Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1541

KNOWLEDGE AND PRACTICES OF PROFESSIONAL NURSES TOWARDS NURSES' DOCUMENTATION AT KAYUNGA REGIONAL REFERRAL HOSPITAL, KAYUNGA DISTRICT. A CROSS-SECTIONAL STUDY.

*Norah Namulanda, Olivia Kyeree, Immaculate Prosperia Naggulu, Jane Frank Nalubega**
Mildmay Uganda School of Nursing and Midwifery

Abstract

Background

Nurses' documentation is a critical aspect of healthcare that ensures continuity of care, patient safety, and effective communication among healthcare professionals. However, gaps in knowledge and inadequate documentation practices compromise patient outcomes and legal compliance. This study aimed to assess the knowledge and practices of professional nurses regarding nurses' documentation at Kayunga Regional Referral Hospital, Kayunga District.

Methodology

The method was a descriptive cross-sectional study design using quantitative research methods. A structured questionnaire was administered, and a checklist for the practice of professional nurses at Kayunga Regional Referral Hospital was selected through purposive sampling. Data was collected on nurses' knowledge and practices regarding documentation and analyzed using descriptive statistics, with results presented in tables, pie charts, and figures.

Results

60% of nurses had adequate knowledge of the importance of documentation, 55% were unaware of the potential consequences of improper documentation, and 53% did not consistently document nursing interventions provided to patients. 78% of nurses practiced real-time or near-real-time documentation, while 68% adhered to standardized documentation protocols.
22 (55%) were between 25 and 44 years old, while the least number of respondents, 2 (5%), were less than 25 years old. The majority, 32 (80%), were female, while the smallest group, 8 (20%), were males. 28 (70%) had attained a certificate in nursing, while the lowest number of respondents, 2 (5%), had attained a diploma in nursing. 24 (60%), had practiced for 1- 5 years, while the smallest group, 2 (5%), had practiced for less than 1 year

Conclusion

The study revealed that nurses understood the importance of documentation but struggled with applying documentation standards in practice.

Recommendation

The study recommended regular training, the use of structured formats, and real-time documentation to improve the quality and accuracy of nursing documentation at Kayunga Regional Referral Hospital.

Keywords: *Nurses' Documentation, Knowledge and Practices, Kayunga Regional Referral Hospital.*
Submitted: *2025-01-10* ***Accepted:*** *2025-02-20* ***Published:*** *2025-03-01*

Corresponding Author: Jane Frank Nalubega*
Email: *janecll.nalubega@gmail.com*
Mildmay Uganda School of Nursing and Midwifery

Background of the study

Nurses' documentation, within the nursing profession, is the comprehensive and systematic recording of a patient's health information, encompassing medical history, assessments, diagnoses, interventions, outcomes, and plans of care (Nyaba, 2021). This documentation serves as a critical communication tool among healthcare professionals, ensuring continuity of care, promoting patient safety, and facilitating informed decision-making (Shala et al., 2021). Accurate, complete, and timely patient documentation is fundamental to quality nursing practice (Tamir et al., 2021). It provides legal and ethical records of patient care, supports clinical decision-making, enables effective communication among the healthcare team, and contributes to a quality improvement initiative (Dwyer et al., 2024). Moreover, nurses' documentation plays a vital role in research, education, and reimbursement processes (Alqahtani et al., 2020). However, professional nurses encounter challenges in maintaining optimal documentation practices (Nakate et al., 2015). These challenges include heavy workloads, time constraints, inadequate staffing, and the increasing complexity of healthcare environments (Hariyati et al., 2020). Additionally, nurses' knowledge of documentation influences their documentation practices (Hariyati et al., 2020).

Globally, the prevalence of effective patient documentation among professional nurses shows considerable variability. High-income countries tend to exhibit higher rates, estimated between 70% and 80%,

likely due to well-established healthcare systems and resources (The Joint Commission, 2023). In contrast, low- and middle-income countries report lower prevalence, ranging from 30% to 60%, attributed to factors like resource constraints and inadequate training, According to WHO (World Health Organization, 2020). In developed countries, such as those with high-income economies, nursing documentation rates range between 70% and 80%, largely due to well-established healthcare systems and access to adequate resources (Witter et al., 2020). However, in developing countries, the prevalence is notably lower, between 30% and 60%, primarily due to limited resources and insufficient training (Bvumbwe & Mtshalin, 2018).

In Africa, the prevalence of effective nurses' documentation among professional nurses varies significantly, with estimates suggesting an overall average of approximately 50-60% adherence to best practices (Shaibu et al., 2021). This wide range reflects the diverse challenges and contexts within the continent's healthcare systems. In Sub-Saharan Africa, the prevalence of effective nursing documentation among professional nurses presents a mixed picture, with an estimated average adherence to best practices ranging between 40% and 60% (Shaibu et al., 2021). Conversely, West African countries such as Nigeria and Ghana exhibit lower rates, averaging approximately 40%, suggesting room for significant improvement (Omoniyi et al., 2022). Central Africa also faces challenges, with studies in Cameroon and the Democratic Republic of Congo reporting documentation rates as low as 30-35%, reflecting the impact of resource limitations and infrastructural constraints (Tshilumba et al., 2019). Tanzania falls somewhere in between, with an estimated prevalence of 60% (Mbembati et al., 2019).

