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NURSING QUALITY: EXPLORING COMPLETENESS AND ACCURACY OF NURSING CARE DOCUMENTATION AT HOSPITAL

Ni Putu Emy Darma Yanti[1], Ni Putu Leni Puswita Sari[2], I Ketut Dian Lanang Triana[3]
[1]Department of Nursing Management and Leadership, Bachelor of Nursing and Professional Nursing Study Program, Faculty of Medicine, Universitas Udayana, Jln P.B. Sudirman, Dangin Puri Klod, Denpasar Barat, Denpasar, Bali 80234, Indonesia
[2]Bachelor of Nursing and Professional Nursing Study Program, Faculty of Medicine, Universitas Udayana, Jln P.B. Sudirman, Dangin Puri Klod, Denpasar Barat, Denpasar, Bali 80234, Indonesia
[3]Post Graduate Program, Universitas Sangga Buana, Jl. Khp Hasan Mustopa No.68, Sukaluyu, Cibeunying Kaler, Bandung, West Java 40123, Indonesia
*emydarmayanti@unud.ac.id

ABSTRACT
Nursing Documentation has significant roles in order to enhancing patient safety. Thus, its accuracy and completeness should perfectly perform based on the standards. This study aims to evaluate the implementation of nursing care documentation among nurses in hospitals. This study employed non-experimental descriptive quantitative research with a retrospective approach and the samples chosen was 114 medical records that met the inclusion criteria using proportional stratified random sampling technique. The research instruments used is an observation sheet for a study documenting the nursing care standards implementation by The Ministry of Health of Republic Indonesia 2005, which has been modified by adding true and false points for each indicator assessed. The data analysis employed univariate analysis which is presented in the form of a frequency's distribution. The study results found that most of the nurses were not able to complete the records correctly by 72,8% as well as grouping the data by 55,3% in the assessment aspects. In the diagnosis and the intervention aspects, most of the nurses are able to completing the documentation perfectly. On the other aspects, the study found that nurses are not able to complete the implementation that refers to the treatment plan by 67 or 58,8%. However, it is also found that the nurses are not able to documented the evaluation refers to objective by 58 or 50,9%. On the general documentation, most of the nurses still are not able to compete the records by standardized format (95;83,3%) as well as put the initials or name clearly and date in the documentation (58;50,9%).

Keywords: accuracy; completeness; nursing care documentation; nursing process

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INTRODUCTION

Nursing services are play pivotal roles to enhance services quality and patient safety. Nursing services are a reflection of the nursing care implementations with the main focus on improving client's health and functionality (Karaca & Durna, 2019; Triana & Yanti, 2018). The nursing process functions as a systematic guide to client-centered care with 5 sequential steps. These are assessment, diagnosis, planning, implementation, and evaluation (Toney-Butler & Thayer, 2023). The role of these stages is very significant and cannot be separated from the importance of the process of documenting nursing care.Documentation of nursing care is a vital component in health services. Thus, can be seen by its significant implications in several aspects including safety and ethics (Ayele et al., 2021; Tajabadi et al., 2020). Nursing documentation considered as a source of clinical information that being a key component in maintaining the legal and professional aspects of nursing (Trisno et al., 2020), and also reflects the implementation of quality and optimal health services (De Groot et al.,

2020). This condition promises to increase patient safety and service quality which having an impact on health service outcomes.

