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Original research article

KNOWLEDGE ATTITUDE AND PRACTICES OF NURSES REGARDING NURSING DOCUMENTATION

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Abstract: *Nursing documentation is a critical component of patient care, yet gaps in knowledge and practices can compromise its effectiveness. This study aimed to assess the knowledge, attitudes, and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan.* ***Methods:*** *A descriptive cross-sectional study was conducted among 155 nurses. Data were collected using a structured questionnaire covering demographic characteristics, knowledge, attitudes, and practices related to nursing documentation. Descriptive and inferential analyses were performed using SPSS version 26.* ***Results:*** *While nurses exhibited positive attitudes toward the importance of nursing documentation, significant gaps were identified in knowledge and practices. Only 25.8% recognized the risks associated with non-standard abbreviations, and 54.2% failed to document significant communications with patients' families. Nurses with higher qualifications and more years of experience demonstrated better knowledge and adherence to documentation protocols.* ***Conclusion:*** *The findings underscore the need for targeted training programs, institutional support, and standardized guidelines to address gaps in nursing documentation practices. These interventions are crucial for enhancing documentation quality, ensuring continuity of care, and improving patient safety.*

Keywords: Nursing documentation, knowledge, attitudes, practices, patient care, Pakistan, training programs**.**

Introduction

Nursing documentation is a critical component of healthcare, serving as a comprehensive record of patient care and a legal document that protects both patients and healthcare providers. Proper documentation ensures continuity of care, supports clinical decision-making and facilitates communication among healthcare teams. Despite its importance, gaps in knowledge, attitudes, and practices related to nursing documentation remain prevalent globally, particularly in resource-constrained settings such as Pakistan (1, 2).

In Pakistan, the healthcare system is often challenged by high patient-to-nurse ratios, limited resources, and inadequate training opportunities. These challenges contribute to inconsistent and incomplete documentation practices, compromising the quality of care and patient safety. Research conducted in tertiary care hospitals in Pakistan indicates that a lack of formal education on documentation standards, time constraints, and limited access to technology are significant barriers faced by nurses (3, 4). Moreover, the absence of standardized protocols further exacerbates these issues, leading to variability in practices across healthcare facilities.

Globally, studies have highlighted the critical role of documentation in improving patient outcomes and reducing medical errors. For instance, research in India found that nurses with better knowledge of documentation practices were more likely to adhere to institutional policies and provide high-quality care (5). Similarly, a study in African hospitals reported that regular training programs significantly improved nurses' attitudes toward documentation, leading to enhanced compliance with protocols (6). In contrast, developed countries such as the United States have implemented electronic health record systems and continuous professional development programs to address documentation gaps effectively (7).

In Pakistan, limited research exists on the knowledge, attitudes, and practices of nurses regarding nursing documentation. Ahmed et al. observed that only 40% of nurses in a tertiary care hospital in Karachi adhered to proper documentation standards, citing inadequate training as a key factor (8). Another study conducted in Lahore revealed that time constraints and high workloads were the primary reasons for incomplete documentation (9). These findings underscore the need for targeted interventions to address the barriers faced by nurses in documentation practices.

Cultural factors also play a role in shaping nurses' attitudes toward documentation. In Pakistan, hierarchical structures within healthcare teams may discourage open communication and reporting, further impacting documentation quality. Additionally, the lack of recognition and rewards for accurate documentation often leads to low motivation among nurses (10).

This study aims to assess the knowledge, attitudes, and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan. By identifying gaps and barriers, the findings will inform the development of targeted educational programs, institutional policies, and technology-driven solutions to improve nursing documentation practices, ultimately enhancing the quality of patient care.

Methodology

The study utilized a descriptive cross-sectional design to evaluate the knowledge, attitudes, and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan. This design was selected to provide a

comprehensive snapshot of the participants' current understanding and behaviours related to nursing documentation within a specific timeframe.