In Uganda, the prevalence of effective nurse documentation among professional nurses varies significantly across different regions, reflecting disparities in healthcare resources, training, and infrastructure (Ministry of Health Uganda, 2023). However, this figure masks significant regional differences. For instance, in the Karamoja region, the prevalence is estimated to be as low as 50%, highlighting substantial challenges in documentation practices (Coffin-Schmitt et al., 2021). In contrast, the Mbarara region reports a higher prevalence of 70%, suggesting better adherence to documentation standards (Ministry of Health Uganda, 2023). Kampala, the capital city, falls somewhere in between, with a prevalence of approximately 60% (Ministry of Health Uganda, 2023). Poor documentation among professional nurses has significant negative impacts on patient care, safety, and the healthcare system as a whole. Incomplete or inaccurate records compromise patient safety by leading to medical errors, miscommunication among healthcare providers, and adverse patient outcomes (O'Brien, 2021). It is upon this background that the researcher is set to determine the factors influencing professional nurses' knowledge and practices regarding nurses' documentation at Kayunga Regional Referral Hospital, Kayunga District, Uganda.

Methodology

Study Design and rationale

This study adopted a cross-sectional descriptive design utilizing a quantitative research method.

It was a cross-sectional type of design because data was obtained at a single point in time.

It was descriptive because it was accessing the knowledge and practices of professional Nurses regarding Nurses' documentation in Kayunga Regional Referral Hospital in Kayunga District.

Study Setting and Rationale

The study was conducted at Kayunga Regional Referral Hospital, located in Kayunga District, approximately 74 kilometers from Kampala, the capital city of Uganda. Kayunga Regional Referral Hospital is a key healthcare facility in the region with a bed capacity of approximately 100 beds, providing both outpatient and inpatient services. On average, the facility attended to around 300 patients daily, offering a range of medical services, including maternity care, surgical services, medical wards, pediatric wards, and emergency services. This setting was particularly suitable for the study on the knowledge and practices of professional nurses towards nurses' documentation because the health center is actively engaged in various healthcare services that require accurate and consistent documentation. The diversity in patient demographics and the range of services offered at Kayunga Regional Referral Hospital provided a comprehensive environment to assess and understand the documentation practices among nurses. Additionally, the facility's significant patient turnover ensured a steady flow of data essential for meeting the study's objectives.

Study Population

The study included all professional nurses in both inpatient and outpatient departments, reviewing patients' files. The study enabled an assessment of the effectiveness of existing documentation practices and identified areas for improvement.

Sample Size Determination

Sample size determination involved calculating the number of participants required for the study. The sample size was determined using Krejcie and Morgan's (1970) formula for sample size determination from Appendix III, which is commonly used to calculate an appropriate sample size based on the population size (*Sample Size Determination Using Krejcie and Morgan Table*, 2012). This formula was selected for the study because it was well-suited to the research objectives and ensured that the sample size was sufficient to capture meaningful insights from the study population. The population size (N) of professional nurses working in the inpatient and outpatient departments at Kayunga Regional Referral Hospital was 45. Based on Krejcie and Morgan's (1970) standard table for sample size determination, the corresponding sample size (S) for a population of 45 was 40 participants (*Sample Size Determination Using Krejcie and Morgan Table*, 2012). This sample size was

representative of the general population of professional nurses in the inpatient and outpatient departments. Thus, the sample size for this study was 40 respondents. This size was considered adequate for ensuring meaningful and reliable results.

Sampling Procedure

A purposive sampling method was used to select the participants for this study. The participants were professional nurses employed at Kayunga Regional Referral Hospital in Kayunga District, who were directly involved in patient care and documentation. The selection of participants was based on specific inclusion criteria that ensured the participants had relevant experience and responsibility in nurses' documentation. The sampling procedure began by identifying professional nurses who met the inclusion criteria, which included having experience in nursing at the health center and being actively engaged in nurses' documentation practices. The list of eligible professional nurses was obtained from the health center's human resources department. From this list, the researcher purposively selected a total of 40 professional nurses who represented a cross-section of different departments within the health center, such as outpatient services, inpatient care, maternity, and specialized units. The selection ensured diversity in terms of experience, gender, and roles within the health center to capture a comprehensive understanding of documentation practices. The rationale for using purposive sampling was to deliberately include those professional nurses who were most knowledgeable and experienced in nurses' documentation, which was central to the study's objectives. The selected participants were approached individually, and their consent was obtained before their inclusion in the study. This method ensured that the sample was representative of the various documentation practices within the health center, allowing for a detailed understanding of the knowledge and practices of professional nurses towards nurses' documentation at Kayunga Regional Referral Hospital.

Inclusion Criteria

The study included professional nurses at Kayunga Regional Referral Hospital in Kayunga District who met the following criteria:

- Professional nurses who were on day duty at Kayunga Regional Referral Hospital and involved in patient care and documentation.
- Professional nurses who voluntarily consented to participate in the study.

Exclusion Criteria

The study excluded:

- Professional nurses who were busy.
- Professional nurses who were on night shift duty.
- Professional nurses who did not provide consent to participate in the study.

Definition of Variables

A variable is an object, event, idea, feeling, period, or any other type of category being measured. There are two types of variables: independent and dependent variables.

