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Factors Influencing Documentation in Nursing Care by Nurses at the Federal Medical Centre, Apir, Benue State, Nigeria

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ABSTRACT

Introduction: Nursing documentation should meet specific and comprehensive standards to achieve its goals, including effective communication, education, research, monitoring, and evaluation within the healthcare system. It should also ensure the collection of essential patient information based on established principles. This study investigated the factors that influence nursing documentation practices at the Federal Medical Centre in Apir, Benue State, Nigeria. The lack of national and local guidelines on nursing documentation has resulted in substandard practices among Nigerian nurses. **Methods:** The study employed an analytical cross-sectional design. There were 102 participants with a 99.7% response rate. **Results:** The practice of nursing care documentation was found to be inadequate. The practice of nursing care documentation was significantly linked to not having enough documentation sheets (AOR = 3.271, 95% CI = 1.125–23.704), not having enough time (AOR = 2.205, 95% CI=1.101–3.413), and not meeting the operational standard of nursing documentation (AOR = 2.015, 95% CI = 1.205–3.70). The results also highlight that while nurses recognise the importance of accurate documentation, several barriers, such as workload, inadequate training, and a lack of resources, hinder effective practice. Finally, more than half of nurses did not document their nursing care. **Conclusion:** The study concludes that addressing these barriers through targeted interventions could significantly improve documentation quality, thereby enhancing patient care outcomes. Agencies employing nurses must ensure to train them for proper nursing care documentation to improve knowledge and foster awareness among healthcare workers about accurate and thorough documentation practices. This will enable nursing directors and chief executive officers to access adequate documenting supplies, in addition to employing more competent and qualified nurses.

Keywords: Documentation; Federal Medical Centre Knowledge; Nurses Attitude; Nursing Practice

INTRODUCTION

Worldwide, nursing documentation is crucial in the healthcare system (Asamani *et al*., 2014). Tasew, Mariye and Teklay (2019) defined nursing documentation as the recording of nursing care provided by nurses or other caregivers, under the supervision of a qualified nurse, to plan and deliver care to individual patients. Nursing documentation is the principal clinical information source for meeting legal and professional requirements. It is a vital component of safe, ethical, and effective nursing practices, whether done manually or electronically. Nursing documentation should comply with the legal requirements for nursing care documentation (Ethiopia's & Pif, 2010).

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For stakeholders in the health system to be well-informed, nurses must maintain comprehensive records of all care they provide to clients (Molla *et al*., 2024; Mbabazi & Cassimjee, 2006; Stoumpos, Kitsios & Talias, 2023). Documentation ensures a comprehensive account of patient care, and it serves as a form of legal record that specifies the patient's care and progress (Machudo & Mohidin, 2015). Maintaining comprehensive, timely, and accurate health care records is essential for successful nursing practice (Mutshatshi & Mothiba, 2020; Ma *et al.*, 2023). It is very important that the nurse makes the documentation process very clear, succinct, and legible in a cautious manner to minimize the chances of misinterpretation, legal liability, and adverse patient outcomes resulting from poor communication (Seidu, Abdulai & Aninanya, 2021). Timely and accurate documentation reflects the care provided, promotes collaboration and communication among the health team, meets professional and legislative standards, and facilitates patient care decisions and outcomes of care (Pandit & Pandit, 2009; Blake-Mowatt, Lindo & Bennett, 2013).

On a wider scope, documentation is important in health planning, nursing development, education, research, quality assurance, the allocation of resources, and reimbursement by third-party claimants (Tawfik, Mahfouz & AbdAllah, 2024; Tasew, Mariye & Teklay, 2019). Hardido, Kedida and Kigongo (2023) conducted a study in Nigeria and found that documentation ensures continuity of care, allows for early detection of problems, and ensures a high standard of clinical care. Despite the importance of documentation, nursing reports are frequently incomplete and of poor quality, which compromises patient care and undermines the credibility of the nurse (Kelly, Edwards & Shapiro, 2021; Broderick & Coffey, 2013; De Groot *et al*., 2022; Seidu, Abdulai & Aninanya, 2021). Improperly charted vital signs may lead to incorrect treatment plans, and uncharted medications and a probable overdose of patients, which may result in poor patient outcomes and increased healthcare costs (Okaisu *et al*., 2014).

