

**PERCEIVED IMPACT OF WORKLOAD ON EFFECTIVE NURSING  
DOCUMENTATION AMONG NURSES IN A TERTIARY HEALTHCARE  
INSTITUTION IN BENIN CITY.**

**BY**

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BENIN CITY**

**OCTOBER, 2025**

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**IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF NURSING AND  
MIDWIFERY COUNCIL OF NIGERIA FOR THE AWARD OF BACHELOR IN  
NURSING SCIENCE (BNSC) CERTIFICATE,**

**OCTOBER, 2025**

## **DECLARATION**

This is to declare that this research project titled “**PERCEIVED IMPACT OF WORKLOAD ON EFFECTIVE NURSING DOCUMENTATION AMONG NURSES IN A TERTIARY HEALTHCARE INSTITUTION IN BENIN CITY**” was carried out by **ONARIMI BETHEL**.

It is solely the result of my work except were acknowledged as being derived from other person (s) or resources.

**EXAMINATION NUMBER:** \_\_\_\_\_

**FACULTY OF NURSING SCIENCE, COLLEGE OF MEDICAL SCIENCE,  
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**CERTIFICATION/APPROVAL**

This is to certify that this research project titled by **OBUKOWO GODSPOWER** with examination number \_\_\_\_\_ has been examined and approved for the award of **Bachelor in nursing science**

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## ABSTRACT

*Nursing documentation is a critical component of professional practice, ensuring continuity of care, enhancing patient safety, and serving as a legal record of nursing activities. However, workload pressures often compromise the accuracy, timeliness, and completeness of documentation. This study investigated the perceived impact of workload on effective nursing documentation among nurses in a tertiary healthcare institution in Benin City. The study adopted a descriptive cross-sectional survey design. Using a stratified random sampling technique, 246 questionnaires were distributed to nurses working in various departments of the University of Benin Teaching Hospital. Out of these, 239 were properly completed and valid for analysis, representing a response rate of 97.1%. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26.0, employing descriptive statistics and chi-square tests. The findings revealed that the majority of respondents (89%) demonstrated good knowledge of nursing documentation. However, workload was perceived to have a high impact on documentation practices, with a grand mean of 3.1. Key factors identified included high patient-to-nurse ratios, time pressure during shifts, emergency situations, multitasking, and lack of support staff. Challenges faced by nurses included inadequate staffing, lack of training, absence of electronic health records, unavailability of documentation tools, and frequent interruptions. Hypothesis testing showed a significant relationship between knowledge of nursing documentation and perceived impact of workload ( $\chi^2 = 6.785, p = 0.041$ ). The study concludes that while nurses possess good knowledge of documentation, workload and systemic challenges remain major barriers to effective practice. This highlights the need for organizational interventions to bridge the knowledge–practice gap. It is recommended that hospital management strengthen staffing, provide adequate documentation tools, adopt electronic health records, and implement regular in-service training programs. Supportive supervision and clear institutional policies should also be established to enhance effective nursing documentation and improve patient care outcomes.*

**Keywords:** Perceived impact, Workload, Effective nursing documentation, Nurses, Tertiary healthcare institution, Benin City

## **DEDICATION**

This study is dedicated to **JEHOVAH** God, the Almighty, for providing me with the strength in the course of my academic journey, also to the memory of Late Mr. **GODWIN OSAZUWA (BABS)** whose vision and foresight played a pivotal role in shaping my educational path.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background to the Study

Clinical nursing documentation is essential in allowing nurses to continuously reflect on their choice of interventions for patients and the effects of those interventions (De Groot et al., 2022). Therefore, it plays a vital role in ensuring the quality and continuity of nursing care. Nursing documentation serves as a reflection of the entire process of providing direct patient care (Khwaji et al., 2024). Globally, there is a consensus that nursing documentation should align with the phases of the nursing process, including assessment, diagnosis, care planning, intervention implementation, evaluation, and handover of care (Gesner et al., 2022). Despite its importance, nursing documentation is often time-consuming and may be perceived as a burden by nurses. Studies indicate that documentation takes up a substantial portion of nurses' time, with variations across different healthcare systems. For example, in Canada, nurses spend approximately 26% of their time on documentation, while in Great Britain, this figure is around 17%. In the United States, the percentage varies from 25% to 41%, and in the Netherlands, nurses report spending up to 40% of their working hours on documentation tasks (Lindsay & Lytle, 2022).

The discrepancies in time spent on documentation among countries may stem from differences in electronic health record (EHR) systems and documentation procedures. Furthermore, the lack of clarity regarding what constitutes documentation contributes to variations in reported workload. Some studies define documentation as activities directly related to patient care, such as care

planning and progress reports, while others include administrative tasks like recording working hours and personnel planning (Almenyan, Albuduh, & Al-Abbas, 2021).

According to the Organisation for Economic Cooperation and Development (OECD), documentation can be categorized into clinical, organizational, and financial documentation. Clinical documentation pertains to patient health records, while organizational documentation includes personnel and shift coordination. Financial documentation encompasses billing and insurance records (Moy et al., 2021). Recent trends suggest that the demand for organizational and financial documentation has increased due to the growing emphasis on accountability and efficiency in healthcare (Banda et al., 2022). While nurses acknowledge the necessity of clinical documentation for high-quality patient care, they may view administrative documentation as an additional burden that detracts from direct patient interactions (Ferramosca et al., 2023).

The transition to electronic health records (EHRs) has also influenced nursing documentation practices. While EHRs can streamline documentation, studies indicate that they may initially increase the time nurses spend on documentation due to unfamiliarity with digital systems (Shafiee et al., 2022). However, over time, nurses may experience improved efficiency as they become more accustomed to EHR systems. Nevertheless, when EHRs are not designed to align with nursing workflows, they can contribute to time pressure and workload-related stress (Bjerkan, Valderaune, & Olsen, 2021). Nurses' workload is a critical concern in healthcare, particularly due to ongoing nursing shortages worldwide. While objective workload is typically measured in terms of staffing ratios and time spent on patient care, perceived workload also plays a role in nurses' overall job satisfaction and well-being (Ebrahimi et al., 2021). Understanding the specific aspects of documentation that contribute to perceived workload can

help in developing strategies to reduce documentation burden while maintaining effective record-keeping practices (Babamohamadi et al., 2023).

Given these challenges, this study aims to explore the impact of workload on nursing documentation and identify possible interventions to enhance documentation efficiency while minimizing the burden on nurses.

## **1.2 Statement of Problem**

Nursing documentation is an essential component of patient care, allowing nurses to continuously reflect on their interventions and assess their effectiveness. Proper documentation is crucial for ensuring the quality and continuity of nursing care. It serves as a primary source of evidence for evaluating performance outcomes, facilitates communication among healthcare professionals, and provides legal protection (Bjerkan et al., 2021). However, despite its significance, nursing documentation is often perceived as burdensome, leading to issues related to its completeness and accuracy (Gesner et al., 2022).

The extensive time required for documentation has emerged as a major challenge for nurses. Studies indicate that nurses spend approximately 25% to 50% of their shifts documenting patient care, which can impact their ability to provide direct patient care (Moy et al., 2021). International data show significant variations in the time allocated to documentation, with nurses in Canada dedicating around 26% of their work hours to documentation, compared to 17% in Great Britain and up to 41% in the United States (De Groot et al., 2022). In Ethiopia, nearly all nursing documentation is still paper-based, further complicating efficiency and accuracy (Ayele et al., 2021). Despite efforts to standardize and improve nursing documentation, inconsistencies persist

in practice due to various factors, including lack of training, high nurse-to-patient ratios, and inadequate knowledge and attitudes toward documentation (Purwandari et al., 2022). Studies have shown that while nurses acknowledge the importance of documentation, they often view it as a secondary task that detracts from direct patient care (Banda et al., 2022). Additionally, poor documentation practices can result in fragmented care, miscommunication, medical errors, and increased legal risks for healthcare providers (Khwaji et al., 2024).

In Ethiopia, existing guidelines from the Federal Ministry of Health emphasize the importance of accurate, timely, and effective documentation for quality patient care. However, evidence suggests that documentation practices remain suboptimal, with significant gaps in adherence to professional standards (Ayele et al., 2021). Furthermore, limited research has been conducted on the attitudes and factors influencing nursing documentation in Ethiopia, particularly in specific regions such as Hawassa city administration public hospitals (Ayele et al., 2021).

Given the critical role of nursing documentation in patient safety, legal accountability, and overall healthcare quality, it is imperative to assess the current practices and challenges faced by nurses (Bjerkkan et al., 2021). This study aims to explore nurses' attitudes toward documentation and identify the factors influencing their documentation practices. The findings will provide essential insights for developing targeted interventions to improve nursing documentation and enhance patient care outcomes (Bunting & de Klerk, 2022; Khwaji et al., 2024)

### **1.3 Objectives of Study**

#### **General Objectives**

To determine the perceived Impacts of Workload on Effective Nursing Documentation Among Nurses in a tertiary healthcare facility in Benin city.

#### **Specific Objectives**

1. To assess the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin city.
2. To assess the perceived impact of workload on effective nursing documentation in a tertiary health care facility in Benin city.
3. To identify the challenges that nurses face in maintaining effective documentation in a tertiary health care facility in Benin city.

#### **1.4 Research Question**

1. What is the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City?
4. What is the perceived impact of workload on nursing documentation in a tertiary health care facility in Benin city?

5. What challenges do nurses face in maintaining effective documentation in a tertiary health care facility in Benin city?

### **1.5 Research Hypotheses**

1. **H<sub>0</sub>:** There is no significant relationship between the level of knowledge of nursing documentation and the perceived impact of workload on nursing documentation among nurses in a tertiary health care facility in Benin City

### **1.6 Significance of the study**

This study will provide insights into the current level of knowledge and attitudes of nurses toward documentation. By identifying the challenges associated with nursing documentation, it can inform the development of targeted training programs and policies that enhance nurses' efficiency in documentation. Improved documentation practices will lead to better continuity of care, reduced medical errors, and enhanced professional accountability among nurses.

Effective nursing documentation is crucial for patient safety, legal protection, and healthcare quality. This study will highlight the impact of workload on documentation practices, helping hospital administrators and policymakers implement strategies to optimize workflow and resource allocation. By improving documentation practices, healthcare institutions can enhance interprofessional communication, streamline patient care processes, and reduce the risks associated with incomplete or inaccurate documentation.

Accurate and timely nursing documentation contributes to better patient outcomes, improved public trust in healthcare services, and enhanced legal protection for patients. This study will contribute to a deeper understanding of how documentation impacts patient care quality,

ultimately leading to improved healthcare experiences and patient satisfaction. Additionally, it can guide policymakers in making informed decisions that promote safer and more efficient healthcare systems for society.

### **1.7 Scope of Study**

This study focuses on assessing the impact of workload on effective nursing documentation among nurses in a tertiary healthcare facility in Benin City.

### **1.8 Operational Definition of Terms**

**1. Nursing Documentation** – The process of systematically recording patient care activities, observations, interventions, and outcomes by nurses to ensure continuity of care, legal accountability, and effective communication within the healthcare team.

**1 Workload** – The number of tasks, responsibilities, and time demands placed on nurses during their shifts, including direct patient care, administrative duties, and documentation requirements.

**2 Effective Documentation** – The practice of maintaining accurate, complete, timely, and standardized nursing records that facilitate quality patient care, legal protection, and efficient communication among healthcare providers.

**3 Knowledge of Nursing Documentation** – The level of awareness, understanding, and competence nurses have regarding the principles, standards, and importance of accurate and timely documentation.

**4 Challenges in Nursing Documentation** – The difficulties and barriers nurses face in maintaining proper documentation, such as time constraints, high patient loads, lack of training, and inadequate institutional support.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

This chapter focuses on the review of related literature under the following headings; conceptual review, theoretical review and empirical review. Necessary literature would be gotten from published and unpublished works, articles and journals in this study.

#### **2.1 Conceptual Review**

##### **2.1.1 Definition and Significance of Nursing Documentation**

Nursing documentation refers to the systematic recording of patient information, nursing assessments, interventions, and outcomes to ensure continuity, safety, and quality of care. It serves as a legal record of the care provided and facilitates communication among healthcare professionals (Shafiee et al., 2022). Effective nursing documentation is a fundamental aspect of healthcare delivery, contributing to patient safety, clinical decision-making, and accountability in healthcare settings (Jasem & Younis, 2024). The significance of nursing documentation cannot be overstated, as it plays a crucial role in enhancing patient care, supporting legal and ethical responsibilities, and improving healthcare outcomes (Khwaji et al., 2024). Proper documentation enables nurses to track patient progress, identify changes in health status, and ensure timely interventions. Moreover, accurate documentation minimizes medical errors and serves as a key component in quality assurance and performance evaluation (Bjerkan et al., 2021). In cases of legal disputes or malpractice claims, well-documented nursing records provide essential evidence that can protect nurses and healthcare institutions from liability (Seidu et al., 2021).