Independent Variables

- Knowledge and practices of professional nurses.
- Knowledge is the collection of information, facts, skills, and understanding that the person has acquired through experience and education.
- Practice is the repeated performance or exercise of activity, skill, or behavior to improve proficiency and reinforce learning.

Dependent Variable

- Nurses' documentation is the systematic and comprehensive recording of patients' health information, which includes medical history, assessments, diagnoses, interventions, outcomes, and plans of care

Research Instruments

The primary data collection tool for this study was a self-administered structured questionnaire.

The questionnaire comprised closed-ended questions, allowing respondents to choose the most appropriate option from a list of provided answers and a checklist for the patients' files, which were assessed for practice. This format ensured uniformity in responses and facilitated the generation of quantifiable data that could be easily analyzed. The questionnaire was developed in English to maintain consistency and clarity. To ensure its effectiveness and clarity, the questionnaire underwent a pre-test with a group of 10 professional nurses from a different healthcare facility. The pre-test helped identify any ambiguities or difficulties in understanding the questions and allowed for necessary revisions before the actual data collection. The questionnaire was organized into sections, with each section corresponding to the specific research objectives. These sections were informed by a comprehensive literature review to ensure the inclusion of relevant and important aspects related to knowledge and practices towards nurses' documentation.

Data Collection Procedure

Data collection took place over four consecutive days at Kayunga Regional Referral Hospital in Kayunga District. The researcher personally administered the questionnaires to ensure consistency in the data collection process. Each day, a target of 10 professional nurses was approached to participate in the study. To ensure a representative sample, participants were selected from different departments within the health center. All participants received a self-administered questionnaire to complete independently. They were instructed to carefully read each question and select the most appropriate response. The researcher was available to address any questions or concerns that arose during the completion of the questionnaire. This approach ensured that all nurses, regardless of their language proficiency, had an equal opportunity to participate in the study. Completed questionnaires were immediately reviewed for completeness. If any questionnaires were

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1541

found to be incomplete, they were returned to the respective participants for completion. Once all questionnaires were fully completed, they were collected by the researcher for further analysis.

Data Management

The filled questionnaires were collected, checked for completeness, and counted after every data collection day to ensure that all were returned, coded, and kept in a safe place as a backup. A flash disk was also used to store data.

Data Analysis

The collected data was sorted manually and tallied, and frequency tables were developed following the numbers assigned to each questionnaire. The information was coded and then entered into the Microsoft Excel program to be analyzed into tables, pie charts, and graphs, which were automatically generated by the computer program. The report was written thereafter.

Ethical Consideration

After obtaining approval from the research supervisor, an introductory letter was sought from the Dean of Mildmay Uganda School of Nursing and Midwifery to facilitate administrative clearance at Kayunga Regional Referral Hospital for data collection. Study participants were provided with a clear explanation of the research objectives and methodology, emphasizing their voluntary participation and the right to withdraw without repercussions. They were allowed to ask questions and receive clarification before providing informed consent, both verbally and in writing. Confidentiality and anonymity were assured throughout the study, with participant identities protected through the use of initials and secure storage of data.

Informed consent

Participants were provided with clear and easily comprehensible details about the study's purpose, objectives, procedures, potential benefits, and risks. They were informed of their voluntary participation, the freedom to withdraw at any point, and the assurance of confidentiality regarding their responses.

Results

Table 1: Showing socio-demographic Characteristics of respondents. (N=40)

Variables	Frequency (n)	Percentage (%)
The age range of respondents		
Less than 25 years	2	5
25 – 34 years	22	55
35 – 44 years	6	15
45 years and above	10	25
Gender		
Male	8	20
Female	32	80
Highest level of Education		
Certificate in Nursing	28	70
Diploma in Nursing	2	5
Bachelors in Nursing	6	15
Others (Masters)	4	10
Years of practice		
Less than 1 year	2	5
1 – 5 years	24	60
6 – 10 years	4	10
More than 10 years	10	25
Employment status		
Government	32	80
Private	6	15
Non-government Organization	2	5

Table 1 Demonstrates a significant proportion of respondents, 22 (55%), were between 25 and 44 years old, while the least number of respondents, 2 (5%), were less than 25 years old. Additionally, the majority of the participants, 32 (80%), were female, while the smallest group, 8 (20%), were males. A significant proportion of respondents, 28 (70%), had attained a certificate in nursing, while the least number of respondents, 2 (5%), had attained a diploma in nursing. Furthermore, demonstrates that the majority of the participants, 24 (60%), had practiced for 1- 5 years, while the smallest group, 2 (5%), had practiced for less than 1 year. A significant proportion of respondents, 32 (80%), were

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1541

employed by the government while a few 2 (5%) were employed by non-government organizations.

Knowledge of professional nurses towards Nurses' documentation at Kayunga Regional Referral Hospital, Kayunga District

Figure 1: Showing whether respondents were aware of accurate documentation.

