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Documentation practices among ICU nurses: Contributory to patient's safety

Piol, Jemmalyn D. ✉
Graduate School, Lyceum of the Philippines University – Batangas, Philippines

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Abstract

A quantitative method approach was used in this study, with a descriptive correlational design to evaluate the results. The purpose of descriptive studies is to examine patterns or associations. This will enable the researcher to devise a program to further improve documentation practices for patient safety. The researcher chose 37 ICU nurses from various tertiary hospitals in Lipa City as target respondents. Purposive sampling was used, which is a sampling technique that works best when the study requires a specific response from the subject matter experts. The results of the study found that proper documentation is an essential component of nursing practice because it helps to ensure that the patient's needs are assessed, diagnosed, planned, implemented, and evaluated correctly throughout the plan of care tailored to various types of clienteles. The most concerning issues encountered by ICU nurses in documentation practices are nurse-patient ratio, poor writing styles of colleagues and doctors, inadequate supervision, and paper-based documentation. Among the strategies employed by ICU nurses in their documentation practices are making complete, accurate, and timely documentation to support effective risk management. An adequate staffing levels and workload management in addition maintaining a safe work environment and ensuring prompt and effective incidence reporting. The study also found that there is a significant relationship between the barriers/problems encountered and the strategies employed in documentation practices of ICU nurses. Considering the findings, the researcher developed a proposed program/plan intervention that will further enhance documentation practices not only in the ICU but in the nursing practice.

Keywords: barriers, documentation practices, ICU nurses, nursing process, patient safety, strategies

Documentation practices among ICU nurses: Contributory to patient's safety

1. Introduction

Patient safety is the prevention of harm or injury to patients during healthcare delivery. Incomplete, inaccurate, or unclear information in nursing documentation can result in errors in medication administration, diagnosis, and treatment. Additionally, poor documentation can make it difficult for healthcare professionals to communicate effectively, which can lead to less-than-ideal patient care. According to the World Health Organization (WHO, 2021), poor documentation is one of the most common causes of adverse events in healthcare. This can lead to errors in patient care, miscommunication between healthcare providers, and poor decision-making. In conclusion, there is a strong correlation between nursing documentation and patient safety. Inadequate documentation can jeopardize patient safety by causing adverse events, patient care errors, and miscommunication among healthcare professionals. To ensure patient safety and raise the standard of patient care, nurses must prioritize accurate and thorough documentation.

As vital members of the healthcare team, nurses make a significant contribution to the delivery of high-quality care. Nurses are undoubtedly required to fulfill a number of responsibilities while providing care, and they bear a heavy responsibility throughout the planning and implementation of care. Keeping thorough and accurate nursing documentation is one of the main duties of nurses. In addition to this, intensive care unit (ICU) nurses are responsible for providing acute and critical care to patients with life-threatening conditions. Documentation is an essential component of this care. Accurate and timely documentation ensures that critical patient information is readily accessible to healthcare providers, thereby reducing the risk of treatment or medication administration errors. Documentation also serves as a communication tool among healthcare providers, ensuring that all health professionals involved in a patient's care are aware of the patient's condition, treatments, and progress.

For patient safety, nursing documentation is a nursing process that should always be executed. However, this has not always been the case. Nursing documentation is often overlooked in clinical documentation, despite its importance for quality assurance and effective team communication in healthcare. There is often a discrepancy between nursing paperwork and the nursing process. The main causes of poor implementation are high documentation workload and poor paper-based record quality. However, because each patient has unique needs and a complex set of problems, many forms of nursing documentation may not be adequate to meet the documentation requirements of today's busy clinical settings. Thus, inadequate documentation practices by ICU nurses can have serious consequences for patient safety. For example, errors in medication administration, missed critical information, and incomplete documentation can lead to adverse events, such as prolonged hospital stays, readmissions, and even death. Therefore, it is essential to research and improve documentation practices by ICU nurses to ensure that patients receive safe and effective care. Furthermore, the purpose of the study, as proposed by the researcher, is to identify the level of nursing documentation practice among ICU nurses, the problems encountered, and the strategies employed. This will enable the researcher to develop an enhancement program that will further improve documentation practices for patient safety.

Objectives of the Study - This study assessed the documentation practices among intensive care unit (ICU) nurses which is contributory to patient's safety. Specifically, this study evaluated the documentation practices among ICU nurses in terms of: assessment, nursing diagnosis, planning, implementation and evaluation; identified the problems/barriers encountered, determined the strategies employed by ICU nurses in their documentation practices and correlated if there was a significant relationship between problem/barrier encountered and strategies employed by ICU nurses in their documentation practices. Lastly, will develop an action program/plan that may be proposed to further develop documentation practices that ensure quality nursing care and patient safety.

