care of.

4.7 Quality of Nursing Care Documentation Results

Quality of nursing care documentation was the dependent variable in this study. Quality of documented nursing care is crucial for improving patient safety and serves as an indicator of the overall quality of healthcare provided (Moldskred et al., 2021). Effective documentation helps the multidisciplinary team identify and monitor changes in a patient's clinical status and take the necessary actions promptly. In a society where healthcare-related litigations are on the rise, maintaining accurate records of care is essential for navigating these cases effectively (Samuels, 2023).

Documented health information is also a key factor in assessing the quality of care delivered by a healthcare system (Ismawati et al., 2021; Tadese et al., 2024). They further note that nursing documentation can establish the quality of care a patient receives. Essentially, the performance of a healthcare system can be evaluated through patient health records, with poor documentation practices closely linked to negative patient care outcomes. Moldskred et al. (2021) support this claim, noting a positive correlation between the quality of documented nursing care and the quality of care delivered. They further emphasize that systematic nursing documentation promotes critical thinking and clinical reasoning, which ultimately leads to improved quality and safety in patient care.

The quality of nursing care documentation was determined through an audit of 158 patient case files across three hospitals in the baseline phase. This audit not only assessed the documentation quality but also cross-checked findings against responses from nurses' questionnaires. The case files of patients who had been in the ward for 72 hours and above were selected and the content of the nursing care documented was analyzed against 11 indicators of quality nursing care documentation. The baseline phase results are outlined in the table below.

Table 4.9

Quality of Nursing Care Documentation in The Baseline Phase

No	Phase/issue	Baseline (n=158) Yes n(%)	No n(%)	Chi square	P-value
1.	Patient's details appearing on every sheet of nursing kardex	70(44.3)	88(55.7)	43.95	3.37
2.	Detailed initial nursing assessment documented	20(12.7)	138(87.3)	5.53	0.02
3.	Focused assessment during every shift indicating the specific status of previous health issues and any new health issues.	28(17.7)	130(82.3)	0.68	0.41
4.	Nursing interventions in line with issues identified clearly documented per shift	36(22.8)	122(77.2)	0.22	0.64
5.	Responses to the nursing interventions documented	39(25.2)	116(74.8)	1.34	0.25
6.	Instructions for next shift indicated	34(21.7)	123(78.3)	0.02	0.89
7.	The nursing kardex entries are specific	15(9.6)	142(90.4)	10.81	0.00
8.	The nursing kardex entries are objective	20(12.7)	137(87.3)	5.38	0.02
9.	The nursing kardex entries are complete	32(20.3)	126(79.7)	0.01	0.94
10.	Timeliness of entries observed	49(31.0)	109(69.0)	8.23	0.00
11.	Ownership of entries done by way of name and signature	18(11.4)	140(88.6)	7.49	0.01

The results in the baseline phase revealed significant gaps in nursing care documentation, a concern confirmed by nursing managers who verbalized to have been facing numerous challenges in this area on a day-to-day basis. Nursing managers play a crucial role in ensuring optimal nursing practice, evidenced by documentation practices that meet expected standards. This ensures accurate and complete records,

which serve different purposes for effective patient care, legal compliance, and organizational performance. The managers have a role of motivating nurses to enhance documentation competence, provide oversight, and create a positive culture of quality documentation.

In terms of patient details appearing on every sheet of paper used, the nurse managers reported this as a perpetual problem, not only on nursing care records, but also those created by other cadres. Only 70 (44.3%) of the files were found to be complete, while 88 (55.7%) were incomplete. This means that if a sheet of documented information were to fall out of a patient's file, it would be difficult to identify the source file and, consequently, the related patient.

This is especially true when the documented information lacks patient centeredness, objectivity and specificity, meaning that it consists of only general statements that can apply well to a number of patients in the care unit, an issue that the nurses' managers reported to be dominant in the nursing care documented. As a way to address this, one nurse manager proposed a bound file for the patient, whether all the papers are tightly put together, with no risk of sheet fall out. While this is great idea, there is need to be cognizant that some sheets such as consent papers, or blood transfusion monitoring charts, among other may not apply to all patients, and cases of loose papers will be encountered from time to time. However, this also demonstrates the need for systems thinking approach in addressing the nursing care documentation process, so as to address all factors that can affect the process.

Incompleteness in nursing care documentation has been highlighted by various authors (Gurung, 2022; Akhu, 2020). Such deficiencies can lead to a breakdown in the care provided to patients or, worse, create mix-ups that result in patients receiving care

intended for others. An example of this occurred at Kenyatta National Hospital, where one patient underwent craniotomy instead of another (Merab, 2018). World Health Organization(2023) highlight patient misidentification as one of the major sources of patient harm, and further indicate that this can have serious consequences, with severe adverse effects.

The effect of such mix up can be catastrophic, with huge consequences to the patient, family and the health system. These may include increased risk of infection, falls, and pressure ulcers, as well as decreased patient satisfaction and potentially increased hospital stays or readmissions. All these are associated with increased care cost, that contribute and worsen the financial strain to the patient and the health system. Wrong care interventions may include missed nursing care or medication errors related to an intervention not required, or related to the patient's condition. These errors may also affect the nurses negatively, resulting to dented professional image that can lead to job dissatisfaction and loss of morale.

As reported by Auraen et al., (2020), quality care promotes patient safety, which remain a critical policy issue. Patient safety is an old, yet essential principles of health practice, and a critical aspect of the journey towards attainment of universal health coverage, and the other health related targets in the Sustainable Development Goals (WHO, 2024). As a policy issue, healthcare quality is a complex, encompassing the overall care delivered to patients, and touching on factors such as safety, cost effectiveness, patient-centeredness, responsiveness and timeliness. It's a crucial aspect of a health system, and evidence that the system is functioning well and optimally, by achieving desired care outcomes, while directly impacting overall well-being of the nation. Being a critical aspect of any health system, healthcare quality improvement demands a multifaceted

approach, to include data collection, analysis, and continuous commitment towards propelling this objective ahead.

Undeniably, the incident at Kenyatta National Hospital posed numerous challenges for the healthcare institution and individual healthcare providers and led to significant health complications for the affected patients. The consequences of inadequate patient identification are further indicated by Sumstine (2023) and Campbell (2021), who report various medical errors that resulted from patient mix-ups, some of which had fatal consequences, including legal suits. Such litigations can be costly for hospitals, both financially and in terms of time, and they can damage the institution's reputation. As such, healthcare leaders, and particularly those in nursing division, bear a huge responsibility when a breach in patient safety arise, which can result to unnecessary pressure and financial losses. Strong leadership has been cited as key towards achieving resilient health systems (American Nurses Association, 2023), that can promote workplace culture towards optimal health care among the nurses and the rest of the multidisciplinary team.

In addition to compromising healthcare and its outcomes, poor nursing care documentation may be perceived as failure of the nursing leadership to superintend this important aspect, and be taken as the leaders own inadequacy. This is because nursing leadership that is effective is of great importance when it comes to delivering high-quality healthcare that improves patient outcomes. Strong leaders have the potential, and are expected to foster a positive working environment, with a culture of safety, teamwork, and commitment to continuous quality improvement.

This includes supporting professional development among the nurses and multidisciplinary team, promoting interprofessional and interprofessional

collaboration, and ensuring that nursing staff have optimal resources and support to provide optimal care. This extends beyond the direct nursing care activities to include care documentation, that is a critical indicator of quality care. In addition, to drive quality improvement, a leader requires to demonstrate expertise and competencies as key qualities to facilitate this key agenda (Akmal, et al., 2022). This enables the leader to have clear understanding of the health system vision and mission, and to align nursing care activities towards achievement of these. Among the key area for a nurse leader to focus on is use of data for decision making. Optimally documented nursing care is great source of data that can be used to drive decisions towards health care quality improvement. As such, nurse leaders occupy a unique and critical space in the health care quality spectrum, and one way that demonstrate how well they fulfil their role is the quality of nursing care documentation.

Additionally, mix-ups can cause psychological distress to patients and erode their trust in the healthcare system. Campbell (2021) observed that a loss of trust can lead patients to abandon their health-seeking journeys or switch healthcare providers. This perspective is supported by Gibson (2022), who found that 50% of patients would change their healthcare provider upon discovering discrepancies in their medical records that jeopardized their identity. These outcomes ultimately lead to further risk by compromising the reputation and financial stability of healthcare facilities, especially when negative opinions can quickly spread through online platforms, reaching millions in seconds.

Singh et al. (2024) have identified medical errors as a significant issue in the healthcare industry due to their wide-ranging effects, with patient record mix-ups being among the primary causes. (Hooiveld, 2024). Alhur (2023) agrees, noting that the loss of medical

records disrupts the continuity of care and significantly contributes to medical errors. Molla et al. (2024) noted that maintaining patient records offers numerous benefits for the healthcare team, the patient, and the overall healthcare system. They emphasized the importance of documenting patient demographics, including names, which not only aids in proper identification during clinical interventions but also enhances patient engagement.

Soetan (2022) argues that a name is the first gift every person receives, and calling patients by their names is a crucial expression of respect. Epic Systems (2021) supports this notion, adding that using patients' names is integral to inclusive care, fostering a sense of respect and comfort. Such practices enhance how patients perceive themselves, conveying that healthcare providers genuinely care about them. Grutman, et al. (2023)cites Confucius's wisdom that "the beginning of wisdom is to call things by their proper names," highlighting the importance of including patients' names on every document used. Further et al. (2020) explain that this is a vital method of patient identification that promotes continuity of care and safety. Wong et al. (2023) advocate that patients prefer to be addressed by their names, viewing this as a way to facilitate respectful interactions between patients and healthcare providers.

Regarding nursing assessment, a gap was observed, where 138 (87.3%) of the patient case files lacked detailed initial nursing assessments. Obtaining and documenting the detailed and comprehensive patient assessment information is time consuming, and require great commitment. The nurses' managers agreed to this observed gap, and attributed it to the workload that the nurse has to handle during the shift, which make task completion difficult. In addition, the managers verbalized an observed tendency by nurses to accomplish nursing care activities, and miss out on documentation. This

presented a challenge of proof, in cases where nursing care activities were questioned. In addition, without assessment data, the nurse is not able to provide justification and rationale of the nursing care activities.

Assessment entail gathering both subjective and objective data, and forms the basis for identifying a patient's needs, formulating a nursing diagnosis, and developing a personalized care plan. Nurses who are committed to the profession, and to patient well-being are more probable to conduct detailed assessments and deliver high-quality care. Bowen et al. (2024) highlight the critical role of initial assessment, as this establishes the baseline for further evaluation and care planning. Bowen et al., (2024) underscore how essential the assessment is for delivering patient-centered care, as the initial assessment provides a comprehensive overview of the patient's health status.

Failure to conduct comprehensive assessment can lead to missed information, that can affect planning and delivery of health care and ultimately, the healthcare outcomes. It is important to note the increasing demand for healthcare providers, as they face ever-expanding tasks and responsibilities from patients and employers alike. With so much to do in limited time, Ernstmeyer et al. (2022) emphasize the necessity of prioritizing patient care. They explain that without effective prioritization, nurses may feel as though they are racing against the clock, which can lead to frustration and burnout. Prioritization can only occur if nurses understand the needs of each patient and the necessary interventions. This understanding is acquired only through comprehensive assessments; without which, nurses may experience chaotic, unfocused, and uncoordinated workdays, risking the timely fulfillment of patient needs.

This situation can compromise the quality of care and result in undesirable patient outcomes, negatively affecting patient experiences. Improved patient experiences have been shown to correlate with lower mortality rates and enhanced overall care outcomes (Guan et al., 2024). Commitment and a comprehensive initial nursing care assessment are crucial for providing effective and patient-centered care. A well-conducted initial assessment, which includes gathering subjective and objective data, forms the foundation for identifying a patient's needs, formulating a nursing diagnosis, and developing a personalized care plan. Nurses who are committed to their profession and patient well-being are more likely to perform thorough assessments and deliver high-quality care. Additionally, in the absence of assessment data, other members of the multidisciplinary team, who recognize the critical importance of this initial step, are likely to overlook nursing notes.

Once the notes are overlooked, the contribution and value addition of the nurses may not be felt by the team. Likewise, the team fails to benefit from the close interaction with patients that nurses enjoy, and that comes with numerous information regarding the patient illness and response to treatment modalities.

Consequently, nurses may feel less confident in contributing to patient management, as they would lack crucial information about the patient and their responses to interventions taken thus far. Vera (2023) confirms the significance of assessment, stating, "the best nurses are excellent in obtaining assessments." Vera, further notes that this is the most critical step in the nursing process. This perspective is supported by Lamar University (2021), which observes that patient assessment is a fundamental nursing responsibility. Nurses must possess strong health assessment skills to identify the unique needs of each patient. Given the longer life expectancy and evolving disease

patterns, patients often present with multiple health problems and complex physiological, social, and psychological challenges, either stemming from the diseases themselves or their treatment modalities.

Nurses are tasked with identifying these diverse issues to incorporate them into the plan of care, necessitating both initial and continuous assessments. Without these assessments, patient care can become fragmented, non-collaborative, and not patient-centered. Moreover, ongoing assessments encourage critical thinking, which leads to evidence-based, patient-centered care. Certainly, data driven decision-making in healthcare enhances responsiveness of the system to the patient's needs, and involves using data to improve patient care and nursing practices. This means relying on evidence, which call as for data collection and analysis to gain insights rather than use intuition to determine patterns, and develop targeted interventions, and care strategies. In absence of assessment, this cannot be achieved, leading to trial and error in resolving patients' health care needs, and hindering innovation and quality improvement efforts.

In terms of focused nursing assessment per shift, only 28(17.7%) of the audited case files included this critical component of nursing care documentation. A focused assessment refers to the systematic process of gathering information about a specific, current patient health issue (Kleber, 2021). It allows nurses to identify changes in the patient's condition early and take timely, appropriate action. This type of assessment is essential at the beginning of each shift, as it equips the nurse with a clear understanding of the patient's present status and any emerging concerns. Without this information, care may be delayed or misdirected. When consistently performed and documented, focused assessments improve the responsiveness of care, contribute to patient safety, and promote continuity between shifts. The low compliance rate observed highlights a

significant gap in documentation and an area needing focused improvement and training for nursing staff.