Although nursing documentation implies comprehensive nursing process documentation, the fact that nursing records were not complied to the documentation criteria. Despite by its vital role, it turns out that there are still many reports of lack nursing care documentation widely. A study in Ethiopia stated that 47.8% of nursing care documentation is declared inadequate (Tasew et al., 2019). Previous research also found that the quality of nursing documentation was not optimal, namely assessment 66.8%, diagnosis 88.9%, even the regular intervention was only complete at 11.1% (Silva et al., 2021). The Study in Indonesia previously implies that the quality of nursing documentation was on average level by 77% and was assessed as not reached the health department standard by 85% (Saputra et al., 2019). Other studies also found varies data which about of 15% nursing documentation is found to be incomplete (Sulastri, 2023).The lack of nursing care documentation' completeness reflects the non-optimal nursing care implementation provided, including patient safety. Mathioudakis et al. (2016) by their study stated that incomplete nursing documentation contribute significantly to the potential for medical errors which also pose a potential danger to patients. Therefore, incomplete nursing documentation can also indicate negligence of nursing personnel, which can reflect inappropriate and non-professional nursing actions (Wang et al., 2016). Previous studies explained that inappropriate nursing care documentation causes information gaps related to patient health in order to decide the proper nursing services (Ahn et al., 2016). This condition can certainly disrupt the nursing service process which results in non-optimal health service delivery (Van Graan et al., 2016).

Documentation is a crucial point that must be done precisely and accurately. The implementation of nursing care documentation must be factual, currently exist as well as comprehensive to provide consistent information related to assessment, intervention given, evaluation and the patient's response to the nursing care (Perry et al., 2019). Nursing documentation must merit the established criteria or health standards in order to support the evaluation of professional nursing staff and can guarantee the quality of nursing care provided. This study ought to evaluate the implementation of nursing care documentation among nurses in hospital.

METHOD

This study employed non-experimental descriptive quantitative research with a retrospective approach. The study population were all patients' medical records who had been discharged and been treated for at least 3 days from the inpatient department at Hospital. The sample was selected as 114 medical records that met the inclusion criteria using proportional stratified random sampling technique. The research was carried out from September 2022 to June 2023.The research instruments used is an observation sheet for a study documenting the nursing care standards implementation by The Ministry of Health of Republic Indonesia 2005, which has been modified by adding true and false points for each indicator assessed. The instrument is used to assess the documentation quality in terms of its completeness and accuracy. Those completeness and accuracy aspects was assessed based on the each of 25 components in the observation sheet. It is met the technical guidelines regarding the filling out nursing care documentation for inpatient department that has been produced at the Hospital.The data analysis employed univariate analysis which is presented in the form of a frequency's distribution. This research has passed the ethical and legal aspects and received a certificate of ethical suitability from the Health Research Ethics Committee of Bali Mandara Regional Hospital, Bali Province number: 004/EA/KEPK.RSBM.DISKES/2023.

RESULT

The study results are presented in the form of a frequency distribution table of each statement item assessed in nursing process, namely assessment, diagnosis, planning, implementation, evaluation and general documentation stages (Table 1)

Table 1.
Frequency distribution of nursing documentation (n=144)

No	Aspect	f	%
Assessment			
1.	Data filled in accordance to the assessment guidelines		
	Filled complete and correct	31	27.2
	Not filled or wrong	83	72.8
2.	Data grouped (bio- psycho -social-spiritual)		
	Filled complete and correct	51	44.7
	Not filled or wrong	63	55.3
3.	Patient data from admitted until discharge		
	Filled complete and correct	109	95.6
	Not filled or wrong	5	4.4
4.	Problem formulatedbased on gapbetween patient' health status		
	Filled complete and correct	90	78.9
	Not filled or wrong	24	21.1
Diagnosis			
5.	Nursing Diagnosis based on the problem		
	Filled complete and correct	89	78.1
	Not filled or wrong	25	21.9
6.	Nursing Diagnosis reflect PE/PES		
	Filled complete and correct	77	67.5
	Not filled or wrong	37	32.5
7.	Nursing Diagnosis formulation becomes actual, risk, or potential		
	Filled complete and correct	101	88.6
	Not filled or wrong	13	11.4
Planning			
8.	Based on Nursing Diagnosis		
	Filled complete and correct	101	88.6
	Not filled or wrong	13	11.4
9.	Arranged according to Priority Order		
	Filled complete and correct	90	78.9
	Not filled or wrong	24	21.1
10.	Goals Formulation contains several components such as patient/subject, changes,behavior, condition patient, and or times' criteria (SMART)		
	Filled complete and correct	109	95.6
	Not filled or wrong	5	4.4
11.	Action plan refers to the goal with sentence order, detailed, and clear		
	Filled complete and correct	111	97.4
	Not filled or wrong	3	2.6
12.	Action plan describes of patient or family involvement		
	Filled complete and correct	74	64.9
	Not filled or wrong	40	35.1
13.	Action plan describes health professionals' cooperation		
	Filled complete and correct	80	70.2
	Not filled or wrong	34	29.8
Implementation			
14.	Action is implemented refers to Treatment plan		
	Filled complete and correct	47	41.2
	Not filled or wrong	67	58.8
15.	Nurse observes patients' response to nursing action		
	Filled complete and correct	112	98.2
	Not filled or wrong	2	1.8