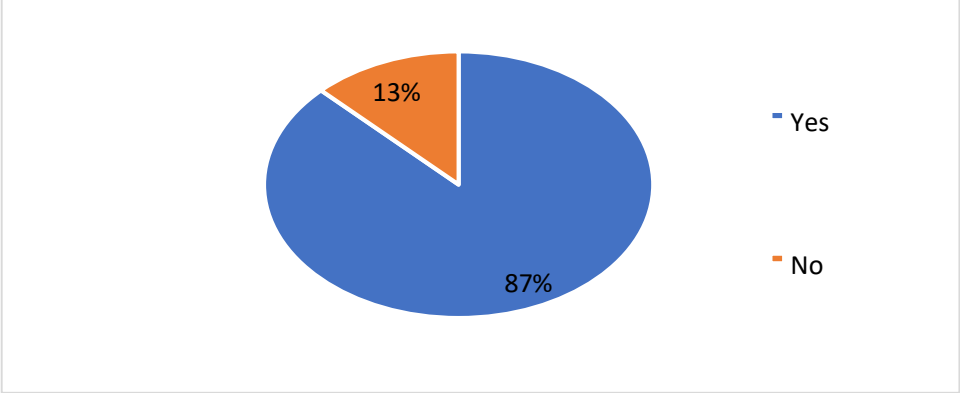


Figure 1 shows that most of the respondents, 35 (87%), were aware of accurate documentation, while a few respondents, 5 (13%), were not aware of it.

Figure 2 shows the importance of accurate documentation in patient care that respondents knew. (N=40)

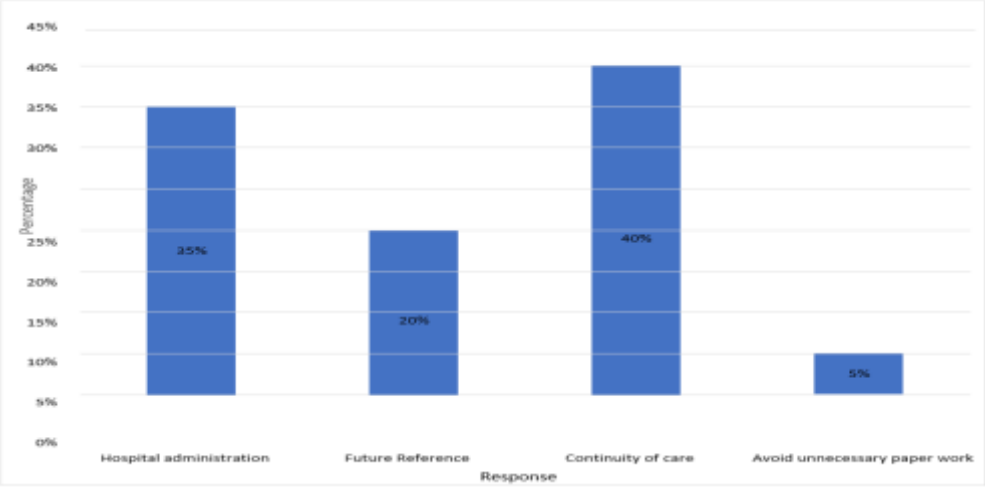


Figure 2 shows that most (40%) of the responses given on the importance of accurate documentation were to ensure continuity of care, while 5% avoided unnecessary paperwork.

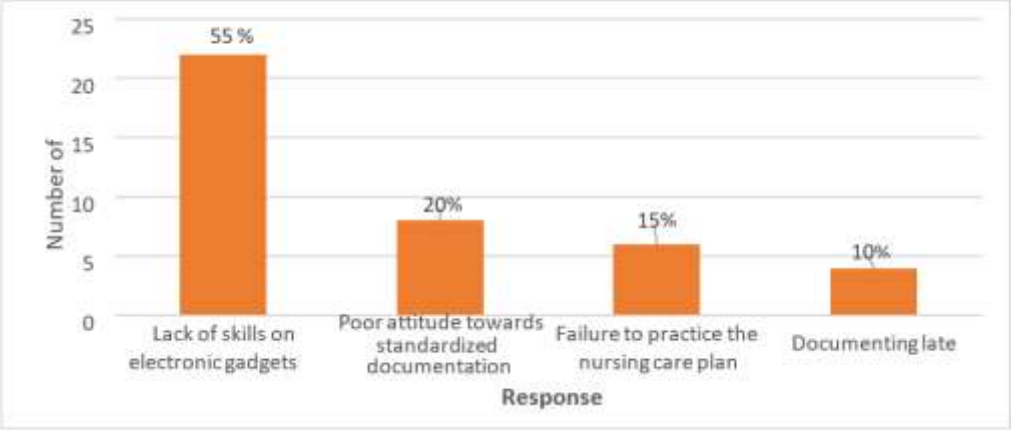
Table 2 Shows when respondents completed documentation in the patient's file.

Variables	Frequency	Percentage (%)
At the end of the shift	40	100
Immediately after providing care	0	0
The following day	0	0
After the patient is discharged	0	0
TOTAL	**40**	**100**

From Table 2, all respondents, 40 (100%), reported that the recommended time to complete patient documentation was at the end of the shift.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1541

Figure 3: Shows respondent's knowledge of what could lead to errors in patient documentation. (N= 40)



From Figure 3, the majority of respondents, 22 (55%), reported that a lack of skills on electronic gadgets could lead to errors in patient documentation, while a smaller number, 4 (10%), reported that documenting late could lead to errors in patient documentation.

Table 3 shows the legal consequences that could result from improper documentation.

