

NURSING DOCUMENTATION IN HOSPITAL HEALTHCARE: INSIGHTS INTO NURSES' ATTITUDES AND PERCEPTIONS

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ABSTRACT

Introduction: Nursing documentation includes records of nursing interventions throughout the nursing process and ensures continuity and integration of all phases of patient care. Although legally required, nursing documentation in hospitals in Croatia is still not maintained comprehensively. Nurses' perceptions and attitudes play a key role in ensuring its consistent and complete management.

Aim: To investigate the attitudes and perceptions of nursing staff with regard to nursing documentation and its importance in hospital practice.

Materials and Methods: The qualitative study was conducted between 15 May and 3 June 2024 in Zadar General Hospital. Data were collected through semi-structured interviews based on the relevant literature.

Results: The analysis revealed three main categories. The first category concerned the importance of nursing documentation, which participants recognised as an official and comprehensive patient record, a supplement to other medical records and a means of legal protection for both patients and nurses. The second category included barriers to high-quality documentation, such as lack of time, lack of staff, inadequate electronic equipment, high patient volume and the limitations of the IBIS system. The third category related to the contribution of nursing documentation to patient safety, emphasising a holistic approach that prevents adverse events, protects patients from unsafe practices and enhances nurses' professional accountability.

Conclusion: Nurses recognize nursing documentation as essential for care quality, patient safety, and legal protection. Its quality is affected by time and staff shortages, technical limitations, workload, and inadequate adaptation of the electronic system. Nevertheless, high-quality documentation supports patient safety through monitoring, information transfer, professional accountability, and prevention of adverse events.

Keywords: Croatia, documentation, general hospitals, nursing.

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INTRODUCTION

One of the most important aspects of nursing practice, which is both an obligation and responsibility of all nurses, is the maintenance of nursing documentation (1). Nursing documentation is now an important tool for critical assessment, the detailed description of the patient's condition, the recording of planned and implemented nursing interventions and the evaluation of the outcomes of the healthcare provided (2). It is therefore an important tool for monitoring the quality of healthcare, rationalising costs and standardising nursing practice (3, 4). Florence Nightingale already recognised the importance of structured data collection in the mid-19th century and emphasised that thorough and systematic documentation enables the identification of problems in healthcare and improves the quality of healthcare (5). The next important step in the development of nursing documentation was taken by Virginia Henderson in the 1930s, with the introduction of the concept of health care plans (6). Since the 1970s, nursing documentation has been formally recognized and accepted worldwide as a professionally and legally binding document (7).

In the Republic of Croatia, keeping nursing documentation became a legal obligation with the adoption of the Ordinance on Nursing Documentation in Hospital Health Institutions since 2011. The aforementioned regulation defines nursing documentation as a set of data that serves to control the quality of planning and implementation of healthcare and forms an integral part of the patient's medical documentation. The obligation to record applies to all procedures performed during

24 hours, thus ensuring continuity of care and permanent availability of data to all members of the healthcare team (7).

Despite the legal obligation, nursing documentation in Croatia is still not kept comprehensively (8). This finding aligns with a recent study, which shows that nurses make nursing diagnoses in only 20.8% of cases (9), and only 47.8% of patients have complete nursing records (10). In contrast, the findings contradict a 2019 study from China, which indicated that documenting nursing care is the second most common duty performed by nurses (11). The differences in development between the two healthcare systems are likely to contribute to the issue. A qualitative study in Indonesia found that nurses often neglect nursing record-keeping due to a lack of motivation and incomplete documentation (12). A similar occurrence is noted in a study conducted by Asmirajanti et al. (2019), which found that nursing records were not kept in a timely or adequate manner. Qualitative research in Norway suggests that while nurses aim to implement healthcare plans, they find documentation time-consuming and believe it detracts from patient care (13). Nurses expect to spend little time on documentation (12).