The results demonstrated nursing interventions aligned with identified issues as missing in 122(77.2%) of the patient case files. Nursing interventions include treatments, actions, and procedures undertaken by nurses that contribute to holistic, patient-centered care (Monteiro, 2024). These interventions should directly align with nursing assessment findings, as these findings serve as a roadmap guiding nursing actions throughout the shift. Therefore, patient assessment is expected at the beginning of the shift and should be followed by clearly defined interventions.

Accurate reflection of the nurses' work, means nursing care documentation that clearly outlines the nursing interventions undertaken, how this was conducted, and the reasoning behind the intervention. Nursing has been recognized and considered as both an art and a science. The scientific facet comprises the application of knowledge, research, and evidence-based practice to in patient care with an aim of improved care outcomes. The scientific aspects of nursing demand demonstration of understanding of medical terms, procedures, and the principles that govern health and illness, contributing to effective and safe patient care. This should come out clearly in documented nursing notes if they to meet the required threshold. This characteristic is closely linked to clinical judgement.

The nursing interventions that the nurses document as carried out should be related and geared to address the clinical needs of the patient. Subsequently, clinical judgment for nurses is a multifaceted process that include gathering and interpreting patient data, demonstration of understanding its clinical importance, and making clinical decisions aligned to the patient information. It's a core nursing skill, and one that requires critical

thinking skills, clinical reasoning, and practical insights. Nurses utilize various models, like Tanner's and the Clinical Judgment Measurement Model (CJMM) models to guide their judgment, emphasizing noticing, interpreting, responding, and reflecting. These have been developed following identification of the importance of this aspect in nursing practice, and the value this adds to patient care and in achieving healthcare outcomes.

The absence of patient assessments in the majority of case files in the baseline findings likely hindered nurses' abilities to identify appropriate nursing interventions, as there were no clear clinical issues to base care upon, an aspect that was addressed by the intervention. In the post intervention phase, the improvement observed in both parameters, denote a relationship between the two areas. Undoubtedly, assessment and nursing interventions are intrinsically linked, and create a cyclical association where assessment findings inform the need and nature of interventions, and interventions are eventually evaluated through ongoing assessment. This continuous process ensures that interventions are altered or sustained for effectiveness, and that they are tailored to individual patient needs. This contributes to patient centered care, that is responsive to individual needs and responses to treatment therapies.

Lack of assessment data result to lack of clarity, which makes it difficult for nurses to prioritize patients' healthcare needs, potentially jeopardizing care outcomes. Understanding patients' healthcare needs enables nurses to determine which doctors' orders to follow and which require clarification or discussion with the prescribing physician. Jemal et al. (2021) highlight the importance of dialogue between nurses and doctors as a means of improving care quality. Asadi, Ahmadi et al. (2024) emphasized that nurses play a crucial role in implementing medical orders. In doing so, they have

an obligation to maintain patient safety, which necessitates being informed about the current health status of the patient.

Both initial and ongoing nursing assessments are essential for keeping nurses updated and prepared for such discussions. Androus (2024) reinforces that nurses are not obligated to follow doctors' orders unconditionally; however, they cannot arbitrarily choose which orders to follow or ignore. Nursing as a profession enjoy some autonomy (Balasi, et al., (2020), where the nurses is required to exercise critical thinking, make clinical decisions, implement the decisions, and take accountability and responsibility of their actions. This, they must do within their defined scope of practice (Nursing Council of Kenya, 2021), that is determined by their education level, while being cognizant of the critical role of multidisciplinary collaboration, and the shared healthcare outcomes.

The multidisciplinary team bring together different healthcare professionals to acts in a collaborative so as to provide comprehensive patient care. This care approach leverages on the expertise of members from the various disciplines so as to address the complex needs of individual patients. By working together, the professionals aim to jointly develop individualized care plans, care outcomes, improve communication within the team, and ensure that patients receive holistic, quality and safe care.

Their decisions must be based on safety concerns about the patient, which requires a solid understanding of the patient's condition, underscoring the necessity of proper and regular nursing assessments. Nurse managers also raised concerns regarding nursing Kardexes that are not well updated, resulting in insufficient communication about the care provided, gaps in content, and delayed entries. This has potential to result to errors due to inconsistencies, delays in treatment interventions or care that is provided based

on outdated information, leading to medication errors. The nurses' managers recognized that accurate care documentation is critical for effective patient care, and for the well-being of the health system They recognized the gap that affect healthcare outcomes.

In the highly important healthcare field, nurses are expected to demonstrate critical thinking and clinical decision-making skills, along with the capacity to take responsibility for their decisions rather than simply executing orders from other team members. Nurses can enhance their image and that of the profession by actively contributing to patient care and asserting their role. Given that they are with patients 24/7, nurses are uniquely positioned to understand the healthcare needs and responses of their patients to treatments and interventions. Their significant contributions to the continuum of care should be reflected in nursing Kardexes and interactions with the multidisciplinary team.

By doing this, nurses can command respect and promote the use of the Kardex by other team members to stay informed about interventions and changes since their last encounter with a patient. This advocacy strengthens the professional image of nursing, showcasing their unique skills and contributions to patient care. It is important to note that globally, nurses have struggled with a poor professional image (Moghbeli et al., 2025; Zhou et al., 2024), but through professional conduct, they can work to change this perception.

Furthermore, omissions in the Kardex can constitute significant barriers to delivering patient-centered care, leading to communication breakdowns among the multidisciplinary team. Such omissions also undermine nurses' positions within the team, making their professional contributions appear minimal and portraying them as

less essential. This dynamic can negatively affect overall teamwork and the quality of care delivered, given that nurses make up a significant portion of the healthcare workforce and play a central role in the multidisciplinary team. In addition to care coordination, nurses also serve as patient advocates.

There is abundant information highlighting the importance of patient assessment; however, this component has often been found to be lacking. According to Wiseman et al. (2024), nursing assessment is a crucial determinant of the other phases of the nursing process. Kurniawan and Douglas et al. (2024) emphasize that nurses' decisions are based on assessment data. If nursing assessments are not conducted, clinical abnormalities may go undetected, jeopardizing patient safety. Without effective assessment data, the subsequent phases and the overall quality of care provided to patients are compromised.

Responses to nursing interventions are a critical component of high-quality nursing documentation and serve as a key indicator of the effectiveness of the care provided. In this study, only 39 (25.2%) of the case files reviewed included documented patient responses to the interventions implemented. These responses describe the patient's observable reactions, behaviors, or physiological changes following specific nursing actions. This documentation is central to the evaluation phase of the nursing process, where the nurse assesses whether the intended outcomes of the interventions were achieved.

It involves comparing the patient's current clinical status to their baseline or initial assessment (Ernstmeyer & Christman, 2021). This comparison helps nurses determine the trajectory of the patient's condition, whether it is improving, deteriorating, or

remaining unchanged. Without proper documentation of these responses, it becomes difficult to make informed adjustments to the care plan. Ultimately, this gap can compromise patient safety, continuity of care, and the ability to evaluate nursing effectiveness.

In relation to documentation of instructions for the next shift, these were contained in 34(21.7%) of the patient case files in the baseline phase. Focusing on key nursing interventions for the next shift is key, and ensures a smooth transition and continuity of care during shift changes, and beyond to the next. Clear and concise shift handover reports that gives priority to patient needs, is key towards this. Moreover, failure to document instructions for the next shift may stem from inadequate evaluations.

The evaluation phase enables nurses to identify patients' responses to the nursing and other medical interventions applied during their shift. Without evaluation data, nurses cannot adequately appreciate patients' responses to health interventions and their current healthcare needs, making it impossible to offer guidance to the incoming nurse. This lack of continuity can hinder handovers, forcing incoming nurses to sift through records to understand the patients' progress, including their responses to illnesses and treatments. Such gaps can lead to medication errors, incorrect patient care plans, delayed care, and unnecessary repeat tests. Fernandez et al. (2022) demonstrate the effectiveness of the SBRA (Situation, Background, Assessment, Recommendations) model as a communication tool among multidisciplinary teams.

Recommendations in SBRA include essential nursing actions that the departing nurse has not completed but should be addressed by the incoming nurse. According to Park (2020), clarity in these communications significantly enhances continuity and quality of care. Furthermore, nurses who leave their shifts without knowing the clinical

trajectory or the success of their interventions may unintentionally convey a lack of motivation and concern for their patients and their illnesses. It has been noted that achievement acts as a motivator, directing behavior and contributing to success (Witte et al., 2024). The improvement observed is also linked to improvement in patient assessment, as the data gathered forms basis of planned patient care activities for the shift and beyond.

Sadler and Snively (2023) observe that the modern work environment demands not only competent nurses but also creativity and a desire to achieve both personal and organizational objectives. Health systems aim to assist individuals in restoring health, and as Gonzalo (2023) explains based on Virginia Henderson's need theory, nursing involves acting on behalf of patients to bridge gaps in knowledge, physical capability, or willpower. Recognizing these gaps is fundamental to nursing actions, and assessing the success of these actions is critical for planning future care.

The desire to understand the outcomes of our actions indicates a commitment to achievement. Sadler and Snively (2023) suggest that this commitment involves measuring performance against others or established standards, which reflects the responsibility nurses take for their actions. It is concerning to observe nurses who do not prioritize evaluating the outcomes of their care. This disregard not only complicates nurses' ability to demonstrate their productivity but also hampers justification for improved remuneration and other work-related benefits. Additionally, it denies nurses the opportunity to contribute to care improvements as the multidisciplinary team works toward healthcare goals. This issue persists despite the National Library of Medicine (2021) recognizing the leadership role of nurses at all levels of healthcare and

highlighting opportunities in clinical settings and training institutions to empower nurses in these roles.

The results review revealed that 142 (90.4%) and 137 (87.3%) of patient case files contained nursing kardex entries that were neither specific nor objective respectively. Further, 126(79.7%) of the entries were found to be incomplete, while 109 (69%) were not made in a timely manner in the baseline phase. Nursing practice, and the nursing profession, is guided by ethical and legal standards. Nurses are obligated to document all relevant patient information. Failure to document critical details can lead to legal issues. Nnursing notes that meet legal obligations need to be accurate, complete, and up-to-date, detailing patient assessments, nursing interventions, and patient responses to the interventions. The notes should be factual, objective, and devoid of opinions or assumptions. Maintain confidentiality is also part of the ethical principles, and an aspect of meeting legal obligation.

Dokuba, et al. (2024) identified objectivity, specificity, completeness, and timeliness as key elements of quality nursing care documentation. The Nursing Council of Kenya (2024) also stresses the necessity for nurses to be specific in their documentation. Specificity in nursing care documentation entail providing detailed and accurate recording of all relevant information about a patient's care, to include their health condition, nursing interventions already implemented, and the responses the patient has had to the interventions. Specificity creates clarity of communication among the healthcare team and promotes continuity of care.

A lack of specificity results in the use of general and subjective terms that fail to accurately reflect a patient's clinical condition. Without precise documentation, effective communication among the multidisciplinary team regarding a patient’s health

status is impaired, altered or delayed, and this can jeopardize healthcare decisions and ultimately compromise the quality of care provided. The nonspecific notes do not communicate the clinical status of the patient, nor do they help the reader develop a clear mental picture of the patient and their clinical condition. This lack of clarity may hinder the prioritization of care and timely interventions, which can be crucial moments that determine life or death for the patient. Furthermore, this situation stifles the development of clinical leadership skills among nurses, which have been found to be more significant for nurses than for clinicians (Mrayyan et al., 2023). Clinical leadership involves collaborating and guiding a multidisciplinary team to enhance the quality of care. Iraizoz et al. (2023) emphasize that nurses are ideally positioned to assume clinical leadership roles because they can quickly identify deviations from the norm as they arise and motivate other team members to implement interventions that address the patient's health problems.

They also note that with strong clinical leadership skills, nurses can drive quality improvements in processes, workflows, and policies, all aimed at enhancing care quality. Given that the Quadruple Aim has been widely accepted as a framework for optimizing performance in health systems (Arnetz et al., 2020), clinical leadership is critical. Every member of the healthcare team must remain vigilant in optimizing the quality of care. Creating medical notes that are specific is one way of achieving this.

Moreover, reading and writing extend beyond mere literacy; they also require contextualization (Christidis et al., 2022) to ensure that the documented information is fit for its intended purpose. The authors continue to point out that higher education tends to focus more on academic aspects, while professional documentation serves to communicate with other team members. Nurses need to recognize this distinction and

tailor the information they document accordingly. Clear communication also benefits by impacting on the overall job satisfaction, and fostering multidisciplinary team cohesion.

In terms of timeliness, 49(31%) of the entry were determined to have been documented on time. Recording nursing notes in a timely manner is key, and means that entries must be made as close as possible (Nursing Council of Kenya, 2024). It involves documenting patient assessments, interventions, and responses to treatment within a reasonable timeframe, typically during or immediately after an event. Timely documentation in nursing is crucial as it can help reduce the risk of errors from forgotten care or forgotten process, this reduces and legal claims while enhancing care quality. Timely entry also allows the notes be documented consequentially. This means that nursing care process and patient responses and narrated chronologically as they occurred.

This sequential narration provides an overview of the patients' journey, and how they are responding to the health care interventions. This sequential documentation helps identify any variance in a timely manner, for early intervention. Early medical intervention is crucial because it allows for early reverse and address of an issue, and this promotes early resolve and prevents complications such as organ damage, with general improvement in overall quality of life.

Of all entries examined, 140 (88.6%) were found to lack ownership in terms of name and signature in this phase. While there is limited information regarding the practice of signing nursing notes, it is considered good practice to do so after each entry. Nurse managers have confirmed this lack of ownership as one of the documentation challenges they face. Consequently, following up on audit queries, or for the purpose

of getting clarity of documented information become an uphill task, with the manager being required to go back to other reference documents such as duty roster to verify who was on duty at the particular time. Wong et al. (2023), highlight that the individual who administers an intervention should be identifiable by their signature. Tadese et al. (2024) observed that nursing care documentation lacked ownership in 57% of the cases they examined. NCK (2024) underscores the importance of signing against one's documentation as a way of taking responsibility and being accountable for its content. Owning one's notes fosters authenticity, which Zircontech (2024) identifies as a key element in maintaining the trust that other providers place in these notes. Trust among healthcare providers is crucial since they rely on each other's decisions and actions to achieve positive outcomes for the patients in their care.