ATTRIBUTES	FREQUENCY	PERCENTAGE (%)
It could result in malpractice litigation	8	20
It has no consequences as long as the patient recovers	22	55
It might only delay patient recovery	7	17
It will result in the patient being transferred to another facility	3	7
TOTAL	**40**	**100**

Table 3 shows the majority of respondents, 22 (55%), reported that improper documentation had no consequences as long the patient recovered, while the minority, 3 (7%), reported that improper documentation resulted in the patient being transferred to another facility.

Table 4 Shows what the recommended format for documenting patient records was.

Attributes	Frequency	Percentage (%)
Using a nursing care plan	2	5
Document only essential information	34	85
Brief notes with key points	4	10
TOTAL	**40**	**100**

Table 4: The majority of the participants, 34 (85%), reported that documenting only essential information was the recommended format for documenting patients' records, while the smallest group, 2 (5%), reported that using a nursing care plan was the recommended format for documenting patients' records.

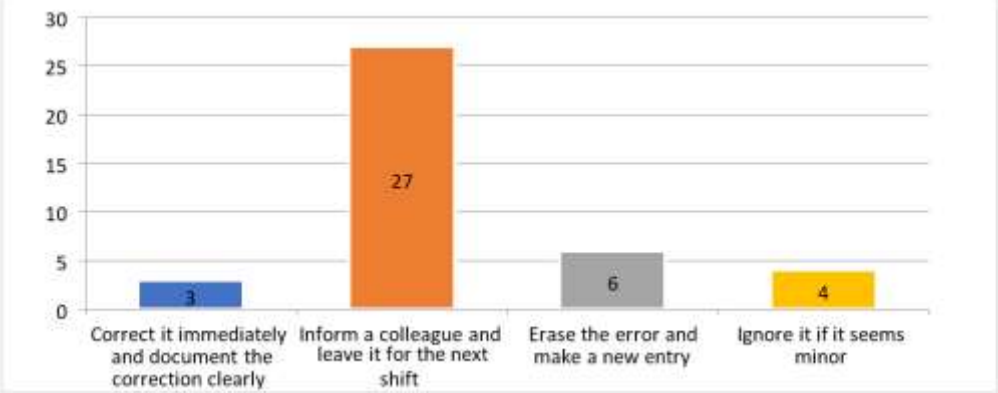
Table 5 Shows how accurate nursing documentation improved interdisciplinary communication.

Attributes	Frequency	Percentage (%)
It helps share clear patient information among healthcare professionals	28	70
It prevents nurses from being questioned	2	5
It increases interaction between healthcare professionals	10	25
TOTAL	**40**	**100**

According to Table 5, a significant proportion of respondents, 28 (70%), reported that accurate nursing documentation helped to share clear patient information among healthcare professionals, while a few 2 (5%) reported that accurate nursing documentation prevented nurses from being questioned.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1541

Figure 4 shows how a nurse should handle an error made during documentation. (N=40)



From Figure 4, the majority of respondents, 27 (68%), reported that a nurse should Inform a colleague and leave the error for the next shift, while a smaller number, 3 (7%), reported that a nurse should Correct it immediately and document the correction.

Discussion

Knowledge of professional nurses towards Nurses' documentation at Kayunga Regional Referral Hospital, Kayunga District

The vast majority of respondents, 35 out of 40 (87%), reported being aware of accurate documentation practices. This high level of awareness suggests that most nurses recognize the importance of proper documentation in their professional roles. This finding aligns with Ali and Sultana (2024), who found that 60% of nurses in Rangpur, Bangladesh, were aware of the significance of accurate documentation. The higher percentage in our study could be attributed to institutional emphasis on documentation or prior training sessions conducted at the hospital.

When asked about the importance of accurate documentation, the most common response given by 40% of participants was "to ensure continuity of care." This indicates that nurses understand the critical role documentation plays in providing seamless patient care across different shifts and healthcare providers. Similarly, 35% recognized that documentation fulfills hospital administrative requirements, and 20% saw it as important for future reference. However, a small percentage (5%) viewed accurate documentation as merely a means of avoiding unnecessary paperwork.

These findings suggest that while nurses are aware of some key reasons for accurate documentation, there is room to enhance their understanding of its broader implications. For instance, the relatively low emphasis on legal and professional accountability indicates a gap. In contrast, Hosseini et al. (2022) found that 70% of nurses in Tehran, Iran, were knowledgeable about the legal implications of accurate documentation.

A significant concern identified in this study is that 22 (55%) of respondents believed that improper documentation has no consequences as long as the patient recovers. This misconception overlooks the potential legal implications and the impact on patient safety and quality of care. Only 8 participants (20%) recognized that improper documentation could result in malpractice litigation. This gap in understanding is critical. According to Alhalal (2020), 75% of nurses in Riyadh, Saudi Arabia, had sufficient knowledge of the legal importance of documentation, which contributed to the accuracy and reliability of patient records. The lack of awareness among nurses at Kayunga Hospital may expose both the nurses and the institution to legal risks. It underscores the necessity for formal training programs that emphasize the legal consequences of documentation errors and omissions.

All respondents (100%) reported that the recommended time to complete patient documentation was at the end of the shift. While this practice ensures that documentation is completed, best practices recommend that documentation should be done immediately after providing care to enhance accuracy and reduce the risk of omissions (Moy et al., 2021). The delay until the end of the shift may contribute to memory lapses and incomplete records.