Furthermore, nursing documentation is essential for interprofessional collaboration. It ensures that all members of the healthcare team, including physicians, pharmacists, and therapists, have access to up-to-date patient information, thereby improving coordinated care and reducing the risk of miscommunication (Mykkänen et al., 2022). The increasing adoption of electronic health records (EHRs) has further emphasized the role of documentation in enhancing efficiency, data security, and ease of access to patient records (Lindsay & Lytle, 2022). However, despite its importance, many nurses perceive documentation as time-consuming and burdensome, particularly in high-workload environments, leading to challenges in maintaining accurate and comprehensive records (Gesner et al., 2022).

Given its legal, ethical, and clinical implications, nursing documentation remains a cornerstone of professional nursing practice (Alhawri et al., 2020). Effective documentation practices ensure compliance with healthcare regulations, improve patient outcomes, and contribute to evidence-based practice (Saba et al., 2018). Therefore, addressing barriers to proper documentation, such as excessive workload, lack of training, and inadequate technological resources, is essential for optimizing healthcare delivery and patient safety (Banda et al., 2022; Monalisa et al., 2023)

### **2.1.2 Standards and Guidelines for Effective Nursing Documentation**

Effective nursing documentation is guided by established standards and guidelines that ensure accurate, timely, and complete recording of patient care. These guidelines help to maintain consistency, legal accountability, and improve patient safety. The standards are typically based on national and international health regulations, including the requirements set by healthcare organizations and regulatory bodies such as the American Nurses Association (ANA) and the Joint Commission. In nursing, documentation serves as both a communication tool and a legal

record. It provides a clear and detailed account of the patient's condition, interventions, and responses, which are essential for continuity of care among healthcare teams. According to Bunting and de Klerk (2022), compliance with documentation guidelines is crucial to achieving high-quality nursing practice and ensuring proper patient management. These guidelines address various aspects of nursing practice, including assessment, planning, implementation, and evaluation, which are recorded in the patient's health records.

The rise of electronic health records (EHR) has transformed how nursing documentation is conducted. The optimization of EHR systems is considered a key factor in enhancing documentation efficiency and accuracy (Lindsay & Lytle, 2022). These systems, however, also introduce challenges, including increased documentation burden, which can contribute to clinician burnout if not properly managed (Gesner et al., 2022). The standards for effective documentation emphasize minimizing the administrative burden while maintaining the thoroughness and accuracy required for clinical decision-making. Nurses are encouraged to follow standardized terminology when documenting care to ensure clarity and uniformity. Mykkänen et al. (2022) highlight the importance of using standardized nursing data for knowledge generation and evidence-based practice. Standardized documentation allows for more reliable data collection, which can be used for generating nursing knowledge and improving care quality.

Furthermore, barriers to effective documentation often arise from heavy workloads and lack of training in documentation practices (Bjerkan et al., 2021). Nurses may be under pressure to meet both clinical and documentation requirements, which can compromise the quality and timeliness of their documentation. According to Ferramosca et al. (2023), the organization of work in

nursing can significantly affect how well documentation guidelines are followed, especially in high-stress settings like intensive care units (ICUs). Effective strategies are needed to reduce the workload while improving documentation practices.

In conclusion, adhering to standards and guidelines for nursing documentation is critical for the provision of high-quality, safe, and legally defensible care. The role of proper documentation is further enhanced by the development of EHR systems and the implementation of standardized terminology, which together improve the accuracy and utility of nursing documentation (Saba et al., 2018). However, addressing the challenges posed by workload and burnout remains an essential part of promoting effective documentation practices in healthcare settings (Khwaji et al., 2024).

### **2.1.3 Legal and Ethical Implications of Nursing Documentation**

Nursing documentation is not only a clinical tool but also a legal and ethical instrument that plays a crucial role in the healthcare system. It serves as a formal record of the care provided to patients and is vital for ensuring accountability, protecting both patients and healthcare providers, and maintaining the integrity of the healthcare system. Legal and ethical implications of nursing documentation are vast, as it intersects with both healthcare law and nursing ethics. From a legal perspective, nursing documentation serves as a critical part of a patient's medical record, which can be used as evidence in a court of law. Inadequate or inaccurate documentation can result in legal consequences, such as malpractice suits or regulatory penalties. Nurses are legally obligated to document all aspects of patient care, including assessments, interventions, patient responses, and any communication with other healthcare professionals. According to Bjerkan et al. (2021), documentation is often examined in legal proceedings to determine the

quality and appropriateness of care provided. If care is not properly documented, it may be presumed that the care was not provided, potentially leading to a breach of duty claims in court.

Documentation also impacts nurses' liability. Nurses are expected to document in a manner that is clear, accurate, and timely. Inaccurate or incomplete documentation can lead to misunderstandings and misinterpretations of patient care, which may affect patient safety. Ferramosca et al. (2023) highlight that when nurses fail to follow documentation standards, it could result in legal ramifications such as charges of negligence, which can severely affect their professional standing. Ethically, nursing documentation must reflect the true nature of the care provided, maintaining honesty, accuracy, and transparency. Ethical dilemmas arise when nurses are pressured to falsify documentation, omit important details, or engage in "charting by exception" practices to save time (Alhawri et al., 2020). These practices violate the ethical principle of honesty and can compromise patient safety. Nurses must uphold ethical standards in documentation by ensuring that they record all relevant observations and interventions, including both positive and negative findings. As Shafiee et al. (2022) argue, the ethical responsibility of nurses to document thoroughly ensures that patient care is properly communicated to all members of the healthcare team, promoting the best possible patient outcomes.

Additionally, nursing documentation is an expression of respect for patient autonomy and confidentiality. Ethical principles of respect for autonomy require that nurses maintain patient privacy when documenting care. This includes ensuring that sensitive patient information is protected from unauthorized access. Documentation systems must adhere to confidentiality regulations, such as those outlined in the Health Insurance Portability and Accountability Act (HIPAA) in the United States, and similar privacy laws worldwide. Saba et al. (2018) notes that

violations of confidentiality through improper documentation practices can lead to severe ethical and legal consequences, including patient harm, loss of trust, and legal sanctions.

Ethical decision-making in nursing often involves documenting patient decisions and care outcomes, particularly in sensitive situations such as end-of-life care, consent for treatment, and refusal of care. Ayele et al. (2021) discuss how nurses' ethical obligations to document patient decisions related to care are essential for ensuring that patients' rights are upheld. Proper documentation also aids in the ethical practice of informed consent, which is central to respecting patient autonomy. Without clear documentation of the patient's consent, healthcare providers may face legal challenges regarding the legality of the treatment provided.

The workload associated with nursing documentation can also create ethical dilemmas. Nurses often face the challenge of balancing thorough documentation with the need to deliver direct patient care. According to Moy et al. (2021), excessive documentation requirements can lead to "documentation fatigue," where nurses may feel compelled to shortcut the documentation process, potentially leading to errors or omissions. This not only raises ethical concerns about the quality of care provided but also affects the nurse's ability to maintain high ethical standards in their practice.

#### **2.1.4 Legal and Ethical Implications of Nursing Documentation**

Nursing documentation is an essential component of the healthcare process, serving both clinical and legal purposes. Its importance extends beyond facilitating effective patient care to influencing legal decisions and upholding ethical standards in healthcare. Proper documentation can protect nurses, healthcare providers, and institutions from legal liabilities, while improper

documentation can lead to legal consequences and ethical dilemmas. Understanding the legal and ethical implications of nursing documentation is crucial for maintaining patient safety, improving care delivery, and ensuring compliance with legal and professional standards. Nursing documentation plays a significant role in the legal domain, as it serves as a written record of the care provided to patients. It can be used as evidence in legal proceedings to defend or challenge claims related to medical malpractice, negligence, or patient harm. Inaccurate or incomplete documentation can undermine the credibility of a nurse's actions and lead to legal liability.

**Documentation as Legal Evidence:** Nurses must understand that their documentation is often considered a legal record of the care provided. In case of disputes or litigation, nursing notes can be reviewed to determine whether care was delivered according to the standards of practice. According to Bjerkan et al., (2021), poor documentation can be detrimental to a nurse's defense in court, especially if it omits vital information or inaccurately represents the care given. In cases of medical malpractice or negligence, nurses may be required to provide documentation to demonstrate that their actions adhered to appropriate protocols and that they exercised professional judgment (Gesner et al., 2022).

**Consequences of Inaccurate or Incomplete Documentation:** Legal challenges often arise when documentation is incomplete, falsified, or inconsistent with other clinical records. Inaccurate documentation could lead to allegations of fraud or misrepresentation, particularly if the nurse is found to have altered patient records intentionally or failed to document significant events or interventions. Lindsay and Lytle (2022) emphasize that nurses must ensure their documentation is thorough, accurate, and up-to-date to protect themselves from legal repercussions. Falsifying documentation, even unintentionally, can result in severe consequences,

including disciplinary action, loss of licensure, or criminal charges in extreme cases (Shafiee et al., 2022).

**Compliance with Legal Standards and Regulations:** In many countries, there are legal regulations and guidelines governing nursing documentation practices, which nurses are obligated to follow. These include laws related to patient privacy (e.g., HIPAA in the United States), accuracy in charting, and maintaining confidentiality. Nurses must be aware of these regulations to avoid legal penalties. For instance, under laws like HIPAA, failing to maintain patient confidentiality or sharing information without consent can lead to legal action (Moy et al., 2021). Legal regulations also require that healthcare providers maintain certain standards of documentation for patient safety and quality of care. If nurses fail to meet these standards, it may be considered negligence (De Groot et al., 2022).

### **Ethical Implications of Nursing Documentation**

The ethical implications of nursing documentation are centered on professional integrity, accountability, and the protection of patient rights. Documentation serves as a tool for ensuring that nurses act in the best interests of patients and that their actions are consistent with ethical standards of practice.

**Ensuring Patient Privacy and Confidentiality** One of the fundamental ethical principles in healthcare is respecting patient privacy and confidentiality. Nurses are ethically bound to ensure that patient information is kept confidential and is only shared with authorized individuals (Almenyan et al., 2021). Documentation, whether in paper or electronic form, must be handled securely, and any breach of confidentiality can result in ethical violations. This includes taking precautions to prevent unauthorized access to patient records and ensuring that sensitive

information is not disclosed without patient consent. Mishandling patient data can not only lead to legal penalties but also undermine the trust that patients place in their healthcare providers (Shafiee et al., 2022).

**Accurate and Honest Reporting** Ethically, nurses are obligated to document all aspects of patient care honestly and accurately. This includes recording information about patient assessments, interventions, outcomes, and any changes in the patient's condition (Saba et al., 2018). Falsifying or omitting critical information from patient records is considered unethical, as it compromises the integrity of the healthcare process and could potentially harm the patient. According to Bjerkan et al. (2021), nurses must document all relevant patient data, even if it may reflect poorly on the healthcare team or institution. Failure to do so undermines the nurse's professional responsibility to provide truthful and transparent care.

**Accountability and Professionalism** Nurses have an ethical duty to maintain accountability for their actions. Accurate and timely documentation is an essential part of this accountability, as it serves as a written record of what has been done for the patient. Documentation provides an objective account of a nurse's decisions and actions, which is necessary for both patient care and professional accountability (Ferramosca et al., 2023). Nurses are ethically required to ensure that documentation reflects the actual care provided and the decisions made, helping to avoid any discrepancies between what was documented and what occurred in practice. This ensures that nurses uphold professional standards and maintain trust in the healthcare system.

**Ethical Responsibility to the Healthcare Team** Ethical nursing practice also involves effective communication with other healthcare team members. Nurses are responsible for accurately documenting their observations, actions, and interventions to ensure that other healthcare

providers can make informed decisions regarding patient care (Moy et al., 2021). Inaccurate documentation or failure to document crucial information can hinder the healthcare team's ability to respond to patient needs effectively, potentially leading to poor patient outcomes. Therefore, nurses must ethically ensure that their documentation is clear, comprehensive, and available to other professionals involved in the patient's care. **Balancing Ethical and Legal Requirements** Nurses must balance ethical considerations with the legal requirements for documentation. While there may be legal obligations to document certain aspects of patient care, nurses must also consider the ethical implications of their documentation practices, such as ensuring patient consent for sharing information and maintaining confidentiality (Khwaji et al., 2024). In situations where legal requirements conflict with ethical considerations, nurses should seek guidance from institutional policies, legal counsel, or their professional organizations to navigate the issue appropriately.