2. Methods

Research Design - This study assessed the documentation practices among intensive care unit (ICU) nurses which is contributory to patient's safety. Specifically, this study evaluated the documentation practices among ICU nurses in terms of: assessment, nursing diagnosis, planning, implementation and evaluation; identified the problems/barriers encountered, determined the strategies employed by ICU nurses in their documentation practices and correlated if there was a significant relationship between problem/barrier encountered and strategies employed by ICU nurses in their documentation practices. Lastly, will develop an action program/plan that may be proposed to further develop documentation practices that ensure quality nursing care and patient safety.

Participants of the Study - Intensive Care Unit (ICU) nurses from various tertiary hospitals in Lipa City was the study's participants. Direct respondents are ICU nurses from four Level III hospitals with a total of thirty-seven (37) ICU nurses with a minimum of six (6) months of experience or above. The list of prospective respondents for the study likewise achieved via purposive sampling. Purposive sampling works best when the study required a specific response from the subject matter experts. This is because the respondents to the study are clinical nurses with firsthand experience dealing with the topic. Furthermore, purposive sampling was a deliberate non-probability sampling technique utilized in research, involving the selection of participants based on predetermined criteria. This method proved valuable when studying proper documentation practices among staff nurses concerning patient safety. It allowed the researcher to choose participants possessing relevant expertise and experience, which enhanced the quality of insights. By focusing on individuals who met specific criteria, the technique improves research validity and reliability, ensuring findings are applicable to the intended population.

Data Gathering Instrument - A self-made questionnaire was the primary instrument for gathering information from the selected ICU nurses in tertiary hospitals of Lipa City. The questionnaire was created by the researcher using publications and other pertinent sources. After creating the questionnaire, the researcher sent it to the thesis adviser and clinical practice experts for feedback and approval. Following approval, the researcher distributed the questionnaire to fifteen (15) participants for pilot testing to ensure the tool's suitability prior to distributing the survey tool to the meant participants. This questionnaire survey assessed the level of documentation practices of intensive care unit (ICU) nurses in selected institutions in Lipa City, the problems encountered, and the strategies employed, which enabled the researcher to propose a program to further improve documentation practices for patient safety. The first part of the questionnaire were intended to identify the documentation practices utilized by ICU nurses in terms of assessment, diagnosis, planning, implementation and evaluation. The second part was used to explore the barriers encountered in their documentation practices. Lastly, was the strategies employed to improve documentation practices based on Vincent Framework. The Likert scale used was: 4= strongly agree, 3= agree, 2=disagree and 1=strongly disagree.

Data Gathering Procedure - The researcher compiled pertinent information and materials from a range of books, journals, reviews of papers, internet databases, and other studies carried out by other researchers. Furthermore, before being disseminated, the questionnaires was presented to the adviser and panelist for approval. The researcher then acquired approval to conduct and carry out the study from the Medical Director and the Human Resource Department through a letter. The researcher was then moved on to the real survey with conventional questionnaires or Google Forms, depending on what is most suitable for the participants, after the research instrument has been developed and pilot tested. The statistician examined the data collected, using the results as the framework for the study's interpretation and findings. As well, the researcher adhered to ethical standards and properly get the respondents' consent to participate as the purpose of the research.

Ethical Considerations - Ethical considerations are critical in any research project, including those investigating proper documentation practices and patient safety. Researchers must follow ethical principles to safeguard participants' rights and welfare, maintain confidentiality, and avoid any potential harm or risks. In

human subject studies, obtaining informed consent is a critical ethical issue. Before providing permission to participate, researchers should explain the nature and purpose of the study, the risks and benefits of participation, and ensure that participants understand their rights and have the opportunity to ask questions. Likewise, researchers ensure that the data gathered is kept confidential and that the identities of participants are protected. They should also consider the study's potential effect on participants and take steps to reduce any harm or discomfort. Furthermore, researchers followed institutional and professional codes of conduct. In this case, the researcher sought the approval of the LPU Ethics committee prior to data gathering, which describes ethical principles for human-participant research. Ethical considerations are especially essential in the study of proper documentation practices and the assessment of patient safety because the data collected directly impacts the health and well-being of patients. Following ethical principles ensures that the study is carried out responsibly and transparently, and that the findings are trustworthy and reliable. As a result, it is critical for researchers to consider ethical issues in study design, execution, and reporting. This serves to maintain the integrity of the research and to protect the rights and welfare of the participants involved.

