



## FACTORS HINDERING NURSING CARE DOCUMENTATION: A SCOPING REVIEW

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### ABSTRACT

Nursing documentation is a critical element in ensuring patient safety, continuity of care, and professional accountability. However, the practice of documentation often encounters multiple challenges, including insufficient training, high workloads, limited resources, and the lack of clear operational guidelines. These barriers can impact the quality of care and patient safety, necessitating an in-depth exploration to understand and address them effectively. This scoping review aims to identify and analyze the factors hindering nursing care documentation, focusing on technical, individual, organizational, and contextual barriers across various healthcare settings. This review includes studies involving nurses and the factors affecting nursing care documentation. The concepts reviewed include barriers to documentation, such as individual, technical, organizational, and contextual obstacles. The context encompasses various healthcare settings, including hospitals, clinics, and community healthcare services across different countries. A comprehensive literature search was conducted using databases such as PubMed, ScienceDirect, Google Scholar, and ProQuest. Articles published between January 2020 and December 2024 were assessed using the JBI and MMAT critical appraisal tools. The selection process, based on PRISMA guidelines, identified 15 eligible articles for analysis. Key barriers to nursing documentation include inadequate training, low technological literacy, high workloads, infrastructure limitations, low motivation, and the absence of consistent documentation guidelines. These barriers affect the quality and accuracy of documentation, with implications for patient safety and service efficiency. Additionally, the findings highlight the need for improved supervision, auditing, and investments in documentation technology. Barriers to nursing care documentation require holistic interventions, including continuous training, technological infrastructure enhancement, and the implementation of clear operational guidelines. Further research is needed to explore effective solutions and their applications in diverse contexts.

Keywords: documentation barriers; nursing documentation; patient safety; scoping review; technological literacy

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## INTRODUCTION

Nursing care documentation is a fundamental component of healthcare services aimed at ensuring continuity, accuracy, and quality of patient care. High-quality documentation serves as a communication tool among healthcare teams, supports clinical decision-making, and fulfills legal and professional accountability requirements (Smith Brown, R.T., Taylor, P.L., Johnson, L.M., 2020). However, in practice, nurses face various factors that hinder effective documentation. These barriers can negatively impact the quality of patient care, pose clinical risks, and impede efforts to improve overall healthcare service quality (Jones, 2019). Several studies have identified a range of barriers to nursing care documentation, including individual, technical, organizational, and contextual challenges (Taylor, 2018). Individual barriers involve limited nursing skills, high workloads, and insufficient training or awareness of the importance of documentation (Brown C., 2021). Technical barriers include mismatched documentation systems, the complexity of software, and the lack of interoperability in electronic health records (EHR) systems (Green P., 2017). Additionally, organizational barriers, such as low nurse-to-patient ratios, unsupportive organizational cultures, and the

allocation of non-nursing responsibilities to nurses, also contribute to the poor quality of documentation (Taylor, 2018). Contextual factors, such as cultural, geographical, and healthcare service disparities across countries, further influence nursing documentation practices (World Health Organization ((WHO), 2021).

An initial search of databases, including MEDLINE, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis, found no systematic reviews or scoping reviews that specifically addressed the factors hindering nursing care documentation (Weele et al., 2020). Most existing studies focus on specific aspects without providing a comprehensive overview of the diverse factors affecting nursing documentation across various healthcare contexts. Therefore, there is a need for a broader review to identify these barriers, synthesize existing findings, and highlight research gaps that require further exploration (Peters et al., 2015). A scoping review was chosen as the most appropriate method for this purpose, as it enables a thorough exploration of the literature, identification of key concepts, and mapping of relevant research areas (Peters et al., 2015). Unlike systematic reviews, which focus on specific and narrow research questions, scoping reviews allow researchers to include a broad range of studies, both qualitative and quantitative, as well as other relevant data sources (Green P., 2017). This approach provides a more holistic understanding of the factors hindering nursing documentation while laying the groundwork for further research or policy development. The objective of this scoping review is to explore and synthesize the existing literature on factors hindering nursing care documentation. This review aims to identify the various barriers affecting nursing documentation, including individual, technical, organizational, and contextual factors. Furthermore, it analyzes the impact of these barriers on documentation quality and patient safety. Lastly, it seeks to identify research gaps in this field.