No	Aspect	f	%
16.	Revise action based on results evaluation		
	Filled complete and correct	95	83.3
	Not filled or wrong	19	16.7
17.	All action implemented is recorded concise and clearly		
	Filled complete and correct	111	97.4
	Not filled or wrong	3	2.6
Nursing Evaluation			
18.	Evaluation refers to objective		
	Filled complete and correct	56	49.1
	Not filled or wrong	58	50.9
19.	Evaluations' results noted		
	Filled complete and correct	63	55.3
	Not filled or wrong	51	44.7
20.	Documentation based on SOAP (Subjective, Objective, Analysis/ Assessment, And Planning) Format		
	Filled complete and correct	99	86.8
	Not filled or wrong	15	13.2
	General Documentation		
21.	Wrote using standardize format		
	Filled complete and correct	19	16.7
	Not filled or wrong	95	83.3
22.	Recorded based on the action implemented		
	Filled complete and correct	108	94.7
	Not filled or wrong	6	5.3
23.	Notes are written withclear, concise, term by standard And Correct		
	Filled complete and correct	113	99.1
	Not filled or wrong	1	0.9
24.	Nurses write initials/name clearly and date O'clock in every nursing action		
	Filled complete and correct	56	49.1
	Not filled or wrong	58	50.9
25.	All notes were saved in accordance with nursing provision applied		
	Filled complete and correct	114	100
	Not filled or wrong	0	0

DISCUSSION

Nursing Assessment

The study on the assessment stages showed that nursing care documentation obtained results on observation items number one namely "recording the data studied in accordance with guidelines assessment" and part of "grouped data (bio- psycho - social -spiritual)" was not filled or filled wrong. By its percentages, its showed that nurses were unable to categorized the patient's data regarding each of aspect assessed. Nursing assessment plays crucial component of the nursing service system, serving as the foundation for patient-centered care and significantly influencing the nursing quality of care. Nursing assessment considered as a baseline service underlying that all decisions and actions taken by professionals, including nurses (Toney-Butler & Thayer, 2023). The nursing assessment process requires specific and comprehensive understanding namely sharp and focus observation, skilled communication, and implementing of nursing theoretical knowledge (McEwan & Wills, 2021). Nursing assessments implementation performed by close observation and assessment aims to build a complete understanding of the patient's current health status and potential patient care needs based on the necessity (Collins & Small, 2019)

Effective nursing assessment is identified through the very careful collection of patients' important information, which then becomes the basis for a tailored nursing diagnosis and the basis for developing patients care plan (Toney-Butler & Thayer, 2023). Through appropriate

and thoughtful evaluation at the assessment stage, nurses can proactively adapt the interventions, ensuring that patient outcomes consistently lead to the highest standards of nursing care. Despite the theoretical value, our study regarding the implementation of nursing assessment based on the guidelines as well as grouping data still have not done precisely. The nursing assessment process should use the hospital's available format that has been produced and standardized. It was proposed to makes the nurse works easily by its check list format. However, these findings indicated that the nursing assessment is still not optimal.Our study findings are similar to those of other previous studies. Study by Jaya et al. (2019) found that the quality of nursing care documentation was still in the poor category, namely 75%. Likewise, other study found that more than 50% of nurses had not documented the nursing assessment process completely (Astuti et al., 2022). The lack and non-optimal of nursing assessment documentation process can be caused by various factors. Lack of nurses' understanding related the hospital guidelines or procedures to filling out the assessment process may lead to this fact (Gassas, 2021). However, it is really important to how stakeholders can implement the internal evaluation as well as socialization regarding how to make a proper and standardized nursing documentation in well manner (Fredericks et al., 2019).