The multidisciplinary healthcare team consists of different professionals who bring unique skills necessary for patient care. Establishing trust within this team is fundamental to harmonious functioning. Shared goals and optimal performance depend on mutual respect and open communication.

This communication is manifested in care documentation, where trusting the information recorded by other providers is essential for fulfilling care obligations to patients. Nurse managers support this finding, noting that the gap in documentation is often due to fear of being held accountable for what one has documented. Finkelstein (2024) explains that the essence of accountability lies in understanding the implications of our actions. Scarlet (2024) reiterates this point, emphasizing the importance of accountability in all social settings, including workplaces.

Accountability is an indispensable quality of a professional nurse (Schmit, 2024), as nurses' actions impact not only the actions of other healthcare providers but also the patients in their care. Amin (2024) also notes that accountability is vital for ensuring

that tasks are completed and for reducing the risk of errors. Taking ownership of what one has documented makes it easier to follow up if questions arise regarding the care provided or when the team wants to learn from their previous actions. Additionally, signing against one's entries serves as evidence that the specific nurse provided care as documented, which can be utilized for various purposes within the facility as needed.

Failing to indicate the individual who carried out an intervention complicates follow-up when care is questioned or when clarification of entries is needed. Moreover, although nursing notes are considered medical records, they are also legal documents. Not clearly identifying one’s name can lead to challenges in accountability and continuity of care. The chi-square and p-values indicate the strength and significance of associations between various documentation practices and observed behaviors.

In the results, the documentation of patient details on every sheet had a high chi-square value (43.95) and a very low p-value ($p < 0.0001$), indicating a highly significant association. The detailed initial nursing assessment also showed statistical significance ($\chi^2 = 5.53$, $p = 0.0187$), suggesting a notable pattern in how it was documented. However, for other practices, for example, focused assessment every shift, nursing interventions, and responses to interventions. p-values were above 0.05, indicating no statistically significant difference. This highlight need for improvement in practice and policy enforcement.

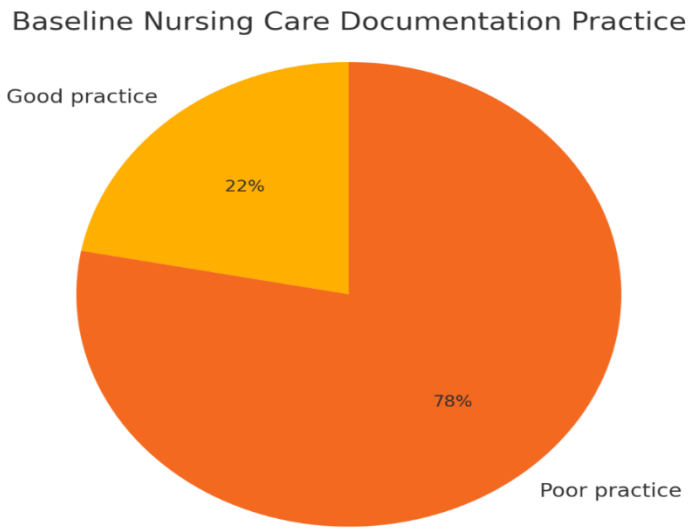
Further analysis of the findings was carried out to evaluate the level of nursing care documentation practices among participants. In this analysis, each "Yes" response was assigned a score of 1, while each "No" response was assigned a score of 0. Consequently, individual scores for documentation practices ranged from 0 to 11,

representing the total number of affirmative responses. These cumulative scores were then categorized into two levels: good and poor documentation practices. The classification was determined using the 75th percentile as the cut-off point. Participants who scored equal to or above this percentile were considered to have demonstrated good documentation practices, while those scoring below were categorized as having poor practices.

This method of classification aligns with the approach used by Wu et al. (2023), who found that the 75th percentile was the most commonly used benchmark in studies assessing healthcare performance, with 87% of reviewed studies adopting it. Similarly, the Nurse Key (2025) emphasized the use of this percentile in quality improvement projects to identify performance gaps and prioritize areas for intervention. Adopting this standard in the current study ensured consistency with best practices in healthcare research and enabled a standardized comparison of documentation performance. The results are summarized in the figure below.

Figure 4.1

Quality of Nursing Care Documentation in the Baseline Phase



4.8 Intervention Phase

4.8.1 Introduction

The results pointed to a gap in nursing care documentation, which has the potential to break communication, negatively impact the quality of care provided, and the achievement of desired healthcare outcomes by the multidisciplinary team. The activities undertaken by nurses are essential for addressing patients' healthcare problems, and each of these activities should be supported by documentation that demonstrates the critical thinking and reasoning involved (Zainal et al., 2025).

To address the identified documentation gaps, a comprehensive framework was developed and implemented through a Continuing Professional Development (CPD) module at Nyeri County Referral Hospital. The initiative aimed to strengthen nurses' documentation competencies, promote standardized practices, and enhance the overall quality and consistency of nursing care records. The CPD session was attended by a healthcare multidisciplinary team that also included the managers both at facility and ward level. Follow up of the documentation process was done over a five-day period following delivery of the module. This was to provide mentorship and demonstration of the process. The follow up targeted the 34-nursing staff who were in the surgical ward, and who were part of the baseline survey. The evaluation was done by checking the quality of nursing care documentation post intervention, and administering the questionnaire section that evaluated on individual factors to the 34 nurses. The post evaluation results were compared with the results at baseline to determine the effectiveness of the intervention.

The CPD module, and its delivery, employed a system thinking approach. Systems thinking is an approach that is all-inclusive, and views problems and challenges not in

isolation, but within a setting of interconnected parts in a system. It provides for understanding of how various components of a system relate and affect one another, and further recognize that the whole is greater than the sum of its parts. Rehbock et al. (2023) emphasize the importance of systems thinking in making contextualized decisions, as it provides a comprehensive understanding of the situation, enabling the development of tailored strategies.

The tailored strategies should be cognizant of the dynamic nature of systems, and the feedback loop nature that exists in systems. As a problem-solving technique, systems thinking is particularly effective when dealing with complex issues (World Health Organization European Region, 2022; Morgan et al., 2023). Health systems are characterized by complexity resulting from multiple interrelating parts, actors and factors, that make managing and improvement efforts challenging. This complexity stems from various sources, including the critical role of healthcare, relatedness of the sector to other sectors, the influence of social and environmental factors on health and healthcare delivery, and the dynamic nature of individual patient health experiences. Likewise, nursing care documentation is a complex matter, as it is affected, and can affect many other issues in the health system.

Various factors such as diverse patients' needs and experiences, the requirement for accurate, timely and clear information, and the likelihood for errors and misinterpretations further complicate the process. The systems approach is reflected in the health systems framework established by the World Health Organization, which outlines six interdependent building blocks essential for health systems strengthening (Kwamie et al., 2021). The framework highlights that these six areas must be addressed concurrently to strengthen health systems.

This provides for room to holistically appraise an intervention, and make a prediction of potential consequences and risks, and thus be in a position to mitigate the same. Applying systems thinking approach to address issues is crucial, given that systems often involve conflicting objectives, multiple decision-making alternatives, and increasingly dynamic contexts. Healthcare systems are not only complex but also adaptive (Kapur, 2023). A complex system consists of numerous and complicatedly interconnected parts (Thelen, et al., 2023). Such a system is dynamic, open, change and evolve as a result of the multiple communications and exchanges within and across the system, including feedback that can either be positive or negative, time lapse and delay, and tipping points that can occur unexpected.

Health systems consist of people, processes, equipment, and infrastructure that work together to deliver desired outcomes. The relationship between these different aspects is not always linear, and easy to predict. Malin (2023) further notes that improvements in one aspect of the system can sometimes create imbalances and disrupt other areas. This calls for a careful consideration process when identifying and addressing gaps in the health system to avoid creating new problems while attempting to solve existing ones. The systems thinking approach applied to the nursing care documentation process aligns with the model proposed by Ferlie and Shortell (2001), which views health systems as organized into four levels: individual patients, care teams, health facilities, and the broader political and economic environment. These four micro-systems are interconnected and significantly influence the overall health system. Contextualizing this to the nursing care documentation, the practice is an output of these four levels.

At the patient individual level, certain factors, such as age, nature of illness, and ability to communicate, their attitude towards the health care workers, among others, can

greatly influence the nursing documentation practice in terms of accuracy and completeness. Likewise, healthcare teams' culture and attitude on nursing care documentation is a key driver on nursing care documentation. The value that the multidisciplinary team, and the commitment of the team towards improving healthcare quality influence how all the team members document their care (Demsash, et al., 2023).

This is crossly linked to factors in the health system such as availability of resources. Insufficient resources, such staffing and materials, can significantly hamper the quality in terms of content and completeness of documentation. On the other hand, well-resourced health care teams are better armed to document optimally, resulting to better-quality patient care and safety. The broader political and economic environment generally influence policies that have implication on the health system. These include resource allocation, and the well-being of the health system.

Notwithstanding the intricate nature of the health systems, nurses need to document observations and interventions specific to individual patients, considering factors like pain, stress, and anxiety. Documentation that reflects these patient-specific factors helps ensure continuity of care and facilitates effective communication between healthcare providers. This calls for innovative ways of addressing the gap observed, focusing on these different aspects so as to lead to sustainable positive change.

The module brought out the interconnectedness of the different levels in ensuring optimum nursing care documentation, as well as how the different levels are affected by poor documentation process.

In addition, the module paid attention to the six (6) health systems building blocks as outlined by World Health Organization (2007), with a focus on the intermediary goal of achieving quality and safety. In addition, the seventh (7^{th}) building block as proposed by Health Systems Global (2014). This is the people, with emphasis on documentation of what the patients say about their own health and clinical manifestations, as opposed to making and documenting conclusions about the same. This results in patient-centered care that manifests attention to the individual needs.

4.8.2 Module Development

A strategy to address the identified gaps in the nursing care documentation was developed in the form of training guidelines. A training guideline is an essential tool for staff development for work improvement (Kulju, et al., 2024). The success of any training is greatly dependent on the soundness of the training guideline being utilized. Suliya et al., (2023) reinforce this by noting the utility of a training module as shaping employee's behavior towards improvement. The following steps were followed in the guideline development process.

4.8.3 Definition of the Goal of the Manual

Education goals are defined as broad statements that describe what is to be learnt (Toraman, 2021). Having clear training goals is key as it guides identification of learning objectives and outcomes, and eventually, the training content. The goal was that by the end of the training, the participants would demonstrate understanding of systems thinking concepts in enhancing nursing care documentation process.

4.8.4 Gather and Organize Content

Broad topics essential for achieving the module's goal were identified, including an overview of the nursing care documentation process, the institutional support required, and quality improvement in nursing care documentation. Learning outcomes for each of these areas were established to guide the selection and organization of content. Content analysis was conducted to ensure the inclusion of relevant information that would support these learning outcomes. The module was structured into three units. Unit One provides an overview of nursing care documentation.

This unit aims to help nurses understand the "golden circle" of "what," "how," and "why" (Chaffey, 2024). Grasping this concept is crucial as it influences behavior in adhering to prescribed rules and standards. Chaffey (2024) also states that Sinek's model suggests that people respond best when messages appeal to the emotional and decision-making areas of the brain. Furthermore, Chaffey (2024) points out that many organizations struggle to articulate the "why" behind their actions. Without clarity on this point, reinforcing desired behaviors can be challenging. At the core of every healthcare system is a desire to improve outcomes, which contributes to the overall well-being of the population. Nursing and nursing care documentation are central to the health system, as nurses are with patients 24/7. Consequently, documenting interactions and the care provided, along with patients' responses to that care, is invaluable for the entire healthcare team.

This documentation serves as the glue that coordinates the efforts of various team members to ensure seamless care delivery. Moreover, effective nursing care documentation is a reflection of professionalism. As Leondsen et al. (2023) note, demonstrating professional capability is a key component of quality and safe patient care, which ultimately leads to patient satisfaction. Nurses play a crucial role in a

multidisciplinary team by communicating and collaborating with other healthcare professionals, patients, and their families.

The module's arrangement was mindful of the ADKAR (Awareness, Desire, Knowledge, Ability, and Reinforcement) change management model. Creasey (2024) emphasizes that making a change proposal concrete is a critical first step toward success. Awareness creation is fundamental in making this proposal tangible by helping stakeholders understand why and how it matters. Nurses must recognize the importance of nursing care documentation, its significance to care teams, patients, and the healthcare system as a whole. Prunuske et al. (2022) add that the ADKAR model directs the change process at the individual level, making it significant in improving the nursing documentation process, which relies on the active participation of each nurse. Therefore, it is essential to comprehend the "why" behind nursing care documentation and its connection to overall health system performance and healthcare goals.

This understanding fosters a desire among nurses to enhance their documentation practices. Realizing this desire is accompanied by gaining knowledge about the subject, enabling nurses to document relevant information effectively. Reinforcement through supervision, standard operating procedures, and quality audits of documented nursing care is vital for sustaining these practices. The unit was designed to highlight the role of documented nursing care and its impact on interventions and decisions made by other multidisciplinary team members. This, in turn, affects the overall achievement of healthcare outcomes. The nursing process has been shown to be an effective way to improve general nursing care, including enhancing nursing care documentation (Moldskred et al., 2021). The module emphasized the importance of this approach, as it also promotes critical thinking.

The module further provided insight on how to document nursing care so that it not reflects the critical thinking aspect of the nursing interventions, but also so that it adds value to the overall care provided to the patient. This will further promote the professional image of the nurse, which has been observed not to be valued and appreciated by the society (Stadnicka & Zarzycka, 2023). Part of changing this perception lies with the nurse being able to demonstrate their capacity, knowledge and competency, and the value addition to the health care that the patients receive. While WHO (20202) advocated for aggressive public awareness of what nurses do and their contribution to health care, nursing care documentation is a vehicle that the nurses can use to leverage their position in the care team, and gain respect amongst the multidisciplinary team.

Unit two (2) of the module was on institutional support towards nursing care documentation. This unit advanced the importance of systems approach in addressing the nursing care documentation gap, by creating an understanding that this important activity is not merely a function of the nurses, but requires the institutions to put mechanisms in place to support and maintain. Anyim (2021) indicate the critical role institutions play in enhancing employee performance, and that of the institution as a whole. Managers in the institution have a responsibility of identifying gaps and opportunities for improvement, and so, are a key performance ingredient.