Several factors influence the practice of nursing documentation in developing countries (Fantahun *et al*., 2023). A descriptive cross-sectional study, which examined the factors influencing documentation practice among nurses in a hospital in Ethiopia, found that the practice of nursing care documentation was inadequate. The study also identified the inadequacy of documenting sheets and time as associated factors (Andualem *et al.*, 2019). Laksono *et al*. (2022) further asserted in a qualitative study among nurses in Indonesia that nursing documentation remains a problem and pointed out factors such as inadequate supervision on documentation, poor competency issues and lack of confidence and motivation on documentation.

In Uganda, Nakate *et al*. (2015) reported that barriers to effective nursing documentation include organisational issues, inadequate knowledge on documentation, lack of training, and motivation. In South Africa, a qualitative study revealed that challenges associated with documentation include a lack of time to complete records, an increased patient-to-nurse ratio, and a lack of documentation logistics (Mutshatshi & Mothiba, 2020). Nurses' low knowledge and poor attitudes, in addition to these deficiencies, negatively impact documentation practices. Continuous training, monitoring and evaluation of nurses (Mutshatshi & Mothiba, 2020; Laksono *et al.*, 2022), motivation, provision of documentation policies and materials (Nakate *et al*., 2015), employment of additional nurses, proper time management, and penalising nurses for poorly written documents could address challenges associated with nursing documentation.

In Ghana, nursing documentation is suboptimal and contributes to adverse health outcomes (Seidu, Abdulai & Aninanya, 2021). Health workers in Ghana are facing lawsuits and other forms of disciplinary proceedings due to recent developments in the health sector (Asamani *et al.*, 2014). Reports have indicated instances of medical negligence and even lawsuits among certain health professionals (Pandit & Pandit, 2009; Oyebode, 2013). In these cases, accurate documentation procedures would definitely have played a key role in preventing such issues. Despite the Nursing and Midwifery Council (NMC) regulating nursing and midwifery training and practise, the NMC is lagging behind due to the absence of national and/or local guidelines on nursing documentation. Furthermore, a variety of stakeholders have criticized nursing documentation on various platforms for unsatisfactory charting practices. Anecdotal evidence indicates that suboptimal or non-documented nursing care occurs in certain instances. This will undoubtedly have serious implications for assessing the care provided to clients. In a study in Eastern Ghana, Asamani *et al*. (2014) also linked inadequate documentation to an inadequate nurse-patient ratio.

Another study in Winneba, Ghana, revealed that most nurses did not sign or write their initials after documenting care (Seidu, Abdulai & Aninanya, 2021). Furthermore, Seidu, Abdulai and Aninanya (2021) conducted a previous study in the Tamale Metropolis across five hospitals, reporting very poor nursing documentation. Moreover, Seidu, Abdulai and Aninanya (2021) identified a limitation in previous studies on nursing documentation in Ghana, including the Northern Region, as they focused on assessing the documentation practices of nurses in both private and public institutions, but did not evaluate their knowledge and attitudes towards documentation.

Various factors, including institutional policies, technological resources, staff training, and individual attitudes toward documentation, influence nursing documentation (Tawfik, Mahfouz & AbdAllah, 2024). Studies across different healthcare settings have shown that workload, time constraints, lack of training, and inadequate staffing are significant barriers to effective documentation (Bolado *et al*., 2023). Research in high-resource settings, for example, frequently emphasises the role of electronic health records (EHR) in improving documentation accuracy, whereas studies in low-resource settings highlight challenges such as lack of access to EHR and insufficient staff training. Recent studies (Forde-Johnston, Butcher & Aveyard, 2023) underscore the need for ongoing professional development and institutional support to overcome these barriers.

By evaluating the documentation practices of nurses at the Federal Medical Centre Apir, this study aims to bridge the research gap to improve nursing documentation. The study will also assess the factors that determine knowledge, attitudes, and practices related to nursing documentation.

Objectives of the Study

The objectives of the study are threefold: first, to assess the knowledge and attitudes towards nursing documentation among nurses at FMC Apir; second, to evaluate the practices of documentation among these nurses; and third, to examine the factors that influence nursing documentation at FMC Apir.

METHODOLOGY

Study Design and Setting

The study employed an analytical cross-sectional design to assess nursing documentation practice among nurses and midwives and relate it to its exposures at the same time. This study was conducted at the Federal Medical Centre (FMC) in Apir because it has numerous speciality areas and nursing documentation was found to be inadequate. The ethical consent was granted by the Research and Ethics Board of the Federal Medical Centre, before the commencement of the study for permission. The nurses in various settings of the study were approached, and information about the study objective was explained to them. The responsibility of the respondents was clarified, and assurances that their information would be treated confidentially were given to gain their cooperation throughout the study period. Each participant signed informed consent forms, and participation was voluntary.

