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EVALUATION OF NURSING DOCUMENTATION PRACTICES AND THEIR IMPLICATIONS ON PATIENT CARE AMONG NURSES AND MIDWIVES IN GENERAL HOSPITAL GUSAU, ZAMFARA STATE

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ABSTRACT

This study evaluates nursing documentation practices and their implications on patient care among nurses and midwives at General Hospital Gusau, Zamfara State. Nursing documentation plays a critical role in ensuring high-quality care, fostering communication, supporting legal and professional standards, and promoting patient safety. However, poor documentation practices often due to reliance on paper records, inadequate training, and workload pose significant challenges to healthcare delivery. The study employed a descriptive cross-sectional design, with 105 respondents selected through simple random sampling from a population of 290 nurses and midwives. Data were collected using a validated, self-structured questionnaire and analyzed using descriptive statistics. The results show that most participants have a good understanding of the importance of documentation, recognizing its role in communication, risk identification, and continuity of care. While a majority reported consistent documentation of patient care, gaps remain in the timeliness and comprehensiveness of entries. Respondents emphasized the need for regular training, orientation, and the integration of electronic documentation systems as key strategies for improvement. The findings highlight the critical need to strengthen nursing documentation practices to support effective care delivery, patient safety, and professional accountability. This study provides insight for healthcare administrators, policymakers, and educators aiming to enhance nursing documentation and, by extension, improve patient outcomes.

Keywords: Nursing documentation, patient care, midwifery, quality improvement, General Hospital Gusau, Nigeria

INTRODUCTION

Nursing documentation forms an integral part of professional practice, encompassing all written information related to patient health status, nursing needs, and the care provided [1]. It is a vital tool for ensuring consistent, safe, and high-quality care while supporting communication among healthcare providers, legal accountability, and professional standards. Effective documentation must be factual, current, comprehensive, legible, and completed in a timely manner [2]. It should accurately reflect nursing assessments, interventions, and outcomes, and it must follow established standards such as including patient identifiers, authorized abbreviations, and chronological entries [3].

The Nursing and Midwifery Council of Nigeria (NMCN) emphasizes the importance of good recordkeeping in promoting safe care and professional development. However, in many healthcare settings in Nigeria, such as General Hospital Gusau in Zamfara State, the documentation practice remains poor due to reliance on paper-based records, lack of training, and work overload [4]. This contributes to communication gaps, reduced care quality, difficulties in conducting audits, and compromised legal and ethical defense [5]. Incomplete or inaccurate records can hinder clinical decision-making, delay treatments, and raise healthcare costs. Tools like the nursing process and partograph are often underutilized, further limiting effective patient evaluation and continuity of care [6]. This study, therefore, aims to evaluate the current documentation practices among nurses and midwives at General Hospital Gusau and how these practices affect patient care. Specifically, it seeks to assess their knowledge of documentation, the accuracy and timeliness of their records, the completeness of assessments and outcomes documented, and strategies for improving documentation quality.

The study's findings are expected to shade more light on patients by understanding the significance of accurate documentation, guide the government in resource allocation, and provide a reference for future research. The study is confined to nurses and midwives in General Hospital Gusau and explores the implications of their documentation practices on the utilization of the nursing process. Operational terms such as evaluation, documentation practice, and nursing process are defined to ensure clarity. Ultimately, the research underscores the necessity for enhanced nursing documentation to promote professional excellence, patient safety, and effective healthcare delivery.

MATERIALS AND METHODS

Study Area

The research was conducted in General Hospital Gusau, one of the oldest health facilities in Zamfara State, established in 1958 and located along General Sani Abacha Way. The hospital comprises several wards, including male and female medical and surgical wards, orthopedic, labor, antenatal, pediatric, and amenity wards. Specialized units such as obstetrics and gynecology, intensive care, physiotherapy, accident and emergency, ENT, psychiatry, and diabetic clinics are also available. It operates two outpatient departments and houses 32 doctors, 180 nurses/midwives, and 124 medical records staff, with a total bed capacity of 360. The choice of this hospital was informed by its size, level of service delivery, and its role as a clinical training center for students.

Ethical Considerations
Ethical approval was obtained through a formal letter from the National Open University, Gusau Study Centre, addressed to the hospital management. Participation was voluntary, and informed consent was obtained from all respondents. Anonymity and confidentiality were strictly maintained throughout the study to protect participant identity and ensure ethical integrity.

Target Population and Sample Size
The target population for this study consisted of 290 nurses and midwives working in various wards and units at General Hospital Gusau, Zamfara State. To determine the appropriate sample size, the Taro Yamane formula was applied using a 5% level of significance, yielding an initial sample size of 168. However, since this exceeded 50% of the total population, the finite population correction formula was used to adjust the sample size, resulting in a final sample of 105 respondents. This adjusted sample ensured adequate representation while preventing oversampling.