Data Analysis **-** To answer the questions placed in the study, the researcher used different statistical treatments. The data were collected, tabulated, analyzed, and interpreted using descriptive statistics. Weighted mean and rank were used to determine the (a) documentation practices among ICU nurses in terms of assessment, diagnosis, planning, implementation, and evaluation, (b) problems/barriers encountered during the documentation process, and (c) strategies employed to improve the documentation practices. The result of Shapiro-Wilk Test showed that p-values of all variables were less than 0.05 which means that the data set was not normally distributed. Spearman’s rho was used as the non-parametric test to determine if there is significant relationship between the variables. All analyses were performed using SPSS version 25. Moreover, patients in ICUs have unique critical conditions, require continuous and complex care, and hence, are more at risk for medical errors. The reasons for the higher prevalence of medical errors in ICUs include the critical conditions of patients, the complex structure of ICUs, the multiplicity of each patient’s medications, the use of sophisticated equipment, patients’ old age, their long stay in ICU, the need for complex drug calculations, the use of medication infusion devices, high occupational stress, difficult work conditions, and emergency situations so certain strategies must me employed in able to improve the quality nursing care by means of complete and comprehensive nursing documentation practices.

3. Results and discussion

Table 1

Brand Management Responsibilities

Indicators	Weighted Mean	Verbal Interpretation	Rank
Assessment	3.65	Strongly Agree	4
Diagnosis	3.42	Agree	5
Planning	3.70	Strongly Agree	1.5
Implementation	3.70	Strongly Agree	1.5
Evaluation	3.66	Strongly Agree	3
Composite Mean	3.63	Strongly Agree	

Legend: 3.50-4.00 = Strongly Agree; 2.50-3.49 = Agree; 1.50-2.49 = Disagree; 1.00-1.49 = Strongly Disagree

Table 1 shows the brand management responsibilities in terms of the five components of nursing documentation: assessment, diagnosis, planning, implementation and evaluation. Based on ranking above, planning and implementation top the indicators both having a weighted mean of 3.70 both verbally interpreted as strongly agree. In correlation to the study, Intensive care unit (ICU) nurses are in charge of providing acute and critical care to patients with life-threatening conditions. This therapy relies heavily on documentation. Accurate and timely documentation ensures that critical patient information is available to healthcare practitioners, reducing the chance of treatment or prescription administration errors. Nursing care documentation is critical for detecting patients' worsening situations as soon as possible. This, together with excellent communication and reaction from members of the multidisciplinary care team, has the potential to reduce

hospital mortality. Nurses should prepare and document what they see rather than what they believe. Nurses hold a significant amount of responsibility for coordinating and implementing the multidisciplinary team's strategy for recording treatment and progress toward goals. This is due to the fact that documentation is a functional framework that provides a comprehensive account of the care provided to a patient (Andualem, 2019).

Documentation, on the other hand, is essential for preserving accurate and complete patient records, particularly in the intensive care unit, guaranteeing treatment continuity, and boosting communication among healthcare professionals (Sorinmade et al., 2019). Documentation is also required for legal and regulatory purposes, as well as to give a record of care delivered, which is required for quality improvement initiatives and certification procedures (Canadian Nurses Association, 2018). Proper documentation is also essential for patient safety since it prevents errors and ensures that patients receive the treatment they require. Breen and colleagues (2018) discovered that using Orlando's Nursing Process Theory as a framework for documentation improved patient safety in a hospital environment in research published in the Journal of Clinical Nursing. The authors claim that the framework assisted in ensuring that all components of the nursing process were examined and recorded, resulting in more consistent and effective treatment. Thus, nursing documentation is an aspect of nursing that must always be documented to be carried out in order to ensure patient safety. Furthermore, guaranteeing patient safety and quality of care requires administering nursing care in a consistent and standardized manner. Documentation of care implementation assists nurses in adhering to established protocols, standards, and evidence-based practices. It ensures that nursing interventions are performed methodically and consistently, encouraging consistency between shifts and throughout multidisciplinary teams.

Followed by evaluation and assessment with weighted mean of 3.66 and 3.65 correspondingly verbally interpreted as strongly agree. In the nursing process, when assessment is insufficient and not properly documented, it will be reflected on the evaluation of care because it has a domino effect on the entire process; similarly, when assessment is comprehensive and complete, it will reflect a positive outcome/evaluation of nursing care. As numerous studies have shown, most nurses have an inadequate attitude, knowledge of documentation, and insufficient information, and their activities are either not documented or not adequately documented, which poses a significant difficulty when evaluating client care. Staff nurses viewed nursing documentation as an important practice in patient care; however, the act of documentation remains problematic due to a lack of pre and post-service training, a lack of resources and supplies, a lack of comprehensive nursing education (CNE), a lack of time, and overcrowding, which has resulted in ongoing efforts to improve documentation practices in the clinical setting (Andualem et al, 2018).