## **2.2 Theoretical Framework**

### **2.2.1 Donabedian's Quality of Care Model**

The Donabedian Model, developed by Avedis Donabedian in 1966, provides a structured framework for assessing healthcare quality. It is widely recognized and utilized in healthcare research and quality improvement initiatives. This model evaluates healthcare quality through three interrelated components: Structure, Process, and Outcome (SPO). Each component plays a crucial role in determining the overall quality of care delivered in healthcare settings.

#### **Structure: The Foundation of Healthcare Quality**

The structure component refers to the foundational elements that shape healthcare delivery, including the physical, human, financial, and technological resources available within a

healthcare system. It encompasses elements like physical infrastructure (e.g., hospitals, clinics, and medical equipment), human resources (the number and expertise of healthcare professionals), and organizational policies, as well as financial investments and technological advancements such as electronic health records (EHRs). A strong structure supports efficient processes and high-quality patient care. However, deficiencies in structure such as understaffing, outdated equipment, or inadequate funding can impair service delivery, resulting in inefficiencies, increased workload, and potential risks to patient safety. For example, a hospital with inadequate staffing may face delays in patient care, which can negatively impact outcomes.

### **Process: The Execution of Healthcare Services**

The process component focuses on the actual delivery of healthcare services, including diagnosis, treatment, and patient care management. It involves activities such as medical examinations, decision-making, adherence to clinical guidelines, and importantly, documentation practices. Effective processes ensure that services are delivered safely and efficiently and in accordance with best practices. In particular, documentation and record-keeping are vital aspects of the process, as they ensure accurate and timely patient information is recorded, shared, and used in clinical decision-making. Proper documentation helps prevent errors, facilitates continuity of care, and enhances communication among healthcare providers. However, inefficiencies in documentation, such as incomplete records or delayed data entry, can lead to errors, miscommunication, and compromised patient safety. Additionally, failures in other processes such as inadequate adherence to clinical protocols can further impact care quality.

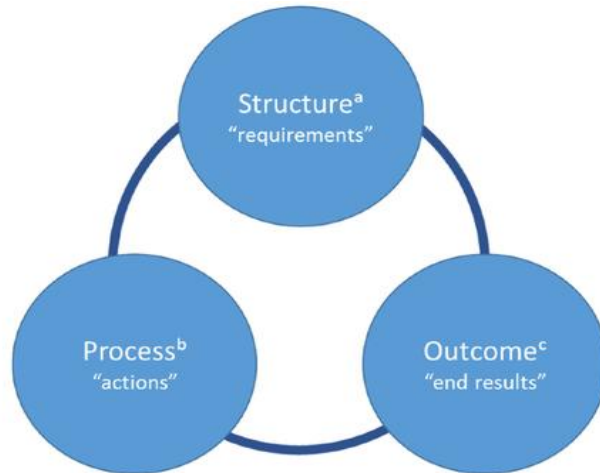
### **Outcome: The Measure of Healthcare Quality**

The outcome component measures the ultimate effects of healthcare services on patient health, safety, and satisfaction. Outcomes are indicators like recovery rates, complication rates, patient

satisfaction, and hospital readmission rates. Positive outcomes suggest that the underlying structure and processes are effective, whereas negative outcomes may indicate deficiencies in these areas. For example, high hospital readmission rates could suggest inadequate care during the initial stay or poor management during follow-up. Similarly, low patient satisfaction may reflect issues like long wait times, miscommunication, or insufficient care.

### **Interconnection Between Structure, Process, and Outcome**

A key strength of the Donabedian Model is its focus on the interconnections between structure, process, and outcome. A strong healthcare structure adequate staffing, up-to-date facilities, and clear policies supports efficient processes such as timely documentation and adherence to clinical guidelines, which contribute to positive patient outcomes. Conversely, deficiencies in structure, such as staffing shortages, can lead to inefficient processes, like rushed documentation, which negatively impacts patient outcomes, including increased medical errors and poor care quality. For example, a hospital facing staffing shortages (structure) might experience nurses struggling to meet documentation requirements (process), resulting in incomplete or delayed records. This could lead to mismanaged care and increased patient risks. On the other hand, investing in advanced EHR systems (structure) can streamline documentation processes (process), which in turn improves patient safety and continuity of care (outcome).



- a. What an organization needs to have to provide health care
- b. The actions in giving and receiving health care
- c. End results as a consequence of providing care

**fig. 2.1 Donabedian's Quality of Care Model**

### **Application of the Donabedian Model to Nursing Documentation**

The Donabedian Model is particularly useful when analyzing the impact of workload on nursing documentation. In this context, the structure component includes resources like staffing levels, physical infrastructure, and organizational policies. These factors directly influence the workload of nurses, impacting their ability to document patient care accurately and thoroughly. For example, if a hospital has insufficient staff or outdated documentation systems, nurses may struggle to complete accurate documentation due to time constraints or technological difficulties. This, in turn, compromises the quality of care provided. The process component focuses on the actual documentation practices that nurses follow in their care delivery. High workload pressure can lead to rushed documentation, where essential details are omitted, or patients' statuses are inaccurately recorded. When documentation is compromised, communication breakdowns between healthcare teams may occur, leading to inconsistencies in patient care and increased

risks to patient safety. Finally, the outcome of nursing documentation directly affects patient care. Inadequate or incomplete documentation can lead to misdiagnoses, delayed treatments, and medication errors, which compromise patient safety. Additionally, poor documentation quality can contribute to decreased patient satisfaction and lower overall healthcare outcomes. Excessive workload can also contribute to nurse burnout, which impacts their performance, further reducing the quality of documentation and care provided. The Donabedian Quality of Care Model provides a comprehensive framework for understanding the impact of workload on nursing documentation. The model highlights how structure, process, and outcome are interconnected and how deficiencies in one component can negatively impact the others. Addressing workload-related issues and providing adequate resources and support for nurses can lead to improved documentation practices, which in turn enhances patient care, reduces medical errors, and promotes better healthcare outcomes. Ultimately, recognizing the relationship between structure, process, and outcome is critical for improving both the work environment for nurses and the quality of care for patients.

## **2.3 Empirical Review**

### **2.3.1 The Level of Knowledge of Nursing Documentation among Nurses**

In a study conducted by Jasem and Younis (2024), titled "Nurses' Knowledge Towards Nursing Documentation: A Descriptive Study," the researchers aimed to assess nurses' knowledge regarding nursing documentation in pediatric wards at Mosul hospitals. The study utilized a simple random sample with a sample size of 60 participants. Data were collected using a questionnaire consisting of three sections: Section I focused on demographic characteristics such as age, gender, education level, and participation in training courses; Section II assessed nurses' knowledge about nursing documentation; and Section III evaluated nurses' practices related to

nursing documentation. The data were analyzed using the Statistical Package for Social Science (SPSS) software (Version 26). The results indicated that the majority of nurses were aged between 30 and 34 years, with 60% of the participants being women. The highest educational level among the participants was found to be graduates of nursing schools (40%), and 53% of the nurses had not participated in any specialized training courses on nursing documentation. The study concluded that the knowledge of nurses regarding nursing documentation was poor, highlighting the need for more targeted training to improve documentation practices.

Bjerkan et al. (2021) conducted a qualitative, exploratory study titled "Patient Safety Through Nursing Documentation: Barriers Identified by Healthcare Professionals and Students," in which they analyzed the barriers to effective documentation in primary care practice. The study involved six focus group interviews with nurses and social educators (n = 12) and nursing and social educator bachelor's degree students (n = 11). Data were analyzed using qualitative content analysis, and four main themes emerged: "Individual factors," "Social factors," "Organizational factors," and "Technological factors." These themes included various sub-themes and highlighted several barriers to documentation practices, such as insufficient training, lack of time, and inadequate support from organizational policies. The study concluded that improving documentation practices in primary care requires increased awareness and efforts from individuals, along with adequate resources and clear policies from healthcare organizations.

Bizimana and Bimerew (2021) conducted a quantitative descriptive survey to examine nurses' knowledge, attitudes, and barriers to quality patient record-keeping in two hospitals in Burundi. The study included 121 nurses and found that 82.6% of the participants demonstrated adequate knowledge of record-keeping. However, 64% of nurses had positive attitudes toward record-

keeping, while 36% displayed negative attitudes. The study also identified several barriers to effective patient record-keeping, including lack of training (81.3%), excessive workload (81.3%), lack of time (38%), and poor administrative support (55.4%). The results indicated significant associations between years of experience and nurses' knowledge, as well as between education level and attitudes toward record-keeping. The study concluded that despite having adequate knowledge and positive attitudes, barriers such as workload and lack of training hinder the quality of patient record-keeping in the selected hospitals.

Alhawri et al. (2020) conducted a study titled "Knowledge, Attitude, Performance, and Associated Factors Towards Nursing Documentation Among Nurses in Public Hospitals, Sana'a City, Yemen." This cross-sectional study involved 115 nurses from Al-Jomhori hospital in Sana'a, Yemen, who were selected through simple random sampling. The study utilized a validated questionnaire with a Cronbach's alpha of 72.5% for knowledge, attitude, and performance questions. The results showed that 46.01% of participants had good knowledge, 68.2% had a positive attitude, and 36.78% exhibited poor nursing documentation performance. The study found that gender and training were significant factors influencing nurses' knowledge and performance. The researchers concluded that nurses in public hospitals in Sana'a demonstrated poor knowledge, attitude, and performance regarding nursing documentation. They recommended that hospitals recruit qualified nurses and implement continuous training programs to improve documentation practices.

These studies underscore the critical role of training, organizational support, and workload management in enhancing nursing documentation practices. They also highlight the barriers nurses face, such as insufficient training, high workload, and lack of time, which negatively

affect the quality of documentation and, consequently, patient care. Effective interventions aimed at improving documentation practices should address these barriers while providing the necessary resources and support to nurses.

### **2.3.2 Perceived Impact of Workload on Effective Nursing Documentation**

In a study by De Groot et al. (2022), titled "Nursing Documentation and its Relationship with Perceived Nursing Workload: A Mixed-Methods Study Among Community Nurses," a convergent mixed-methods design was employed. The study involved 195 Dutch community nurses who completed a quantitative survey, and 28 nurses participated in qualitative focus groups. The quantitative data were analyzed using descriptive statistics, Wilcoxon signed-ranked tests, Spearman's rank correlations, and Wilcoxon rank-sum tests, while qualitative data were analyzed using thematic analysis. The results revealed that the majority of community nurses perceived a high workload due to documentation activities. Although nurses estimated spending twice as much time on clinical documentation as on organizational documentation, the perceived workload for both types were found to be similar. Focus-group discussions revealed that organizational documentation was often perceived as redundant. The study concluded that reducing the time spent on organizational documentation and improving the user-friendliness of electronic health records could help decrease the perceived workload of community nurses, ultimately enhancing their documentation practices.

Also, in a study conducted by Gesner et al. (2022) on documentation burden in nursing and its role in clinician burnout syndrome, a cross-sectional survey design was used. The study utilized three tools: the Burden of Documentation for Nurses and Midwives Survey, the System Usability Scale, and the Maslach Burnout Inventory for medical professionals. The results indicated that

documentation burden had a weak to moderate correlation with clinician burnout syndrome. Additionally, poor usability of electronic health records (EHR) was found to be associated with documentation burden and clinician burnout. The study concluded that improving the usability of EHR for nursing documentation is necessary to reduce clinician burnout. The researchers suggested that further studies should focus on understanding the specific factors contributing to documentation burden across different nursing specialties.

Banda et al. (2022) conducted a qualitative descriptive study on nurses' perceptions of the effects of high nursing workload on patient care in an intensive care unit of a referral hospital in Malawi. The study was carried out in the general ICU at Queen Elizabeth Central Hospital in Blantyre, Malawi, using a purposive sample of 12 full-time ICU nurses. Data were collected through 10 in-depth interviews, using a semi-structured interview guide, until data saturation was reached. Thematic analysis was used to analyze the data. The findings revealed that a high nursing workload compromised the quality of nursing care for critically ill patients, negatively impacted patient safety, and affected the well-being of nurses. The study concluded that ICU nurses were aware of the adverse effects of high workload on patient care. The researchers recommended increasing the number of ICU nurses and implementing strategies by nurse managers and policymakers to manage workload and its effects on patient care.