Sampling Technique, Data Collection Instrument, Validity, and Reliability
A simple random sampling technique was employed to select participants, allowing equal chances of participation among nurses and midwives regardless of their shift schedules. Data were collected using a self-structured, closed-ended questionnaire, which was divided into four sections: Section A focused on demographic data, Section B assessed the respondents' knowledge of nursing documentation, Section C evaluated documentation practices related to patient assessment, care, and outcomes, while Section D explored measures for improving documentation practices. To ensure the validity of the instrument, the questionnaire was reviewed and approved by the research supervisor, confirming its relevance and appropriateness in measuring the intended variables. Reliability was established by the instrument's ability to consistently yield accurate and reproducible results under similar conditions.

Data Analysis
Collected data were analyzed using simple descriptive statistics and presented in frequency distribution tables with percentages for easy interpretation.

RESULTS AND DISCUSSION

Demographic Data
Of the respondents, 79% were female, while 21% were male. Nearly half (49%) were aged 26–35 years, followed by 22% in the 21–25 age group; the estimated mean age was 33 years. The most common professional rank was NOI (28%), followed by NOII (23%). In terms of qualification, the majority held RN (34%) or RM (29%). The most represented experience group was those with 1–5 years of experience, accounting for 36% of respondents (Table 1).

Table 1: Demographic Characteristics of Respondents

S/N	Items	Respondents	Frequency	Percentage
1	Sex	Male	22	21%
		Female	83	79%
		Total	105	100%
2	Age	21–25 years	23	22%
		26–35 years	52	49%
		36–45 years	20	19%
		46 and above	10	10%
		Total	105	100%
3	Rank	NOII	24	23%
		NOI	30	28%
		SNO	16	15%
		PNO	14	13%
		ACNO	11	11%
		CNO	10	10%
		Total	105	100%
4	Qualification	RN	36	34%
		RM	30	29%
		RN/RM	26	25%
		BNSc	13	12%
		Others	0	0%
		Total	105	100%
5	Years of Experience	1–5 years	38	36%
		6–10 years	28	27%
	1	11–15 years	19	18%
	2	16 years and above	20	19%
		Total	105	100%

Knowledge on Documentation Practices

A large majority (87%) strongly agreed that documentation is essential for recording patient status and nursing care. Most participants (59%) also affirmed its role in facilitating communication and continuity of care, while 63% recognized its importance in identifying safety risks. Additionally, 46% strongly disagreed with the notion that documentation is unnecessary in busy wards, and 48% rejected the idea that not all procedures require documentation demonstrating a clear consensus on the critical role of documentation in all aspects of nursing practice (table 2).

Table 2: Knowledge on Documentation Practices

S/N	Item	Response	Frequency	Percentage
1	Documentation is the total writing of information concerning patient's health status and nursing care rendered	SA	91	87%
		A	14	13%
		SD	0	0%
		D	0	0%
		Total	105	100%
2	Documentation is fundamentally a communication that reflect patient perspective on his/her health and continuity of care	SA	62	59%
		A	41	39%
		SD	1	1%
		D	1	1%
		Total	105	100%
3	Documentation identifies actual and potential risk to the patient's safety.	SA	66	63%
		A	38	36%
		D	1	1%
		SD	0	0%
		Total	105	100%
4	Documentation of nurses/midwives' services is not necessary in busy ward	SA	15	14%
		A	18	17%
		SD	48	46%
		D	24	23%
		Total	105	100%
5	Not all procedures/services are meant to be documented in nursing	SA	7	6%
		A	20	19%
		SD	50	48%
		D	28	27%
		Total	105	100%

SA= strongly agreed, A= agreed, SD= strongly disagreed, D= disagreed

Assessment, Care, and Outcomes

A significant majority of respondents demonstrated positive documentation practices: 67% strongly agreed that they document all patient care, while 54% affirmed that they communicate clinical decisions and observations through documentation. Furthermore, 71% strongly agreed that documentation provides a clear picture of the patient's health, and a combined 84% (24% strongly agreed, 60% agreed) believed that documenting assessments helps them meet professional standards (Table 3).

Table 3: Documentation of Assessment, Care and Outcomes

S/N	Item	Response	Frequency	Percentage
1	Nurses/midwives document all patient care	SA	70	67%
		A	25	24%
		SD	4	3%
		D	6	6%
		Total	105	100%
2	Communication of observation and outcome is done via documentation	SA	57	54%

S/N	Item	Response	Frequency	Percentage
		A	28	27%
		SD	15	14%
		D	5	5%
		Total	105	100%
3	Documentation provides a clear picture of the patient's health status	SA	75	71%
		A	20	19%
		SD	5	5%
		D	5	5%
		Total	105	100%
4	Nurses meet professional standards through documentation	SA	25	24%
		A	64	60%
		SD	10	10%
		D	6	6%
		Total	105	100%

Measures to Improve Documentation Practice

A majority of respondents (63%) strongly agreed that education and orientation improve documentation competence. Nearly half (46%) supported the introduction of electronic documentation methods. Additionally, 54% strongly agreed that documentation should be done immediately after procedures, regardless of workload, while 51% strongly believed that documentation is essential for quality patient care (Table 4).