Ranked on the last is diagnosis with a weighted mean of 3.42 and verbally interpreted as agree. Even though nurses' general knowledge, attitude, and practice towards nursing care documentation has a great impact, no attention was given in lieu to the nursing process when broken down into separate aspects since it is a process itself. Therefore, this study quantified the level of nurses' documentation practices; identified barriers associated with strategies employed will further assess the current status of nursing care documentation and recommend effective solutions for the identified problems. At the same time, to enhance and promote standardized nursing care, every hospital should create standards and criteria for recording nursing care and give training on them. It is also suggested that multisite quantitative and qualitative research be conducted to increase the quality of the results. Nursing care documentation procedures were significantly influenced by factors such as work environment, work experience, and nurse expertise (Andualem et al., 2018).

To conclude, the summary of the indicators garnered a grand composition mean of 3.63 which is verbally interpreted as strongly agree. Furthermore, the utilization of the nursing process in nursing documentation practices in the ICU is important for promoting a systematic approach to care, individualizing patient care, facilitating communication and collaboration, fostering critical thinking and clinical judgment, evaluating care and outcomes, and ensuring legal and regulatory compliance. By documenting each step of the nursing process, nurses enhance patient care's quality, safety, and effectiveness.

Nurses are vital members of the healthcare team and can substantially contribute to delivering high-quality care. They are responsible for a number of tasks during care delivery, and they play a major role in the planning and implementation of care. Inadequate documentation practices among ICU nurses can have serious consequences for patient safety. For example, errors in medication administration omitted important information, and insufficient documentation can lead to adverse outcomes such as longer hospital stays, readmissions, and even death. Therefore, it is important to research and improve documentation practices among ICU nurses to ensure that patients receive safe and effective treatment. Studies have shown that the majority of nursing documentation is inaccurate, ambiguous, and of poor quality. However, there are a number of factors that influence nursing documentation, and these factors are all interconnected.

Table 2

Problems Encountered in Documentation Practices

Indicators	Weighted Mean	Verbal Interpretation	Rank
Poor internet connection causes delay in my documentation processes.	3.00	Agree	7
In documentation practices, the use of paper and pen in documentation eats most of my time	3.35	Agree	4
Poor writing style of my colleagues and even doctors may lead to commission of mistakes in documentation.	3.57	Strongly Agree	2.5
Uncooperative patients and relatives arrive me to inadequate documentation.	3.30	Agree	5
Lack of operational standard of nursing documentation (AOR).	3.24	Agree	6
Nurse-patient ratio affects documentation practices.	3.78	Strongly Agree	1
Inadequate supervision and training on operational standard of nursing documentation.	3.57	Strongly Agree	2.5
Composite Mean	3.40	Agree	

Legend: 3.50-4.00 = Strongly Agree; 2.50-3.49 = Agree; 1.50-2.49 = Disagree; 1.00-1.49 = Strongly Disagree

Inadequate documentation methods among ICU nurses can have major ramifications for patient safety, particularly if the nurse-patient ratio remains extremely high. Medication errors, omitting vital information, and poor documentation can all result in negative outcomes such as extended hospital stays, readmissions, and even death. To ensure that patients receive safe and effective care, conducting research and improving documentation procedures among ICU nurses is vital. According to studies, the majority of nursing paperwork is incorrect, unclear, and of low quality. Nursing documentation is influenced by a variety of factors, many of which are linked. Some of the issues raised include a shortage of personnel, a lack of understanding of the importance of documentation, a high nurse-patient ratio, a lack of hospital education, and a lack of support from nursing managers. According to Alhawsawi (2021), the most prevalent hurdles to documenting are a lack of time, resources, and knowledge. Mutshatshi et al. (2018) discovered that nurses in South African public hospitals encounter obstacles such as a shortage of time, recording materials, and a high patient load.

Furthermore, Wong (2022) claims that the solution to increasing nurse-to-patient ratios is not as easy as simply recruiting more nurses. Improving working conditions is also an important part of tackling the nurse shortage. Several studies have found that improving nurse-to-patient ratios can assist enhance patient safety. However, safe staffing is determined by a complicated collection of factors, including hospital type, patient demographic, care delivery methods, unit architecture, patient acuity, and the nurse's education and experience. Nurse staffing ratios that are mandated indicate a "one-size-fits-all" approach to patient care, which is not necessarily effective. Nurse leaders and nurses are the best prepared to establish suitable staffing for their patients' requirements. Mandated nurse staffing ratios are a static and ineffective tool that do not ensure quality care, optimal patient experience, and staff well-being.