The nurse's perception regarding the importance of nursing care documentation it's also important to be reason caused this phenomenon. Previous studies stated that there are still lots of nurses who think that nursing documentation as a trivial matter and less important (Jaya et al., 2019; Mangole et al., 2015). However, those factors were not analyzed in this study and may contributed to further research. The lack of nursing assessment documentation will lead to the lack of nursing documentation. Despite its theoretical explanation, the practical knowledge based on the patient complain is also necessary in order to build a proper and perfect nursing diagnoses. It is very important and should be matter of concern for nurses to filled and categorized the data based on the patients' statements to establish better nursing diagnoses as well as nursing care.

Nursing Diagnosis

The formulation of nursing diagnoses plays an important role in patient care and health services. Our study found that at the diagnosis stage based on the three observation items observed, there were most nurses had filled them in completely and correctly. It is also implied that an optimal nursing diagnosis is able to reflect the nurses' good reasoning while formulating the diagnoses based on the patient condition. Our study findings are similar to previous study that stated if nurses proven to be had good diagnoses formulation. Study by Yunawati (2022) found that 54.5% of nurses had written down complete nursing records at the diagnosis stage. Another study also found that 100% nurses had implemented the formulation of nursing diagnoses completely with a total of 52 medical records (Suwignjo et al., 2022).The nursing diagnosis represents a clinical judgment regarding a patient's response to an actual or potential health problem experienced. These assessments are important in guiding the planning and implementation of patient care, contributing significantly to the prioritization of interventions based on patient-centered outcomes (Doenges et al., 2022).

The formulation of nursing diagnosis is very important through implementing the identification process and assessment results in accordance with clinical nursing recommendations. This component is considered very important in providing holistic and comprehensive patient care (Kinchen, 2019). The identification of patient needs through assessment which is then conveyed into a diagnosis allows nurses to formulate a comprehensive understanding of the patient's health problems and challenges, thus enabling

them to provide care (Doenges et al., 2022; Lotfi et al., 2021). The other importance of nursing diagnoses formulation is the ability to determining patient priorities and build a prospective nursing care plan (De Groot et al., 2022). Thus will help health professionals, in this case a nurse to create strategic nursing care plans that meet the patient's most critical needs while meeting other needs (Doenges et al., 2022). By using diagnosis as a framework, nurses could implement systematic strategies that emphasize patient well-being, leading to overall improvement of nursing services (Asmirajanti et al., 2019; Doenges et al., 2022)Nursing diagnoses can also play a significant role in improving patient safety. Nursing diagnoses help to identify potential health problems that contributing significantly to the side effects reduction. For an instance, by diagnosing potential risks, nursing personnel can take proactive actions that lead to a reduction in patient-related complications (Bjerkan et al., 2021). Additionally, the role of nursing diagnoses promising huge impact in order to improve the quality of health care. A well-formulated nursing diagnosis facilitates improved patient care planning, thereby improving the overall quality of nursing services and ensuring patient-centered outcomes (Doenges et al., 2022). By perfect nursing diagnoses, healthcare providers can prioritize and implement effective interventions to meet patient needs quickly and comprehensively.