The development of informatics technology in recent decades has significantly influenced the way nursing documentation is maintained (14). The implementation of hospital informatics systems has enabled the digitalization of healthcare documentation, which contributes to more efficient work and significantly faster and greater availability of data. In the Republic of Croatia, the implementation of the Integrated Hospital Informatics System covers all segments of

medical documentation, including nursing documentation, but in practice, certain difficulties are often highlighted, such as technical limitations, insufficient informatics equipment, or the need for multiple data entry (15).

The results of international research show that well-managed nursing documentation contributes to better communication within the team and greater patient safety (3, 4), but also that nurses encounter various obstacles in the practice of applying nursing documentation. The most common ones are lack of time, heavy administrative burden and limited informatics resources (16, 17). Studies conducted around the world confirm that electronic documentation systems can significantly increase work efficiency, but can also cause frustration if they are not adapted to the needs of users (3, 16, 18). Previous research in Croatia and the surrounding region shows that nurses perceive documentation as an important element of professional responsibility and legal protection, but they also highlight administrative difficulties and the need for additional education (8, 19).

Based on historical development, professional significance, legal regulations and previous research, it is clear that nursing documentation is not just an administrative obligation, but a key element that connects all aspects of healthcare. The quality of its management directly reflects on patient safety, the effectiveness of healthcare and the professional responsibility of nurses. In this context, examining nurses' attitudes and experiences regarding nursing documentation management is important for a better understanding of the barriers in

practice and for finding opportunities to improve this segment of healthcare.

Therefore, this study aimed to investigate the attitudes and perceptions of nursing staff with regard to nursing documentation and its importance in hospital practice.

MATERIALS AND METHODS

The qualitative study was conducted at Zadar General Hospital between 15 May 2024 and 3 June 2024 through face-to-face interviews with the participants. Inclusion criteria for participation in the study included bachelor's or master's degrees in nursing, being actively employed at the Zadar General Hospital, having at least one year of clinical experience, participating in daily nursing documentation, and providing informed consent to participate in the study. Exclusion criteria were: nurses who do not actively participate in document management, have less than one year of work experience, are temporarily not engaged in clinical work (e.g., on sick leave or maternity leave), and do not agree to participate. The sample size was determined using the principle of data saturation, including participants until additional interviews no longer produced new information.

After the participants had been informed about the purpose and objectives of the study and had given their consent, they were interviewed on their respective hospital wards at pre-arranged times. Participation in the study was voluntary and the interviews were conducted on 14 hospital wards with a total of 12 nurses with a bachelor's degree and 2 nurses with a master's degree who were actively involved in the work process. All participants completed the study, with no

withdrawals occurring during data collection.

Instruments

The data were collected through semi-structured interviews, allowing a combination of prepared questions and flexibility to explore additional topics. The interview was divided into two parts: the first part dealt with the socio-demographic data of the participants, including age, gender, educational level and professional experience; the second part comprised questions specifically related to nursing documentation, such as: "Please specify what you mean by the term nursing documentation?" or "Are there any challenges you face when maintaining nursing records?". The questions were formulated on the basis of a prior review of the relevant literature (12, 20–25).

Data analysis

The data collected from the participants through the interview method was recorded in writing, after which a thematic analysis of the data collected through the interview was conducted. In a first step, the researchers were introduced to the collected data in detail, followed by the reduction of the collected data, a clear documentation of the data, i.e. data coding,

and finally the drawing of conclusions. The conclusions were categorized into specific categories/themes from which the main categories and subcategories were derived. The analysis process involved returning from the main themes to the codes and then to the original data to ensure the reliability and validity of the results.

The conduct of the study was approved by the Ethics Committee of the Zadar General Hospital at its 11th meeting on 29 March 2024 (Ref. No. 01-2658/24-9/24). All participants gave informed consent to participate in the study.

RESULTS

Participant characteristics

A total of 12 bachelor's and two master's graduates in nursing took part in the study, with an average age of 35 and an average length of service of 12 years. The interviewees worked in the departments of cardiology, traumatology, urology, general and pediatric surgery, intensive care medicine, pulmonology, coronary care unit, pediatrics, nephrology, hemodialysis, gastroenterology, neurosurgery and neurology. The majority of respondents (8/14) had participated in medical record keeping training in the past year. The demographic data of the respondents is shown in Table 1.