In line with systems thinking, the unit brought out the central role that nurses play in the health system, and how they are well placed to influence patient care outcomes. This is in addition to the fact that the quality of care derived to the patients can only be realized through what is documented. Since the nurse is with the patient seven (7) days in a week, 24 hours in a day, the nursing care documentation is a powerful

communication tool between the nurses, and among the multidisciplinary team. This communication is key in promoting patient safety and healthcare outcomes (Bjerkan et al., 2021).

This can only be realized if the nursing care documentation is appropriate. Kumah et al. (2025) demonstrate that suboptimal or absent nursing documentation contributes substantially to adverse events and increased costs of care. In addition, they continue to say that approximately 73% of these are preventable. As such, it is to the best interest of the institution to foster improvement in this area as this is what communicates the quality of care that the facility is providing, and can greatly impact on the cost as well as the outcome of the care provided.

The institution also functions as a training ground for numerous nursing and midwifery schools. Therefore, fostering a positive culture around nursing care documentation extends beyond our facility and influences every institution where our learners will eventually work. Additionally, nursing education encompasses both theoretical and clinical learning experiences (Zhang et al., 2022). Strengthening nursing care documentation creates a strong foundation for all learners who rotate through this facility.

According to Zhang et al. (2022), clinical experience plays a crucial role in developing clinical competencies and achieving desired learning outcomes. Nurses at the clinical site are essential in promoting positive behaviors that lead to the acquisition of these competencies, which will serve as the basis for future practice. Zulu et al. (2021) emphasize that adequate support from nurses in the clinical setting is vital for effective learning and achieving educational outcomes. Regarding nursing care documentation, it is the nurses' responsibility to review and ensure the accuracy of the documentation

completed by learners, as they remain accountable for it according to the code of conduct.

The nursing care modality utilized in the ward was total nursing care. Nursing care modality explains how nursing duties are organized and distributed with a purpose of creating efficiency and patient safety. Under this modality, a nurse is responsible for all the care a patient requires during a shift.

Health facilities organize care delivery mechanisms in a way that pursues excellence of quality while paying attention to cost of care delivery (Parreira et al., 2021) to Unit two of the module focused on institutional support for nursing care documentation. This involved creating an environment that promotes effective nursing care documentation practices. Hospitals are inherently complex organizations, managing growing numbers of elderly patients with multiple comorbidities, mounting funding pressures, workforce deficits, stringent regulatory requirements, and ever-increasing patient expectations (Jones et al., 2024).

Hospitals are dynamic environments with multiple interacting stakeholders; including patients, providers, regulators, suppliers, and administration, that must coordinate and understand their roles to maintain institutional continuity (McLaney et al., 2022). Pollack et al. (2021) emphasize that for a single hospital encounter, effective collaboration among clinicians, administrative staff, and caregivers supports shared situational awareness, which is essential to safe, high-quality care.

The multidisciplinary team within the facility comprises clinicians, nurses, physiotherapists, nutritionists, and others. Therefore, effective communication among team members is vital; without it, care can become fragmented and compromised. Rosen et al. (2021) highlight that this is not only a public concern but also emphasize

that high-quality and safe care delivery requires teamwork and a high level of coordination across the healthcare setting.

Efforts such as jointly setting clinical objectives, conducting joint ward rounds, facilitating nursing ward rounds, providing mentorship and supervision, fostering a positive culture for nursing care documentation, and managing patient load are essential for success. The module specifically targeted nurse managers, as they are key drivers of change within their units and play a critical role in shaping the behaviors of the multidisciplinary team and nursing students.

Unit three (3) of the module focused on improving the quality of nursing care documentation. Quality improvement is essential in any healthcare system, as these systems consistently strive to provide safe, high-quality, and efficient care.

Bennani (2024) describes quality improvement programs as dynamic forces within an institution that drive processes toward excellence. While the approaches and efforts may vary, they share a common goal of achieving positive changes in outcomes (Simons, 2023), much like a system thinking approach. When quality improvement is embraced as an active process, it becomes a powerful tool for enhancing both processes and patient experiences. The outcomes of quality improvement programs benefit patients, healthcare providers, and the healthcare system as a whole. Gagnon (2024) defines quality improvement as a systematic effort driven by data to enhance processes in a healthcare setting, ultimately promoting patient safety.

The module specifically targeted nurse managers, who are responsible for leading quality improvement initiatives in their units. It also emphasized the interrelatedness of the various subsystems within the healthcare setup, consistent with the systems thinking approach. This was intended to help managers understand how nursing care

documentation impacts, and is impacted by, each of the six pillars of health systems strengthening.

Recognizing this interconnectedness is crucial, and as Williams and Best (2022) state, a systems approach is a “pot of gold” at the end of the rainbow. Despite this understanding, Dickinson et al. (2021) observe that applying a systems approach can be a challenging task. Clearly understanding how different system inputs interact to bring about change is essential for effectively implementing this approach to improvement (Williams & Best, 2022). Moldskred et al. (2021) noted that optimal nursing care documentation is fundamental to improved patient safety and healthcare outcomes, making it a vital concern for the entire health system. The module focused on the role of each of the health systems strengthening pillars in enhancing nursing care documentation.

4.8.5 Chose the Format

The module was written in Microsoft word, and Microsoft PowerPoint was chosen as the format of presentation. Savannah technical College (2020), note these as among the most widely used programs. In addition to Microsoft Word being common, Geek for Geeks highlight this as a user-friendly application, and one that is easy to use to most people. The two applications also allow offline utility, and this is key in circumventing the challenge of internet accessibility that may be faced by some of the users while away from the office space. Taylor (2024) describes PowerPoint as an effective way of delivering information, while enabling the presenter to exercise creativity, and enhancement to the content. The researcher chose this application so as to take advantage of these features.

4.8.6 Validation

A validation meeting was held with ten subject matter experts to review the content and provide further insights and input towards enhancing the training guideline. Training materials facilitate the process of learning, and as such, should be properly prepared (Kulju et al., 2024). Adefolarin and Gershim (2022) explain that validation as a process of authenticating course materials to ensure they contain appropriate and adequate content to enable attainment of the learning outcomes. The subject matter experts' input was incorporated ahead of the content delivery phase.

4.8.7 Content Delivery

A training session was held at Nyeri County Referral Hospital. The session was attended by a healthcare multidisciplinary team that also included the managers both at facility and ward level. The study findings were first presented to the participants, with emphasis on quality of nursing care documentation. Samples of previously documented kardexes were used during the session to allow internalization and contextualization of the documentation process. Follow up of the documentation process was done over a five-day period following delivery of the module. This was to provide mentorship and demonstration of the process. The follow up targeted the nursing staff who were in the surgical ward, and was meant to ingrain the knowledge into practice, and from a basis of their mentorship to others.

Clinical mentorship programs have been shown to help employees progress from one strength to another. It has been categorized as one of the eight high impact actions in improving the work environment for junior doctors (Newham, 2023). Further, clinical mentorship that involves on the job training has been demonstrated as a vital resource for strengthening knowledge and the skills of health care providers (Isangula et al., 2022). Sjarifudin and Rony (2023) note mentorship as a powerful tool towards overcoming performance gaps. Mentorship has been cited as an important way through

which development of human capacity in nursing can be achieved (Narayanan, et al., 2025), and is pivotal in learning in the clinical set up (Raustøl, et al., 2024).

While Isangula et al. (2022) asserts that mentorship is important for newly graduated nurses, the role of mentorship extends beyond to nurses who have been in practice to help in continuously shaping behavior to conform to expectations. Undeniably, performance management is not only about evaluating the performance of the employee, but it also entails building their capacity to achieve the desired performance. Employers encounter performance challenges in various job aspects, and mentoring and coaching can assist performance management by building the capacity, and assisting employees become more confident in their roles. This leads to overall improvement of system performance, open communication and quicker decision making, with a more shared problem-solving approach.

Appreciation of the gaps that require to be addressed is key in mentorship, and in any quality improvement effort. Real examples of cases where omission or a short fall in nursing care documentation were provided to put into perspective not only the role of documentation, but also the repercussions that can follow if the care is questioned, and audited for extent of quality. Ghaith et al. (2022) opines that antidote to malpractice allegations does not exist; however, documentation that is thorough and thoughtful provides proof of communication and action, and this can guard against litigations and their consequences.

To make it even more effective, documentation must go beyond the care provided, to include the thoughts, views, statements as well as aims and goals of the provider and the patient or client. Since being sued is a rigorous and tedious process for all involved parties Guarino, and Tremont (2025) to include employer and the patient, mitigating

the same is critical and time saving. Ghaith et al. (2022) agrees with this, and further notes that poorly documented patient care is a catalyst to malpractice lawsuits and disciplinary activities in the health arena. This is in addition to documentation being the proof of the capacity of the nurse, and a reflection of their knowledge that they have gained through their education and practice.

During handover sessions, nurses and students had the opportunity to interrogate and critique the documented nursing notes, to identify both gaps and strengths, to serve as learning points for future documentation. While this sounded embarrassing at first, the team quickly adapted, cognizant of the learning opportunities in the exercise, and even had their notes checked by each other well before handing over. From this exercise, other areas of learning observed included a deep sense of and focus on self-development, better understanding of one's role in the health system, and deep reflection of what it means to or not to communicate effectively with the other team members, and improved self-confidence coupled with willingness to support others in their nursing care documentation journey.

This observation is in line with documented evidence by Antonsen et al. (2023) who say that reflection exercises generate profound understanding through stimulation of critical thinking over the subject matter. Reflecting about nursing care documentation provides the nurse an opportunity to have a deeper thought about their roles, and the importance of documenting properly. It enables the nurses to identify gaps and challenges, and as well as make them more intentional in improving the process.

Some of the students opted to have draft write ups on their notebooks for a thorough think through of what they intended to eventually put down. While Gesner et al. (2022 and Jacques et al. (2025), says that nurses spend a quarter to a half of their time

documenting, the need to write drafts lengthened the time required for documenting the care provided. However, eventually, the practice was also observed to go down as the learner's competencies in nursing care documentation increased, and confidence to document straight in the nursing kardex was attained. Ghaith et al. (2022) identified lack of training as part of the reason why poor nursing care documentation occurs.

The quality of training is key in acquisition of competencies, and Ortega et al. (2023) add that ongoing acquisition of competencies is at the core of every nurse. This is more applicable to the nursing student, whose exposure to the clinical area provides an opportunity to learn from the qualified nurses. This is in addition to the nursing student having been taken through the theoretical concepts for them to appreciate and link with clinical practice.

The acquisition of the competencies may be hindered when the clinical practice does not align to the theoretical teaching, leading to confusion on the student. Mbombi, Ophilia, Bopape and Muthelo (2023) affirm this, and note the critical role of a supportive clinical environment in the learning process of the nursing students. This includes the availability of a competent nursing workforce that is applying recommended standards in the nursing care processes. Jebet et al. (2023), observed that a deficiency in the clinical instruction would result in an ineffective provider, negatively affecting the quality of care provided.

This is supported by Yaseen and Ibrahim (2023), who note that obstacles in the clinical area, such as lack of proficiency in underrating clinical procedures and failure to demonstrate critical thinking among others, can create a perilous educational environment.

The importance of this can be viewed from the fact that about half of the nursing education is covered in clinical practice, where professional knowledge that has been acquired in class is transferred to practical patient care, in addition to fostering essential skills such as communication and critical thinking (Negm et al., 2024; Sahan & Guven, 2020). Feedback and supervision by the instructor are also key in promoting learning (Alluhidan, et al., 2020), but the supervisor who demonstrates little competency in nursing care documentation will less be able to mentor a student in the same concept.

The clinical environment thus has a great potential to shape and reinforce theoretical learning. The art of nursing care documentation process learnt in class should be reinforced in the clinical set up. If this staff nurse documents poorly, the end result is for the practice to deteriorate from one generation of nurses to another, while greatly compromising the quality of care in the process. Apt nursing care documentation is thus not a fulfilment of the patient care obligation by the nurses, but in teaching hospitals, it will enhance future documentation by the graduate nurses. This is key as it will allow safe and quality nursing practice, and by the time nursing students graduate, they should have acquired sufficient clinical aptitudes to accomplish care obligations of the patients under their care. Nursing care documentation is part and parcel of the competencies that they should achieve.

Putting down the draft notes was part of the learning process, and over time led to mastery of the practice., and active participation in the learning process. Active participation in learning has been shown to cause enhanced motivation and inspire critical thinking among nursing students (Pivac, et al., 2021). This practice is similar to what occurs in the skills laboratory, which offers a transitional space between classroom and the clinical set up. Additionally, peer review of the nursing notes was

observed, where the students checked on each other's work, to critique and make suggestions for improvements. Peer learning is helpful in building confidence, and as Antonsen et al. (2023) says, it provides a safe space in the learning process. This also ensured that the student put down relevant information in the kardex, that would prevent erasure and cancellation, or worse still, nursing notes that did not add value to the care process.

This demonstrated a positive attitude and desire to learn and perfect the competence. Attitude is important in nursing practice, and indeed in every field. Indeed Mulgeta (2020) says that a positive attitude among the nurses is associated with patient satisfaction with the care they received. The importance of positive attitude has also been highlighted by Nordin and Mahadi(2021), who indicate that the staff attitude is a determinant of performance of an organization. Given that nurses are the front-line workers in the majority of the healthcare organizations, and their contribution valuable in attainment of the health care goals, a positive attitude, not only towards nursing care documentation, but also in other spheres of their work is critical.

Over the five (5) day period, the team expressed a sense of obligation to give out their best in the documentation process cognizant of the fact that the notes would be audited during the next handover session. This reaffirmed the critical role that supervision has on the nursing care documentation process. The levels of supervision will vary from peers, to shift lead, ward incharge and eventually the hospital nursing officer incharge. The nurses supervising the nurse’s student have the primary responsibility of counter checking and counter signing the nursing notes made by the learner. This is rooted in the standards of nursing education and practice, which stipulates that each learner should work under the supervision of a qualified nurse, not only for patient safety, but

also for the safety of the nurses and ensuring that the learner is acquiring the prescribed learning outcomes.