Nursing Care Planning

The results of our data analysis at the planning stage were not much different from the diagnosis stage. The majority of nurses have filled out intervention documentation based on six observation indicator items completely and correctly. It is meaning the nurses had been professionals to documented their nursing care plan. Our study is similar to the other study findings which found that almost all nurses had completed the nursing intervention completely. Suwignjo et al. (2022) from their study found that 48 out of 4 medical records or 92.31% had written nursing interventions completely. Another study also found that 61.96% of nurses had written the nursing care plans completely as stages of nursing care for patients (Juniarti et al., 2020). Nursing interventions, as an important aspect of the nursing process considered as an integral part of ensuring positive patient outcomes (Potter et al., 2021). Nursing interventions play an important role in patient care, is an important part of the nursing process and is critical to the quality of patient outcomes. These interventions are not just routine tasks; and evidence-based that ensure patient well-being and are indispensable for promoting enjoyable healthcare experiences ((Potter et al., 2022; Younas & Quennell, 2019). In essence, the implementation of thoughtful nursing interventions is synonymous with the delivery of high-quality nursing services that ultimately shape the patient's recovery trajectory and level of satisfaction.

Nursing interventions are able to foster a culture of safety and trust which considered as critical elements for a healing environment, and contribute directly to the alleviation of preventable patient injuries that matters as an important indicator of excellence in healthcare delivery (Sherwood & Barnsteiner, 2021). Nursing interventions, when implemented effectively, are the basis for maintaining and improving patient safety (Gunawan & Hariyati, 2019; Zaitoun et al., 2023). By diligently adhering to proven principles and systematic guidelines, nurses can significantly minimize the occurrence of preventable harm others namely encouraging patient participation, encouraging collaborative practices among healthcare providers, and rigorously implementing standard care processes are known to contribute greatly to safer patient outcomes (Vaismoradi et al., 2020). These components of nursing care are not simply recommendations; it is an integral part of a safety culture in a healthcare environment, ensuring that the risk of error and patient harm is minimized as much as possible (Arnold & Boggs, 2019).

Adherence to strict nursing documentation practices plays an important role in ensuring the quality and continuity of patient care, ultimately driving positive outcomes (Al Munajjam et al., 2023). When nursing staff meticulously keeping the patient records, they provide a strong foundation for sharing knowledge among their colleagues, fostering effective communication that is critical in the multifaceted healthcare environment. Proper documentation not only facilitates smooth handover and supports clinical decision making but also builds accountability (Tajabadi et al., 2020), allows for a clear audit trail for nursing services provided and enables accurate assessment of treatment outcomes (Bjerkan et al., 2021). In this case, documentation serves as a key in the nursing process, helping maintain patient safety by ensuring that pertinent information is captured accurately and accessible to all health care providers involved (Tasew et al., 2019). The effectiveness of nursing interventions in the nursing process is paramount, because it directly impacts patient safety, satisfaction levels, and the broader spectrum of health care outcomes. Recognizing the impact of systemic factors while actively engaging in continuous improvement is critical to improving nursing care practice. This, in turn, will provide better outcomes for patients if care delivered safely and compassionately is the benchmark. In addition, implementing a culture that encourages continuous learning and adherence to patient safety principles is the basis for improving the quality of services provided by nurses (Vaismoradi et al., 2020; Zegers et al., 2020).

Nursing Care Implementation

This study results at stage of nursing implementation showing that mostly nurse have not out action yet based on nursing intervention. Nursing documentation is a key component in patients' maintenance, which could function as tools of communication that important among nursing service and plays an important role to ensure patients safety and optimal health outcomes. Our study found that it was less similar to the other studies findings. Juniarti et al. (2020) found that nurses had completed documentation on the nursing care implementation by 64.80%. Likewise, Suwignjo et al. (2022) by their research stated that 40 medical records or 76.92% of nursing implementation documentation had been filled in completely. Therefore, another study also found that most of the nurses are able to completing the implementation phases sufficiently by 66% (Trisno et al., 2020). The differences between these findings compared to our study could be influenced by several factors. Tasew et al. (2019), states that the nursing care documentation process can varies depending on nursing personnel characteristics such as gender, age, training and even supervision of the head of the room. However, some of these factors were not examined and analyzed in this study and could be the limitation of our study.