Moy et al., (2021) conducted a scoping review to measure clinical documentation burden among physicians and nurses using electronic health records. The study followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) Extension for Scoping Reviews (ScR) guidelines. The researchers assessed multiple databases, including MEDLINE, Embase, Web of Science, and CINAHL, from inception to April 2020, to identify studies that

investigated documentation burden in ambulatory and inpatient settings. Two reviewers independently screened and evaluated studies for inclusion. Out of 3482 articles retrieved, 35 studies met the inclusion criteria. The review identified 15 measurement characteristics, including seven effort constructs such as EHR usage and workload, clinical documentation and review, administrative tasks, and fragmentation of workflow. Additionally, four-time constructs were identified, including average time, proportion of time, timeliness of completion, and activity rate. The findings showed that only 45% of the studies assessed the impact of EHRs on clinicians and patients, while 40% mentioned clinician burnout. The study concluded that there is no standardized or validated measure of documentation burden, and further research is required to develop reliable methods to assess and reduce documentation burden among healthcare professionals.

### **2.3.3 Challenges that Nurse face in Maintaining Effective Documentation**

In a study conducted by Bibi et al. (2023) on the barriers faced by nurses regarding proper nursing documentation at teaching hospitals in Peshawar, Pakistan, a qualitative case-study design was used. The study had a sample size of 12 participants, determined by data saturation, and employed a purposive sampling technique. Data was collected in November 2022 from two tertiary care hospitals in Peshawar. Semi-structured interviews, lasting between 60 to 90 minutes, were conducted with each participant using a topic guide. The interviews were translated from Urdu to English, and thematic analysis, based on Braun and Clarke's six steps, was applied to analyze the data. The study was approved by the Advanced Studies and Research Board and the Ethical Review Board of Khyber Medical University, Peshawar. The results revealed four main themes: individual issues, incompetence in documentation, technical issues, and organizational

issues. The study concluded that nursing documentation is a critical component of quality care that is hindered by factors such as staff shortages, lack of training, heavy workload, managerial challenges including verbal instructions and ambiguous writing, individual issues such as lack of motivation, coordination, time, and knowledge, as well as software and hardware-related challenges.

Similarly, a study conducted by Bjerkan et al. (2021) explored patient safety through nursing documentation and identified barriers faced by healthcare professionals and students. The study utilized a qualitative, exploratory design and conducted six focus group interviews. Participants included 12 nurses and social educators involved in primary care practice, as well as 11 nursing and social educator bachelor's degree students from a university college. The data was analyzed using qualitative content analysis. The findings revealed four themes that influenced documentation practices and patient safety: individual factors, social factors, organizational factors, and technological factors, with each theme further broken down into sub-themes. The study concluded that various barriers negatively impacted documentation practices and the exchange of information, potentially placing primary care patients in a vulnerable situation. To ensure effective documentation, increased awareness and efforts from individual healthcare professionals are necessary. However, the study emphasized that primary care services must also provide adequate resources, clear mission statements, and well-defined policies to support successful nursing documentation.

## **2.4 Summary of Literature Review**

Nursing documentation plays a crucial role in patient care, professional accountability, and healthcare system efficiency. It encompasses various aspects, including knowledge and

awareness, workload impact, standards and guidelines, as well as legal and ethical implications. Nurses' knowledge and awareness of documentation are fundamental to maintaining accurate, complete, and effective records. Proper documentation enhances communication among healthcare professionals, supports clinical decision-making, and improves patient outcomes (Jasem & Younis, 2024). However, knowledge gaps and lack of training often lead to inconsistencies in documentation practices (Seidu et al., 2021). Nursing workload significantly influences documentation quality and effectiveness. High workloads can lead to documentation errors, omissions, or delays, negatively affecting patient safety (Almenyan et al., 2021). Studies highlight that excessive administrative tasks contribute to clinician burnout and reduce the time available for direct patient care (Gesner et al., 2022). Standardized documentation guidelines ensure consistency, completeness, and legal compliance. Best practices in nursing documentation emphasize accuracy, clarity, timeliness, and adherence to institutional policies (Lindsay & Lytle, 2022). The integration of electronic health records (EHRs) aims to improve documentation efficiency and accessibility while reducing the burden on nurses (Shafiee et al., 2022). Nursing documentation serves as a legal record and can be used in court proceedings in cases of malpractice or negligence (Bjerkkan et al., 2021). Incomplete or inaccurate records may expose nurses and healthcare institutions to legal risks (Moy et al., 2021). Ethically, nurses are responsible for maintaining honesty, accountability, and confidentiality in their documentation practices (Ferramosca et al., 2023).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Research Methodology**

This chapter describes the research methodology that the researcher intends to adopt in conducting this study. The various components of research methodology are discussed under their respective headings, including research design, study setting, target population, sample and sampling technique, instruments of data collection, validity and reliability of instruments, method of data collection, method of data analysis, and ethical considerations.

#### **1.1 Research Design**

A descriptive cross-sectional survey design was adopted because it allowed the researcher to collect data at a single point in time from a large group of nurses within the tertiary healthcare institution. This design was suitable since the study focused on assessing the level of knowledge, perceived impact of workload, and challenges associated with nursing documentation without manipulating any variables. It was also appropriate because it enabled the researcher to describe existing conditions and relationships as they were, providing a snapshot of the nurses' experiences and perceptions regarding workload and documentation practices.

#### **1.2 Research Setting**

This study was carried out in University of Benin Teaching Hospital (UBTH), Benin City, Edo State. UBTH is a tertiary healthcare facility which was established in 1973. It is located in Ugbowo, Egor Local Government Area. Edo State comprise of 18 local government areas. Egor Local government area where University of Benin Teaching Hospital is located falls within the

southern senatorial district of Nigeria. UBTH offers both clinical and diagnostic services and offers a wide range of services, which makes it an important healthcare facility in the state, region and the nation at large. It is estimated that UBTH has a bed capacity of over nine hundred and ten (910) (UBTH, 2024). UBTH has nineteen (19) clinical departments and three (3) Medical Laboratory Department and 3 emergency departments. These departments offer emergency services for the general/primary health needs of the people. They offer both outpatient and in-patient services and they are staffed with health professionals such as Doctors, Nurses and paramedics to carry out their daily routines.

### **3.3 Target Population**

The target population comprised of 511 nurses working in the various departments in University of Benin Teaching Hospital (UBTH), Ugbowo, Benin City.

**Table 3.1 Number of nurses in various units/wards in University of Benin Teaching Hospital.**

<b>IN-PATIENT WARDS</b>	<b>NUMBER OF NURSES.</b>
Renal unit	18
Male medical ward(A1)	22
Female medical ward(A3)	21
Maternity ward 1(M1)	19
Maternity ward 2(M2)	21
A2	18
Ophthalmic ward	19
Male surgical ward(B4)	21
Children surgical ward	17
B2	21
Female gynecological ward(A4)	15
Neurological ward	29
Female Orthopedic ward	21
Male Orthopedic ward	18
Emergency ward	18
Labour ward	26
Children's Emergency ward (CHER)	21
Pediatric ward	19
Pediatric extension	19
Special care baby unit (SCBU)	26
C2	19
SIU	6
Main theater	22
Accident and Emergency unit	14
Intensive care unit	21
Burns and plastic	20
Total	511

*(Source, Human Resources Department, February 2025).*

### **3.4 Sample Size Determination**

The sample size was calculated as indicated below:

Using Taro Yamane's Formula

$$n = \frac{N}{1 + N(e)^2}$$

Where

N= Population under study

E= Constant 0.05%) margin error

$$n = \frac{511}{1 + 511(0.05)^2}$$

$$n = \frac{511}{1 + 511(0.0025)}$$

$$n = \frac{511}{1 + 1.2775}$$

$$n = \frac{511}{2.2775}$$

$$n = 224.37 = 224$$

adding attrition rate of 10% which is 22.4 approximately 22.

$$224 + 22 = 246$$

Therefore, the sample size is approximately 246.

### 3.5 Sampling Technique

Stratified random sampling was employed because the nurses in University of Benin Teaching Hospital were distributed across various wards and departments. This technique was appropriate as it ensured that all categories of nurses, regardless of their units, had a fair chance of being included in the study. By dividing the target population into strata based on their wards and randomly selecting participants proportionately, the researcher obtained a more representative sample. This increased the accuracy of the findings and reduced the risk of bias that could have occurred if certain departments were overrepresented or underrepresented.

**Table 3.2: Proportional Sampling Calculation**

Ward / Unit	Population (Ni)	Sample Calculation	Allocated Sample
Renal unit	18	$18/511 \times 246 = 8.66$	9
Male medical ward (A1)	22	$22/511 \times 246 = 10.59$	11
Female medical ward (A3)	21	$21/511 \times 246 = 10.11$	10
Maternity ward 1 (M1)	19	$19/511 \times 246 = 9.15$	9
Maternity ward 2 (M2)	21	$21/511 \times 246 = 10.11$	10
A2	18	$18/511 \times 246 = 8.66$	9
Ophthalmic ward	19	$19/511 \times 246 = 9.15$	9
Male surgical ward (B4)	21	$21/511 \times 246 = 10.11$	10
Children surgical ward	17	$17/511 \times 246 = 8.19$	8
B2	21	$21/511 \times 246 = 10.11$	10
Female gynecological ward (A4)	15	$15/511 \times 246 = 7.22$	7
Neurological ward	29	$29/511 \times 246 = 13.96$	14
Female Orthopedic ward	21	$21/511 \times 246 = 10.11$	10
Male Orthopedic ward	18	$18/511 \times 246 = 8.66$	9
Emergency ward	18	$18/511 \times 246 = 8.66$	9
Labour ward	26	$26/511 \times 246 = 12.51$	13
Children's Emergency (CHER)	21	$21/511 \times 246 = 10.11$	10
Pediatric ward	19	$19/511 \times 246 = 9.15$	9
Pediatric extension	19	$19/511 \times 246 = 9.15$	9
Special care baby unit (SCBU)	26	$26/511 \times 246 = 12.51$	12
C2	19	$19/511 \times 246 = 9.15$	9
SIU	6	$6/511 \times 246 = 2.89$	3
Main theater	22	$22/511 \times 246 = 10.59$	11
Accident & Emergency unit	14	$14/511 \times 246 = 6.74$	7
Intensive care unit	21	$21/511 \times 246 = 10.11$	10
Burns and plastic	20	$20/511 \times 246 = 9.63$	10
<b>TOTAL</b>	<b>511</b>		<b>246</b>

### 3.6 Instrument for Data Collection

The instrument for data collection in this study was self-structured questionnaire. This was developed based on the objectives of the study. The questionnaire was made up of five sections with. Questions which were carefully drafted, sequenced and constructed in a bid to get in-depth information that is useful and relevant to the study will be used.

**Section A:** consist of the demographic data of the participants (Age, Marital Status, Current Level, Ethnicity).

**Section B:** knowledge of nursing documentation

**Section C:** perceived impact of workload on effective nursing documentation

**Section D:** challenges that nurses face in maintaining effective documentation

### **3.7 Validity of the Instrument**

The instrument's validity pertained to its capability to accurately measure the intended construct or concept (Surucu & Maslakci, 2020). Researchers assessed various validity types such as content, construct, criterion, and face to evaluate the instrument's accuracy. For this research, face and content validity will be utilized to validate the research tool. The questionnaire underwent validation by both the project supervisor and a field expert, and necessary adjustments were implemented by the researcher before starting the main study.

### **3.8 Reliability of the Instrument**

The reliability of an instrument referred to its stability and consistency in delivering uniform outcomes when assessing the same criteria under identical circumstances (Surucu & Maslakci, 2020). It essentially gauged how consistently the instrument produced similar results across multiple trials. A reliable instrument is one that could produce the same results if the behavior was measured again by the same scale. The Cronbach's alpha reliability technique was employed in this study. This researcher conducted reliability testing on the instrument by distributing 15 questionnaires, which constituted 10% of the total sample size of 150, to working nurses of Faith MediPlex (which are outside the sampled population). A coefficient of 0.71 was obtained making the instrument to be considered reliable.

### **3.9 Method of Data Collection**

A well-structured questionnaire was administered to the nurses working in medical and surgical unit until the required sample size of 150 is achieved. The nurses were approached at their various unit. The purpose of the study will be explained to them, and the instrument for data collection will be administered. Data collection was conducted by the researchers. The data collection will take place during break periods, and on-the-spot retrieval of the administered copies of the questionnaire will ensure that all copies are collected on the same day. Data collection lasted for about two weeks.

### **3.10 Method of Data Analysis**

The data collected was analyzed using the Statistical Package for the Social Sciences (SPSS) version 27.0. Descriptive statistics such as mean, frequency, and percentages will be computed to summarize the data. Hypothesis testing will be conducted using the Chi-square test of association, with the level of significance set at  $p < 0.05$ . The results of the analyses were then be presented using tables, graphs, frequencies, and percentages to provide a clear overview of the findings.