Regarding the recommended format for documenting patient records, the majority (85%) believed that they should "document only essential information." This approach may lead to the omission of critical details that could affect patient care. Only 5% recognized the use of a nursing care plan as the recommended format, which is essential for comprehensive and systematic documentation. This study is in contrast with another study by Moy et al. (2021), which reported that 80% of nurses in New York, USA, demonstrated knowledge of the correct format for documentation, emphasizing the impact of formal training on documentation standards.

The majority, 22 (55%), of respondents indicated that a lack of skills in electronic gadgets could lead to errors in patient documentation. This finding highlights the challenges nurses face with electronic health records (EHRs) and the need for training in digital competencies. Only 10% identified "documenting late" as a factor leading to errors, suggesting an underestimation of the risks associated with delayed documentation. These insights are consistent with a study by Dwyer et al. (2024), who found that 70% of nurses in Brisbane, Australia, acknowledged the influence of sociocultural factors on

compliance with documentation guidelines, including the adoption of electronic systems. Addressing technological barriers through targeted training could reduce errors and improve the quality of documentation.

A study where 27 (68%) of respondents said that when they make a documentation error, they inform a colleague and leave the error for the next shift. This approach is not aligned with best practices, which recommend that errors should be corrected immediately and documented clearly to maintain the integrity of patient records (Nomvungu, 2024). Only 3 (7%) of participants selected the correct procedure, which is correcting it immediately and documenting the correction. This indicates a significant knowledge gap in error reporting and correction procedures. Fear of punitive measures may also hinder proper error handling, as suggested by Nomvungu (2024), who found that fear of punishment discouraged nurses from reporting errors. Encouraging a non-punitive culture and providing clear guidelines on error correction could improve compliance with proper documentation practices.

A significant proportion of respondents, 28 (70%), recognized that accurate nursing documentation helps share clear patient information among healthcare professionals. This understanding reflects awareness of the role documentation plays in facilitating interdisciplinary communication and collaboration. A study by Alqahtani et al. (2020) similarly found that 85% of nurses in Riyadh, Saudi Arabia, were knowledgeable about the role of documentation in facilitating interdisciplinary communication, leading to improved patient outcomes. However, 25% believed that accurate documentation merely "increases interaction between healthcare professionals," and 5% thought it "prevents nurses from being questioned." These responses suggest a need to further clarify how precise documentation directly contributes to patient care coordination and safety rather than being seen as a means to protect oneself from scrutiny.

The knowledge gaps identified in this study, particularly regarding the legal consequences of improper documentation, recommended documentation practices, handling of documentation errors, and technological competencies, highlight the urgent need for formal training programs. The lack of formal education on these aspects may contribute to suboptimal documentation practices and increased risk of errors. Studies have demonstrated that structured training improves nurses' knowledge and documentation practices. This study is in line with another by Hosseini et al. (2022), which showed that nurses who understood the legal implications of poor documentation were more diligent in their record-keeping, reducing legal risks for themselves and the healthcare institution. A study by Dwyer et al. (2024) also found that standardized training on documentation formats led to increased compliance and reduced variability in documentation practices. Implementing comprehensive training programs at Kayunga Hospital could address these knowledge gaps. Such programs should focus on the legal, ethical, and clinical importance of accurate documentation, proper error-handling procedures, and the use of electronic documentation systems. This approach would not only enhance the quality of patient care but also align the hospital's practices with global standards.

Practices of professional nurses towards Nurses' documentation at Kayunga Regional Referral Hospital, Kayunga District

Documentation is foundational in nursing, ensuring continuity of care, patient safety, and legal compliance. As seen in this study, 75% of participants consistently used approved medical abbreviations and comprehensive documentation. Nurses in our study who documented patient information in near-real-time during shifts (78%) helped reduce preventable errors. However, a notable gap was found in recording adverse reactions to medications, mirroring similar trends highlighted by Ahmed (2024), who associated prompt documentation with improved patient outcomes. Inaccurate or delayed entries can lead to serious medical errors, impacting patient health and increasing liability risks for healthcare institutions.

An alarming finding was the belief held by 55% of participants that improper documentation has no consequences if a patient recovers. This misconception points to a critical knowledge gap about the broader implications of inaccurate documentation, including legal liability and the risk of compromised patient safety. In contrast, studies, such as that by Hosseini et al. (2022) in Iran, have shown that 70% of nurses were aware of the legal consequences of improper documentation, suggesting that targeted training programs at Kayunga Hospital could bridge these gaps in understanding.

Our study found that nurses generally documented medication administration accurately (78%), including the dosage, time, and route. However, as noted, adverse reactions were often not recorded. This gap highlights a critical area for improvement, as accurate medication records are essential for patient safety. A similar study by Tamir et al. (2021) emphasized the role of standardized documentation in reducing medication errors, further supporting the need for detailed and timely entries to enhance patient outcomes.

The findings suggest that the observed gaps in knowledge and practices may be attributed to insufficient formal education. As noted in the supervisor's feedback, formal training could address misunderstandings about the importance of documentation, the potential consequences of errors, and best practices for confidentiality and accuracy. In contrast, similar studies like those by Ali and Sultana (2024) and Moy et al. (2021) in the USA and Bangladesh have demonstrated the effectiveness of structured training in improving nurses' documentation practices and fostering a culture of accountability and accuracy.