Table 1. Demographic data of respondents

Variable	N	%
Gender		
Male	2	14.29
Female	12	85.71
Age		
24-29	7	50.00
30-40	5	35.71
>41	2	14.29
Work experience (years)		
2-9	10	71.42
10-20	2	14.29
>21	2	14.29
Level of education		
Bachelor of Nursing	12	85.71
Master of Nursing	2	14.29

Attitudes and opinions of nurses about keeping nursing records

The main topic of this study was the quality of nursing documentation, which comprised three main categories relating to the importance of nursing documentation, barriers to the quality of nursing documentation and the contribution of the

quality of nursing documentation to patient safety. Within the first category there are a total of five subcategories, and within the second and third categories there are seven subcategories each. An overview of the main categories and subcategories is shown in Table 2.

Table 2. Main categories and subcategories of nursing documentation quality

Theme	Main categories	Subcategories
Quality of nursing documentation	The importance of quality nursing documentation	Official document; Complete data; Control and monitoring of healthcare; Supplement to other medical documentation; Legal protection of patients and nurses
	Barriers to the quality of nursing documentation	Lack of time; Lack of staff; Lack of informatics equipment; Large number of patients; Inadequate adaptation of IBIS to certain categories of patients; Insufficient data; Copying of previous data
	The contribution of nursing documentation quality to patient safety	Continuous monitoring of the patient's condition; Easy transfer of information; Encourages professional responsibility; Detailed insight into the patient's condition; Holistic approach; Prevents adverse events; Protects the patient from unsafe practices

The importance of quality nursing documentation

Participants emphasize that nursing documentation is an official document and a legal obligation, the quality of which is crucial for legal protection, patient safety, and the quality of healthcare provided. Respondent 6 states: "Nursing documentation is an official document... irregularities can be noticed and controlled promptly." Respondent 7 adds: "I am positively influenced by the motivation from the head nurse, but also by self-protection when I document everything that is done."

The completeness of the documentation allows patient monitoring from admission to discharge and continuous data recording. Respondent 1 points out: "Nursing documentation includes all information recorded from the time of admission to the hospital until the patient is discharged." Respondent 12 adds: "Nursing documentation is a set of data that nurses record chronologically and continuously, for the purpose of supplementing the written handover." The documentation also facilitates communication and information transfer within the team. Respondent 3 states: "The

continuous monitoring of the patient's condition and facilitated information transfer are the greatest advantages of maintaining nursing documentation." Respondent 4 emphasizes: "It serves as an aid when transferring the patient to another department or when being discharged."

Legal protection is a strong motivating factor. Respondent 10 adds: "Legal protection... confirms that we have provided appropriate health care."

Barriers to the quality of nursing documentation

Participants identify seven main barriers. The most common are a lack of time and staff. Respondent 7 states: "Nursing documentation is negatively affected by lack of time due to lack of staff and excessive workload." Respondent 2 adds: "The work needs to be redistributed so that one nurse can write documentation without interruption and the patients are taken care of."

The lack of informatics equipment also makes data entry difficult. Respondent 1 says: "The biggest challenge is the lack of computers in the departments because most of the time everyone is busy." Respondent 6 suggests: "Two tablets can be purchased... which is more feasible than increasing staff."

Other barriers include too many patients, inadequate electronic documentation, duplication of data and insufficient quality of records. Respondent 2 notes: "The decursuses should not contain just one word 'sleep' or 'round', but should be meaningful in content." Respondent 10 adds: "As I sat down at the computer and started entering data, the alarm rang, and the data was already needed by someone and deleted."

The contribution of nursing documentation quality to patient safety

Participants highlight seven subcategories that contribute to patient safety. Continuous monitoring of the condition allows for timely recognition of changes and care planning. Respondent 3 states: "Nursing documentation enables continuous monitoring of the patient's condition and facilitates the transfer of information about the patient." Respondent 6 adds: "Continuous monitoring of the patient's condition and legal protection are the greatest advantages of keeping records."