### **3.11 Ethical Considerations**

Ethical approval was obtained from the Health Research Committee, University of Benin Teaching Hospital, Benin City. Permission was obtained from the various ward managers before proceeding with the research. Before data collection begins, participants received detailed explanations about the research's purpose, content, and implications. They were assured of confidentiality, ensuring the protection of their personal and private information. Throughout the research, ethical guidelines were strictly adhered to, including the following considerations:

**Confidentiality:** Respondents' information was treated confidentially, with no request for names or addresses in the questionnaire. Participants understood that their responses are confidential and solely used for research purposes. No personal identifiers were used in any document or questionnaire to maintain anonymity.

**Voluntary Participation:** Participants were informed of their right to voluntary participation without facing penalties or bias. They can choose to withdraw or decline to provide information at any point if they feel uncomfortable or unsure.

**Avoidance of Plagiarism:** Proper citation of all authors used in the study was ensured, both within the content and in the reference page.

## **CHAPTER FOUR**

### **RESULTS**

This chapter deals with the representation of data collected regarding the perceived impact of workload on effective nursing documentation among nurses in a tertiary healthcare institution in Benin City. A total of 246 questionnaires were distributed to nurses working in the various departments in University of Benin Teaching Hospital, 239 were properly filled and valid for data analysis, giving a response rate of 97.1%.

**Table 4.1: Socio-Demographic Characteristics of Respondents**

<b>Variable</b>	<b>Frequency (n = 239)</b>	<b>Percent (%)</b>
<b>Age</b>		
18–29 years	45	18.8
30–39 years	98	40.9
40–49 years	72	30.2
50 years and above	24	10.1
<b>Gender</b>		
Male	72	30.1
Female	167	69.9
<b>Marital Status</b>		
Married	154	64.4
Single	58	24.2
Divorced	16	6.7
Widowed	11	4.7
<b>Religion</b>		
Christianity	178	74.5
Islam	37	15.4
African Traditional Religion	18	7.4
Other	6	2.7
<b>Ethnic Group</b>		
Bini	93	38.9
Igbo	53	22.1
Yoruba	40	16.8
Hausa	14	6.0
Other (e.g., Esan, Urhobo)	39	16.1
<b>Years of Work Experience</b>		
0–5 years	47	19.5
6–10 years	72	30.2
11–15 years	63	26.2
16 years and above	57	24.1
<b>Years in This Facility</b>		
0–2 years	34	14.1
3–5 years	58	24.2
6–10 years	75	31.5
11 years and above	72	30.2
<b>Educational Level</b>		
RN	58	24.3
RM	37	15.5
B.Sc. Nursing	94	39.3
M.Sc. Nursing	44	18.4
PhD	6	2.5

Table 4.1 shows the socio-demographic characteristics of the respondents. The majority of the nurses were aged 30–39 years (40.9%), followed by those aged 40–49 years (30.2%), while 18–29 years and 50 years and above accounted for 18.8% and 10.1% respectively. Most respondents were female (69.9%), while males constituted 30.1%. With respect to marital status, 64.4% were married, 24.2% single, 6.7% divorced, and 4.7% widowed. Christianity was the predominant religion (74.5%), followed by Islam (15.4%), African Traditional Religion (7.4%), and others (2.7%). In terms of ethnicity, the Bini ethnic group was the most represented (38.9%), followed by Igbo (22.1%), Yoruba (16.8%), Hausa (6.0%), and other ethnic groups such as Esan and Urhobo (16.1%). Regarding years of work experience, 30.2% had 6–10 years, 26.2% had 11–15 years, 24.1% had 16 years and above, while 19.5% had 0–5 years of experience. Similarly, in terms of years of service in the facility, 31.5% had worked for 6–10 years, 30.2% for 11 years and above, 24.2% for 3–5 years, and 14.1% for 0–2 years. On educational qualification, the highest proportion were B.Sc. Nursing holders (39.3%), followed by RN (24.3%), M.Sc. Nursing (18.4%), RM (15.5%), while a few held PhDs (2.5%).

### **Answering Research Questions**

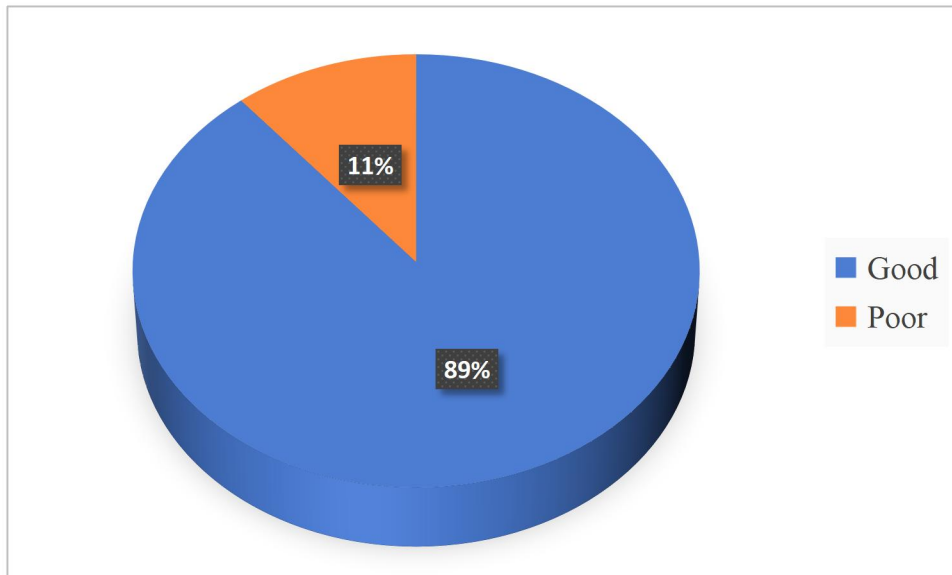
**Research Question 1:** What is the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City?

**Table 4.2: The level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City**

<b>Items and Options</b>	<b>Frequency (%)</b>	<b>Correct (%)</b>	<b>Wrong (%)</b>	<b>Mean</b>	<b>Remark</b>
<b>Definition of Nursing Documentation</b>		212 (88.7)	27 (11.3)	1.9	Good
A formal record of nursing care and patient responses	212 (88.7)				
A list of medications prescribed by a doctor	17 (7.1)				
A financial record of hospital expenses	10 (4.2)				
<b>Primary Purpose of Nursing Documentation</b>		205 (85.8)	34 (14.2)	1.9	Good
To communicate patient care info to the healthcare team	205 (85.8)				
To monitor hospital equipment	21 (8.8)				
To report staff attendance	13 (5.4)				
<b>Essential Component of Accurate Documentation</b>		217 (90.8)	22 (9.2)	1.9	Good
Personal opinions of the nurse	8 (3.3)				
Timely and factual recording of patient care	217 (90.8)				
Use of informal language and abbreviations	14 (5.9)				
<b>When should a Nurse Document Patient care?</b>		210 (87.9)	29 (12.1)	1.9	Good
At the end of the week	6 (2.5)				
Immediately after providing care	210 (87.9)				
Only when patient's condition changes drastically	23 (9.6)				
<b>Practice that may lead to Legal Issues</b>		207 (86.6)	32 (13.4)	1.9	Good
Using standard nursing language	11 (4.6)				
Omitting or falsifying info	207 (86.6)				
Signing with full name and designation	21 (8.8)				
<b>Importance of Legibility in Documentation</b>		221 (92.5)	18 (7.5)	1.9	Good
Helps the nurse write faster	10 (4.2)				
Ensures communication & prevents errors	221 (92.5)				
Reduces amount of documentation required	8 (3.3)				
		<b>Grand Mean</b>		<b>1.9</b>	<b>Good</b>

**Mean Cut-off = 1.5**

**Table 4.2 shows** the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City. The highest mean score of 1.9 was recorded across all items, indicating a good level of knowledge of nursing documentation among the respondents. Specifically, 92.5% correctly identified the importance of legibility in documentation, 90.8% recognized timely and factual recording as an essential component of accurate documentation, 88.7% understood the definition of nursing documentation, 87.9% knew that documentation should be done immediately after providing care, 86.6% identified omission or falsification of information as a practice that may lead to legal issues, and 85.8% acknowledged that the primary purpose of documentation is to communicate patient care information to the healthcare team. The grand mean of 1.9 further confirms that the respondents demonstrated good knowledge of nursing documentation.



**Figure 4.1: Pie Chart showing the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City.**

**Figure 4.1 shows** the level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City. The majority of respondents (89%) demonstrated good knowledge of nursing documentation, while only 11% exhibited poor knowledge, indicating that most nurses in the facility possess adequate understanding of proper documentation practices.

**Research Question 2:** What is the perceived impact of workload on nursing documentation in a tertiary health care facility in Benin City?

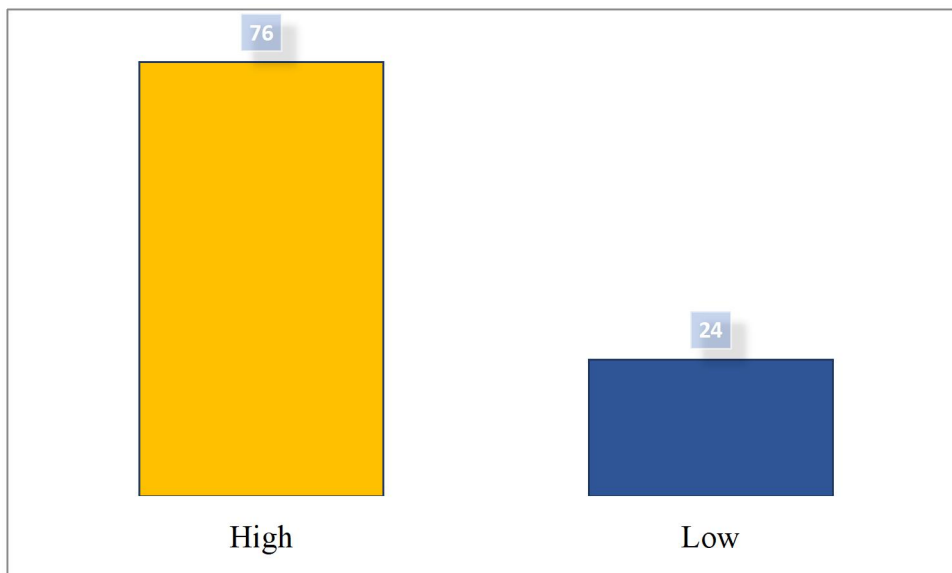
**Table 4.3: Perceived Impact of Workload on Nursing Documentation among Nurses in a tertiary health care facility in Benin City.**

Item	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
High patient-to-nurse ratio affects accurate documentation	111 (46.4)	75 (31.4)	34 (14.2)	19 (8.0)	3.2	High
Time pressure during shifts impacts completeness of documentation	103 (43.1)	85 (35.6)	29 (12.1)	22 (9.2)	3.1	High
Emergency situations affect timeliness of documentation	93 (38.9)	95 (39.8)	35 (14.6)	16 (6.7)	3.1	High
Number of procedures per shift affects ability to document effectively	106 (44.4)	77 (32.2)	37 (15.5)	19 (7.9)	3.1	High
Interruptions during shift affect concentration during documentation	99 (41.4)	83 (34.7)	32 (13.4)	25 (10.5)	3.1	High
Volume of documentation affects job satisfaction	82 (34.3)	90 (37.7)	45 (18.8)	22 (9.2)	3.0	High
Shift length impacts quality of documentation	88 (36.8)	79 (33.1)	40 (16.7)	32 (13.4)	2.9	High
Lack of support staff affects ability to complete documentation	98 (41.0)	80 (33.5)	39 (16.3)	22 (9.2)	3.1	High
Physical workload reduces energy for documentation tasks	95 (39.7)	86 (36.0)	31 (13.0)	27 (11.3)	3.0	High
Multitasking during care affects real-time documentation	109 (45.6)	74 (31.0)	34 (14.2)	22 (9.2)	3.1	High
<b>Grand Mean</b>					<b>3.1</b>	<b>High</b>

**Mean Cut-off = 2.5**

**Table 4.3 shows** that the perceived impact of workload on nursing documentation among nurses in a tertiary health care facility in Benin City was generally high, with a grand mean of 3.1. The highest mean value was recorded for high patient-to-nurse ratio affecting accurate documentation

(3.2), followed by time pressure during shifts impacting completeness of documentation (3.1), emergency situations affecting timeliness of documentation (3.1), number of procedures per shift affecting ability to document effectively (3.1), interruptions during shift affecting concentration during documentation (3.1), lack of support staff affecting ability to complete documentation (3.1), and multitasking during care affecting real-time documentation (3.1). Physical workload reducing energy for documentation tasks (3.0) and volume of documentation affecting job satisfaction (3.0) both had mean values of 3.0, while shift length impacting quality of documentation recorded the lowest mean of 2.9.