Table 4: Measures to Improve Documentation Practice

S/N	Item	Response	Frequency	Percentage
1	Education and orientation will improve documentation	SA	66	63%
		A	35	33%
		SD	2	2%
		D	2	2%
		Total	105	100%
2	Telephone/online documenting methods should be introduced	SA	48	46%
		A	42	40%
		SD	5	4%
		D	10	10%
		Total	105	100%
3	Documentation should be immediate, even on stressful days	SA	57	54%
		A	40	38%
		SD	6	6%
		D	2	2%
		Total	105	100%
4	Documentation is mandatory for quality patient care	SA	54	51%
		A	33	31%
		SD	8	8%
		D	10	10%
		Total	105	100%

Discussion

The evaluation of nursing documentation practices among nurses and midwives in General Hospital Gusau presents a comprehensive insight into the real-world challenges and perceptions of frontline healthcare providers. The study population had a mean age of 33 years, suggesting a workforce that is relatively young and potentially adaptable to new practices and innovations in healthcare delivery. Nursing documentation, as emphasized in the background, is more than a bureaucratic requirement; it is a clinical and legal imperative, influencing patient care quality, continuity, and safety [7]. Within the hospital setting, the professional responsibility of nurses and midwives in recording care

delivered is closely tied to how effectively they can observe, assess, plan, implement, and evaluate care.

A notable finding is the high overall knowledge score of 96.8%, indicating that nurses and midwives possess strong awareness and understanding of the principles and importance of proper documentation. This impressive score reflects a solid foundational knowledge base that can serve as a springboard for improving practice, especially when supported by institutional policies and continued professional development. Such a high level of knowledge suggests that gaps in documentation practice may be less about competence and more about structural or environmental constraints.

Several systemic and institutional factors appear to shape documentation behavior, including training gaps, workload, and infrastructure [8]. Nurses and midwives, as shown by the general attitudes conveyed during the study, largely understand the purpose and importance of proper documentation. This shared understanding highlights a potential area of strength that can be leveraged through policy and managerial support [9]. When nurses acknowledge that documentation improves communication, provides a holistic view of the patient's condition, and aligns with professional standards, it signals readiness for improvement if appropriate systems are put in place [10].

However, even with such knowledge, the reality of routine practice can diverge. Institutional limitations like paper-based records, lack of digital tools, or high patient-to-nurse ratios often create an environment where accurate and timely documentation becomes a secondary priority [11]. This gap between knowledge and practice is a common occurrence in many under-resourced healthcare settings. It indicates that awareness alone is not sufficient to effect behavioral change in clinical documentation practices. Rather, change must also be driven by system-level interventions such as continued professional education, real-time supervision, structured documentation formats, and workflow redesign [12].

There is also a practical concern over when documentation occurs. The belief that documentation should happen immediately after procedures, regardless of workload, demonstrates an aspirational standard that may not always be realistic under current working conditions. Yet, the emphasis placed by nurses and midwives on timely documentation suggests a professional conscience that recognizes how lapses in recordkeeping can affect clinical decisions and patient outcomes. This is especially relevant in a hospital like General Hospital Gusau, which not only provides primary care but also serves as a training ground for healthcare students, meaning that any documentation habit formed here can have ripple effects on future healthcare delivery [13].

The acceptance of technological solutions like electronic and telephonic documentation methods is particularly significant. While such systems are not yet universally implemented, their endorsement by staff implies that there is openness to innovation, especially if it helps reduce redundancy and increases efficiency. This openness can be a valuable entry point for interventions aimed at improving documentation without increasing workload. Digital tools, if well-integrated, could also support real-time data entry, reduce errors, and make nursing records more accessible and standardized [14, 15].

In addressing gaps, education and orientation emerged as leading factors perceived to improve documentation practices. This points to the need for not just academic training but also continuous professional development sessions that are practically oriented [16]. Moreover, the call for consistent training reflects a desire for clarity in documentation standards and accountability expectations. Workshops, refresher courses, and supervision may serve as avenues to build these competencies and reinforce the importance of documentation beyond just administrative necessity [17].

Overall, the findings from General Hospital Gusau suggest a relatively high level of awareness about the significance of documentation among nurses and midwives, tempered by challenges in practice stemming from workload, resource limitations, and system inefficiencies. The implications are clear: without addressing these systemic issues, efforts to improve documentation may remain aspirational. But with the right support, including policy enforcement, digital health investment, and targeted training, nursing documentation can evolve into a more robust pillar of patient care, ultimately improving clinical outcomes and operational efficiency in the healthcare system [18].

CONCLUSION

In conclusion, the evaluation highlights that while nurses and midwives at General Hospital Gusau generally understand the importance of accurate and timely documentation, various challenges such as high workload, inadequate training, and lack of digital tools hinder optimal practice. Despite these limitations, there is a strong willingness among staff to improve, particularly through education and the adoption of electronic documentation systems. Strengthening support systems, providing regular training, and integrating technology into nursing workflows are essential steps toward enhancing documentation quality and, ultimately, improving patient care outcomes.

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