The following two indicators “Poor writing style of my colleagues and even doctors may lead to commission of mistakes in documentation.” and “Inadequate supervision and training on operational standard of nursing documentation.” with the same weighted mean of 3.57, the three above-mentioned indicators are all verbally interpreted as strongly agree. The following indicators “In documentation practices, the use of paper and pen in documentation eats most of my time.” ranked 4th with a weighted mean of 3.35 verbally interpreted as

agree.

Despite the fact that both paper-based and electronic nursing documentation adhere to various principles such as objectivity, specificity, clarity and consistency, comprehensiveness, respect for confidentiality, and factuality, nurses' insufficient attitude and knowledge about how to document nursing care in accordance with these principles can have an impact on the quality of nursing documentation. However, it is evident that paper and pen documentation requires more time and effort than entering it into electronic devices (Andualem et al., 2018). Time constraints in nursing documentation might also have an impact on its efficacy. Poor communication and coordination among healthcare professionals may impede this, with nurses frequently depending on information supplied by other healthcare team members. Incorrect or partial information may be transmitted, resulting in documentation mistakes that endanger patient safety (Lisby et al., 2018). Furthermore, oversights of nursing documentation can seriously influence patient safety. Documentation is an important aspect of nursing care since it acts as both a record of the patient's care and a communication tool for other healthcare providers. Lapses in nursing documentation can lead to mistakes in patient care and even jeopardize their safety. The following are some of the potential consequences of nursing documentation gaps on patient safety: Communication breakdown: When nursing documentation is insufficient or erroneous, it can lead to miscommunication between healthcare personnel. As a result, medication mistakes, missing treatments, or delayed care may occur.

Delays in treatment might occur when nursing documentation is delayed or inadequate. This can be harmful to the patient's health and safety. missing diagnoses: When nursing documentation is insufficient or erroneous, missing diagnoses can occur. This can delay or prevent the patient from obtaining the necessary care. Increased risk of falls: When nursing paperwork is poor or wrong, patients are more likely to fall. This is because nurses may be unaware of the patient's risk factors for falls or the treatments necessary to avoid them. The nurse manager must constantly lead, supervise, and evaluate nursing activity and documentation. They must constantly deliver high-quality results. They should always perform high-quality nursing tasks that improve patient satisfaction, patient safety, and cost-effectiveness (Asmirajanti et al., 2019). Ranked fifth and sixth are the indicators "Uncooperative patients and relatives arrive me to inadequate documentation." and "Lack of operational standard of nursing documentation." with weighted mean of 3.30 and 3.24 respectively verbally interpreted as agree. Nursing tasks are crucial in a hospital and must meet the needs of patients, but they can be difficult if patients and their relatives are unwilling to cooperate. Since critical thinking should be documented as a result of every nursing activity in the intensive care unit. Interprofessional communication and nursing care assessment cannot be optimized if nursing documentation is not precise and unambiguous (Asmirajanti et al, 2019).

Nursing documentation, on the other hand, is an effective instrument for treating resistant patients with leg ulcers, according to Olson and Friman's (2020) study. Patients reported a worse quality of life, which may make wound healing more difficult. This study also discovered major flaws in nurses' reporting of patients with painful leg ulcers' perceived quality of life. Issues with quality of life were noticed seldom, and when they were, they were typically related with treatments. Nonetheless, as healthcare becomes more complex, it is critical that nursing staff consider documentation as a need for providing high-quality nursing care as well as a critical component of care planning and assessment. The deficiencies in the nurses' documentation indicate to areas that require improvement in order to effectively support patients' health and wellbeing. Furthermore, a lack of operational standards of nursing documentation can result in mistakes in drug administration, diagnosis, and treatment due to incomplete, incorrect, or ambiguous information arising from erroneous nursing documentation. Documentation methods may make it difficult for healthcare personnel to communicate effectively, resulting in subpar patient care. Finally, there is a significant link between nursing documentation and patient safety, and lacking standardized operational documentation may compromise patient safety by creating adverse events, patient care mistakes, and misunderstanding among healthcare personnel. Nurses must emphasize precise and detailed documentation to ensure patient safety and increase the level of patient care. Inadequate training and education is also a key impediment, with some nurses lacking the essential knowledge and abilities to

successfully document. This can lead to inconsistencies in documentation practices and incomplete or incorrect data being recorded, both of which can have severe repercussions for patient safety (Fernandes et al., 2019).