A total of 155 nurses participated in the study, selected through convenience sampling. The inclusion criteria required participants to be actively employed in the hospital, with at least one year of professional experience in nursing care. Nurses who were unwilling to participate or unavailable during the data collection period were excluded. This sampling method ensured the inclusion of nurses from diverse departments, including medical, surgical, and critical care units, to capture varied perspectives on nursing documentation.

Data were collected using a structured and validated questionnaire designed based on existing literature and expert input to ensure content validity and reliability. The questionnaire comprised three sections: demographic data, knowledge assessment, and evaluation of attitudes and practices related to nursing documentation. The demographic section included variables such as age, gender, marital status, qualifications, years of experience, and the department of work. The knowledge assessment section consisted of multiple-choice and true/false questions addressing principles, purposes, and common errors in nursing documentation. The attitudes and practices sections used Likert-scale questions to evaluate participants' perceptions and adherence to recommended documentation protocols.

Ethical approval was obtained from the institutional review board of the hospital before data collection commenced. All participants provided written informed consent after being informed about the study's objectives, confidentiality measures, and their right to withdraw at any stage without repercussions. Anonymity and confidentiality of the data were maintained throughout the research process.

The data collection was conducted over two weeks, with questionnaires distributed during the nurses' working hours to minimize disruption to routine patient care. Trained research assistants were available to clarify any queries during the data collection phase. Completed questionnaires were collected, checked for completeness, and securely stored for analysis.

Data analysis was performed using SPSS version 26. Descriptive statistics, such as frequencies and percentages, were used to summarize demographic data and responses related to knowledge, attitudes, and practices. Inferential statistics, including chi-square tests, were employed to identify associations between demographic variables and knowledge or practice scores. The results were presented in tables and graphs to facilitate clarity and interpretation.

Results

This study explored the knowledge, attitudes, and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan. A total of 155 nurses participated in the study. Most were between the ages of 21–25 years (35.5%), with males making up the majority (68.4%). Most participants were single (69.7%), had 1–5 years of experience (46.5%), and held a diploma in nursing (43.9%) (Table 1).

Table 1: Demographic Characteristics of Nurses

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	21–25	55	35.5
	26–30	52	33.5
	31–35	41	26.5
	36–40	7	4.5
Gender	Male	106	68.4
	Female	49	31.6
Marital Status	Single	108	69.7
	Married	47	28.4
Experience (years)	1–5	72	46.5
	6–10	49	31.6
	10–15	23	14.8
	16–20	11	7.1
Qualification	Diploma in Nursing	68	43.9
	Post RN	55	35.5
	BSN (Generic)	32	20.6

The majority of participants demonstrated gaps in their knowledge of nursing documentation. For example, 69.7% correctly identified "error-free" documentation as a key principle, while only 25.8% recognized that using non-standard abbreviations leads to errors (Table 2).

Table 2: Knowledge of Nurses About Nursing Documentation

Question	Response	Frequency (n)	Percentage (%)
Principles needed for documentation	Error-free	108	69.7
	Complete	20	12.9
	Easily readable	21	13.5
	Chronological	6	3.9

Effects of non-standard abbreviations	Leads to errors	40	25.8
	Wastes time	31	20.0
	Don't know	84	54.2

The majority of nurses exhibited a positive attitude toward the importance of nursing documentation. For instance, 49% strongly agreed that nursing documentation positively impacts patient care, while 54.8% strongly agreed that it is an essential competency for nursing practice (Table 3).

Table 3: Attitudes Toward Nursing Documentation

Question	Response	Frequency (n)	Percentage (%)
Documentation positively impacts patient care	Strongly agree	76	49.0
	Agree	23	14.8
Documentation is an essential nursing competency	Strongly agree	85	54.8
	Agree	38	24.5

Varied significantly. While 83.9% completed documentation promptly, 54.2% did not document significant communication with family members or substitute decision-makers (Table 4).