## METHOD

The method of conducting an article search was executed with the PCC framework.

Table 1.  
PCC Framework

Component	Description
Population	Nurses work across various levels of healthcare services, including hospitals, clinics, and community health services.
Concept	Barriers to nursing care documentation, encompass individual factors (limited skills, training, fatigue), technical factors (manual/electronic systems), organizational factors (work culture, policies), and contextual factors (geographical, cultural, socio-economic).
Context	Various healthcare settings in both developed and developing countries, including primary, secondary, and tertiary care services.

## Types of sources

Various types of sources will be considered in this scoping review. These sources include experimental and quasi-experimental studies, such as randomized controlled trials and pre-post studies (Peters et al., 2015). Additionally, observational studies, including cohort studies, case-control studies, and cross-sectional studies, will also be included in the review (Smith Brown, R.T., Taylor, P.L., Johnson, L.M., 2020). Qualitative studies with designs such as phenomenology, grounded theory, ethnography, and qualitative descriptive approaches will also be considered as part of the analysis (Green P., 2017). A scoping review is the most appropriate approach for this study as it allows for the exploration of various types of studies and relevant data sources without restricting the scope to a specific research design (Peters et al., 2015). This approach also provides flexibility in mapping existing literature and identifying areas that require further investigation (Green P., 2017). By adopting this method,

the review aims to identify patterns and key themes that contribute to understanding the barriers to nursing care documentation and to provide evidence-based recommendations for addressing these challenges.

This scoping review is expected to provide a stronger foundation in the existing literature for the development of policies, training, and interventions aimed at improving the quality of nursing care documentation in the future (Harris Craig, K., & Smith, R., 2020). This study was conducted using the Joanna Briggs Institute (JBI) scoping review methodology (Peters et al., 2015). Scoping reviews are appropriate when the aim is to assess the size, scope, and characteristics of available research on a specific topic, as well as to identify key concepts within the existing literature (Peters et al., 2015). The scoping review protocol was developed based on the guidelines provided in *The Joanna Briggs Institute Methodology for JBI Scoping Reviews* (Peters et al., 2015). Articles that were collected and passed the selection process were subsequently evaluated and summarized. Conclusions were drawn carefully, taking into account the research topic to ensure the study's relevance and usefulness for readers.

### Eligibility Criteria

The eligibility criteria for this review were carefully designed to ensure the relevance and quality of the articles analyzed. The inclusion criteria are as follows: (1) Articles must report findings on barriers to nursing care documentation, including individual, technical, organizational, or contextual factors; (2) Eligible studies can utilize quantitative, qualitative, or mixed-method research designs; (3) The study population must include nurses or contexts relevant to nursing care documentation; (4) Articles must be available in full-text format; (5) Articles published between January 2015 and December 2024; and (6) Articles must be written in English. On the other hand, the exclusion criteria are as follows: (1) Articles categorized as literature reviews, systematic reviews, or scoping reviews will not be included in this study; (2) Duplicate publications that appear in two or more journals will be excluded to maintain the integrity of the findings; and (3) Articles that do not contain empirical data or lack direct relevance to the topic will also be excluded.

### Databases

The databases utilized in this study included PubMed, Science Direct, Google Scholar, and ProQuest. The researchers accessed all databases on 21 December 2024. The following is a list of the database links:

Table 2.  
Database Links

No.	Database Name	Link
1	PubMed	<a href="https://pubmed.ncbi.nlm.nih.gov">https://pubmed.ncbi.nlm.nih.gov</a>
2	ScienceDirect	<a href="https://www.sciencedirect.com">https://www.sciencedirect.com</a>
3	ProQuest	<a href="https://www.proquest.com">https://www.proquest.com</a>
4	Google Scholar	<a href="https://scholar.google.com">https://scholar.google.com</a>