**Figure 4.2: Bar Chart showing the perceived impact of workload on nursing documentation in a tertiary health care facility in Benin City.**

Figure 4.2 shows the perceived impact of workload on nursing documentation in a tertiary health care facility in Benin City, where a majority of the respondents (76%, n=181) reported a high impact, while 24% (n=58) indicated a low impact.

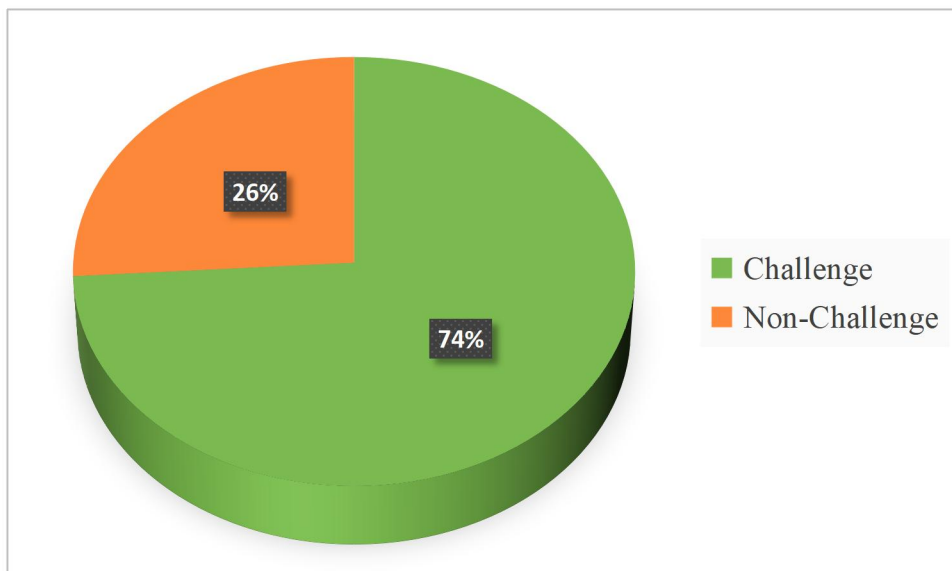
**Research Question 3:** What challenges do nurses face in maintaining effective documentation in a tertiary health care facility in Benin City?

**Table 4.4: Challenges in Maintaining Effective Nursing Documentation among Nurses in a tertiary health care facility in Benin City**

Item	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
Lack of time due to workload affects proper documentation	106 (44.4)	79 (33.0)	29 (12.1)	25 (10.5)	3.1	Challenge
Inadequate staffing leads to incomplete documentation	98 (41.0)	83 (34.7)	37 (15.5)	21 (8.8)	3.1	Challenge
Lack of adequate training on documentation standards is a challenge	91 (38.1)	87 (36.4)	34 (14.2)	27 (11.3)	3	Challenge
Unavailability of documentation tools (e.g., charts, forms) affects work	95 (39.8)	80 (33.5)	35 (14.6)	29 (12.1)	3	Challenge
Poor handwriting and legibility make documentation difficult	87 (36.4)	81 (33.9)	42 (17.6)	29 (12.1)	2.9	Challenge
Frequent interruptions reduce concentration during documentation	101 (42.3)	77 (32.2)	32 (13.4)	29 (12.1)	3	Challenge
Lack of motivation affects the quality of documentation	88 (36.8)	85 (35.6)	39 (16.3)	27 (11.3)	3	Challenge
Inconsistent supervision on documentation practices leads to lapses	84 (35.1)	90 (37.7)	40 (16.7)	25 (10.5)	3	Challenge
Absence of electronic health records increases documentation burden	96 (40.1)	75 (31.4)	37 (15.5)	31 (13.0)	3	Challenge
Language or communication barriers impact clarity in documentation	93 (38.9)	80 (33.5)	43 (18.0)	23 (9.6)	3	Challenge
				<b>Grand Mean</b>	<b>3.0</b>	<b>Challenge</b>

**Mean Cut-off = 2.5**

**Table 4.4 shows** challenges do nurses face in maintaining effective documentation in a tertiary health care facility in Benin City. The highest mean score of 3.1 was recorded for lack of time due to workload and inadequate staffing leading to incomplete documentation. This was followed by mean scores of 3.0 for lack of adequate training on documentation standards, unavailability of documentation tools, frequent interruptions, lack of motivation, inconsistent supervision, absence of electronic health records, and language or communication barriers. The lowest mean score of 2.9 was observed for poor handwriting and legibility. The grand mean of 3.0 indicates that these factors are generally perceived as challenges to maintaining effective nursing documentation.



**Figure 4.3: Pie Chart showing Challenges in Maintaining Effective Nursing Documentation among Nurses in a tertiary health care facility in Benin City.**

**Figure 4.3 shows** challenges nurses face in maintaining effective documentation in a tertiary health care facility in Benin City. 74% of the respondents identified challenges in maintaining effective nursing documentation, while 26% reported no challenges.

## Hypothesis Testing

1. There is no significant relationship between the level of knowledge of nursing documentation and the perceived impact of workload on nursing documentation among nurses in a tertiary health care facility in Benin City.

**Table 4.5: Relationship between the level of knowledge of nursing documentation and the perceived impact of workload on nursing documentation among nurses in a tertiary health care facility in Benin City.**

Knowledge	Perceived Impact		Test Statistics ( $\chi^2$ )	df	P value	Decision
	High	Low				
Good	212(89%)	181(76%)	6.785	1	0.041	Rejected
Poor	27(11%)	58(24%)				

**Table 4.5 shows** the relationship between the level of knowledge of nursing documentation and the perceived impact of workload on nursing documentation among nurses in a tertiary health care facility in Benin City. The findings revealed that nurses with good knowledge accounted for 212 (89%), while those with poor knowledge were 27 (11%). Among the respondents, 181 (76%) perceived a high impact of workload on nursing documentation, while 58 (24%) perceived a low impact. The chi-square test statistic ( $\chi^2 = 6.785$ ,  $df = 1$ ,  $p = 0.041$ ) indicates a significant association, hence the null hypothesis was rejected.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

This chapter discusses the major findings of the research compared with the literature reviewed, the implication for nursing, summary, conclusion, Recommendations and Suggestions for further Studies.

#### 5.1. Discussion of Major Findings

The study assessed the perceived impact of workload on effective nursing documentation among nurses in a tertiary healthcare institution in Benin City. The socio-demographic characteristics of the study's 239 respondents reveal several notable patterns when contrasted with the previous empirical studies reviewed. The age distribution shows a concentration in the middle career years, with 40.9% of participants aged 30-39 years and 30.2% aged 40-49 years, representing 71.1% of the sample in their prime professional years. This contrasts with Jasem and Younis's (2024) study, which found the majority of nurses aged between 30-34 years, suggesting a similar demographic trend across different healthcare settings and geographical locations. The gender composition reveals a strong female predominance at 69.9%, which aligns closely with Jasem and Younis's (2024) findings of 60% female participation and Alhawri et al.'s (2020) study that identified gender as a significant factor influencing nurses' knowledge and performance in documentation. This consistent gender distribution across studies reflects the traditional composition of the nursing profession globally. Educational attainment in the study demonstrates a notably higher level of professional preparation compared to previous research. While Jasem and Younis (2024) found that 40% of participants were nursing school graduates, the study reveals that 39.3% hold Bachelor of Science in Nursing degrees, 18.4% possess Master's degrees, and 2.5% have doctoral qualifications. This represents a significant

advancement in educational credentials, with nearly 60% of respondents holding university-level nursing degrees, suggesting an increasingly professionalized workforce that may have different documentation knowledge and practice patterns. The work experience profile shows a well-distributed range, with 30.2% having 6-10 years of experience and 26.2% having 11-15 years, indicating a mature workforce with substantial clinical experience. This distribution is particularly relevant when considered alongside Bizimana and Bimerew's (2021) findings, which identified significant associations between years of experience and nurses' knowledge of record-keeping. The sample's experience profile suggests a workforce positioned to have developed considerable documentation expertise over time. Religious and ethnic diversity characteristics provide important contextual information, with Christianity representing 74.5% of participants and the Bini ethnic group comprising 38.9% of respondents. This demographic composition reflects the study's geographical location and may influence cultural attitudes toward documentation practices and professional responsibilities. The facility tenure data reveals that 61.7% of nurses have worked at their facility for six years or more, with 30.2% having over eleven years of service. This stability contrasts with the high turnover often reported in healthcare settings and suggests that the study population represents nurses with established relationships with their workplace systems and documentation protocols. When examining the educational composition alongside previous studies' findings about training deficits, the sample presents an interesting contrast. While Jasem and Younis (2024) found that 53% of nurses had not participated in specialized training courses on nursing documentation, and Bizimana and Bimerew (2021) identified lack of training as a barrier for 81.3% of nurses, the higher educational credentials in the study may suggest different baseline knowledge levels. However, formal education does not necessarily translate to practical documentation competency, as

highlighted by Alhawri et al.'s (2020) finding that only 46.01% of participants demonstrated good knowledge despite educational preparation. The demographic profile suggests a study population that is professionally mature, educationally well-prepared, and stable in their employment, characteristics that may influence their approach to documentation practices. This contrasts with some previous studies that examined populations with lower educational preparation and potentially different professional development experiences. These demographic differences are crucial for interpreting findings and understanding how various contextual factors may influence documentation knowledge, attitudes, and practices across different nursing populations.

#### **The level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin city.**

The findings regarding the level of knowledge of nursing documentation among nurses in this tertiary healthcare facility in Benin City reveal remarkably positive results that stand in stark contrast to several previous studies, while aligning with others in unexpected ways. These findings warrant careful examination within the broader context of nursing documentation research. The study demonstrates exceptionally high knowledge levels, with 89% of respondents exhibiting good knowledge of nursing documentation practices and achieving a grand mean score of 1.9 (above the 1.5 cut-off). This finding presents a striking contrast to the results reported by Jasem and Younis (2024), who concluded that nurses' knowledge regarding nursing documentation was poor in pediatric wards at Mosul hospitals. Similarly, Alhawri et al. (2020) found that only 46.01% of participants in public hospitals in Sana'a, Yemen, demonstrated good knowledge of nursing documentation, representing less than half the proportion observed in the

study. However, the findings align more closely with Bizimana and Bimerew's (2021) study in Burundi, which reported that 82.6% of nurses demonstrated adequate knowledge of record-keeping. The similarity between these two African contexts (Nigeria and Burundi) compared to Middle Eastern settings (Iraq and Yemen) suggests potential regional, cultural, or healthcare system influences on nursing education and knowledge retention regarding documentation practices. The detailed analysis of individual knowledge areas reveals consistently high performance across all assessed domains. The highest knowledge scores were achieved in understanding the importance of legibility in documentation (92.5% correct responses), followed by recognizing essential components of accurate documentation (90.8% correct). These findings are particularly significant given the emphasis in previous literature on the critical importance of clear, accurate documentation for patient safety and continuity of care. The strong performance in identifying the definition of nursing documentation (88.7% correct) and its primary purpose (85.8% correct) suggests that the fundamental conceptual understanding among these nurses is well-established. This contrasts sharply with the knowledge deficits identified in earlier studies and may reflect improvements in nursing education curricula or institutional training programs since those studies were conducted. Particularly encouraging is the finding that 87.9% of nurses correctly identified that documentation should occur immediately after providing care, and 86.6% recognized practices that could lead to legal issues. This temporal awareness addresses one of the critical challenges identified by De Groot et al. (2022), who found that nurses often struggled with timely documentation due to workload pressures. The high level of legal awareness also suggests that nurses understand the medicolegal implications of their documentation practices, which is crucial given the increasing emphasis on healthcare accountability and patient safety. While these knowledge findings are overwhelmingly positive,

they present an interesting paradox when considered alongside the documented barriers and challenges identified in previous research. Bizimana and Bimerew (2021) found that despite 82.6% of nurses having adequate knowledge, significant barriers including lack of training (81.3%), excessive workload (81.3%), and poor administrative support (55.4%) continued to hinder effective documentation practices. This suggests that knowledge alone may be insufficient to ensure quality documentation practices. The demographic profile of the study, showing a mature and experienced nursing workforce, may partially explain these positive knowledge outcomes. With 80.5% of nurses having more than five years of experience and 61.7% having been in their facility for more than five years, this workforce has had substantial opportunity to develop and refine their understanding of documentation requirements through both formal education and practical experience. The high knowledge levels observed in this study may reflect the impact of improved nursing education programs and institutional training initiatives that have addressed the knowledge gaps identified in earlier research. Jasem and Younis (2024) noted that 53% of nurses in their study had not participated in specialized training courses on nursing documentation, which may partially explain their poor knowledge outcomes. The results suggest that either formal education or institutional training programs in this Nigerian tertiary facility have been more effective in establishing fundamental documentation knowledge. However, it is important to note that while Alhawri et al. (2020) found training to be a significant factor influencing nurses' knowledge and performance, they still reported poor overall knowledge and performance levels. This discrepancy highlights the complexity of factors influencing documentation knowledge and the potential variations in training quality and implementation across different healthcare contexts. While the high knowledge levels demonstrated in this study are encouraging, they must be interpreted cautiously in light of previous research showing that

knowledge does not always translate to effective practice. Bibi et al. (2023) identified numerous barriers including individual issues, technical challenges, and organizational factors that can impede effective documentation despite adequate knowledge. Similarly, Bjerkan et al. (2021) emphasized that individual, social, organizational, and technological factors all influence documentation practices and patient safety outcomes. The findings establish a strong foundation of theoretical knowledge among these nurses, but the true test lies in whether this knowledge translates into consistent, high-quality documentation practices in the face of real-world challenges such as heavy workloads, time constraints, and technological barriers. Future research should examine the relationship between this demonstrated knowledge level and actual documentation quality and practices, particularly in the context of the organizational and systemic challenges that have been well-documented in the literature. The exceptionally positive knowledge outcomes in this study provide hope that targeted educational interventions can be effective in establishing strong foundational understanding of documentation principles among nursing staff, even as the healthcare system continues to grapple with the practical challenges of implementing these principles in daily practice.