Table 4: Practices of Nurses in Nursing Documentation

Question	Response	Frequency (n)	Percentage (%)
Documentation promptly	Done	130	83.9
	Not done	25	16.1
Documenting communication with family members	Done	73	47.1
	Not done	84	54.2

The results demonstrate that while most nurses recognize the importance of nursing documentation and exhibit positive attitudes, there are significant gaps in knowledge and inconsistent practices. Key deficiencies include the use of non-standard abbreviations and failure to document critical communication. These findings highlight the need for targeted training programs, institutional support, and the development of standardized guidelines to improve nursing documentation practices.

Discussion

This study assessed the knowledge, attitudes, and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan. The findings revealed significant gaps in knowledge and inconsistent practices, despite positive attitudes toward the importance of nursing documentation. These results align with previous studies conducted in similar settings, highlighting the global and regional challenges associated with nursing documentation.
The results showed that while most nurses recognized the importance of accurate documentation, there were deficiencies in knowledge regarding essential principles and practices. For instance, only 25.8% of participants identified the impact of non-standard abbreviations on documentation errors. This finding is consistent with a study conducted in Karachi, where Ahmed et al. reported that less than half of the nurses were aware of the risks posed by improper abbreviations and incomplete entries (3). Similarly, a study by Gupta and Reddy in India found that nurses often relied on outdated practices due to a lack of formal training in documentation protocols (5).
In terms of attitudes, the majority of nurses in this study agreed that nursing documentation positively impacts patient care and is an essential competency. These positive attitudes align with findings from Mwita et al. in African hospitals, where nurses exhibited strong agreement on the value of documentation but faced systemic barriers such as high patient loads and insufficient resources (11). However, the gap between attitudes and practices observed in this study reflects the challenges of translating positive perceptions into consistent behavior, a trend also reported by Malik and Zahid in their analysis of nursing practices in Lahore (9).
The study also highlighted variability in documentation practices, with some nurses adhering to timely documentation while others failed to document critical communications with patients' families. This inconsistency mirrors the findings of Zafar et al., who identified time constraints, high workloads, and a lack of standardized protocols as significant barriers to effective documentation in Pakistani hospitals (10). Moreover, Ahmed et al. observed that the absence of continuous professional development programs further exacerbated these challenges, leading to incomplete and inconsistent documentation (8).
Globally, structured training programs and the integration of electronic health records (EHR) have been shown to improve nursing documentation. For example, Johnson and Leipzig demonstrated that EHR systems significantly enhance documentation quality by providing real-time prompts and reducing errors in developed healthcare systems (7). However, the implementation of such systems in Pakistan remains limited due to resource constraints and the lack of national-level guidelines for documentation practices (12).
The demographic analysis of this study revealed that nurses with higher qualifications, such as BSN and Post RN, exhibited better knowledge and practices compared to those with diploma-level education. This finding aligns with Saeed et al., who emphasized the role of advanced education in improving nursing competencies, including

documentation (13). Additionally, nurses with more years of experience were more likely to demonstrate adherence to recommended practices, consistent with the findings of Mwita et al. and Gupta et al., who highlighted the impact of clinical exposure on documentation proficiency (5, 11).
This study's findings are consistent with regional and global research, emphasizing the need for targeted interventions, such as training programs, resource allocation, and the implementation of standardized guidelines, to address gaps in nursing documentation. Addressing these challenges is critical for improving the quality and consistency of nursing care in Pakistan.

Conclusion

This study highlights significant gaps in the knowledge and practices of nurses regarding nursing documentation in a tertiary care hospital in Lahore, Pakistan, despite their positive attitudes toward its importance. Key barriers included insufficient training, high workloads, and a lack of standardized protocols. Nurses with higher qualifications and more clinical experience demonstrated better knowledge and adherence to recommended practices. Addressing these gaps through targeted training programs, resource allocation, and the implementation of standardized guidelines is essential for improving the quality and consistency of nursing documentation, ultimately enhancing patient care.

Declarations

Data Availability statement
All data generated or analyzed during the study are included in the manuscript.
Ethics approval and consent to participate.
Approved by the department Concerned. (IRBEC-SNU-055612/23)
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Conflict of interest

The authors declared an absence of conflict of interest.

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