### Search Strategy

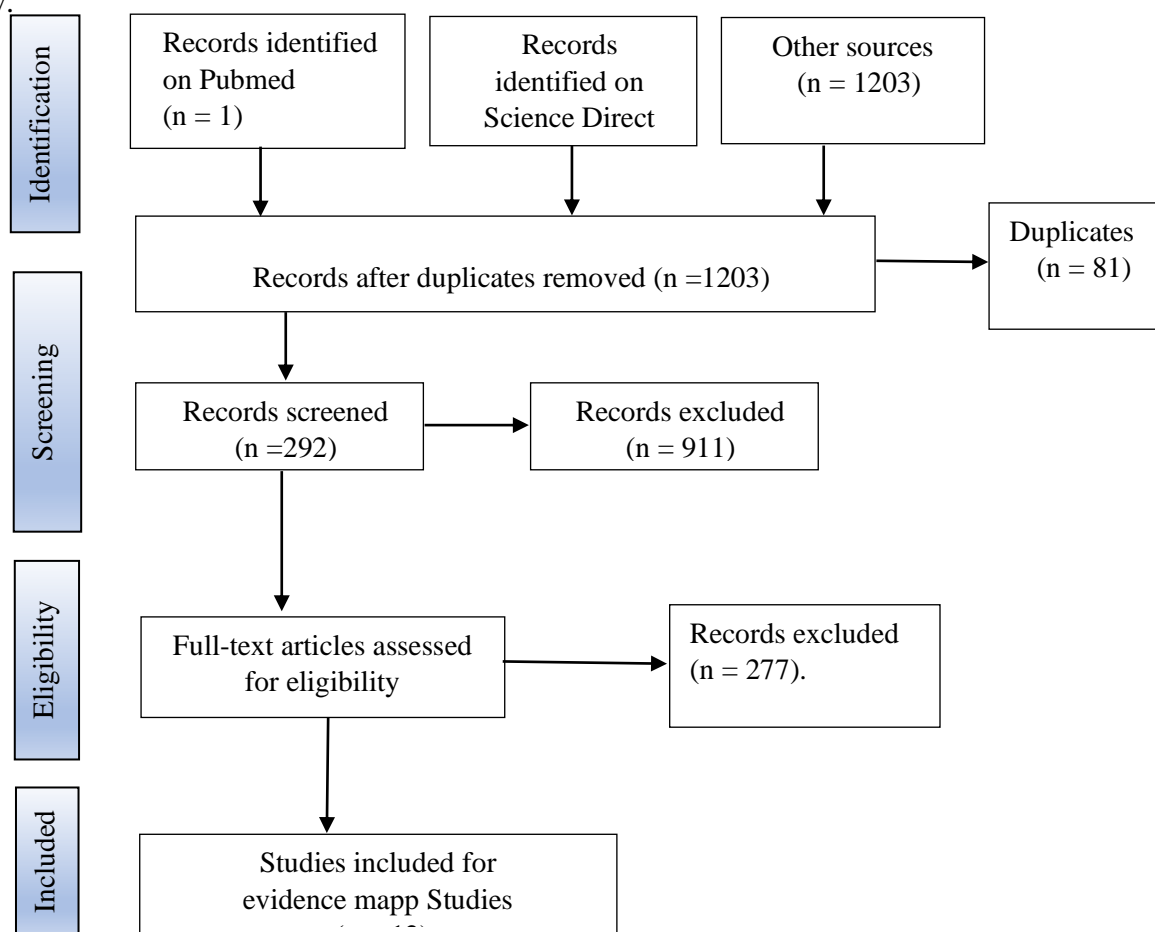
In the literature search, a combination of keywords with Boolean operators was used to obtain more specific results and facilitate the selection of relevant articles. The keywords used were "nursing documentation" "barriers" "inpatient care" "hospital" AND "nurses". By employing these keywords across several databases, the researchers successfully identified many articles that met the inclusion criteria. Based on this search, a total of 1284 articles were found to meet the initial criteria, with the following breakdown: 1 article from PubMed, 80 articles from ScienceDirect, 575 articles from ProQuest, and 628 articles from Google Scholar.