Easy transfer of information and professional accountability improve coordination within the team. Respondent 9 says: "Nursing documentation ensures legal protection, continuous monitoring of the patient's condition and facilitates access to data." Respondent 4 emphasizes: "Keeping nursing documentation encourages professional accountability of nurses."

Detailed insight into the patient's condition and a holistic approach to the patient enable a comprehensive examination and planning of healthcare. Respondent 2 states: "The advantages are a complete insight into both the patient's condition and the medical and technical procedures performed." Respondent 10 adds: "The biggest advantages are systematic monitoring of the patient's condition, a holistic approach and easier communication within the team."

Nursing documentation also contributes to the prevention of adverse events and the reduction of the risk of unsafe practices. Respondent 8 points out: "We record all procedures and therapies performed in the decursus... which leaves no room for

error.” Respondent 3 adds: “Documentation increases patient safety because it ensures continuous monitoring and availability of information.” Respondent 6 concludes: “With all the written data, nurses have a better insight into the entire patient care process.”

DISCUSSION

This research aimed to examine the attitudes and opinions of nurses on the maintenance of nursing documentation and its importance in hospital practice. Although the participants are employees of only one health institution, their sociodemographic characteristics are similar to the population of nurses employed in the Republic of Croatia. Namely, a similar gender distribution, average age of the respondents and length of service have been shown in previous research (26, 27).

The recorded results indicate the nurses' awareness of the importance of the quality of nursing documentation. Similar results were published in a recent study highlighting how nurses understand the importance of quality nursing documentation (28). Respondents in this study emphasize that nursing documentation is an official document that supplements other medical documentation and requires comprehensive data that serves to control and monitor healthcare, which is confirmed by previous research (7). Furthermore, respondents recognize nursing documentation as a means of legal protection for both nurses and patients. Similar results are reported in a study from 2021 that describes the importance and strength of nursing documentation as part of the patient's medical documentation in misdemeanor or even criminal court

proceedings (29). For example, it is stated that nursing documentation should not be viewed separately from patient care, but rather, on the contrary, it belongs to the patient care process (30).

In this research, the main obstacles to the quality of nursing documentation are highlighted as lack of time, lack of staff and technical difficulties, which is in line with the results of previous studies (17, 31). In the study by Bjerkan et al., highlighted barriers, in addition to lack of time and staff, included the complexity of nursing documentation and the lack of standardization of the informatics system (32), which partly confirms the findings of this research. The lack of time and staff, which is currently particularly pronounced in health institutions (33), causes incomplete or inadequate documentation, which can increase the risk of medical errors and adverse events and affect the continuity and quality of healthcare (7, 34). Furthermore, similar results were recorded in a study conducted in Iran, where lack of time, lack of staff, technical difficulties and insufficient education of nurses were also cited as the main challenges (20). In this research, education was not particularly emphasized, which is probably a consequence of the fact that all respondents had previously attended education, most of them in the previous year. Namely, other research also directly links the maintenance of nursing documentation with the education of nurses and the level of education (35). One of the obstacles that respondents cited was missing data and copying of previous patient data, which significantly impairs the quality of nursing documentation (36). Although digital hospital informatics systems are recognized as a significant tool

for improving the efficiency and quality of nursing documentation, respondents perceive it as an obstacle and a significant challenge, which has been confirmed in other research (16). For example, a study conducted in Nigeria reported that half of nurses faced at least minor challenges when using digital nursing records, while 36.8% of nurses reported experiencing moderate challenges (16). Furthermore, research participants point out that the current implementation of electronic documentation still has limitations: insufficient computers, unsuitability for certain departments, and duplication of data entry, which was also confirmed in a study conducted in Iran (18). Nurses emphasize that they are ready to use electronic nursing documentation, but that certain problems in the implementation and use of the software must first be resolved to make the system more easily acceptable (18). Similar problems in the digitalization of documentation were observed in the study by Dall'Ora et al., which emphasizes that the use of tablets, for example, can reduce the time spent on documentation and allow more time for direct patient care (37).