### **The perceived impact of workload on effective nursing documentation in a tertiary health care facility in Benin city.**

The findings regarding the perceived impact of workload on nursing documentation among nurses in this tertiary healthcare facility in Benin City reveal a compelling picture of systemic challenges that strongly corroborates and extends previous research in this field. With a grand mean score of 3.1 and 76% of respondents reporting high workload impact on documentation practices, these results provide substantial evidence of the persistent barriers that nurses face in

maintaining effective documentation despite possessing good theoretical knowledge. The findings demonstrate remarkable consistency with established research on workload-related barriers to effective nursing documentation. The high perceived impact scores across all measured dimensions align closely with De Groot et al. (2022), who found that the majority of Dutch community nurses perceived high workload due to documentation activities. The study's finding that 77.8% of nurses agreed that high patient-to-nurse ratios affect accurate documentation particularly resonates with De Groot's observation that nurses estimated spending twice as much time on documentation activities than they preferred. These results also strongly support the conclusions of Banda et al. (2022), whose qualitative study in Malawi revealed that high nursing workload compromised the quality of nursing care for critically ill patients and negatively impacted patient safety. The quantitative findings provide measurable validation of these qualitative insights, with specific attention to how workload affects documentation quality rather than just general patient care. The finding that 78.7% of nurses reported that time pressure during shifts impacts completeness of documentation directly corroborates the barriers identified by Bizimana and Bimerew (2021), who found that 38% of nurses in Burundi cited lack of time as a significant barrier to effective patient record-keeping. The study's more pronounced time pressure findings (78.7% vs. 38%) may reflect differences in healthcare system demands, patient acuity levels, or staffing patterns between the Nigerian tertiary care setting and the Burundian hospital context. Similarly, the high agreement levels regarding emergency situations affecting timeliness of documentation (78.7%) and the impact of procedure volume on documentation ability (76.6%) provide quantitative support for the organizational factors identified by Bjerkan et al. (2021). Their qualitative study highlighted organizational factors as key barriers to effective documentation, and the findings offer specific metrics demonstrating how acute care

demands compete with documentation responsibilities. The finding that 74.5% of nurses reported that lack of support staff affects their ability to complete documentation aligns with the staffing shortage concerns raised by Bibi et al. (2023), who identified staff shortages as a critical organizational barrier to proper nursing documentation. This convergence of findings across different healthcare contexts suggests that inadequate staffing support is a universal challenge affecting documentation quality regardless of geographic location or specific healthcare system characteristics. The study's identification of interruptions during shifts as significantly affecting concentration during documentation (76.1% agreement) provides quantitative validation of the workflow fragmentation issues highlighted in Moy et al.'s (2021) scoping review. Their identification of "fragmentation of workflow" as one of seven key effort constructs affecting documentation burden finds concrete expression in the study's findings about interruption-related challenges. The finding that 75.7% of nurses reported that physical workload reduces energy for documentation tasks offers important insights into the multidimensional nature of workload impact that extends beyond previous research. While studies like Gesner et al. (2022) focused primarily on documentation burden's relationship with clinician burnout syndrome, the findings specifically identify physical exhaustion as a distinct factor affecting documentation quality. This adds a crucial dimension to understanding how comprehensive workload management must address both cognitive and physical demands on nursing staff. The high agreement levels regarding multitasking effects on real-time documentation (76.6%) directly support the workflow challenges identified in previous research while highlighting the specific impact on documentation timeliness. This finding is particularly significant given the study's earlier demonstration that 87.9% of nurses possess knowledge that documentation should occur immediately after providing care, creating a clear knowledge-practice gap mediated by workload

pressures. While the study does not explicitly address electronic health record usability issues, the high perceived impact of workload on documentation practices provides important context for understanding the technological factors identified by Gesner et al. (2022). Their finding that poor EHR usability was associated with both documentation burden and clinician burnout suggests that the workload impacts identified in the study may be amplified by technological challenges, creating a compounding effect on documentation quality. The volume of documentation affecting job satisfaction (72% agreement) in the study resonates with De Groot et al.'s (2022) finding that organizational documentation was often perceived as redundant. This suggests that workload impact extends beyond time and energy constraints to affect professional satisfaction and potentially long-term retention, creating broader implications for healthcare system sustainability. The convergence between the study's findings and previous research creates a compelling case for systematic interventions addressing workload-related barriers to effective documentation. Unlike studies that identified poor knowledge as a primary concern, the research context—where 89% of nurses demonstrate good documentation knowledge—highlights that knowledge deficits are not the primary barrier to effective documentation practices. The high perceived workload impact (76% of respondents) despite good knowledge levels suggests that interventions must focus on systemic organizational changes rather than individual education initiatives. This aligns with Bjerkan et al.'s (2021) conclusion that effective documentation requires not just individual awareness and effort but also adequate resources, clear policies, and organizational support from healthcare institutions. The findings, while validating previous research on workload-related documentation challenges, also highlight the complexity of translating documentation knowledge into effective practice. The juxtaposition of high knowledge levels (89% good knowledge) with high perceived workload impact (76%)

creates a paradox that demands nuanced intervention strategies addressing structural rather than educational deficits.

These results suggest that future research should focus on measuring the effectiveness of organizational interventions designed to reduce workload impact on documentation practices, rather than continuing to document the existence of these barriers. The consistency of findings across diverse healthcare contexts indicates that the fundamental challenges are well-established, and the focus should shift toward solution implementation and evaluation.

### **The challenges that nurses face in maintaining effective documentation in a tertiary health care facility in Benin city.**

The findings regarding challenges in maintaining effective nursing documentation among nurses in this tertiary healthcare facility in Benin City reveal a comprehensive pattern of systemic barriers that closely mirror and validate the challenges identified in previous research, while also introducing some context-specific insights. With a grand mean score of 3.0 and 74% of respondents identifying challenges in maintaining effective documentation, these results provide robust confirmation of the persistent organizational and structural barriers that continue to impede quality documentation practices across diverse healthcare settings. The findings demonstrate remarkable alignment with the barrier frameworks established in previous research. The challenges identified in this study map closely onto the four main themes identified by Bjerkan et al. (2021): individual factors, social factors, organizational factors, and technological factors. Similarly, the results strongly corroborate the four main themes found by Bibi et al. (2023): individual issues, incompetence in documentation, technical issues, and organizational issues. This convergence across different healthcare contexts suggests that the fundamental

challenges to effective nursing documentation are universal rather than context-specific. The finding that 77.4% of nurses identified lack of time due to workload as affecting proper documentation directly validates the temporal barriers highlighted in multiple previous studies. This result shows striking consistency with Bizimana and Bimerew's (2021) findings, where 38% of nurses cited lack of time as a barrier, though the study reveals a more pronounced impact. The higher percentage in the study may reflect the increased complexity and documentation requirements in tertiary care settings compared to the general hospital settings in the Burundi study. The identification of inadequate staffing as leading to incomplete documentation (75.7% agreement) strongly supports the staffing shortage concerns raised by Bibi et al. (2023) and Banda et al. (2022). This finding is particularly significant because it creates a cyclical problem: inadequate staffing increases workload, which reduces time available for documentation, which potentially compromises patient safety and continuity of care, ultimately requiring more nursing time to address the consequences of incomplete documentation. Paradoxically, despite the earlier finding that 89% of nurses in this facility demonstrated good knowledge of documentation practices, 74.5% still identified lack of adequate training on documentation standards as a challenge. This apparent contradiction provides crucial insights into the complexity of translating theoretical knowledge into practical application. The finding suggests that while nurses possess fundamental conceptual understanding of documentation principles, they may lack specific training on institutional standards, electronic systems, or advanced documentation techniques. This gap between knowledge and training needs aligns with the concerns raised by Jasem and Younis (2024), who noted that 53% of nurses in their study had not participated in specialized training courses on nursing documentation. However, the study's context—where basic knowledge is high but training challenges persist—suggests that the nature of needed training

may be more sophisticated than basic documentation principles, possibly focusing on system-specific applications, legal requirements, or quality improvement techniques. The finding that 71.5% of nurses reported that absence of electronic health records increases documentation burden provides important insights into the technological challenges facing healthcare systems in resource-constrained settings. This finding contrasts with studies like Gesner et al. (2022) and De Groot et al. (2022), which focused on problems with existing electronic health record systems rather than their absence. The study's context suggests that the implementation of EHR systems remains incomplete in many healthcare settings, creating different types of documentation burdens related to manual processes rather than system usability issues. The identification of unavailability of documentation tools (73.3% agreement) as a significant challenge highlights basic infrastructure deficits that may be more pronounced in resource-limited healthcare settings. This finding extends beyond the technological factors identified in previous studies to encompass fundamental resource availability issues that may not be as prominent in more developed healthcare systems. The finding that 72.4% of nurses identified language or communication barriers as impacting clarity in documentation introduces a dimension that has received limited attention in previous research. This challenge may be particularly relevant in diverse, multilingual healthcare environments where nurses may be documenting in languages that are not their primary languages, or where patient communication occurs across multiple linguistic contexts. The identification of inconsistent supervision on documentation practices (72.8% agreement) as a challenge directly supports the organizational factors identified by Bjerkan et al. (2021) and the managerial challenges highlighted by Bibi et al. (2023). This finding suggests that even when nurses possess good theoretical knowledge and recognize the importance of quality documentation, inconsistent organizational oversight can undermine the translation of this

knowledge into consistent practice. The finding that 72.4% of nurses reported that lack of motivation affects documentation quality provides important insights into the psychological and professional satisfaction dimensions of documentation challenges. This result aligns with De Groot et al.'s (2022) finding that organizational documentation was often perceived as redundant and with the job satisfaction impacts identified in the study's workload assessment. The identification of poor handwriting and legibility issues (70.3% agreement) as ongoing challenges suggests that despite technological advances in healthcare, fundamental documentation skills remain problematic. This finding is particularly noteworthy given that 92.5% of nurses in this study correctly identified the importance of legibility in documentation, again highlighting the gap between knowledge and practice. The finding that 74.5% of nurses identified frequent interruptions as reducing concentration during documentation validates the workflow fragmentation issues identified by Moy et al. (2021) in their scoping review. This challenge creates a compounding effect where time pressures are exacerbated by the inability to complete documentation tasks efficiently due to constant interruptions, potentially leading to either delayed documentation or documentation errors. The study's identification of multiple, con challenges facing nurses in maintaining effective documentation creates a complex intervention landscape. Unlike studies that identified single primary barriers, the findings suggest that effective solutions must address multiple, interconnected challenges simultaneously. The fact that 74% of respondents identified challenges despite high knowledge levels (89%) underscores that knowledge-based interventions alone are insufficient to improve documentation practices. The convergence of findings across different healthcare contexts and populations suggests that these challenges represent fundamental systemic issues rather than isolated problems. However, the specific manifestation of these challenges—such as the absence of electronic health records

rather than poor EHR usability—highlights the importance of context-specific intervention strategies that address the particular combination of barriers present in each healthcare setting. The findings also suggest that the relationship between knowledge, perceived workload impact, and specific challenges is complex and multidirectional. High knowledge levels do not eliminate challenges, high perceived workload impact exacerbates challenges, and the presence of multiple con challenges creates a cumulative burden that may exceed the capacity of individual nurses to overcome through personal effort alone, necessitating systematic organizational interventions to address the structural barriers that undermine effective documentation practices.