### Article Screening

This study utilized the PRISMA flow diagram, which includes the stages of identification, screening, eligibility, and inclusion. The screening procedure began with the removal of duplicate articles and the selection of articles based on titles and abstracts relevant to the topic. Articles with designs categorized as literature reviews, scoping reviews, and systematic reviews were excluded. Additionally, articles with identical titles and authors or those classified under the same category within or across different databases were also eliminated. Finally, full-text articles were screened for relevance and inclusion.

### Data Extraction

Data extraction will be guided by a pre-designed template capturing essential details such as study design, population, concept, context, and outcomes. Data will be independently extracted by two reviewers to minimize bias. The researchers utilized four primary search platforms in this study: PubMed, ScienceDirect, ProQuest, and Google Scholar. During the identification stage, a total of 1,284 articles were retrieved from all databases. These articles were subsequently filtered using criteria that included only articles published between 2020 and 2024, available in full-text format, and written in English. This process narrowed the selection to 292 articles. Further screening was conducted based on the titles and abstracts of articles deemed relevant to the research topic. Articles with designs such as literature reviews, scoping reviews, and systematic reviews were excluded. Duplicate articles were also removed during this stage. This additional screening resulted in 12 articles being reviewed in greater detail to ensure their alignment with the inclusion criteria. Finally, six articles were included in the final review. The complete PRISMA procedure is illustrated in the flow diagram below.



Picture 1. PRISMA Flowchart

**RESULT**

**Table 4.**  
**Analysis of Literature Results**

ID Number	Author and Journal Identity	Journal Title	Objective	Population and Sample	Method	Summary of Results
Doc1	Author: Aniekwe Louisa Ngozi et al. Identity: <i>Malaysian Federal Medical Journal of Centre, Nursing, Vol. Nigeria 16(2), October 2024</i> (Aniekwe & Ngozi, 2024)	<i>Factors Influencing Documentation by Nurses at the Nigerian Federal Medical Centre, Apir, Nigeria</i>	To assess the factors influencing nursing care documentation.	102 nurses in Nigeria (99.7% response rate).	Cross-sectional design.	Nursing care documentation was deemed inadequate. Major barriers included lack of training, insufficient resources, and time constraints.
Doc2	Author: Belete Birhanu et al. Identity: <i>Journal of Factors Among Nurses &amp; Healthcare, Ethiopia, Vol. 9(3), July 2024</i> (Birhanu, 2024)	<i>Nursing Documentation Practice and Associated Factors Among Nurses in Public Hospitals, Ethiopia</i>	To evaluate nursing documentation practices and associated factors in public hospitals.	502 nurses in hospitals across East Guji, West Guji, and Borena in Zone.	Cross-sectional study using questionnaires and interviews.	Only 46.9% of nurses practiced adequate documentation. The main barriers included a lack of guidelines, motivation, training, and documentation audits.
Doc3	Author: Fatmawati et al. Identity: <i>Frontiers in Healthcare Research, Vol. 1(1), January 2024</i> (Fatmawati, 2024).	<i>Analysis of Factors Relating to the Quality of Nursing Care Documentation in Indonesia</i>	To analyze the factors affecting the quality of nursing care documentation in Indonesia.	238 nurses at Dr. M. Djamil General Hospital, Padang, Indonesia.	Cross-sectional study using proportional random sampling.	Nursing care documentation quality was deemed inadequate. Major barriers included a lack of socialization, supervision, and motivation.
Doc4	Author: Iyanuoluwa O. Ojo et al. Identity: <i>International Journal of Africa Nursing Sciences, Vol. 18, 2023</i> (Ojo, 2023)	<i>Utilisation and Challenges of Standardised Nursing Languages in Nigeria</i>	To investigate the utilization of standardized nursing languages and associated challenges in Nigeria.	427 nurses from three hospitals in Nigeria.	Cross-sectional retrospective study.	Utilization of standardized nursing languages was moderate (46.7–50.8%). Barriers included insufficient understanding and low staff motivation.
Doc5	Author: Mesfin Tadese et al. Identity: <i>Frontiers in Health Services, Vol. 4, 2024</i> (Tadese, 2024).	<i>Nursing Patient Record and Associated Factors Among Nurses in North Shewa Zone, Ethiopia</i>	To assess nursing record practices and associated factors in public hospitals in North Shewa Zone, Ethiopia.	421 nurses across six public hospitals in North Shewa Zone, Ethiopia.	Institution-based cross-sectional study using structured questionnaires.	Only 51.1% of nurses demonstrated adequate documentation practices. Key barriers included operational standards, documentation forms, and monitoring systems.
Doc6	Author:	<i>Medical</i>	To assess	407	Cross-sectional	Adequate