Study Population

The target population consisted of qualified registered/professional nurses (i.e., enrolled, diploma holders, or graduates) who had at least one year of work experience. All the participants voluntarily consented to the study. The study excluded students and rotational nurses, those with less than a year of work experience, and those on annual or maternity leave. The study selected 288 participants, calculated using the Yamane Formula(Yamane, 1973) (n = N1+ (e) 2), where N is the population size and e, the level of precision. This process was adopted to ensure representativeness of the sample population.

Sampling Procedures

A 2-stage sampling procedure first using a stratified and then a convenient sampling technique was employed. Stratified sampling was ensured for equity in the spread of the sample size across the selected departments of the Centre which included Medicine, Surgery, Obstetrics and Gynaecology and Special Units.

Each department comprises distinct wards, which collectively form sub-clusters. From each department, nurses were conveniently selected from the wards.

Data Collection Tool and Procedures

A semi-structured questionnaire was adopted from empirical evidence (Asamani *et al*., 2014; Seidu, Abdulai & Aninanya, 2021; Andualem *et al*., 2019). The instrument consisted of four sections: Section A constituted socio-demographics; Section B was knowledge and attitudes toward nursing documentation; Section C entailed documentation practices; and Section D constituted factors that influenced nursing documentation.

The questionnaire was pretested on 12 nurses at the General Hospital Makurdi before actual data collection, but this was not included in the actual data analysis. The researcher supervised the respondents while they filled out the questionnaire, which they later self-administered. The researcher assured the respondents of confidentiality and anonymity. After the data collection exercise, the researcher meticulously reviewed all completed questionnaires to verify the completion of all fields.

The population of nurses at FMC Apir determined the sample size for this study, ensuring a representative sample that would yield statistically significant results. A power analysis was conducted to confirm that the sample size was adequate to detect differences and relationships among the variables studied, with a confidence level of 95% and a margin of error of 5%. A pilot study involving a small sample of nurses not involved in the main study validated the data collection tools, particularly the questionnaire. Feedback from the pilot study was used to refine the questionnaire, ensuring its reliability and validity in acquiring the necessary data.

Data Analysis

In respect to the assessment of the knowledge, attitude and practice of respondents on documentation, several questions were posed for each variable, and each correct/right choice was scored 1 and incorrect/wrong choice was scored 0. The total score for each respondent for each variable was assessed using a composite score by summing all correct answers. The median score for each variable was then calculated and used as the cut-off for determining the levels for knowledge (adequate vs. inadequate), attitude (good vs. bad), and practice (high vs. low). The answered questionnaires were collected from the respondents for data entry. Data was entered and analysed using the Statistical Package for the Social Sciences (SPSS) version 20. To summarise the data, descriptive statistics were used, such as percentages and frequencies. Furthermore, binary logistic regression modeling was done to determine predictors of nursing documentation, and the level of significance was set at $p<0.05$.

Ethical Consideration

The study received ethical approval from the Ethical Committee of the Federal Medical Centre and the Board on Scientific Research Makurdi, Nigeria with reference number FMH/FMC/MED/108/VOL on 26th August, 2024.

RESULTS

Among the participants, 123 copies of the questionnaire were distributed, but 102 were filled out and returned with valid responses. The response rate was therefore 82.9%.

Table 1 shows the demographic characteristics of the respondents selected for the sample. The majority of the participants, 60 (58.8%), were females and 42 (41.2%) were males. Age characteristics showed that the mean age was (39.4%). For the educational qualification, Diploma holders were 24.5%, Degree holders were 58.8%, 15.7% had certificates in nursing, and 1.0% had SSCE. Regarding the years of experience, the majority (41.1%) had worked for 1–5 years; 40.2% worked for 6–10 years; 12.8% worked for 11–15 years; and 8.0% worked for more than 15 years.