Conclusion

This study investigated the knowledge and practices of professional nurses toward documentation at Kayunga Regional Referral Hospital, identifying strengths as well as critical areas for improvement. While most nurses

demonstrated an understanding of accurate documentation's role in continuity of care, compliance with privacy standards, and patient communication, significant gaps remain, particularly in legal awareness, error correction, and the use of recommended documentation formats. Notably, misconceptions were identified regarding the legal consequences of improper documentation, and a majority of nurses incorrectly believed that poor documentation has no impact on a patient's recovery. Additionally, practices such as delaying documentation until the end of shifts and overlooking adverse reactions to medications were observed, which could compromise patient safety and quality of care. The findings emphasize the importance of formal training to bridge these knowledge gaps, enhance compliance with global best practices, and foster a culture of accountability. Addressing these deficiencies would improve patient outcomes, reduce legal risks, and support effective interdisciplinary collaboration within the hospital setting.

While the majority of nurses at Kayunga Regional Referral Hospital are aware of the importance of accurate documentation, significant knowledge gaps exist regarding the legal implications of improper documentation, recommended documentation practices, handling of errors, and technological skills. These gaps underscore the necessity for formal training programs to enhance nurses' knowledge and compliance with best practices. Addressing these deficiencies will improve patient care, reduce legal risks, and promote effective interdisciplinary communication, ultimately contributing to better healthcare outcomes.

The study underscores both strengths and areas for improvement in documentation practices among professional nurses. While there is an awareness of certain documentation standards, misconceptions and knowledge gaps around error correction, privacy, and consequences of inadequate documentation remain. Implementing formalized, ongoing training programs could bridge these gaps, align practices with global standards, and ultimately ensure higher quality patient care, legal compliance, and continuity of care.

However, the limitations of the Study included the following;

Time constraints in the course of the study, balancing the research study and the other school activities like clinical placement, demanding course work.

Resource Limitations: Limited resources, such as time and funding, might have restricted the extent of data collection or analysis.

Busy staff struggle to find time to participate, leading to lower response rates, incomplete data, and reduced sample size, which can impact the study's validity and representatives.

Recommendation

There should be regular training, the use of structured formats, and real-time documentation to improve the quality and accuracy of nursing documentation at Kayunga Regional Referral Hospital.

The Ministry of Health (MOH) should develop and implement comprehensive training programs focused on accurate nursing documentation, including the use of structured formats such as the SOAP format. Training should emphasize the legal and clinical consequences of improper documentation to address current knowledge gaps.

Kayunga Regional Referral Hospital should provide education at Kayunga Hospital on the comprehensive importance of documentation, including its legal and ethical dimensions.

Further Research should be conducted research to assess the effectiveness of structured formats such as SOAP on improving the quality and thoroughness of nursing documentation in clinical settings.

Acknowledgment

I hereby acknowledge the contribution of the following people towards the success of this research. My supervisor, Ms. Kyere Olivia, the Dean and the tutors of Mildmay Uganda School of Nursing and Midwifery, and the entire classmates.

May God Bless them

List of Abbreviations

EHRS:	Electronic Health Records
Et al.:	And others
MOH:	Ministry of Health
SOAP:	Subjective, Objective, Assessment Plan
USA:	United States of America
WHO:	World Health Organisation

Source of funding

This study was not funded

Conflict of interest

No conflict of interest was declared

Author contributions

NM designed the study, conducted the data collection, cleaned and analyzed data, and drafted the manuscript. OK supervised the study from conceptualization of the topic to manuscript writing and submission, and IPN supported study conceptualization and general supervision as well as mentorship.

Data availability

Data is available upon request.

Author Biography

Norah Namulanda is a student of Diploma in Nursing Extension at Mildmay Uganda School of Nursing and Midwifery, Olivia Kyeree is a tutor at Mildmay Uganda School of Nursing and Midwifery, and Immaculate Prosperia Naggulu is a principal tutor at Mildmay Uganda School of Nursing and Midwifery.