Subsequently, the supervisor must demonstrate proficiency in the nursing care activities being implemented, and in nursing care documentation. This has been cited by Alhassan et al. (2025), who indicate that expertise of the supervisor is a key component of the success of the activity being supervised. Herrity (2024) adds that a good supervisor must continually demonstrate desire for continued learning. This ensures that the supervisor remains updated on current trends, and in addition, the person will proactively initiate process modification where there is a change of practice. This, however, does not happen all the time.

As Alan and Baykal (2021) point out, human behavior is a multifaceted phenomenon that can be difficult to understand. Additionally, human behavior is influenced by various factors, some of which are internal while others relate to the context in which individuals are operating. While the personality of a nurse plays a crucial role in maintaining optimal nursing care documentation and other aspects of nursing care, it is also essential that they work in a supportive environment that fosters continuous improvement. A lack of supervision creates a gap in practice, leading to poor nursing care documentation. When learners observe this inadequate practice, they may imitate the nurses, resulting in further deterioration of care standards.

Ravik and Bjork (2020) say that clinical supervision plays a major role in nursing education, allowing acquisition of competencies. This also applies to nursing, and indeed to the multidisciplinary team, where supervision enhances clinical competencies for better and safer healthcare. They further indicate the supervision process is complex, and the experience of the student determines how successful the supervisory activity is.

This principle also applies to the qualified health care providers, where negative supervisory experiences are less likely to give desired outcomes. Tuomikoski et al. (2020) and Zhang et al. (2022) continue to emphasize that positive supervisory experiences are normally overshadowed by negative aspects during the process, and this hinder positive behavior change in regard to the activity being supervised.. Antonsen et al. (2023) opines that clinical learning can be affected by the relationships between the supervisor, and those being supervised, as the environment is social and cultural.

As such, the supervision exercise should take into consideration the approach, and how comments are derived to enhance learning and positive behavior change. In addition to taking charge of the documentation of the learners attached to a particular nurse, each nurse has a supervisory role over the notes documented by the nurses from whom they take over from. This creates check points that enhance the documentation process.

In addition, the tendency to document at the end of the shift was observed. Once this was done, it was observed that many tasks that were performed were not documented as the nurses tended to summarize the activities of the shift yet, as Yulianita et al. (2020) reports, all nursing care activities are undertaken towards achieving desired health care outcomes for individual patients. This, in itself-constituted a gap, as it did not reflect the workload of the nurses, nor a whole range of nursing interventions undertaken to address health care needs and problems. This would further hinder efforts to identify, and thus advance best practices in dealing with different health issues.

Further, it can lead to duplication of nursing care activities (Huang et al., 2024)), and this can be fatal in cases where the duplication is in administration of medication that can lead to overdose and health complications. The Nursing Council of Kenya (2023)

expresses the need for timeliness in nursing care documentation. This ensures that nursing interventions are documented in a chronological way, and none is forgotten.

Managerial ability in a ward setup is a critical ingredient in successful implementation of health care activities by all members of the multidisciplinary team. Through supervision, the nursing care documentation process can be streamlined, particularly by the ward incharge who is in touch with the ward activities, and is present during most of the handover times. Huang et al. (2024), highlight the importance of supervision as key in reducing noncompliance to nursing care documentation. The ward n shift in-charges were encouraged to take an active role in ensuring apt nursing care documentation through supervision and continued coaching in this aspect.

A deep level of commitment towards documented care is key, and will keep all nurses and nursing students on toes, in addition to ensuring that optimum nursing care documentation becomes a culture in the ward, that is not only embraced, but also understood by all to be a pillar of quality of care provided. The Reported Evidence of Nursing and Midwifery Office Mentorship Programmes (Martina, 2025) indicates that structured mentorship in nursing and midwifery is strongly associated with professional development, improved job satisfaction, and retention.

4.8.8 Challenges

Nurses provide care to patients 24 hours a day, seven days a week, working in shifts that ensure continuous coverage. This shift system often makes it challenging to have all nurses and present at the same time, leading to the need for repetition as individual nurses join at different times. With existing nursing shortage in the ward, having full

attention of the nurse for evaluation and analysis of their documented care required delicate art of balancing.

4.9 Post-intervention Phase

The post-intervention evaluation focused on two (2) aspects of the study, the individual factors affecting nursing care documentation, and the quality of documented nursing care. The intervention entailed the development and delivery of a continuous professional development module. This was delivered at Nyeri County Referral Hospital, to a healthcare multidisciplinary team that also included the managers both at the facility and ward level. The study findings were first presented to the participants, with emphasis on the quality of nursing care documentation. Samples of previously documented kardexes were used during the session to allow internalization and contextualization of the documentation process. A follow up of the documentation process was done over a five days period following delivery of the module in the medical ward.

This was to provide mentorship and demonstration of the process. An evaluation was carried out six months after the intervention to assess the quality of nursing care documentation and identify individual contributing factors. The assessment utilized the same standardized tools that were employed during the baseline survey, ensuring consistency and comparability of results across both evaluation periods. Comparison of baseline and post analysis result was done using bivariate and multivariate analysis. The results demonstrated variance, with post intervention quality of nursing care documentation being better as per tabulated results below.

Table 4.10

Bivariate (Chi-square and p-values) and Multivariate (Logistic Regression Coefficients and P-values) Results for Each Issue

Issue	Chi-square	P-Value-x	Logit Coefficient	P-Value-y
Patients detail on every sheet	23.26	-2.9	0	23.26
Initial nursing assessment documented	23.04	-2	0	23.04
Focused assessment during shift	20.55	-1.76	0	20.55
Nursing interventions documented	45.38	-3.13	0	45.38
Responses to interventions	40.62	-3	0	40.62
Instructions for next shift	47.64	-3.2	0	47.64
Entries are specific	73.93	-3.67	0	73.93
Entries are objective	72.43	-3.83	0	72.43
Entries are complete	23.29	-1.97	0	23.29
Timeliness of entries	9.04	-1.26	0	9.04
Ownership of entries	89.28	-4.73	0	89.28

The results from the table demonstrate strong and statistically significant improvements in all aspects of nursing care documentation following the intervention. Each issue, ranging from recording patient details on every sheet to documenting ownership of entries, shows very high chi-square values and extremely low p-values (all < 0.005), confirming strong associations with the intervention. Additionally, the logistic regression logit coefficients are all negative and highly significant, indicating reduced odds of poor documentation in the post-intervention phase. The most notable improvements were seen in specificity, objectivity, and ownership of entries, highlighting the effectiveness of structured support in enhancing documentation quality.

4.9.1 Quality of Nursing Care Documentation Results in The Post Intervention Phase

An evaluation of the quality of nursing care documentation was conducted six months after the intervention phase to assess the impact of the implemented changes. During this evaluation, a total of 62 patient case files were audited using the same 11 parameters that had been assessed during the baseline phase. The primary aim of this post-intervention audit was to determine whether the intervention led to any measurable improvements in the documentation practices of nurses.

The audit was carried out in the medical ward of Nyeri County Referral Hospital, the facility where the intervention had been implemented. This allowed for a focused assessment of changes within a controlled setting. Consistent with the baseline phase, the selection criteria for case files required that patients must have been admitted for at least 72 hours. A total of 61 patient case files met the specified inclusion criteria and were evaluated during the post-intervention phase.

This number closely matched the 63 case files reviewed during the baseline assessment, thereby enhancing the consistency and reliability of comparisons between the two phases. Maintaining a similar sample size helped to minimize variability and strengthen the validity of the findings. The requirement that patients must have been admitted for at least 72 hours ensured that there were adequate nursing care interactions recorded in each file. This timeline was crucial for capturing a comprehensive picture of documentation practices over an extended care period.

Each case file was reviewed in detail, and the documented nursing care was assessed against the same 11 quality indicators previously used. These indicators encompassed aspects such as completeness, timeliness, specificity, objectivity, and continuity of care

documentation. Maintaining consistency in the evaluation criteria enabled a reliable comparison between pre- and post-intervention findings. The results of this post-intervention review are presented in Table 4.11.

Table 4.11

Comparison of Quality of Nursing Care Documentation in the Baseline and Post Intervention Phase in Nyeri County Referral Hospital

No	Phase /issue	Baseline results at Nyeri referral hospital (n=63)		Chi square	P-value	Post intervention (n=62)		Chi square	P-value
		Yes n (%)	No n (%)			Yes n (%)	No n (%)		
1.	Patient's details appearing on every sheet of nursing kardex	28(44.4)	35(55.6)	0.2	0.66	58(93.5)	4(6.50)	47.03	0.00
2.	Detailed initial nursing assessment documented	9(14.3)	54(85.7)	16.82	0.00	32(51.6)	30(49.4)	0.065	0.80
3.	Focused assessment during every shift indicating the specific status of previous health issues and any new health issues.	10(15.9)	53(84.1)	15.1	0.00	40(64.5)	22(35.5)	5.23	0.02
4.	Nursing interventions in line with issues identified clearly documented per shift	9(14.3)	54(85.7)	16.82	0.00	54(87.1)	8(12.9)	34.13	0.00
5.	Responses to the nursing interventions documented	10(15.9)	53(84.1)	15.1	0.00	54(87.1)	8(12.9)	34.13	0.00
6.	Instructions for next shift indicated	13(20.6)	50(79.4)	10.64	0.00	54(87.1)	8(12.9)	34.13	0.00
7.	The nursing kardex entries are specific	7(11.1)	56(88.9)	20.66	0.00	50(80.6)	12(19.4)	23.29	0.00
8.	The nursing kardex entries are objective	9(14.3)	54(85.7)	16.82	0.00	54(87.1)	8(12.9)	34.13	0.14

9.	The nursing kardex entries are complete	13(20.6)	50(79.4)	10.64	0.00	40(64.5)	22(35.5)	5.23	0.02
10.	Timeliness of entries observed	22(34.9)	41(65.1)	2.35	0.13	38(61.3)	24(38.7)	3.16	0.00
11.	Ownership of entries done by way of name and signature	8(12.7)	55(87.3)	18.67	0.00	58(93.5)	4(6.5)	47.03	0.07

In the post intervention phase, an improvement was observed with 58(93.6%) of the case file having the details on every sheet. The improvement noted can go a long way towards reducing medical errors and missed nursing care, with improved quality and care outcomes. Awang, et al. (2023) shed light on the role of quality in a health system, to include reducing wastage and avoiding adverse health care outcomes such as death, and disease complications. This requires a paradigm shift from perceiving the consumers of health care services as patients to customers (Young & Smith, 2025).

Treating patients as customers in healthcare entail concentrating on patient satisfaction and engagement, just like how businesses treat their customers. This change of focus involves understanding and appreciating patient preferences, and providing excellent service that meet their expectation. This ensures that patients feel valued, involved, and respected. It goes beyond simply providing medical care and meeting the health needs, and aims at creating a positive experience for the patient.

World Health Organization (2023), highlighted that at least 10% of patients sustain harm while receiving care, while at least three million deaths occur following unsafe care. Further, WHO continue to say that more than 80% of the harm can be avoided. An improvement in identification of the patient records is a cheap and effective way, that can contribute to the 80%. Beyond the immediate clinical implications, patient

harm has macro-economic consequences estimated to reduce global economic growth by 0.7 percent, because healthcare errors consume resources and suppress labour productivity (Slawomirski & Klazinga, 2020).

The downstream burden encompasses not only the direct expenditures of additional diagnostics, extended hospital stays, and complex treatments required to remedy preventable injuries, but also indirect costs. Families may experience reduced income while caregivers miss work, employers absorb diminished productivity, and society forfeits potential tax revenues. When aggregated, these opportunity costs amplify the hidden price of unsafe care, diverting funds that could otherwise drive social development and innovation.

Regarding nursing assessment, there was an observed improvement with 32(51.6) of the case files identified to have had detailed assessment. While appreciating the improvement, it was observed that this was the areas that recorded least improvement. This, perhaps is because the assessment phase of the nursing process is time consuming, with a great deal of documentation, and with existing nurse shortage, translating to heavy patient-to-nurse ratios a nurses must juggle complex clinical tasks against inflexible shift deadlines, and spread their time across the different care activities.

None the less, collecting, synthesizing, and then recording holistic assessment data remains labor-intensive and demands sustained concentration, especially in a ward set up where interruptions are frequent. Consequently, nurses often prioritize performing hands-on care administering medications, turning immobile patients, counselling families while documentation is postponed until the end of the shift or omitted entirely. This behavioral pattern carries several downstream risks. First, the absence of contemporaneous assessment notes deprives subsequent care providers of critical

baseline information, increasing the likelihood of duplicated tests, delayed interventions, or contradictory care plans.

Second, when adverse events occur, incomplete charts severely hinder the team's ability to demonstrate that appropriate assessments informed their actions, exposing both individuals and the institution to medico-legal liability. Finally, missing assessment data obstructs quality-improvement initiatives, because managers cannot reliably analyse patterns of patient acuity, resource utilisation, or outcomes without a robust documentary trail.

According to Bjerkan et al. (2021), quality nursing care documentation should possess seven characteristics it should be patient-centered, accurately reflect the nurses' actual work, demonstrate the clinical judgment of nurses, be recorded in a timely manner, be written sequentially, note any variances in care, and meet legal obligations. Every patient is unique, and has his or her own healthcare and other needs. Patient-centered nursing care documentation entail seizing patient information in a way that reflects their own individual needs, likes, and care objectives. It demonstrates appreciation and respect of the patient as an individual, with a deeper indication of patient engagement in their own care. This leads to enhances patient satisfaction, a key pointer of health service outcomes (Gao, et al., 2022).

Upon intervention, a significant improvement was observed in the alignment of nursing interventions with the health issues identified in patient cases. Specifically, 54 out of 62 patient case files (87.1%) were found to reflect this key characteristic, suggesting a meaningful enhancement in nursing practice. This improvement demonstrates not only increased attentiveness to patient needs but also a greater integration of critical thinking and evidence-based decision-making into nursing care plans.

Asadi et al. (2024) emphasize the importance of nurses demonstrating their roles as independent professionals rather than being perceived merely as physician assistants. This distinction is critical for the evolution and recognition of nursing as a standalone profession with its own body of knowledge, scope of practice, and standards. Historically, as Teresa, et al. (2022)) highlight, nurses have faced a persistent struggle against societal stereotypes, often being viewed as "physician maids." This image has long undermined the professional identity of nurses and has contributed to undervaluing their contributions to patient care and the healthcare system as a whole.