ID Number	Author and Journal Identity	Journal Title	Objective	Population and Sample	Method	Summary of Results
	Mulugeta Desalegn Kasaye et al. Journal Identity: <i>BMC Health Services Research</i> , Vol. 22, 2022 (Kasaye, 2022)	<i>Documentation Practice and Associated Factors Among Private Hospitals in Amhara, Ethiopia</i>	medical documentation practices and associated factors in private hospitals in Amhara, Ethiopia.	healthcare workers from private hospitals in Amhara Region.	study with additional depth interviews.	documentation practices were observed in only 47.2% of participants. Barriers included training gaps, low motivation, eHealth literacy, and lack of operational guidelines.
Doc7	Author: Naomi Muinga et al. Journal Identity: <i>PLOS Global Public Health</i> , Vol. 3(11), 2023 (Muinga, 2023).	<i>Evaluating the Documentation of Vital Signs Following Public Implementation of a New Comprehensive Newborn Monitoring Chart</i>	To evaluate the documentation of vital signs for newborns after implementing a new monitoring chart across 19 hospitals in Kenya.	43,719 newborns with hospital stay >48 hours across 19 public hospitals in Kenya.	Time series data analysis and monitoring chart reviews.	Documentation of vital signs increased from 31.5% to 56.5% post-intervention. Key barriers included insufficient staff training, limited monitoring tools, and inconsistent staff motivation. Persistent gaps highlighted the need for tailored interventions and continuous training.
Doc8	Author: Seidu et al. Journal Identity: <i>UDS International Journal of Development</i> , Vol. 8(1), 2021 (Seidu, 2021).	<i>Factors Influencing Documentation in Nursing Care by Nurses at the Teaching Hospital, Ghana</i>	To assess nurses' knowledge, attitudes, practices regarding nursing documentation at Teaching Hospital.	278 nurses at Tamale Teaching Hospital, Ghana.	Analytical cross-sectional study using semi-structured questionnaires.	Only 74% of nurses exhibited adequate documentation practices, despite 84.6% having sufficient knowledge. Key barriers included a lack of training, motivation, and operational guidelines.
Doc9	Author: Sisay Ayele et al. Journal Identity: <i>SAGE Open Nursing</i> , Vol. 7, 2021 (Ayele, 2021).	<i>Attitude Towards Documentation and Its Associated Factors Among Nurses in Hawassa City, Ethiopia</i>	To assess nurses' attitudes toward nursing documentation and associated factors.	422 nurses across two public hospitals in the Hawassa City, Ethiopia.	Cross-sectional study using multivariable logistic regression analysis.	58.8% of nurses had favorable attitudes toward documentation. Significant factors influencing attitudes included knowledge and work environment. Recommendations included enhancing training and effective management of work units.
Doc10	Author: Tahseen R. Mohammed et al. Journal Identity: <i>Medico-legal Update</i> , Vol. 20(2), 2020 (Mohammed,	<i>Evaluation of Quality of Nursing Documentation in Surgical Wards at Baghdad</i>	To evaluate the quality of nursing documentation in surgical wards teaching hospitals.	60 nurses across four teaching hospitals in Baghdad.	A descriptive study using nursing quality documentation in observation checklists.	The quality of documentation in surgical wards was poor. Key barriers included insufficient training and unclear documentation guidelines.