References

1. Ahmed, S. S. (2024). The Relationship between Nursing Knowledge about Documentation Skills and Auditing Retrospective of Patient's Records. Helwan International Journal for Nursing Research and Practice, 3(5), 213-228. https://doi.org/10.21608/hijnrp.2024.252313.1091
2. Alhalal, E. (2020). Nurses' knowledge, attitudes, and preparedness to manage women with intimate partner violence. International Nursing Review, 67(2), 265-274. https://doi.org/10.1111/inr.12584
3. Ali, A. S., & Sultana, N. (2024). Nurse's Practice Regarding Nursing Documentation in Rangpur Medical College Hospital. Asia Pacific Journal of Nursing Research, 1(1), 29-35. https://doi.org/10.70818/apjnr.2020.v01i01.06
4. Alqahtani, N., Oh, K. M., Kitsantas, P., & Rodan, M. (2020). Nurses' evidence-based practice knowledge, attitudes and implementation: A cross-sectional study. Journal of Clinical Nursing, 29(1-2), 274-283. https://doi.org/10.1111/jocn.15097
5. Coffin-Schmitt, J. L., Moore, E. V., McKune, S. L., Mo, R., Nkamwesiga, J., Isingoma, E., ... & Mariner, J. C. (2021). Measurement and sampling error in mixed-methods research for the
6. Control of Peste des Petits Ruminants in the Karamoja subregion of Northeastern Uganda: A cautionary tale. Preventive Veterinary Medicine, 196, 105464. https://doi.org/10.1016/j.prevetmed.2021.105464
7. Dwyer, T., Flenady, T., Signal, T., Boyle, C. M., Connor, J., Le Lagadec, D., ... & Browne, M. (2024). A theoretical framework for identifying sociocultural factors that influence nurses' compliance with early warning systems for acute clinical deterioration: A cross-sectional survey. International Journal of Nursing Studies, 158, 104846. https://doi.org/10.1016/j.ijnurstu.2024.104846
8. Hariyati, R. T. S., Hamid, A. Y., Eryando, T., & Hasibuan, Z. A. (2020). Usability and satisfaction of using electronic nursing documentation, lesson-learned from new system implementation at a hospital in Indonesia. International Journal of Healthcare Management. https://doi.org/10.1080/20479700.2018.1504387
9. Hosseini, N., Mostafavi, S. M., Zendehdel, K., & Eslami, S. (2022). Factors affecting clinicians' adherence to principles of diagnosis documentation: A concept mapping approach for improved decision-making. Health Information Management Journal, 51(3), 149-158. https://doi.org/10.1177/1833358321991362
10. Mbembati, N. A. A., Lugina, H. I., &Urassa, D. P. (2019). Nurses' knowledge and practices
11. Regarding patients' medical records documentation at a tertiary hospital in Tanzania. BMC Health Services Research, 19(1), 1-8.
12. Ministry of Health Uganda. (2023). Health sector performance report. Kampala: Ministry of Health Uganda.
13. Moy, A. J., Schwartz, J. M., Chen, R., Sadri, S., Lucas, E., Cato, K. D., & Rossetti, S. C. (2021). Measurement of clinical documentation burden among physicians and nurses using electronic health records: A scoping review. Journal of the American Medical Informatics Association, 28(5), 998-1008. https://doi.org/10.1093/jamia/ocaa325
14. Nakate, G., Dahl, D., Drake, K. B., &Petrucka, P. (2015). Knowledge and attitudes of select Ugandan nurses towards documentation of patient care. African Journal of Nursing and Midwifery, 2(1), 056.
15. Nomvungu, X. (2024). Nurses' knowledge, attitudes, and experiences on the implementation of tuberculosis preventive therapy among HIV-positive patients in the north sub-district, eThekwini (Doctoral dissertation).
16. Nyaba, R. (2021). An Audit of Nurses' Clinical Documentation Practices; the Case of Baptist Medical Centre, Nalerigu (Doctoral dissertation, University of Cape Coast).
17. O'Brien, J. (2021). The importance of nursing documentation. Nursing2021 Critical Care,16(2), 43-46.
18. Omoniyi, B., Ologun, Y., & Abiodun, A. (2022). Assessment of nurses' knowledge and documentation practices on pressure injury prevention in a tertiary healthcare facility in Southwest Nigeria. International Wound Journal, 19(5), 881-889.
19. Sample Size Determination Using Krejcie and Morgan Table. (2012, August 25). https://www.kenpro.org/sample-size-determination-using-krejcie-and-morgan-table/
20. Shaibu, S., Kachimba, M., & Chirwa, M. (2021). Factors influencing nursing documentation practice in Malawi: A qualitative study. BMC Nursing, 20(1), 1-10.
21. Shala, D. R., Jones, A., Fairbrother, G., & Tran, D. T. (2021). Completion of electronic nursing documentation of inpatient admission assessment: Insights from Australian metropolitan hospitals. International journal of medical informatics, 156, 104603. https://doi.org/10.1016/j.ijmedinf.2021.104603
22. Tamir, T., Geda, B., &Mengistie, B. (2021). Documentation practice and associated factors among nurses in Harari regional state and Dire Dawa administration governmental hospitals, eastern Ethiopia. Advances in Medical

Education and Practice, 453-462. https://doi.org/10.2147/AMEP.S298675
23. The Joint Commission. (2023). The state of patient safety. Oakbrook Terrace, IL: The Joint Commission.
24. Tshilumba, P. P., Mapatano, M. A., & Ferrer, R. (2019). Nursing documentation practices and associated factors in a referral hospital in the Democratic Republic of Congo. BMC Nursing, 18(1), 1-7.
25. Witter, S., Hamza, M. M., Alazemi, N., Alluhidan, M., Alghaith, T., & Herbst, C. H. (2020). Human resources for health interventions in high-and middle-income countries: findings of an evidence review. Human Resources for Health, 18(1), 43. https://doi.org/10.1186/s12960-020-00484-w
26. World Health Organization. (2020). Nursing and midwifery: Key resources for health professionals. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/nursing and-midwifery

PUBLISHER DETAILS:

Student's Journal of Health Research (SJHR)
(ISSN 2709-9997) Online
(ISSN 3006-1059) Print
Category: Non-Governmental & Non-profit Organization
Email: studentsjournal2020@gmail.com
WhatsApp: +256 775 434 261
Location: Scholar's Summit Nakigalala, P. O. Box 701432, Entebbe Uganda, East Africa