Despite the above obstacles, the participants in this study clearly emphasize that comprehensive nursing documentation contributes to patient safety in the hospital healthcare system. Namely, documentation offers a view of continuous patient monitoring through detailed insight into the patient's condition and a holistic approach (7). Nursing documentation ensures the easy transfer of information and encourages professional responsibility of nurses. Ultimately, respondents state that complete and high-quality nursing documentation protects patients from

unsafe practices and thus directly prevents adverse events (32).

Limitations

This research had certain limitations. The primary limitation is related to the small sample size of the nursing staff. Furthermore, because the study only evaluated a single hospital, the applicability of the results may be restricted. Moreover, the interviews were conducted face-to-face, which could have influenced the respondents' honesty and led to them giving desirable answers.

CONCLUSION

Nurses understand that quality nursing documentation is crucial for ensuring patient safety and enhancing healthcare efficiency. They have identified several key obstacles to effective and comprehensive nursing documentation, including a lack of time, staff, and technical resources. By improving working conditions and optimizing information systems, it is possible to enhance nurses' attitudes and perceptions toward nursing documentation. This can lead to better management of nursing documentation, a reduction in the risk of errors, and ultimately, an overall improvement in patient care.

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SESTRINSKA DOKUMENTACIJA U BOLNIČKOJ ZDRAVSTVENOJ ZAŠTITI: UVID U STAVOVE I PERCEPCIJU MEDICINSKIH SESTARA

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SAŽETAK

Uvod: Sestrinska dokumentacija obuhvaća zapise o postupcima medicinskih sestara tijekom zdravstvene njege te osigurava kontinuitet i povezanost svih faza zdravstvene skrbi. Iako je zakonski obvezna, sestrinska dokumentacija u bolnicama u Hrvatskoj još uvijek se ne vodi cjelovito. Percepcija i stavovi medicinskih sestara imaju ključnu ulogu u osiguravanju njezinog dosljednog i cjelovitog vođenja.

Cilj: Ispitati stavove i mišljenja medicinskih sestara o vođenju sestrinske dokumentacije i njezinoj važnosti u bolničkoj praksi.

Materijali i metode: Kvalitativno istraživanje provedeno je u Općoj bolnici Zadar od 15. svibnja do 3. lipnja 2024. godine. Podaci su prikupljeni polu-strukturiranim intervjuom koji je temeljen na dostupnoj relevantnoj literaturi.

Rezultati: Analizom podataka kao glavna tema izdvojila se kvaliteta sestrinske dokumentacije unutar koje su izdvojene tri glavne kategorije. Prva je važnost sestrinske dokumentacije, koju ispitanici prepoznaju kao službeni i cjeloviti dokument, dopunu medicinskoj dokumentaciji te sredstvo pravne zaštite. Druga su prepreke kvalitetnom vođenju dokumentacije, među kojima dominiraju nedostatak vremena, osoblja, informatičke opreme, velik broj pacijenata te neprilagođenost elektronske dokumentacije. Treća kategorija odnosi se na doprinos sestrinske dokumentacije sigurnosti pacijenata kroz holistički pristup, prevenciju neželjenih događaja i jačanje profesionalne odgovornosti.

Zaključak: Medicinske sestre prepoznaju sestrinsku dokumentaciju kao ključan element kvalitete skrbi i sigurnosti pacijenata te kao pravnu zaštitu pacijenata i osoblja. Kvalitetu dokumentacije otežavaju nedostatak vremena i osoblja, tehnička opremljenost, preopterećenost i neadekvatna prilagodba elektronskog sustava. Unatoč tome, kvalitetna dokumentacija doprinosi sigurnosti pacijenata kroz praćenje stanja, olakšan prijenos informacija, profesionalnu odgovornost i prevenciju neželjenih događaja.

Ključne riječi: Hrvatska, dokumentacija, opće bolnice, sestrinstvo.

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