Having the least mean of 3.00 is the indicator “Poor internet connection causes delay in my documentation processes.” which is verbally interpreted as agree. Technological issues, such as difficult-to-use electronic health record (EHR) systems prone to errors, might obstruct effective nurse recordkeeping. Nurses might find it difficult to enter data into the EHR in a timely and accurate way, possibly jeopardizing patient safety (Bastani et al., 2018). Nursing documentation hurdles, in general, can have a major impact on patient safety. Addressing these hurdles necessitates healthcare organizations providing enough training and teaching, allocating sufficient time for documentation, improving communication and coordination among healthcare workers, and dealing with technology-related challenges. By addressing these barriers, healthcare organizations may guarantee that nursing documentation is accurate, full, and trustworthy, boosting patient safety.

Table 3

Strategies Employed to Improve Documentation Practices

Indicators	Weighted Mean	Verbal Interpretation	Rank
I will ensure that I am educated and attend up-to-date training's needed to improve my nursing documentation that will uplift the quality of my care and patient care outcomes.	3.70	Strongly Agree	7.5
I will follow the standardized documentation templates and tools provided by my institution which promote comprehensive and consistent documentation practices that are aligned with patient safety goals and practices.	3.73	Strongly Agree	5.5
I will adapt to efficient workflows and processes that always prioritize safety by means of effective nursing documentation.	3.70	Strongly Agree	7.5
As a nurse, I will advocate for the properly allocate the resources of the unit I am assigned and help in the development of policies and procedures that support effective patient safety documentation practices.	3.73	Strongly Agree	5.5
As a nurse, I will establish and maintain a safe work environment that supports accurate and complete nursing documentation to promote patient safety.	3.76	Strongly Agree	3.5
I will ensure that incidents, errors, and patient falls are documented promptly and effectively to address them in a timely manner.	3.76	Strongly Agree	3.5
As a nurse, I will ensure that patient safety documentation is complete, accurate, and timely, to support effective risk management and quality improvement.	3.81	Strongly Agree	1.5
I will advocate for adequate staffing levels and workload management to help prevent errors in nursing documentation that may compromise patient safety.	3.81	Strongly Agree	1.5
Composite Mean	3.75	Strongly Agree	

Legend: 3.50-4.00 = Strongly Agree; 2.50-3.49 = Agree; 1.50-2.49 = Disagree; 1.00-1.49 = Strongly Disagree

Table 3 explored the strategies employed to improved documentation practices of ICU nurses. The two indicators “As a nurse, I will ensure that patient safety documentation is complete, accurate, and timely, to support effective risk management and quality improvement.” and “I will advocate for adequate staffing levels and workload management to help prevent errors in nursing documentation that may compromise patient safety.” tied on the first place having a weighted mean of 3.81 and verbally interpreted as strongly agree. ICU nurses should keep a consistent and professional patient health information record to guarantee excellent patient care, constant communication among all clinicians caring for the patient, and an effective defense in the event of litigation. This can be accomplished by conducting and documenting an informed consent discussion with the patient prior to implementing any aspect of the treatment plan involving potential risk, which includes asking the patient to repeat the main points of the discussion and obtaining their stated and written consent, describing patient and family healthcare education encounters, listing the presence of specific family members and their relationship to the patient, and providing a written consent, if needed, and include the interpreter’s contact information.

Consequently, advocating for patients necessitates adequate task management and safe staffing. In the face

of cost-cutting pressures and the need to make the most use of limited nurses, flexible staff deployment (floating employees between units and temporary employment) guided by a patient categorization system may appear to be an effective way to fulfill changeable demand for treatment in hospitals. increased baseline roster staffing plans resulted in increased expenses but improved patient outcomes (Griffiths et al., 2021).

The following two indicators also tied and ranked next, "As a nurse, I will establish and maintain a safe work environment that supports accurate and complete nursing documentation to promote patient safety." and "I will ensure that incidents, errors, and patient falls are documented promptly and effectively to address them in a timely manner." having the same weighted mean of 3.76 both verbally interpreted as strongly agree. Accurate and thorough nursing documentation is required to ensure a safe work environment and increase patient safety. Documentation of high quality is characterized as being correct, complete, using clear language, accessible and readable, timely, brief, and plausible. Poor nursing documentation in the acute care situation can have a detrimental influence on patient outcomes and may lead to litigation. As a result, it is critical to explore techniques for improving the quality of nursing documentation in the acute care context.