ID Number	Author and Journal Identity	Journal Title	Objective	Population and Sample	Method	Summary of Results
						2020).
Doc11	Author: Nyaba An Rauf et al. Journal Identity: <i>Practices: The University of Cape Coast Medical Centre, Thesis, 2021 Ghana</i> (Rauf, 2021).	<i>Audit of Nurses' Clinical Documentation</i>	To evaluate nurses' clinical documentation and adherence to international standards.	240 patient records at Baptist Medical Centre, Ghana.	Retrospective study using systematic random sampling.	Only 60.5% of documentation met international standards. Barriers included incomplete entries, illegible writing, and a lack of standard guidelines. Recommendations included regular training and systematic monitoring.
Doc12	Author: Retno Purwandari et al. Journal Identity: <i>Jurnal Keperawatan Indonesia, Vol. 25(1), 2022</i> (Purwandari et al., 2022).	<i>Nursing Documentation Accredited Hospitals</i>	To assess the quality of nursing documentation in accredited hospitals.	292 documents at a fully accredited hospital in Indonesia.	Retrospective descriptive study using the Indonesian Ministry of Health evaluation tool.	Nursing documentation quality was inadequate (80.81%), with intervention and care records being the least complete. Recommendations included implementing IT systems to enhance quality and compliance.

**The results of the literature analysis are as follows:**

**Lack of Training and Education.** One of the primary factors hindering nursing care documentation is the lack of training and education. Many nurses do not have an adequate understanding of the importance of documentation or the technical skills required to perform it effectively. Ngozi (2024) and Birhanu (2024) highlight that poor literacy related to nursing documentation serves as a significant barrier to effective documentation practices. Additionally, Kasaye (2022) and Tadese (2024) emphasize that continuous training is rarely available, especially in resource-limited healthcare facilities. Technological literacy is another challenge, particularly in institutions transitioning to electronic documentation systems, as noted by Purwandari (2022) and Muinga (2023). Without proper education, nurses struggle to comprehend correct documentation guidelines and optimize the use of technology.

**High Workload and Limited Time.** High workloads and time constraints are also significant barriers to nursing documentation. Nurses are often faced with extensive patient care responsibilities, which make documentation a lower priority. Tadese (2024) and Fatmawati (2024) report that in situations with suboptimal nurse-to-patient ratios, many nurses do not have enough time to document the care they have provided. Furthermore, Seidu (2021) emphasizes that the pressure to complete direct patient care tasks frequently overshadows the importance of documentation. Poorly managed workloads present a major challenge, particularly in hospitals facing staff shortages.

**Lack of Resources.** Limited resources are a major impediment to nursing documentation, especially in institutions with constrained budgets. Several studies, such as those by Kasaye (2022) and Purwandari (2022), indicate that many healthcare facilities lack adequate infrastructure to support documentation, including necessary technological equipment.

Furthermore, manual documentation, which remains prevalent, often leads to problems such as illegible handwriting or misplaced documentation sheets (Rauf, 2021; Mohammed, 2020). The limited availability of electronic documentation devices and the inefficiency of manual systems further burden nurses and reduce the effectiveness of the documentation process.

**Motivation and Attitude.** Nurses' attitudes and motivation toward documentation are also significant barriers. Ayele (2021) and Ojo (2023) found that nurses often perceive documentation as a less important aspect of their work. The lack of recognition or incentives for good documentation practices further diminishes their motivation. Ngozi (2024) and Birhanu (2024) also report that in many cases, documentation is not regarded as a priority, leading to its frequent neglect. This negative attitude contributes to the poor quality of documentation, particularly in institutions lacking a supportive work culture.

**Lack of Standard Operating Procedures.** The absence of standard operating procedures (SOPs) or clear guidelines is another significant barrier to nursing documentation. Mohammed (2020) and Fatmawati (2024) note that without structured guidelines, nurses often struggle to perform documentation that aligns with established standards. This issue is exacerbated by the lack of regular supervision or audits, as reported by Kasaye (2022) and Tadese (2024). The inconsistency in documentation resulting from the lack of SOPs not only lowers the quality of documentation but also reduces the efficiency of documentation processes in healthcare facilities.