Nursing documentation quality is not only meeting legal and professional requirements, but also serves as a comprehensive record of the patient's history, medications, and response to the nursing care. Nursing implementation documentation is critical point to improving patient care by ensuring efficient integration of evidence-based nursing practices (Kitson et al., 2021; McCarthy et al., 2019). This results is improved the patient outcomes, alleviated the hospital-acquired infections, and minimized medication errors (Vaismoradi et al., 2020). Through effective implementation, nursing services are also able to simplify processes, optimize resource allocation, and provide personalized care tailored to each patient's unique needs (Lotfi et al., 2021). This, in turn, fosters a culture of continuous improvement, ensuring that the highest quality and safety standards are met consistently.Patient outcomes improvements are a direct result of the nursing implementation, with a focus on evidence-based nursing practice that leads to an alleviation of hospital-acquired infections and elevated patient satisfaction scores (Aiken et al., 2021). Additionally, the streamlined nursing processes have

contributed significantly to more effective nursing service delivery, enabling faster response times and better allocation of resources to meet patient needs immediately. This has increased efficiency by optimizing workflow management, reducing documentation errors, and ultimately improving the overall quality of nursing services (Makota et al., 2023).

Nursing implementation is critical in providing high-quality patient care. By ensuring the implementation of effective nursing practices, hospital can continually improve patient care through evidence-based interventions and streamlined processes. Embracing innovation and growth in nursing implementation allows for the incorporation of new technologies and best practices, ultimately improving the overall quality of nursing services. As a result, patients receive the best possible nursing service while professional nursing personnel can operate efficiently in a rapidly evolving medical landscape.

Nursing Evaluation

Our results of data analysis obtained one of the observation items from the nursing care documentation sheets especially at the evaluation stage showing that mostly the nurses have fill completely and correct. However, we still found if that is still not refers to the purpose of nursing intervention.Our findings are supported from previous research study. The study previously stated that almost all over the nurse has fill the nursing evaluation completely by 96.15 (Suwignjo et al., 2022).The Other studies also found that the most nurses has fill in the evaluation points correctly by 60% (Trisno et al., 2020). The Nursing Evaluation considered as critical point in the nursing process. It is purposing as an indispensable standard of measurements tools for evaluating the intervention effectiveness as well as decisive nursing care based on the necessity (Toney-Butler & Thayer, 2023). Through careful observation, data collection, as well as perfect data analysis, nurse can ensure the purpose of the treatment that need to be achieved or considering the alternative approach is required. This continuous evaluative cycle is not only ensuring the provision of high-quality, patient-centered services, but also fosters a culture of continuous improvement in the healthcare system. By consistently evaluating and improving their practices, nurses can optimize care delivery, increase patient satisfaction, and contribute to better overall health outcomes for the individuals they care for (Ferreira et al., 2023).

Nursing evaluation is an integral and indispensable component of the nursing process, a systematic framework that guides nurses in providing comprehensive and individualized patient care (Potter et al., 2021). This requires a methodical assessment of the patient's response to implemented nursing interventions and progress in achieving pre-determined goals. The importance of nursing evaluations cannot be overstated, as they serve as important feedback, allowing nursing personnel to assess the effectiveness of their nursing interventions and make necessary adjustments to optimize patient outcomes (Piro & Ahmed, 2020). By continually evaluating and re-assessing a patient's condition, nurses can identify areas that require further attention or modification, ensuring that the care provided is tailored to each individual's unique needs. Additionally, nursing evaluation plays an important role in improving the overall quality of health care by promoting evidence-based practice, encouraging continuous improvement, and facilitating effective communication among interdisciplinary health care teams (Gutierrez-Puertas et al., 2020; Mahmood et al., 2021). The nursing process culminates in the evaluation phase, an important step that assesses the effectiveness of implemented nursing interventions and the overall plan of nursing care. Through careful evaluation, nurses can determine whether the patient's desired outcomes have been achieved, identify deviations or unmet goals, and make necessary adjustments to optimize care delivery. This critical analysis not only improves the quality of care for

individual patients but also drives continuous improvement in nursing practice, contributing to broader efforts to achieve excellence in health care. By systematically evaluating results, nurses gain valuable insights that inform assessment, diagnosis, and future care planning, driving a cyclical process of refinement and adaptation to meet patients' evolving needs.