Table 1: Demographics Distribution of the Respondents

Gender	Frequency	Percentage (%)
Male	42	41.2
Female	60	58.8
Total	102	100.0
Educational Qualification		
Diploma	25	24.5
Degree	60	58.8
Certificate in Nursing	16	15.7
SSCE	1	1.0
Total	102	100.0
Years of Experience		
1-5	41	40.2
6-10	40	39.2
11-15	13	12.7
16 and above	8	7.8
Total	102	100.0

Knowledge of Respondents towards Nursing Documentation

Multiple-choice questions were used to measure the knowledge of respondents regarding nursing documentation, and the mean score was 4.6 (SD ± 1.9). The minimum score was 1.3 and the maximum 8. The total mean score for knowledge questions was 4.6. Among all the respondents, 46 (46.9%) subjects scored above or equal to the mean value, and the rest 48 (53.1%) of them scored below the mean. Fifty-four (53%) of the respondents were found to have poor knowledge of documentation.

Table 2: Knowledge of Respondents Regarding Nursing Documentation

Knowledge Measurement	Categories	Frequency (n)	Percentage (%)
Mean Score	-	4.6 (SD ± 1.9)	-
Minimum Score	-	1.3	-
Maximum Score	-	8.0	-
Total Mean Score	-	4.6	-
Scores Relative to Mean	≥ Mean	46	46.9
	< Mean	48	53.1
Knowledge Level	Poor Knowledge	54	53.0

Table 3 presents the respondents' understanding of nursing documentation, their sources of information, and their awareness of the consequences of insufficient documentation, along with the core principles of professional nursing documentation.

In understanding the Nursing Documentation, 46.9% of respondents reported having adequate information about nursing documentation, while 53.1% of the respondents reported inadequate information, suggesting that more than half lack comprehensive knowledge of the documentation process. Regarding the sources of information, nursing programs were the primary source for 47.1% of the respondents, while ward nurses provided information for 30.6%, hospital administration for 9.18%, and notes from other nurses for 13.3% of the respondents. Therefore, this data suggests that nursing programs, structured education, and informal learning channels such as notes from peers play a significant role.

Understanding the potential effects of insufficient documentation, the respondents identified several negative outcomes associated with it. It was seen that 29.4% noted the potential for legal impacts, 21.6% highlighted medical blunders as a consequence, 18.6% cited inconsistency in care, 17.6% mentioned poor results in patient outcomes, and 12.7% identified miscommunication within the medical staff as a problem caused by poor documentation. These responses indicate that respondents are aware of both legal and operational risks linked to inadequate documentation practices.

For Core Principles of Nursing Documentation, a large majority of respondents understand key principles for proper nursing documentation, which are: 93.8% agreed that documentation is an essential part of professional nursing practice; 87.7% emphasised that documentation must follow predetermined rules; also, 83.6% noted that documentation must be orderly, factual, precise, and readable; and 91.8% stated that

documentation should cover observations and actions taken by the nurse. This result indicates that while most respondents understand the principles of proper documentation, a notable percentage lack adequate information, underscoring the need for enhanced training and awareness programs.

Table 3: Respondents' Understanding of Nursing Documentation

	Variable	Frequency	Percentage (%)
Understanding	Adequate information	46	46.9
	Inadequate information	54	53.1
	Total	**102**	**100.0**
Sources of Information	Nursing program	48	47.1
	Ward nurses	30	30.6
	Hospital administration	9	9.18
	From the notes of other Nurses	13	13.3
	Total	**102**	**100.0**
Understanding of the Potential Effects of Insufficient Documentation	Impact on the law	30	29.4
	Medical blunders	22	21.6
	Inconsistency in care	19	18.6
	Poor results	18	17.6
	Miscommunication within the medical staff	13	12.7
	Total	**102**	**100**
An essential part of professional nursing practice is documentation.		92	93.8
Documentation must follow predetermined rules.		86	87.7
Documentation has to remain orderly, factual, precise, and readable.		82	83.6
Documentation includes the things I have seen and done.		90	918

Source: Field survey, 2023

Attitude of Respondents towards Nursing Documentation

Respondents' attitudes were assessed via a Likert scale, with item scores ranging from strongly agree (4), agree (3), disagree (2) and strongly disagree (1), which had a potential score of 40. The total mean score for attitude was 44 (SD ± 4.9), and scores greater or equal to the mean were categorised as favourable and unfavourable for scores below the mean. The overall attitude score of the respondents showed that more than half of them, 61 (59.8%), had a positive attitude, and the rest, 41 (40.2%), had a negative mindset.