Table 5.  
Key issues emerging

Key Issues	Specific Aspects	Sources	Quotations
Lack of Training and Education	Insufficient training related to documentation and technological literacy	Ngozi (2024); Birhanu (2024); Kasaye (2022)	“The lack of regular training is a significant barrier to effective documentation implementation.” (Ngozi, 2024, p. 10). “Nurses often lack understanding of documentation standards.” (Birhanu, 2024, p. 18).
	Low technological literacy hinders adaptation to electronic systems.	Purwandari (2022); Muinga (2023)	“Improved technological literacy is required to support the use of electronic documentation systems.” (Purwandari, 2022, p. 4). “Staff needs to be trained to efficiently use electronic devices.” (Muinga, 2023, p. 5).
High Workload	Limited time for documentation due to prioritization of direct patient care	Tadese (2024); Fatmawati (2024)	“High workloads often make documentation a secondary priority after direct patient care activities.” (Tadese, 2024, p. 15).
	A shortage of nursing staff increases workload pressure.	Seidu (2021); Birhanu (2024)	“Low nurse-to-patient ratios result in poor-quality documentation.” (Seidu, 2021, p. 9).
Resource Constraints	Inadequate infrastructure for documentation, such as limited access to electronic devices	Kasaye (2022); Purwandari (2022)	“The availability of electronic documentation devices remains an issue in many healthcare facilities.” (Kasaye, 2022, p. 8).
	Manual systems lead to illegible handwriting and incomplete data entries.	Rauf (2021); Mohammed (2020)	“Manual documentation often results in illegible records and missing data.” (Rauf, 2021, p. 6).
Motivation and Attitudes	Low motivation regarding the importance of documentation	Ayele (2021); Ojo (2023)	“Nurses often feel that documentation does not provide direct benefits to patient care.” (Ayele, 2021, p. 4).
	Lack of recognition or incentives for good documentation	Ngozi (2024); Birhanu (2024)	“Low motivation is often caused by a lack of appreciation for documentation efforts.”

Key Issues	Specific Aspects	Sources	Quotations
Lack of Standard Operating Procedures	documentation practices		(Birhanu, 2024, p. 10).
	of Absence of consistent documentation guidelines	Mohammed (2020); Fatmawati (2024)	“Clear documentation guidelines are still urgently needed to ensure consistent practices.” (Mohammed, 2020, p. 12).
	Minimal supervision and documentation audits	Kasaye (2022); Tadesse (2024)	“Regular documentation audits can help improve consistency and quality.” (Kasaye, 2022, p. 7).

## DISCUSSION

### Lack of Training and Education

One of the most significant challenges in nursing documentation is the lack of adequate training and education for nursing staff. Training plays a crucial role in equipping nurses with the necessary skills to perform documentation by standards. However, in many cases, such training is rarely conducted regularly or is entirely unavailable (Aniekwe & Ngozi, 2024). The absence of regular training leads to nurses having an insufficient understanding of the applicable documentation standards, whether manual or electronic (Birhanu, 2024).

**Challenges in Technological Literacy.** In addition to inadequate training, low technological literacy is a major obstacle in electronic documentation. Transitioning from manual to electronic systems often requires significant adaptation. However, the lack of training on how to use electronic systems makes it difficult for nurses, ultimately reducing the quality of their documentation (Purwandari et al., 2022). Muinga (2023) highlights that adequate technology training can improve staff confidence and efficiency in using electronic devices for documentation (Muinga, 2023).

**Recommended Solutions.** To address this issue, healthcare institutions need to develop structured and continuous training programs. These programs should cover not only the technical aspects of documentation but also its importance in ensuring patient safety and professional accountability (Aniekwe & Ngozi, 2024). Furthermore, managerial support in providing resources and time for training can help improve nurses' competence in documentation (Birhanu, 2024).

### High Workload

High workload is one of the most frequently mentioned barriers to nursing documentation. In busy work environments, nurses often prioritize direct patient care over documenting the care provided (Tadesse, 2024). Fatmawati (2024) found that in certain conditions, such as in emergency units, documentation is often rushed or even neglected (Fatmawati, 2024).