However, Florence Nightingale, widely regarded as the founder of modern nursing, envisioned the profession as both respectable and intellectually rigorous. She laid the foundation for nursing to be seen as a discipline that combines compassion with scientific knowledge. Over time, the definition of nursing has evolved to encompass both art and science. Today, there is an increasing emphasis on the scientific component of nursing, as noted by Motter et al. (2021). This shift reflects the growing expectation for nurses to possess in-depth understanding of disease processes and to apply critical thinking in delivering evidence-based care.

The scientific side of nursing involves comprehending disease pathophysiology and connecting that knowledge with patient symptoms and prescribed interventions. According to Fedyk (2023), this scientific foundation enables nurses to interpret clinical signs and symptoms accurately, assess the effectiveness of treatments, and recognize potential complications. Moreover, this knowledge empowers nurses to seek clarification when treatments do not align with the observed patient condition, thereby ensuring patient safety and reinforcing the nurse's role as an advocate.

Such capabilities underscore the importance of recognizing nurses as active and integral members of the multidisciplinary team. Nurses do not simply execute orders; they contribute meaningfully to care planning, decision-making, and patient evaluation. Their role extends to auditing the clinical decisions of others, ensuring consistency with best practices and established care standards. Ndiangu et al. (2021) argue that nurses must deliberately cultivate professional visibility, not only to assert their competence but also to highlight their indispensable role in delivering high-quality healthcare.

Cross-auditing among healthcare team members is essential to promoting accountability and safety. In a dynamic and complex clinical environment, the ability to question, review, and improve upon existing care plans contributes to better outcomes. Glenngard and Anell (2021) recognize audit and feedback as fundamental processes for improvement and accountability within healthcare systems. These tools facilitate the identification of care gaps, allow for ongoing performance monitoring, and foster a culture of continuous learning and development.

Feedback, particularly when it is timely and specific, plays a crucial role in driving improvements. Mossel et al. (2021) stress that day-to-day feedback represents a paradigm shift from traditional quality assurance, which often focuses on compliance, to a more progressive model of quality improvement. This shift reflects a growing understanding that learning and improvement must be embedded in daily practice, not reserved for periodic review.

The empowerment of nurses through professional autonomy is central to this transformation. Balasi et al. (2020) state that autonomy enables nurses to apply their expertise in clinical decision-making, thereby enhancing care quality and outcomes. Such autonomy requires a comprehensive understanding of the patient's condition,

achievable only through thorough and ongoing assessments. When nurses are equipped with knowledge, autonomy, and critical thinking skills, they become primary contributors to the healthcare process, rather than secondary participants.

In conclusion, promoting professional autonomy and visibility for nurses is essential for enhancing patient care, improving job satisfaction, and achieving overall healthcare goals. Recognizing the scientific and decision-making capabilities of nurses ensures their role is both respected and impactful within the multidisciplinary team. Through audit, feedback, and continuous professional development, the nursing profession can continue to grow in both stature and effectiveness, fulfilling the vision set forth by pioneers like Florence Nightingale.

As far as documentation of instructions, an improvement was noted, with 54(87%) of the case file bearing this aspect post intervention. Clearly documented instructions for the next shift in nursing care is not only key, but is also a requirement of continuity, safety, and quality of patient care. Documenting instructions for the next shift in nursing care is a fundamental component of safe and effective healthcare delivery. It ensures continuity of care by providing the incoming nurse with accurate, up-to-date information on the patient's condition, ongoing interventions, and pending tasks. This continuity prevents interruptions or lapses in care that could adversely affect patient outcomes.

Well-documented instructions also enhance time management and efficiency during shift handovers, as they minimize the reliance on verbal reports and allow the incoming nurse to prioritize tasks more effectively. In high-acuity settings or busy units, this level of organization is crucial. Seada et al. (2022) identify shift handovers as high-risk moments for patient safety, emphasizing that errors are more likely to occur when there

is inadequate communication or no standardized procedure in place for documenting care.

Facilities lacking formal handover protocols or clear nursing documentation practices face increased chances of missed treatments, duplicated efforts, or miscommunication regarding critical care decisions. Moreover, detailed documentation fosters legal protection and accountability, serving as a verifiable record of the care provided and instructions given. It also promotes teamwork and collaboration by keeping all healthcare providers informed and aligned with the care plan. For nurses, this practice underscores professional responsibility and enhances clinical decision-making, allowing for better judgment and more informed interventions. Ultimately, consistent documentation of shift-to-shift instructions is vital for ensuring patient safety, maintaining high standards of care, and supporting the overall effectiveness of the healthcare system.

In the post-intervention phase, there was a significant improvement in the quality and completeness of nursing documentation. This improvement was particularly evident in the recording of specific and objective patient care information. A review of the patient case files revealed that 50(80.6%) and 54(87.1%) of the files included detailed documentation that reflected a clear understanding of the patient's condition and the interventions administered. This indicates enhanced alignment between nursing actions and the identified health needs of the patients.

The increase in accurate and comprehensive documentation suggests that nurses were better equipped to assess, implement, and evaluate patient care effectively following the intervention. Additionally, the presence of specific notes on post-intervention evaluations demonstrates a commitment to accountability and continuous improvement

in clinical practice. Such progress not only improves patient outcomes but also supports professional nursing standards by promoting clearer communication, better care planning, and more efficient collaboration among healthcare providers.

In a similar breath, the post-intervention results revealed notable improvements in the timeliness and completeness of nursing documentation. Specifically, 40(64.5%) of the reviewed case files were found to be complete, while 38(61.3%) were documented in a timely manner. These findings reflect a positive shift in documentation practices following the intervention. Accurate, complete, and timely documentation is essential in nursing practice, as it not only facilitates continuity of care but also supports the legal and ethical responsibilities of nurses. Nursing as a profession is governed by a code of ethics and legal standards that require practitioners to record all relevant patient information thoroughly and promptly. According to Nathanson (2022), completeness and timeliness are critical components of high-quality documentation, enabling the smooth progression of patient care activities and ensuring that vital information is accessible when needed.

Failure to document care appropriately can lead to adverse patient outcomes, communication breakdowns, and potential legal implications. Nursing notes must be factual, objective, and free from bias or personal opinions. They should clearly detail patient assessments, nursing interventions, and the patient's responses to those interventions. Confidentiality must also be upheld at all times, aligning with both ethical expectations and legal obligations. The improvements observed post-intervention suggest that nurses became more mindful of their documentation duties, resulting in better-organized, accurate, and ethically sound records. These

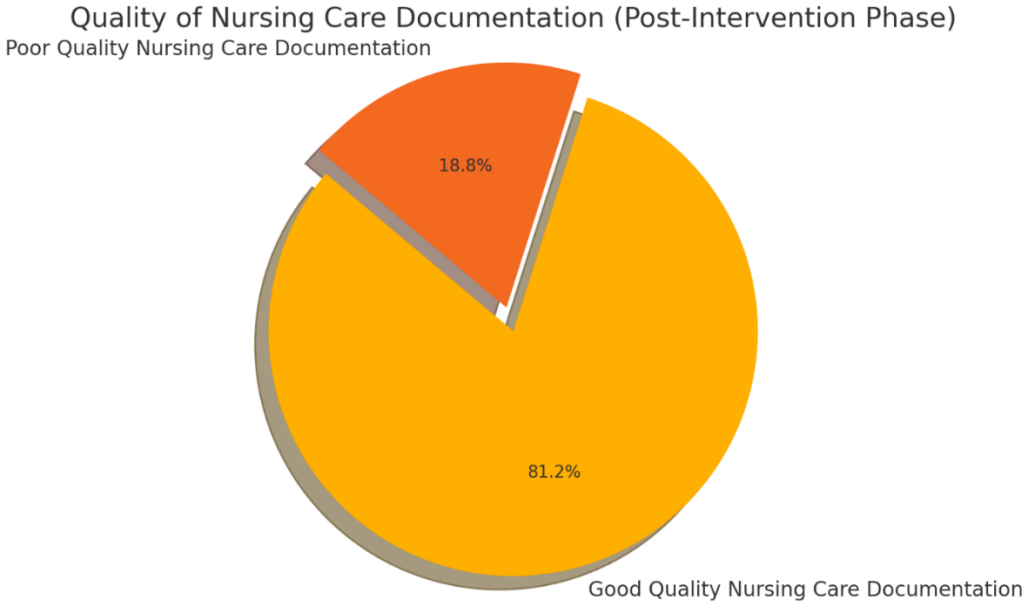
improvements not only enhance the quality of patient care but also strengthen the professional accountability and credibility of the nursing workforce.

An improvement in all examined entries was observed in terms of inclusion of the nurse's name and signature, with 58(93.5%) of the case files showing proper ownership through these two critical elements. This significant improvement reflects not only enhanced compliance with documentation standards but also an increased sense of accountability and professional responsibility among the nursing staff. Including one's name and signature in nursing notes is essential, as it indicates who provided the care and who is responsible for the recorded interventions and observations. This practice is fundamental to maintaining the integrity and traceability of patient records. The marked increase suggests that nurses have developed improved knowledge of documentation protocols and greater confidence in the content of their nursing records.

Signing documentation is also a legal and ethical requirement, as it ensures that every entry is verifiable and attributable to a specific practitioner. It promotes transparency and fosters trust within the multidisciplinary healthcare team. Additionally, clear identification of the documenting nurse is essential during audits, reviews, or legal inquiries, where accurate tracking of care decisions is necessary. Overall, the high compliance rate of 58(93.5%), up from 16(12.7%) in the baseline phase in regard to documentation ownership is a strong indicator of the positive impact of the intervention on reinforcing professionalism and accountability in nursing practice.

Figure 4.2

Quality of Nursing Care Documentation in the Post Intervention Phase



The Chi-square analysis of post-intervention nursing documentation practices revealed mixed outcomes, highlighting areas of both progress and persistent challenges. Statistically significant deviations from an even distribution ($p < 0.05$) were observed in several key indicators, suggesting continued deficiencies. For instance, documentation of patient details on every sheet and clear ownership (name and signature) had extremely high Chi-square values ($\chi^2 = 47.03$, $p < 0.001$), indicating that these practices were rarely followed. Similarly, the documentation of nursing interventions, responses to interventions, instructions for the next shift, and objectivity in entries all showed significant gaps, with Chi-square values above 23 and p-values less than 0.001.

On the other hand, some parameters demonstrated moderate improvements. “Focused assessment during each shift” and “entries are complete” showed significant results ($p = 0.022$), suggesting a positive shift post-intervention. However, documentation of detailed initial assessments ($\chi^2 = 0.065$, $p = 0.800$) and timeliness ($\chi^2 = 3.16$, $p = 0.075$)

did not show statistically significant changes, indicating limited or no effect of the intervention in these areas. Overall, while the intervention led to improvement in a few aspects of documentation, several critical components remain poorly executed. This highlights the need for further targeted efforts, training, and monitoring to ensure consistent adherence to quality nursing documentation standards. Additionally, this highlights the need to address other underlying factors affecting nursing care documentation, such as staffing ratios, which remained unchanged throughout the study period and fell short of recommended standards.

4.9.2 Responses on Individual Nurses' Factors on Quality of Documentation of Nursing Care

In the intervention phase**,** individual factors affecting nursing care documentation were evaluated using the nurse's questionnaire as had been used in the baseline phase. This was to evaluate if the continuous professional development module had caused any change in these factors. All 16 parameters indicative of the individual factors were evaluated. The results at baseline from Nyeri County Referral Hospital were extracted, and a comparison of the results was done. The results demonstrated improvement in the individual factors, and the results are presented in Table 4.12.

Table 4.12

Responses on Individual Factors and Nursing Care Documentation in the Baseline and Post Intervention Phase

No	Nursing care documentation (n=34)	Baseline				Post intervention			
		Agree n(%)	Disagree n(%)	Chi square	P-value	Agree n(%)	Disagree n(%)	Chi square	P-value
1.	I always believe that nursing care documentation is just as important as other patient's records.	34(100)	0(0)	34	0.01	34(100)	0(0)	34	0.01
2.	I am convinced that nursing care documentation is a tedious process	10(29.4)	24(70.6)	19.88	0.00	8(23.5)	26(76.5)	9.53	0.02
3.	Nursing care documentation process always takes a lot of time and effort	30(88.2)	4(11.8)	9.53	0.00	30(88.2)	4(11.8)	19.76	0.02
4.	I know that nursing notes are often useful to other members in the multidisciplinary team	30(88.2)	4(11.8)	23.06	0.00	30(88.2)	4(11.8)	19.76	0.00
5.	The quality of nursing notes always positively influences patients care outcomes	30(88.2)	4(11.8)	19.88	0.00	30(88.2)	4(11.8)	19.76	0.00
6.	I make entries in to the nursing kardex in a timely manner	31(91.2)	3(8.8)	23.06	0.00	31(91.2)	3(8.8)	23.53	0.01
7.	I always refer to what the nurse in the previous shift indicated in the nursing kardex.	34(100)	0(0)	34	0.00	34(100)	0(0)	34	0.00
8.	I always expect the	30(88.2)	4(11.8)	19.88	0.00	34(100)	0(0)	34	0.00

	nurse taking over from me to refer to my nursing kardex notes								
9.	My experience in nursing often influences the way I document nursing care	26(76.5)	8(23.5)	9.53	0.00	25(73.5)	9(76.5)	6.76	0.00
10.	I always make documentation of the care I have provided priority	31(91.2)	3(8.8)	23.06	0.00	31(91.2)	3(8.8)	19.76	0.00
11.	I have ever been questioned before by my colleagues and supervisors about my nursing care documentation	26(76.5)	8(23.5)	9.53	0.00	30(88.2)	4(11.8)	23.53	0.01
12.	I have ever questioned the documentation of nursing care by my colleagues	26(76.5)	8(23.5)	9.53	0.00	31(91.2)	3(8.8)	34	0.00
13.	Litigations often arise from the documentation of care they provided	34(100)	0(0)	34	0.00	34(100)	0(0)	6.76	0.01
14.	I often have the opportunity to learn about nursing care documentation	22(64.7)	12(35.3)	2.94	0.11	25(73.5)	9(76.5)	23.53	0.00
15.	I well understand the key aspects I should include in the documentation of the care I provide	31(91.2)	3(8.8)	23.06	0.00	31(91.2)	3(8.8)	34	0.00
16.	I always ensure that I include the key aspects that should be included as I document care	34(100)	0(0)	34	0.00	25(73.5)	9(76.5)	6.76	0.01

A comparison of the baseline and post-intervention responses to the 16 individual factors relating to nursing care documentation reveals significant consistency and positive attitudes among nurses. Notably, 100% of participants in both phases agreed that documentation is just as important as other patient records, reflecting a strong foundational belief in its relevance, and key towards improvement of the process. However, perceptions of documentation as a tedious process showed a shift. At baseline, 10(29.4)) agreed it was tedious, but this decreased to 8(23.5%) post-intervention, indicating improved attitudes toward the process. Similarly, while 30(88.2%) in both phases agreed that documentation takes time and effort, the persistence of this belief underscores a need to streamline processes or enhance support systems. Recognition of documentation's value to the multidisciplinary team and its impact on patient outcomes remained high in both phases 30(88.2%), as did agreement on the importance of timely entries and reference to previous shift notes at 31(91.2%) and 34(100%), respectively.