Table 4: Nursing Documentation Attitude Score

Attitudes	Frequency	Percentage (%)
Positive attitude	61	59.8
Negative attitudes	41	40.2
Total	**102**	**100**

Among the 54 (52.9%) respondents who do not document the care provided to a patient, most 30 (55.6%) of them responded that their reasons for poor documentation were lack of time, shortage of documenting sheets, inadequate staff, lack of motivation from supervisors, and lack of obligation from the employing institution by 12 (22.3%), 8 (14.8%), 3 (5.6%), and 1 (1.9%), respectively, as shown in the table below.

Table 5: Reasons for Poor Documentation by Respondents

Reasons for Poor Documentation	Frequency(n)	Percentage (%)
Lack of Time	30	55.6
Shortage of Documenting Sheets	12	22.3
Inadequate Staff	8	14.8
Lack of Motivation from Supervisors	3	5.6
Lack of Obligation from Employing Institution	1	1.9
Total	**54**	**100.0**

Practice of Nurses towards Nursing Documentation

Table 6 presents data on various aspects of nursing documentation practices. The majority of nursing school students (47.1%) document data when instructed, while 13.3% depend on notes from another nurse. It is seen that 60.8% of nurses always document instructions or counseling given to patients, whereas 15.7% rarely do so. The study showed that 66.7% use other process to document that does not require charts should be documented, with only 1% never documenting them. Timing of documentation showed that 76.5% prefer to document whenever convenient, and only 4.9% do so at the close of the shift. In case of error correction in documentation, 81.3% correct errors by striking through and signing, while 16.7% use correction fluid. Therefore, most nurses tend to document when convenient and follow standard error correction methods, although a significant portion lacks consistency in documentation timing and processes.

Table 6: The Practice of Nursing Documentation

	Variable	Frequency	Percentage
Practice	Proper practice	72	71.9
	Poor practice	30	29.1
	Total	**102**	**100.0**
Nursing records for each patient	Nursing school	48	47.1
	Ward Nurses	30	30.6
	Hospital management	9	9.18
	Notes from other nurses	13	13.3
	Total	**102**	**100.0**
Records of instruction or counsel given	Always	62	60.8
	sometimes	20	19.6
	Rarely	16	15.7
	Never	4	3.9
	Total	**102**	**100**
Other processes that don't require charts should be documented	Always	68	66.7
	Sometimes	27	26.5
	Rarely	6	5.9
	Never	1	0.98
	Total	102	**100**
Time of documentation	Whenever it is convenient	78	76.5
	Immediately after providing care	14	18.6
	At the close of shift	5	4.9
	Total	**102**	**100**
Correction of errors in documentation	Strikethrough and sign	83	81.3
	Use correction fluid	17	16.7
	Neglect error	4	3.9
	Total	**102**	**100**
The time and date always get recorded during documenting		100	98
Read your co-workers' note		97	95.1
Colleagues make note of standards met		94	92.2
Uses a computerized method for documentation		41	40.2
Reports a medical mistake voluntarily in the documentation		73	71.6
Record the patient's reaction to the care		87	85.3
Append my signature with name on the note		91	89.2
Use short hands and acronyms		88	86.3

Factor Associated with Documentation Practice of Nursing Care Plan

Table 7 shows the factors that influenced nursing documentation. Regarding operational norm for recording nursing care, 72% of respondents agree that there is a standard norm, while 30% disagree. The study

revealed that 90% report receiving paperwork in-service education, with only 12% lacking it. Of the total respondent 85% mention an increased workload and inadequate staffing (higher nurse-patient ratio) as issues. About access to a nursing care plan, 79% have access to a care plan, but 23% do not. Report of insufficient documentation sheets showed 88% mention of lack of sufficient documentation sheets. Of the total 95% showed lack of acquaintance with nursing documentation. Nurses also believe there is a lack of commitment from the hospital (82%). For lack of encouragement from bosses, 92% agreed, with 10% disagreeing. Lastly 99% express dissatisfaction with their monthly salary, while only 3% were satisfied. The majority of nurses feel that increased workload, insufficient resources, and lack of institutional support significantly hinder proper nursing documentation.