Based on Eltaybani et al. (2018), there are strategies that will help improve the healthcare system; first is to ensure that occurrences and errors are documented as soon as possible and as thoroughly as possible. When nurses feel protected and the reporting procedure is not cumbersome, they are more likely to report errors. However, a globally defined language for defining and analyzing nursing mistakes is required. Another strategy is to enhance the management and the atmosphere. This might assist in minimizing the occurrence and severity of nursing mistakes in ICUs. Targeting error-prone times in the ICU, such as mid-evening and midnight shifts, as well as increased monitoring and proper personnel redeployment, might also assist in minimizing the occurrence and severity of nursing errors. Finally, establishing specific nurse interventions for patients with inadequate health literacy and patients in isolation might lead to more meaningful ICU healthcare safety discourse. Next indicators "As a nurse, I will advocate for the properly allocate the resources of the unit I am assigned and help in the development of policies and procedures that support effective patient safety documentation practices." and "I will follow the standardized documentation templates and tools provided by my institution which promote comprehensive and consistent documentation practices that are aligned with patient safety goals and practices." both garnered a weighted mean of 3.73 both verbally interpreted as strongly agree.

Ahmandi et al. (2019) cited that the individual, organizational, and national variables all have an impact on nursing documentation in clinical practice. To improve the quality of nursing documentation, hospitals can hire more nurses, reform the healthcare management structure, develop appropriate regulations regarding division of labor, provide continuous education of healthcare staff, establish clinical governance, improve interpersonal relationships, develop hardware and software documentation techniques, and provide support for nurses. Improving and better arranging human and non-human resources is a high priority for preventing or minimizing nursing mistakes. Policy changes, teaching and training, and likeness reduction are generally inexpensive and simple measures for reducing the prevalence of nursing mistakes in impoverished nations. Staff nurses should play an active role in policy reform. Adoption of current technologies and workplace change should help to improve patient safety education. These studies show that appropriate documentation is intrinsically tied to the nursing process, and that employing standardized nursing process models may improve documentation practices (Eltayban et al., 2020)

The last two indicators "I will ensure that I am educated and attend up-to-date training needed to improve my nursing documentation that will uplift the quality of my care and patient care outcomes." and "I will ensure that I am educated and attend up-to-date training's needed to improve my nursing documentation that will uplift the quality of my care and patient care outcomes." ranked least both having a weighted mean of 3.70 and verbally interpreted as strongly agree. Herisiyanto et al. (2020) discovered that contact between nurses and their patients is positively and substantially connected with patient safety in a study on nursing practices at Pemalang Ashari Hospital. This implies that hospitals should continue to help nurses by giving current training and information on how to maintain a safe working environment for everybody, particularly new nurses. This will

aid in the improvement of their nursing process documentation and communication abilities, which will aid in the safety of patients. Correspondingly, organizational concerns such as the availability of operational standards, in-service training, a lack of personnel, a lack of incentive packages, and apathy all had an impact on the documentation. Although nursing documentation knowledge, attitude, and practice were all good, some organizational factors may have influenced this. Nursing managers and policymakers, according to the researchers, should offer nursing people, logistics, and nursing documentation regulations in order to improve nursing documentation (Seidu et al, 2021).

Overall composite mean of strategies employed by ICU nurses on their documentation practices was 3.75 and verbally interpreted as “strongly agree”. Moreover, patients in ICUs have unique critical conditions, require continuous and complex care, and hence, are more at risk for medical errors. The reasons for the higher prevalence of medical errors in ICUs include the critical conditions of patients, the complex structure of ICUs, the multiplicity of each patient’s medications, the use of sophisticated equipment, patients’ old age, their long stay in ICU, the need for complex drug calculations, the use of medication infusion devices, high occupational stress, difficult work conditions, and emergency situations so certain strategies must me employed in able to improve the quality nursing care by means of complete and comprehensive nursing documentation practices.

Table 4

Relationship Between Problems / Barriers Encountered and Strategies Employed

Variables	Spearman’s Rho	p-value	Interpretation
Problems / Barriers Encountered in Documentation Practices and Strategies Employed to Improve Documentation Practices	0.370	0.024	Significant

Legend: Significant at p-value < 0.05

Table 4 represents the correlation of significance between problems/barriers encountered and strategies employed to improve documentation of ICU nurses. Based on the results, there was statistically significant relationship between the problems/barriers encountered in documentation practices and strategies employed by the respondents to improve documentation practices (p=0.024) because the computed p-value was less than 0.05. The more problems/barriers they encounter in documentation practices, the more they employ strategies to improve documentation practices. According to the findings, various impediments have had a significant impact on documentation procedures and information interchange, potentially putting primary care patients in a vulnerable and exposed position. Increased awareness and the use of tactics by a particular professional are critical for good documentation. High-quality patient recording is critical in primary care for assuring service quality, continuity, and patient safety. For many years, the quality of nursing documentation has been found to be poor; therefore, understanding primary care staff perspectives of barriers to recording in electronic health records is required to guarantee patient safety in services. Because of the growing complexity in primary care nursing, there is a greater need for awareness and a focus on providing suitable nursing-supportive tools and techniques to improve nurse documentation practices. Furthermore, patient safety, obstacles, and nursing documentation practices are all intertwined. Nursing documentation, whether paper-based or computerized, is critical to ensuring continuity, quality, and safety of patient care (Berkjan et al., 2021).