Positive shifts were also seen in accountability, with high agreement on having been questioned or having questioned others' documentation, 30(88.2%) and 31(91.2%), respectively). Moreover, awareness of litigation risks 34(100%) and understanding of documentation elements 31 (91.2%) were consistently strong. Overall, the results suggest that the intervention reinforced nurses' awareness, professionalism, and commitment to documentation. These attitudes, if sustained, can support improved practice and documentation quality long-term.

In both phases, the individual factors were found to be positive, and these are essential elements for nursing care documentation. This could be shaped by the quality of nursing education, and the fact that weight given to nursing care documentation process during

training, a fact supported by Wang (2023), Cheung and Yip (2024). Adequate training is consistently highlighted in their respective studies as a key factor influencing the quality of nursing care documentation. The analysis further revealed several items had 100% agreement in both phases: These include, *"*Documentation is just as important as other records", "I refer to previous shift notes", and "Litigations can arise from documentation".

The statements demonstrated full consensus from the start, with no measurable change taking place, but strong awareness in both phases. Positive shift was observed in several elements such as; I expect the nurse taking over from me to refer to my notes". This improved 88.2% to 100% (χ^2 rose from 19.88 to 34), showing stronger shared accountability post-intervention. An improvement in the statement "I have ever been questioned about my documentation", from 76.5% to 88.2% (χ^2 rose from 9.53 to 23.53), suggesting growing peer and supervisory accountability. Similarly, an improvement was noted in the area the statements, "I have questioned colleagues' documentation" and I often have the opportunity to learn about documentation". These rose from 76.5% to 91.2%, with χ^2 increasing from 9.53 to 34, and, 2.94 ($p = 0.11$) to 23.53 ($p < 0.001$), respectively. The findings suggest the intervention successfully increased access to learning, and there was greater critical engagement with peer practices.

In conclusion, the intervention reinforced strong pre-existing beliefs about the importance of nursing documentation and led to notable increases in peer-to-peer accountability, expectations between shifts, and perceived learning opportunities. However, for the of attitudes that were already positive at baseline, the post-intervention changes were more about strengthening rather than shifting mindsets. In

light of these findings, future interventions should prioritize behavioral reinforcement and routine practice audits to bridge the gap between positive attitudes and the actual quality of nursing care documentation.

4.9.3 Effect of the Moderating Variable Equation

From the results, the moderating variable equation examined how individual nurse characteristics influenced the relationship between the intervention and nursing care documentation outcomes. Specifically, the study used logistic regression models to assess whether factors such as nursing experience, level of education, or prior documentation training modified the effect of the intervention on documentation quality.

The results revealed that while the intervention itself had a direct and positive impact on improving specific documentation practices; particularly in conducting detailed initial nursing assessments, the effect was moderated by the nurses' experience and education level. For instance, more experienced nurses (with over five years in practice) were significantly more likely to adopt and sustain improved documentation behavior post-intervention compared to their less experienced counterparts. This suggests that experience strengthens the responsiveness to documentation-focused interventions.

Similarly, nurses with higher formal education (diploma or degree holders) showed greater gains in adherence to documentation standards. The moderating effect of education implies that better academic preparation may enhance understanding of the importance of accurate and comprehensive documentation, making such individuals more receptive to intervention strategies. Similarly, prior exposure to documentation training also emerged as a meaningful moderator. Those who had received training in

the last year responded more positively to the intervention, likely due to reinforcement of existing knowledge.

In summary, the moderating variable equation highlighted that while the intervention was effective, its impact was not uniform. Nurse-specific characteristics played a crucial role in determining the depth and sustainability of improvement, underscoring the importance of tailoring interventions based on workforce profiles.

4.9.3 New Knowledge from this Study

This study examined four key determinants of nursing care documentation: individual nurse factors, institutional conditions, multidisciplinary dynamics, and patient attributes. The findings revealed that each of these factors independently influences documentation quality, highlighting that it is not driven by a single bottleneck but rather shaped by a complex system of interrelated elements. This systemic perspective underscores the need for comprehensive strategies when seeking to improve documentation practices. Efforts focused solely on one area are unlikely to yield lasting change. Instead, targeted interventions must address all four domains; enhancing nurse competencies, improving institutional support, fostering team collaboration, and considering patient engagement, to achieve sustainable improvements in the quality of nursing care documentation. Further, given the varied impact of the intervention, it is essential to tailor improvement strategies, as a one-size-fits-all approach may not be effective for all nurses or healthcare settings. Customized interventions can better address individual and contextual differences, enhancing the overall effectiveness of documentation improvement efforts.

The study identified the most significant gaps in nursing care documentation as missing patient identifiers, incomplete initial assessments, and inadequate shift-to-shift instructions. These areas represent critical weaknesses in the documentation process and offer clear, measurable benchmarks for future audits and evaluations. By pinpointing these specific deficiencies, the study provides valuable guidance for targeted improvement efforts. Focusing on these priority areas can enhance the overall quality and consistency of nursing documentation, ultimately contributing to better patient care and communication among healthcare providers. These findings offer a practical foundation for refining documentation practices and shaping future training and quality improvement initiatives.

Patient-related factors, particularly the acuity of illness and the willingness to ask questions, emerged as significant predictors of nursing documentation quality in this study. Nurses were found to be more meticulous and attentive in their documentation when caring for critically ill or actively engaged patients. This finding challenges the traditional view that documentation is purely a provider-led responsibility and introduces a new perspective; the potential influence of patient engagement on clinical record-keeping. Encouraging patients to inquire about their care and participate actively in their treatment process may indirectly enhance the quality and completeness of nursing documentation.

This insight presents a valuable opportunity for further research into how patient empowerment strategies can improve not only documentation but also overall communication and care outcomes. It also reinforces the evolving perception of patients as active partners or customers in the care process, rather than passive recipients, thereby advancing the principles of patient-centered care in clinical practice.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Nursing care documentation remains a critical component of the clinical roles of the nurses. Documented nursing care is a vehicle of communicating clinical information amongst the multidisciplinary team, and a critical link to continuity of care. Despite its importance, nursing care documentation is marred by numerous challenges and gaps. This gap in care documentation hinders effective communication among the nurses, and between the nurses and the multidisciplinary team. The breakdown in communication that ensues is a catalyst of fragmented and delayed care, and a setback on the effort towards achieving the desired healthcare outcomes, Universal Health Coverage and other national and global health goals.

5.2 Summary

The main objective of this study was to develop evidence-based measures to improve the quality of nursing care documentation in selected counties in Kenya. Nursing documentation is a critical aspect of healthcare delivery, serving not only as a record of patient care but also as a communication tool among health professionals and a legal and professional accountability measure. Incomplete or inconsistent documentation can compromise patient safety and clinical outcomes. This study was therefore guided by five specific objectives:

i. To assess the influence of individual nurse factors on the quality of documentation of nursing care;
ii. To establish the influence of institutional factors on the quality of documentation;

iii. to determine the influence of multidisciplinary collaboration on documentation practices;

iv. to evaluate the influence of patient-related factors;

v. To develop a continuous professional development (cpd) module aimed at enhancing the quality of nursing care documentation in county referral hospitals.

The study was conducted in three distinct phases. Phase 1 focused on establishing a baseline understanding of the quality of nursing care documentation and the various factors that influenced it. This phase was implemented in three county referral hospitals; Nyeri, Isiolo, and Nyandarua, selected to reflect a cross-section of healthcare environments in Kenya. A mixed-methods approach was used, involving both quantitative data from file audits and qualitative insights from nurse respondents.

In relation to objective one, findings showed that individual nurse factors significantly influenced documentation practices. Notably, nurses with more than five years of experience and those who had recently undergone documentation-related training demonstrated markedly better documentation quality. Moreover, while many nurses held positive attitudes toward the importance of documentation, often acknowledging its value in supporting patient-centered care, these attitudes did not consistently translate into strong documentation practices. For instance, timely and complete entries were not always observed during the file audits. This mismatch highlighted a key insight: that knowledge and positive disposition alone are insufficient unless supported by consistent practice and reinforcement over time.

Objective two, which explored institutional factors, revealed several systemic challenges. A lack of structured training opportunities on nursing documentation was widespread across the facilities. Inadequate staffing levels and poor supervision further compounded the problem, limiting the time and support available for comprehensive documentation. These findings emphasize the role of the organizational environment in shaping clinical behaviors and highlight the need for systemic reforms.

Under objective three, the study found that multidisciplinary collaboration had a strong positive influence on documentation quality. Nurses who regularly participated in joint clinical meetings or ward rounds with other health professionals tended to document more thoroughly and accurately. However, participation was not always active, and in some cases, nurses played passive roles during collaborative discussions. This suggests that strengthening team dynamics and encouraging nurse engagement in care planning could significantly enhance documentation practices.

Regarding objective four, patient-related factors also emerged as important. Nurses were more meticulous in their documentation when caring for patients with high acuity levels or when patients actively engaged by asking questions or seeking information. This observation challenges the traditional notion that documentation is solely provider-driven. Instead, it points to the importance of patient engagement in indirectly influencing the quality of record-keeping. Encouraging patients to be involved in their own care processes may therefore support improvements in clinical documentation.

The baseline findings from phase one showed that only 22% of the patient files audited met the threshold for "good" quality documentation, indicating a substantial gap in current practices. In response, phase 2 of the study involved the design and implementation of an intervention aimed at addressing the identified shortcomings.

This intervention took the form of a continuous professional development (CPD) module, which was delivered to nurses in the medical ward of Nyeri County Referral Hospital.

The CPD module was designed using a systems thinking approach, acknowledging the multifaceted nature of the documentation problem. It addressed individual competencies, institutional support, teamwork, and patient dynamics, ensuring that the intervention was both comprehensive and context-sensitive. Content included practical training, peer demonstrations, and bedside coaching to reinforce the learning in real-time clinical environments.

Finally, in phase 3, the effectiveness of the intervention was evaluated. Post-intervention audits demonstrated a remarkable improvement in documentation quality, with 81.2% of patient files rated as "good." This significant increase confirmed the intervention's success and highlighted the potential of structured, targeted training supported by a systems-level perspective to transform nursing documentation practices in public health facilities.

In conclusion, the study underscores that improving nursing documentation requires an integrated approach that addresses not only individual knowledge and attitudes but also institutional systems, team collaboration, and patient engagement. The developed CPD module, anchored in systems thinking, offers a practical and scalable solution for enhancing nursing care documentation quality in Kenya and similar low-resource settings.

5.3 Conclusion

The findings of this study reveal that nursing care documentation is shaped by a complex interplay of individual competencies, institutional cultures, and systemic structures within the healthcare environment. This interconnectedness highlights that documentation practices are not merely administrative tasks but reflect broader theoretical relationships among knowledge management, professional accountability, and patient safety.

Applying a systems thinking perspective, these interrelationships demonstrate that documentation practices cannot be understood, or improved in isolation. Instead, they function as part of a wider healthcare ecosystem in which individual, organizational, and policy-level elements continuously influence one another. Theoretically, the study contributes to an understanding of documentation as both a behavioral and organizational phenomenon; where individual motivation and institutional support interact to influence compliance and quality. Strengthening documentation practices, therefore, requires interventions that address these interdependencies rather than isolated factors.

From a practical perspective, actionable strategies should operate at multiple levels. At the policy level, regulatory bodies should establish clear, enforceable standards on documentation on nursing care. At the institutional level, health facilities should foster a culture that values accurate record-keeping through supportive supervision, adequate staffing, and performance feedback mechanisms. At the training level, nursing education programs should integrate evidence-based documentation competencies into curricula and continuous professional development initiatives to reinforce lifelong

learning and accountability. Ultimately, sustainable improvement in nursing documentation demands a coordinated, multi-level response, one that unites policy, institutional, and educational reforms to enhance both documentation quality and overall patient care outcomes.

5.4 Recommendations

Based on the findings, the following recommendations are proposed for implementation at various levels, including individual nurses, healthcare institutions, and policy makers.

i) Individual nurses need to keep themselves appraised with nursing care documentation process as a way of promoting quality of health care provided.

ii) Institutions need to establish their current nursing care documentation gap – This will serve as a baseline as and a point of reference as they undertake measures to enhance the process.

iii) Using systems thinking approach, institutions to invest on enablers of nursing care documentation towards enhancing this process.

iv) Institutions to embed nursing care documentation as an parameter in their quality assurance programme for continuous monitoring and evaluation of this practice.

v) At policy level, nursing care documentation should be integrated as a quality indicator, and embedded in policies that address quality of health services.

5.5 Recommendations for further research

Based on the conclusions and recommendations of this study the following areas need further research;

i) A comparative study on the quality of nursing care documentation in manual versus electronic systems

ii) A correlational study between public and private health institutions to determine how the nursing documentation differs, and the factors attributed to the difference

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APPENDICES

Appendix A: Nurses' Questionnaire

Introduction

My name is Mukuna Njeri Anne, and I am a postgraduate student at Kenya Methodist University (KeMU). I am conducting a study on "Improving Nursing Care Documentation in Clinical Practice in Selected County Referral Hospitals in Kenya." The information you provide will be valuable in designing initiatives to enhance the quality of care by improving nursing care documentation.