General Documentation

This study showed that the majority of nurses do not fill out or do not write nursing care documentation in a standard format. Besides, every action/activity the nurses carries out does not include clear initials/names and the complete date of the action.These findings are not in line with the other previous studies findings. De Groot et al. (2020) in their research found that the majority of nursing documentation had been filled in completely by 71.15%. Likewise, other research shows that almost all nursing implementation documentation is 76.9% (Juniarti et al., 2020).Nursing documentation can be described as a reflection of the entire process of providing direct nursing care to patients (De Groot et al., 2022). High-quality nursing documentation is a fundamental component of patient care, playing a critical role in improving the quality of care and ensuring perfect patient outcomes. The completeness and accuracy of nursing notes serves as the basis for clinical decision making and continuity of care (Zegers et al., 2011). Inadequate documentation practices can lead to adverse events and medical errors, whereas thorough record-keeping is associated with improved patient safety (McCarthy et al., 2019). Therefore, the focus on nursing care documentation has grown, with research showing that effective documentation contributes to patient care by facilitating communication among health professionals and supporting nursing care management (Gutierrez-Puertas et al., 2020).

Nursing care documentation is an important practice that requires careful and systematic recording of all pertinent patient information by healthcare professionals. This process serves as an integral part of patient care and treatment, providing a comprehensive picture of the patient's health history, treatment plan, nursing interventions, medications, and response to care. The goals fulfilled by these systems go beyond record keeping, as they ensure continuity of care, support diagnostic and therapeutic decision making, and ultimately contribute to the evaluation of patient outcomes.One of the identified barriers to quality of nursing care documentation is individual factors that influence healthcare professionals' documentation practices. These individual factors include knowledge, attitudes, workload, and level of proficiency of health service providers in using documentation systems (Asmirajanti et al., 2019; Dawood, 2021; De Groot et al., 2022)Varying expertise among practitioners often leads to inconsistencies in the details and accuracy of nursing documentation. In addition, personal perceptions and understanding of the importance of thorough documentation can significantly influence the quality of recorded data (Cocchieri et al., 2023). When the benefits of thorough record keeping are not well appreciated, documentation can be misused or underutilized, which will certainly reduce the quality of patient care.The quality of nursing care documentation is critical to the overall quality of services offered to patients, and acts as a foundation in the health care delivery system. Proper and comprehensive documentation ensures effective communication between healthcare providers, which is fundamental for continuity of patient care and for avoiding medical errors (Bjerkan et al., 2021). As Akhu-Zaheya et al. (2018) explained, careful recording of nursing interventions allows evaluation of patient outcomes, strengthening the quality of services provided. Additionally, good documentation practices serve as a reflection of service standards, greatly influencing the patient experience and perceived quality of healthcare institutions.

CONCLUSION

The description regarding the quality of nursing care documentation at the Hospital was found to be of not in optimum quality. Each aspect obtained very perfect condition, however the other should need to be optimize. The optimalization needs to be carried out at the nursing assessment process by grouping the data found based on their categorical aspects such as biological, psychological, social and spiritual aspects. The improvements also need to be a concern of matter regarding the evaluation point that needs to be referring to the nursing care plans' objectives, put the initial and date as well as time to ensure the patient safety. Overall based on this finding, the nurses need to follow the guidelines from the hospital regarding the nursing documentation standards. Thus, significant improvements will ensure the professional nursing services as well as the perfect nursing services based on the standards. This research has limitations that not identify the factors which can contribute to the nursing documentation. It is advised to carry out further research both qualitatively and quantitatively in order to assess the quality of nursing care documentation by assessing both medical records and observation to the nurses. The examination on regarding the factors that influence the quality of nursing care documentation is also needed for further research.

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