According to Ramos et al (2018) in "The Relationship of Nursing Documentation to Patient Outcomes," this study is being conducted in a tertiary hospital in the Philippines to explore the link between nursing documentation and patient outcomes. Medication errors and hospital-acquired infections are among the bad patient outcomes connected to insufficient and erroneous recordkeeping. Proper documentation is critical in maintaining patient safety, as recognized in Filipino nursing literature. Ebora and Beltran (2018) observed in the Philippines that adequate documentation considerably helps to patient safety and quality care. The importance of precise and timely recording was underlined by the authors since it provides a comprehensive record of the patient's health, treatment, and growth. Furthermore, proper recordkeeping aids in identifying potential dangers and mitigating unfavorable situations. Chua and Baluyot (2020) researched Filipino nurses' documentation procedures in the emergency department and discovered that insufficient documentation is a common flaw that

can lead to medical mistakes and jeopardize patient safety. The authors urged for continued education and training in correct documentation processes to improve patient outcomes.

The Philippines' Department of Health (DOH) has likewise acknowledged the necessity of proper recordkeeping in protecting patient safety. To guarantee accurate and complete patient information recording, the DOH's Health Facility Operation and Development Bureau has developed rules and standards on health facility documentation (DOH, 2018). The accurate use of medical charts, patient identification, prescription and treatment recording, and documenting of adverse events are among the suggestions. The adoption of these recommendations is crucial in order to emphasize patient safety and great treatment. Subsequently, the Filipino nursing literature emphasizes the need of good recordkeeping in maintaining patient safety. The hazards of poor documentation are highlighted in studies, which argue for continual education and training on good documentation procedures. The DOH has also recognized the need of adequate documentation and has established recommendations to promote accurate and full patient information recording. These projects contribute to better patient outcomes and the promotion of high-quality healthcare in the Philippines.

4. Conclusions and recommendations

The nursing process, adapted from Ida Orlando's Nursing Process Theory and encompassing assessment, diagnosis, planning, implementation, and evaluation, emerges as an effective framework for understanding the documentation practices of ICU nurses. Highlighting the pivotal role of proper documentation, it is evident that accurate recording ensures that patients' needs are meticulously addressed, diagnosed, planned for, executed, and evaluated in line with individualized care plans catering to diverse patient categories. Focusing on key result areas of documentation practices underscores the heightened managerial responsibilities associated with planning and implementation, among the five nursing process components. Pressing issues encountered by ICU nurses during documentation practices, which encompass challenges related to nurse-patient ratios, suboptimal communication through writing among colleagues and physicians, insufficient supervision, and reliance on paper-based documentation methods. Illuminates the strategies predominantly employed by ICU nurses to enhance their documentation practices. These strategies primarily involve meticulous, accurate, and timely documentation to facilitate effective risk management, maintaining optimal staffing levels and managing workloads, fostering a secure work environment, and ensuring prompt and efficient incident reporting. Significant correlation emerges between the encountered barriers and problems, and the strategies implemented in documentation practices by ICU nurses. This underlines a dynamic interplay between the challenges faced and the corresponding solutions implemented by nurses to mitigate these obstacles.

To enhance ICU nursing documentation, a multifaceted approach is recommended. Initiatives include structured training sessions focusing on the nursing process stages, emphasizing their significance in guiding patient care and documentation requirements. Periodic audits should be conducted to ensure accurate documentation, with constructive feedback provided to improve proficiency. Resource allocation strategies, addressing nurse-patient ratios during critical documentation periods, can reduce stress and enhance accuracy. Workshops on effective communication within healthcare teams aim to improve writing styles and interdisciplinary collaboration. Implementing a mentoring program for experienced nurses to guide less experienced colleagues enhances supervision and knowledge exchange. Transitioning to digital documentation through comprehensive training and IT support is advised, promoting a seamless shift from paper-based to electronic methods. Standardized documentation checklists should be implemented to guide nurses and ensure completeness, accuracy, and consistency across patient records.

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