There are no right or wrong answers; all responses will be treated confidentially and will not be traceable to you. Please choose the responses that best reflect your situation. Thank you for your participation.

Section 1. Individual factors that influence nursing care documentation

1. What is your gender?
    i. Male ( )
    ii. Female ( )
2. What is your age in years? .....

3. How many years of experience have you? …….

4. What is your nursing education level/qualification?
    i. Certificate ( )
    ii. Diploma ( )
    iii. Higher diploma ( )
    iv. Bachelor's Degree ( )
    v. Master's Degree ( )

5. What are the results of poor nursing care documentation?

……
……
……

6. The items in this section on nursing kardex documentation are organized in five-point likert scale that range from strongly agree (SA), agree (A), neither agree nor disagree (N), disagree (D) and strongly disagree (SD). Please indicate as accurately and truthfully as possible your opinion about each one of them. There are no correct or wrong answers.

No	Statement	**SA**	**A**	**N**	**D**	**SD**
	Nursing care documentation:					

i.	I always believe that nursing care documentation is just as important as other patient's records.					
ii.	I am convinced that nursing care documentation is a tedious process					
iii.	Nursing care documentation process always takes a lot of time and effort					
iv.	I know that nursing notes are often useful to other members in the multidisciplinary team					
v.	The quality of nursing notes always positively influences patients care outcomes					
vi.	I make entries in to the nursing kardex in a timely manner					
vii.	I always refer to what the nurse in the previous shift indicated in the nursing kardex.					
viii.	I always expect the nurse taking over from me to refer to my nursing kardex notes					
ix.	My experience in nursing often influences the way I document nursing care					
x.	I always make documentation of the care I have provided priority					
xi.	I have ever been questioned before by my colleagues and supervisors about my nursing care documentation					
xii.	I have ever questioned the documentation of nursing care by my colleagues					
xiii.	Litigations often arise from the documentation of care they provided					
xiv.	I often have the opportunity to learn about nursing care documentation					
xv.	I well understand the key aspects I should include in the documentation of the care I provide					
xvi.	I always ensure that I include the key aspects that should be included as I document care					

Section 2: institutional factors that influence quality documentation of nursing kardex
The items in this section on factors that influence nursing kardex documentation are organized in five-point Likert scale that range from strongly agree (SA), agree (A), neither agree nor disagree (N), disagree (D) and strongly disagree (SD). Please indicate as accurately and truthfully as possible your opinion about each one of them. There are no correct or wrong answers

No	**Statement**	**SA**	**A**	**N**	**D**	**SD**
i.	My institution has adequate SOPs on nursing care documentation					

ii.	The SOPs offers sufficient guideline on nursing care documentation					
iii.	The patient load per shift is per the nursing Council of Kenya recommendations					
iv.	The patient load per shift positively affects my ability to document nursing care					
v.	The institutional culture on nursing care documentation is appropriate					
vi.	The institutional culture affects nursing care documentation					
vii.	The quality of nursing notes positively influences patients care outcomes					
viii.	My supervisor offers guidance frequently on nursing care documentation					
ix.	The institution has a system in place to audit nursing care documentation					
x.	My supervisor often audits the quality of nursing care documentation					
xi.	My supervisor often raises concerns regarding nursing care documentation in the unit					

Section 3: Influence of Multidisciplinary collaboration on nursing care documentation

The items in this section on influence of multidisciplinary collaboration on nursing kardex documentation are organized in five-point Likert scale that range from strongly agree (SA), agree (A), neither agree nor disagree (N), disagree (D) and strongly disagree (SD). Please indicate as accurately and truthfully as possible your opinion about each one of them. There are no correct or wrong answers

No	Statement	SA	A	N	D	SD
i.	We often set health care outcomes for the patients jointly with the multidisciplinary team					
ii.	The multidisciplinary team often jointly evaluate patients' progress					
iii.	I often receive consultations from the multidisciplinary team regarding care and progress of the patients					
iv.	We often conduct nursing rounds in my unit					
v.	We often hold clinical meetings in my unit					
vi.	We often carry out joint ward rounds with the multidisciplinary team in my unit					
vii.	The nurse contributes towards patient's management during the joint ward rounds					

viii.	There are set out parameters to check out for while receiving report at the commencement of a shift					
ix.	I often encounter situations where nursing kardex is not inappropriately documented					
x.	I always act when I encounter nursing kardex that has not inappropriately documented					

Section 4: Patient factors that influence quality documentation of nursing kardex

7. The items in this section on patient factors that influence nursing kardex documentation are organized in five-point Likert scale that range from strongly agree (SA), agree (A), neither agree nor disagree (N), disagree (D) and strongly disagree (SD). Please indicate as accurately and truthfully as possible your opinion about each one of them. There are no correct or wrong answers.

No	**Statement**	**SA**	**A**	**N**	**D**	**SD**
	I would more careful to document the nursing kardex when;					
i.	I am dealing with patients who ask for explanation of the care they are receiving					
ii.	I am dealing with pediatric clients					
iii.	Caring for patients who know their rights					
iv.	Caring for patients with acute life-threatening conditions					
v.	Handling clients in end-of-life stage					
vi.	Caring for severely ill patients					
vii.	Handling social-economically stable patients					

Appendix B: Guide to Review of the Patients' Case File

Issue		Yes	No	Remarks
1.	Patient's details appearing on every sheet of nursing kardex			
2.	Detailed initial nursing assessment documented			
3.	Focused assessment during every shift indicating the specific status of previous health issues and any new health issues.			
4.	Nursing interventions in line with issues identified clearly documented per shift			
5.	Responses to the nursing interventions documented			
6.	Instructions for next shift indicated			
7.	The nursing kardex entries are specific			
8.	The nursing kardex entries are objective			
9.	The nursing kardex entries are complete			
10.	Timeliness of entries observed			
11.	Ownership of entries done by way of name and signature			

Appendix C: Guide to Review of the Patients' Case File

SCORE CARD

Issue	Yes	No
Patient's details appearing on every sheet of nursing kardex	Patient's details appear in at least 75% of the sheets used	Patient's details appear in less than 75% of the sheets used
Detailed initial nursing assessment documented	History taken of present illness and past medical surgical history Head to toe or systemic Physical examination done	No present or pat medical surgical history No head to toe or systemic examination done
Focused assessment during every shift indicating the specific status of previous health issues and any new health issues.	History detailing progress in relation to manifestations of present illness	No history and physical examination relating to the manifestations of present illness
Nursing interventions in line with issues identified clearly documented per shift	Nursing interventions addressing at least 75% of the clinical issues identified	Nursing interventions addressing less than 75% of the clinical issues identified
Responses to the nursing interventions documented	Response to at least 75% of the nursing interventions documented	Response to less than 75% of the nursing interventions documented
Instructions for next shift indicated	Specific instructions regarding care continuity indicate d	No specific instructions regarding the continuity of care
The nursing kardex entries are specific	At least 75% of the Kardex entries are specific	Less than 75% of the Kardex entries are non-specific
The nursing kardex entries are objective	At least 75% of the nursing kardex entries are objective	Less than 75% of the nursing kardex entries are objective
The nursing kardex entries are complete	At least 75% of the nursing kardex entries are complete	Less than 75% of the nursing kardex entries are complete
Timeliness of entries observed	Timeliness of entries observed in at least 75% of the cases	Timeliness of entries observed in less than 75% of the cases
Ownership of entries done by way of name and signature	Ownership of entries done by way of name and signature in at least 75% of the instances	Ownership of entries done by way of name and signature in less than 75% of the instances.

Appendix D: Key Informant Interview Guide for Nurse Managers

1. What challenges do you face regarding nursing care documentation in your unit, department, or hospital?
2. What individual factors or characteristics of nurses have you identified that influence their nursing care documentation practices?
3. How have you addressed these challenges?
4. Are there policies, standard operating procedures, or guidelines in place within the institution to support quality nursing care documentation?
5. How often do you audit nursing Kardex documentation?
6. Is there a system in place to ensure the quality of nursing care documentation?
7. What role does the multidisciplinary team play in maintaining the quality of nursing care documentation?
8. Have you identified any connections between the quality of nursing care documentation and patient characteristics?
9. In your opinion, how is the quality of nursing care documentation linked to the overall quality of care that a patient receives?

Appendix E: Consent to Take Part in Research

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,
My name is Anne Njeri Mukuna. I am a PhD candidate from Kenya Methodist University. I am conducting a study titled: **Improving Quality of Nursing Care Documentation in Clinical Practice in County Referral Hospitals in Kenya.** The findings will be utilized to strengthen the service delivery by improving nursing care documentation and by extension the quality of care delivered to patients by the multidisciplinary team.

Procedure to be followed
Participation in this study will involve asking you some questions and accessing all hospital departments to address the six pillars of the health system. I will record your responses using a questionnaire checklist.

You have the right to refuse participation in this study. There will be no penalties or negative consequences for choosing not to join, and your decision will not impact your employment in any way.

Please remember that participation in the study is completely voluntary. You may ask questions about the study at any time. You also have the right to decline to answer any specific questions and may stop the interview whenever you wish. Additionally, you can withdraw from the study at any time without any consequences to the services you are providing.

Discomforts and risks
Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits
By participating in this study, you will contribute to strengthening health systems in Kenya and other low-income countries in Africa. This effort will lead to improved healthcare services for countries, communities, and individuals. This field attachment is essential for enhancing health systems, as it will generate new knowledge that can inform decision-makers and help them make research-based decisions.

Rewards
There is no reward for anyone who chooses to participate in the study.

Confidentiality
The interviews will be conducted in a private setting within the hospital. Your name will not be recorded on the questionnaire and the questionnaires will be kept in a safe place at the University.
Contact Information
If you have any questions, you may contact the following supervisors:
Prof. Wanja Tenambergen, Department of Health Systems Management, Kenya Methodist University, Nairobi campus; Tel: 0726-678020/ Email: wanja.tenambergen@gmail.com OR Dr. Kezia Njoroge, Lecturer Department of Health Systems Management of Kenya Methodist University, Nairobi campus Tel: 0738-970746 Email: kezia.njoroge@kemu.ac.ke

Participant's Statement
The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.

Name of Participant…… Date…….
Signature…….

Investigator's Statement
I, the undersigned, have explained to the volunteer in a language s/he understands the procedures to be followed in the study and the risks and the benefits involved.

Name of Interviewer……Date…….
Interviewer Signature……

Appendix F: Training Guide for Nurses and Nurse Managers

Title: Systems Thinking Approach Application in Nursing Care Documentation

Introduction

This guide was developed to enhance the competencies of nurses and hospital managers in using a system thinking approach to address the challenges of nursing care documentation. Gaps in nursing care documentation have been identified, yet this process is fundamental to nursing practice. Nurses are with patients around the clock, making it essential for them to communicate effectively with other nurses and members of the multidisciplinary team.

Given the complexity of the health system, it is crucial to recognize that improving one process may adversely impact another. Therefore, when seeking to enhance nursing care documentation, it is wise to adopt a systems perspective to prevent unintended consequences in other areas of the system.

Training Methodology

The training guide employs a lecturer approach supported by demonstrations and mentorship to achieve the learning outcome of acquiring skills, specifically in nursing care documentation practices.

Objectives

By the end of this training, participants will be able to:

1. Explain the purpose and concepts of the nursing care documentation process
2. Demonstrate capacity to document nursing care that conforms to the existing guidelines and the nursing process.
3. Explain mechanisms the institution needs to put in place to support nursing care documentation process
4. Describe systems thinking approach towards improving nursing care documentation

Participants

This module focuses on nurses in the service delivery areas, and where nursing care documentation is an integral part of their daily work.

Training Location

The training is planned to take place at the Nyeri County Referral Hospital. The lecturer will be delivered in the hall, while follow up for demonstration and mentorship will be done in the medical and surgical wards.

Training Materials

Stationery

- Flip chart stand

- Flip chart papers
- Markers
- Masking tape
- Participant registration form

Teaching Aids

- Lap top
- Projector

Training Schedule

Day 1 Work	
Time	Activity
8:30–9:30	• Welcome • Introductions • Objectives and expectations of the training • Unit one
9:30–5.00 pm	• Follow up in the wards
Day 2 Work	
Time	Work
8:30–10.00 am	• Welcome • Introductions • Objectives and expectations of the training • Unit two and Three
10.00- 5.00pm	• Follow up in the wards
	Day 3, 4 and 5
8.00- 5.00pm	• Follow up in the wards

LESSON PLANS

Session 1: Welcome, Introductions, Training Objectives and overview of nursing care documentation

Learning Outcome

By the end of this session, participants will be able to explain the purpose and concepts of the nursing care documentation process

CONTENT

Definition of a system; concept of health system; Nurses and the healthcare system; Nursing care documentation, rationale, principles, characteristics, types of nursing care documentation, importance and consequences.

Materials:

Flip chart #1, marker, masking tape

Lap top

Projector

Total Time: 1 hour

Process:

Step 1: 10 minutes

- Welcome the participants and discuss the problem and the learning outcomes.

Step 2: 40 minutes

Project and explain the power point presentation

Step 3: 10 minutes

- Take any questions and comments

Session 2: Institutional support towards nursing care documentation and Nursing care documentation quality assurance

Learning Objective:

By the end of the session, the participants will be able to:

1. Explain mechanisms the institution needs to put in place to support nursing care documentation process
2. Describe systems thinking approach towards improving nursing care documentation

Content

Introduction; institutional support towards nursing care documentation: Standard operating procedures (SoPs), patient load, Institutional culture, training and mentorship, supervision and audit, multidisciplinary collaboration & documentation tools; Nursing care documentation quality assurance, introduction, principles of quality

improvement, Nursing care documentation and quality, nursing care documentation and the six Health systems building blocks.

Materials:
Flip chart #2, paper, markers
Lap top
Projector
Total Time: 1 hr 30 minutes

Process:
Step 1: 10 minutes
- Welcome the participants and discuss the problem and the learning outcomes.

Step 2: 40 minutes
Project and explain the power point presentation
Step 3: 10 minutes
- Take any questions and comments

Demonstration and follow up phase
- Review documented nursing care
- Provide feedback as per the content of the module.
- Receive and address questions and concerns