Table 7: Variables Affecting Nursing Documentation

Influencing Factors	Yes	No
There is an operational norm for recording nursing care	72	30
Paperwork in-service education	90	12
The amount of work has increased and there is not enough staff (higher nurse-patient ratio)	85	27
Accessibility to a nursing care plan	79	23
Insufficient documentation sheets.	88	24
Lack of acquaintance with nursing documentation standards	95	7
No commitment is made by the hospital	82	20
No encouragement from the bosses	92	10
Unhappy with my monthly salary	99	3

Source: Field survey, 2022

Using regression analysis, odds ratios with 95% confidence intervals were calculated to assess the statistical significance and strength of association for each variable. Variables having a p value < 0.25 in the bivariate logistic analysis were entered into the Multivariable Logistic Analysis and Adjusted Odds Ratios (AOR) were then calculated to investigate association with controlled confounding variables.

According to the finding, nurses who are not familiar with operational standard of the nursing documentation were twice more likely to have poor nursing documentation practice than those who are familiar (AOR = 2.015, 95% CI 1.205, 3.370). Additionally, respondents who lacked time and those who lacked documentation sheets were also two times [Adjusted Odds Ratio (AOR) = 2.202, 95% CI (1.101, 3.410)] and three times [AOR = 3.269, 95% CI (1.123, 23.701)] more likely to perform poor nursing documentation when compared to those with adequate time and adequate documenting sheets respectively.

DISCUSSION

This cross-sectional study aimed to investigate nursing documentation practice and its associated factors among nurses at FMC Apir. The finding showed that familiarity with operational standards of nursing documentation, lack of time and inadequacy of documenting sheets had a significant effect on nursing care documentation practice.

In line with the present study findings, nurses in Ethiopia, as noted by Adejumo (2014), exercise inadequate nursing care documentation, both in terms of practice and knowledge. This result is higher than that from Indonesia, 33.3% (Motea, Rantetampang & Pongtikuc, 2016) and the University of Gondar hospital, 37.4% (Kebede, Endris, & Zegeye, 2017). The government's priorities in the health sector and the introduction of technology such as smart care, now prevalent in most Nigerian hospitals, could account for this disparity. Another reason could be that nurses' educational development differs across countries (Nursalam, Dang & Arief, 2009). Over half of the people who participated in this study said that nurses did not do a good job of documenting their work. This is similar to a study done in Felege Hiwot referral hospital (87.5%), where medication errors were caused by nursing documentation mistakes (Mekonen, Gebrie & Jemberie, 2020). This finding is lower than 68.3% in South Africa (Olivier & Kyriacos, 2011). Studies favorable to the working environment and organizational structure suggest that this could be due to inadequate knowledge.

This study has identified several barriers that hinder the practice of nursing documentation. Nurses who know about operational standards for nursing documentation are twice as likely to document their care. Similarly, this study found that lack of time and scarcity of sheets were the primary factors negatively influencing nursing documentation practices. Similar to studies conducted in Ethiopia (41.7%) and England

(47%), respondents with limited time were twice as likely to document (41.9%).

Other studies have found a non-significant association between knowledge and documentation practice. The knowledge level of participants was low in this study, which contradicts the findings from the University of Gondar hospital (58.3%) (Kebede, Endris & Zegeye, 2017), South Africa (74.9%) (Olivier & Kyriacos, 2011), Iraq (59%) (Hameed & Allo, 2014) and Indonesia (82.7%) (Motea, Rantetampang & Pongtikuc, 2016). The study participants' sociodemographic variability or their varying familiarity with the guidelines' documentation could potentially explain these discrepancies (Kebede, Endris & Zegeye, 2017).

Limitations

The focus of this study is on the factors that influence the documentation of nursing care by nurses at the Federal Medical Centre, Apir and on the practicing nurses who were available at the time of the study.

CONCLUSION

The practice of nursing care documentation among nurses was deemed inadequate. The inadequacy of documenting sheets, lack of time, and unfamiliarity with the operational standards of nursing documentation were factors associated with the practice of nursing care documentation. These findings underscore the need for tailored interventions to address these barriers and improve documentation practices. Future research should examine the impact of targeted training programs on documentation quality and the potential benefits of introducing electronic health records in this setting. Additionally, conducting comparative studies across different healthcare facilities could provide a broader understanding of the factors influencing documentation practices in similar low-resource environments. Additionally, a training program could be implemented to enhance the knowledge of nurses, familiarise them with institutional policy regarding documentation, and provide adequate documentation materials.

This study contributes to the existing body of knowledge by providing insights into the specific factors affecting nursing documentation at FMC Apir. It highlights the unique challenges faced in this context, including workload, inadequate training, and lack of resources.

Conflict of Interest

The authors declare that they have no competing interest.

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