**Impact of Nurse-to-Patient Ratios.** Low nurse-to-patient ratios are also a key contributor to high workloads. Seidu (2021) observed that in hospitals with suboptimal nurse-to-patient ratios, nurses have very limited time to perform comprehensive documentation (Seidu, 2021). This affects the completeness and accuracy of documentation, ultimately impacting patient safety.

**Strategies to Reduce Workload.** Strategies to reduce workload include increasing the number of nursing staff and utilizing technology to enhance documentation efficiency (Birhanu, 2024). Well-designed electronic documentation systems can save nurses time, allowing them to focus on other pressing tasks (Purwandari et al., 2022).

### Resource Limitations

The availability of adequate resources is a prerequisite for effective nursing documentation. However, many healthcare facilities, particularly in developing countries, face limitations in terms of technological tools and other supporting infrastructure (Kasaye, 2022). Purwandari (2022) noted that in some hospitals, the electronic devices needed for documentation are often insufficient, forcing nurses to rely on less efficient manual methods (Purwandari, 2022).

**Challenges with Manual Systems.** Manual documentation has numerous drawbacks, including

illegible handwriting and the risk of data loss (Rauf, 2021). Mohammed (2020) found that in hospitals still using manual systems, data entries are often incomplete, which can lead to errors in clinical decision-making (Mohammed, 2020). Investments in Technology. To address these issues, investments in health information technology are essential, including hardware and software to support electronic documentation. Moreover, training on how to use these tools is crucial to ensure their effective utilization (Kasaye, 2022).

### **Motivation and Attitude**

The motivation and attitude of nurses toward documentation have a significant impact on the quality and consistency of documentation. Ayele (2021) found that many nurses feel that documentation does not directly benefit patient care, leading them to neglect it (Ayele, 2021). Additionally, the lack of incentives or recognition for good documentation practices further reduces nurses' motivation (Ojo, 2023). Recognition and Incentives. Ngozi (2024) noted that providing recognition to nurses who perform good documentation can enhance their motivation (Aniekwe & Ngozi, 2024). Integrating documentation as part of performance evaluations can also encourage nurses to pay more attention to it (Birhanu, 2024). Developing a Supportive Work Culture. A supportive work culture, where documentation is considered an integral part of patient care, can help foster a positive attitude among nurses. This can be achieved through education and socialization about the importance of documentation in promoting patient safety (Ayele, 2021).

### **Lack of Standard Operating Procedures**

The absence of clear guidelines or standard operating procedures (SOPs) for nursing documentation presents a significant challenge. Mohammed (2020) noted that the lack of consistent standards results in varying documentation practices among nurses, ultimately affecting the quality of recorded data (Mohammed, 2020). Fatmawati (2024) also found that many nurses feel uncertain about what to document and how to document it (Fatmawati, 2024). Importance of Audits and Supervision. Regular supervision and audits can help ensure that documentation is carried out by established standards. Kasaye (2022) observed that periodic documentation audits can provide feedback to nurses and help improve the quality of documentation (Kasaye, 2022). Additionally, training on applicable documentation standards is essential to reduce errors (Tadese, 2024). Implementation of Standard Guidelines. To address this issue, the development and implementation of clear and easy-to-follow standard guidelines for all nurses are necessary. These guidelines should include detailed instructions on what to document, when, and how to document it (Mohammed, 2020).

### **CONCLUSION**

Nursing care documentation is a key element in improving the quality of patient care and ensuring their safety. However, various barriers such as insufficient training, high workloads, limited resources, low motivation, and the lack of standard operating procedures hinder the effectiveness of this practice. To address these challenges, recommended strategies include the development of continuous training programs on documentation and technological literacy, investment in technological infrastructure to support electronic documentation, provision of incentives for nurses to enhance motivation, and the implementation of consistent audits and supervision. By overcoming these obstacles, the quality of nursing documentation can be significantly improved, ultimately resulting in positive impacts on patient safety and the overall efficiency of healthcare services.

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