## **5.2 Implications to Nursing Practice**

The findings of this study have important implications for nursing practice. Although the majority of nurses demonstrated good knowledge of nursing documentation, their ability to translate this knowledge into practice was significantly hindered by workload-related pressures. This highlights the presence of a knowledge–practice gap, suggesting that possessing theoretical understanding alone is insufficient without supportive systems that enable its application. Continuous supervision, mentorship, and reinforcement of best practices are therefore essential to ensure that nurses consistently document care accurately and in a timely manner.

Workload emerged as a critical determinant of documentation quality. High patient-to-nurse ratios, time pressure, multitasking, and long shifts were shown to negatively impact the completeness, accuracy, and timeliness of nursing records. This underscores the need for nursing managers and administrators to prioritize workload management as a quality-of-care issue. Measures such as adequate staffing, redistribution of tasks, and deployment of support staff can help ease the burden on nurses, thereby improving their ability to maintain proper documentation.

The study also revealed that despite high knowledge levels, nurses still perceived inadequate training on documentation standards as a challenge. This implies that while foundational knowledge may be present, there is a continuous need for capacity building through in-service training, workshops, and refresher courses that emphasize institutional standards, medico-legal implications, and advances in documentation techniques. Such initiatives will not only enhance competence but also foster consistency in documentation practices across the workforce.

Another significant implication is the role of technology in supporting documentation. The absence of electronic health records was identified as a challenge, indicating that manual documentation systems contribute to workload and inefficiency. The integration of electronic documentation systems into nursing practice would streamline record-keeping, reduce errors, and enhance continuity of care. Investment in health information technology should therefore be considered a priority for improving documentation outcomes.

Furthermore, many of the challenges identified, such as unavailability of documentation tools, inconsistent supervision, and frequent interruptions, point to organizational shortcomings. These findings emphasize that effective documentation is not solely the responsibility of individual nurses but is influenced by the systems and policies within which they work. Hospital administrators and nursing leaders must therefore ensure that enabling environments, adequate resources, and supportive policies are in place to strengthen documentation practices.

Finally, accurate documentation is not only a professional expectation but also an ethical and legal responsibility that safeguards patient safety. Poor documentation can compromise continuity of care and increase the risk of medical errors. Therefore, improving documentation practices through workload management, training, technological support, and organizational

commitment directly enhances patient safety, strengthens professional accountability, and improves overall quality of care.

### **5.3 Summary**

This study investigated the perceived impact of workload on effective nursing documentation among nurses in a tertiary healthcare facility in Benin City. A total of 246 questionnaires were distributed, out of which 239 were properly filled and valid for analysis, giving a high response rate of 97.1%. The respondents were predominantly female, mostly aged between 30 and 49 years, and a large proportion held higher academic qualifications, particularly Bachelor's and Master's degrees in nursing. The workforce also reflected maturity and stability, with many nurses having over five years of professional and facility experience.

The study first examined the level of knowledge of nursing documentation among the respondents. Findings revealed that the nurses demonstrated a high level of knowledge, with 89% of them exhibiting good understanding of documentation principles and practices. Most participants correctly identified the definition, purpose, essential components, importance of legibility, and the appropriate timing for documentation. These results indicate that the nurses possessed a solid conceptual foundation in nursing documentation.

The second focus of the study was the perceived impact of workload on nursing documentation. The results showed that workload had a generally high impact, with a grand mean score of 3.1. High patient-to-nurse ratios, time pressure during shifts, emergency situations, multitasking, and lack of support staff were identified as major workload factors that compromised timely and accurate documentation. Overall, 76% of respondents reported that workload exerted a significant effect on their ability to document effectively.

The study also identified challenges faced by nurses in maintaining effective documentation. These included lack of time due to workload, inadequate staffing, insufficient training on documentation standards, unavailability of tools, absence of electronic health records, poor handwriting and legibility, frequent interruptions, inconsistent supervision, and lack of motivation. A grand mean of 3.0 confirmed that these factors were generally recognized as significant barriers.

Hypothesis testing further revealed a statistically significant relationship between nurses' level of knowledge and the perceived impact of workload on documentation, with the chi-square result ( $\chi^2 = 6.785$ ,  $df = 1$ ,  $p = 0.041$ ) leading to the rejection of the null hypothesis. This finding indicates that while nurses demonstrated good knowledge, workload pressures still significantly influenced their documentation practices.

The study established that nurses in the facility possessed good knowledge of documentation; however, heavy workload and systemic challenges hindered effective documentation practices. The findings highlight the need for organizational interventions such as improved staffing, better workload distribution, provision of adequate tools, continuous training, and adoption of electronic health records to ensure accurate, timely, and complete nursing documentation.

#### **5.4 Conclusion**

This study set out to assess the perceived impact of workload on effective nursing documentation among nurses in a tertiary healthcare facility in Benin City. The findings revealed that while nurses possessed a high level of knowledge of documentation practices, their ability to translate this knowledge into consistent practice was significantly influenced by workload and systemic challenges. High patient-to-nurse ratios, time pressures, emergency situations, multitasking, and

lack of support staff were found to compromise the accuracy, timeliness, and completeness of documentation. In addition, organizational factors such as inadequate staffing, unavailability of documentation tools, absence of electronic health records, inconsistent supervision, and frequent interruptions further hindered documentation practices.

The hypothesis testing confirmed that there was a significant relationship between nurses' knowledge of documentation and the perceived impact of workload, indicating that knowledge alone does not guarantee effective practice when organizational and workload pressures persist. These findings demonstrate that while educational preparation and professional awareness are strong among the nursing workforce, the persistent challenges of workload and systemic barriers limit the full realization of effective documentation.

The study establishes that effective nursing documentation cannot be achieved through knowledge alone but requires supportive organizational structures, adequate resources, manageable workloads, and enabling policies. Addressing these factors is essential not only for improving documentation practices but also for enhancing patient safety, ensuring continuity of care, and strengthening the overall quality of nursing services.

### **5.5 Limitations of the Study**

This study, like many others, was not without its limitations. Firstly, the research was conducted in a single tertiary healthcare facility in Benin City, which may limit the generalizability of the findings to other healthcare institutions within Nigeria or beyond. Different hospitals may operate under varying policies, staffing levels, and documentation systems, which could produce different outcomes. Secondly, the study relied on self-reported data obtained through

questionnaires. This approach may have introduced response bias, as participants might have provided socially desirable answers rather than reflecting their actual practices and challenges.

## **5.6 Recommendations**

Based on the findings of this study, the following recommendations are made to improve effective nursing documentation and address the challenges posed by workload:

- Hospital administrators should ensure adequate nurse staffing levels to reduce the patient-to-nurse ratio and ease workload pressures. Redistribution of tasks and deployment of support staff will also enable nurses to dedicate more time to accurate and timely documentation.
- Regular in-service training, workshops, and refresher courses should be organized to reinforce nurses' knowledge and skills in documentation, with emphasis on institutional standards, medico-legal requirements, and best practices.
- The introduction and integration of electronic documentation systems should be prioritized to reduce paperwork, minimize errors, and improve efficiency in record-keeping. Adequate training and technical support should accompany the implementation of such systems.
- Hospitals should ensure the availability of essential documentation materials such as charts, forms, and stationery, to eliminate delays and inconsistencies in record-keeping.
- Nursing leaders should institute consistent supervision and monitoring of documentation practices. Supportive leadership that motivates and guides nurses will help translate their knowledge into effective practice.

- Policymakers and hospital management should develop clear policies that emphasize the importance of nursing documentation as a professional, ethical, and legal obligation. Such policies should also address workload distribution, supervision, and resource allocation.
- Efforts should be made to minimize frequent interruptions during care, improve communication systems, and provide a conducive environment that allows nurses to focus on timely and accurate documentation.

### **5.7 Suggestions for Further Study**

1. Future studies should be conducted across multiple healthcare facilities, including private, secondary, and primary health centers, to allow for broader generalization of findings and comparison across different contexts.
2. Longitudinal studies are recommended to examine how workload and documentation practices change over time and to establish causal relationships between these variables.
3. Further research should include an audit of actual nursing records to objectively assess the quality of documentation and compare it with nurses' self-reported knowledge and perceptions.
4. Studies should explore the impact of introducing electronic health record systems on nursing documentation practices, workload, and patient outcomes.
5. Qualitative studies such as interviews or focus group discussions could provide deeper insights into nurses' lived experiences, challenges, and coping strategies regarding documentation.

6. Future research may also examine the role of organizational culture, leadership styles, and institutional policies in shaping effective nursing documentation.
7. Comparative studies across different regions or countries could highlight cultural and systemic factors influencing nursing documentation practices and provide lessons for best practices.

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**APPENDIX I**

**DEPARTMENT OF NURSING SCIENCE  
SCHOOL OF BASIC MEDICAL SCIENCES  
UNIVERSITY OF BENIN  
BENIN CITY**

Dear Respondent,

I am a 500-level student of the Department of Nursing Science in the above-named institution. I am conducting a research study titled: "**Perceived Impact of Workload on Effective Nursing Documentation among Nurses in a Tertiary Healthcare Institution in Benin City.**" Your responses will be treated with the utmost confidentiality and used solely for academic purposes.

Thank you for your valuable time and cooperation.

**Yours faithfully,**

**Onarimi Bethel**

Instruction: please do not write your name, provide and tick the appropriate answer.

**SECTION A: Socio-Demographic Data;**

1. **Age:**  18 – 29  30 – 39  40 – 49  50 and above
2. **Gender:**  Male  Female
3. **Marital Status:**  Single  Married  Divorced  Widowed

4. **Work Experience (Years):**  0 - 5 years  6 - 10 years  11 - 15 years  16 years and above
5. **Religion:**  Christianity  Islam  African Traditional Religion  Other
6. **Ethnic Group:**  Igbo  Yoruba  Hausa  Bini  Other
7. **How long have you worked in this healthcare facility?**  0 - 2 years  3 - 5 years  6 - 10 years  11 years and above
8. **Educational Level:**  RN  RM  B.Sc. Nursing  M.Sc. Nursing  PhD

**SECTION B:** Level of knowledge of nursing documentation among nurses in a tertiary health care facility in Benin City."

1. Which of the following best defines nursing documentation? A. A formal record of nursing care and patient responses.  B. A list of medications prescribed by a doctor.  C. A financial record of hospital expenses.
2. What is the primary purpose of nursing documentation? A. To communicate patient care information to the healthcare team . B. To monitor hospital equipment . C. To report staff attendance .
3. Which of the following is an essential component of accurate nursing documentation? A. Personal opinions of the nurse . B. Timely and factual recording of patient care . C. Use of informal language and abbreviations .
4. When should a nurse document patient care? A. At the end of the week . B. Immediately after providing care . C. Only when a patient's condition changes drastically .

5. Which of the following practices may lead to legal issues in nursing documentation? A. Using standard nursing language ( ). B. Omitting or falsifying information in the patient's record ( ). C. Signing your documentation with your full name and designation ( ).

6. What is the importance of legibility in nursing documentation? A. It helps the nurse write faster ( ). B. It ensures effective communication and prevents errors ( ). C. It reduces the amount of documentation required ( ).

**SECTION C: Perceived Impact of Workload on Nursing Documentation**

S/N	Item	Very Impactful	Impactful	Neutral	Less Impactful
1	High patient-to-nurse ratio affects accurate documentation				
2	Time pressure during shifts impacts completeness of documentation				
3	Emergency situations affect timeliness of documentation				
4	Number of procedures per shift affects ability to document effectively				
5	Interruptions during shift affect concentration during documentation				
6	Volume of documentation affects job satisfaction				
7	Shift length impacts quality of documentation				
8	Lack of support staff affects ability to complete documentation				

9	Physical workload reduces energy for documentation tasks				
10	Multitasking during care affects real-time documentation				

S/N	Item	Strongly Agree	Agree	Disagree	Strongly Disagree
1	Lack of time due to workload affects proper documentation				
2	Inadequate staffing leads to incomplete documentation				
3	Lack of adequate training on documentation standards is a challenge				
4	Unavailability of documentation tools (e.g., charts, forms) affects work				
5	Poor handwriting and legibility make documentation difficult				
6	Frequent interruptions reduce concentration during documentation				

7	Lack of motivation affects the quality of documentation				
8	Inconsistent supervision on documentation practices leads to lapses				
9	Absence of electronic health records increases documentation burden				
10	Language or communication barriers impact clarity in documentation				