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Perceived Motivators and Barriers of Nursing Documentation Practice Among Ethiopian Nurses at Specialized Hospital: A Qualitative Inquiry

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Abstract

Background

Nursing documentation is a record or chart of nursing care that is organized and provided to individual patients by nurses. Accurate, complete, and timely documentation of nursing care ensures continuity of care across shifts, supports clinical decision-making, enables effective healthcare providers' communication, and provides legal and quality-assurance records of care delivered. There is a paucity of qualitative studies in Ethiopia regarding nursing documentation practice. Therefore, the purpose of the study was to explore the barriers and motivators affecting nursing documentation practices among nurses at Hiwot Fana Specialized University Hospital.

Methods

A qualitative descriptive study design was employed among 10 staff nurses who were actively involved in providing direct patient care at Hiwot Fana Comprehensive Specialized Hospital from November 10 to November 21, 2025. A purposive sampling technique was used to recruit participants from different clinical wards, and data were collected using face-to-face, in-depth interviews guided by a semi-structured interview. Data were analyzed thematically using Braun and Clarke's methodology, and MAXQDA Pro v26 software was used throughout the analysis to support systematic data management, organization, and coding process.

Result

Three themes emerged from the analysis: "barriers to nursing documentation", "motivators for nursing documentation", and "suggested recommendations to nursing documentation improvement". Each theme also includes two sub-themes, totaling six sub-themes. Continuity of patient care, evidence of care, professional responsibility, and legal accountability were motivators for nursing documentation. Major barriers to nursing documentation were heavy workload, staff shortages, lack of training, punitive supervision, and unavailability of patient cards. Suggested improvements by nurses included improved staffing, providing training, regular supportive supervision, electronic systems, and recognition of staff with good documentation.

Conclusions

This study reveals a clear disconnect between nurses' professional values regarding documentation and the realities of their working environment. To address these challenges, human resource strengthening, supportive leadership, and sustainable training mechanisms are required.

Clinical trial number:

Not applicable

Background

Nursing documentation is a record or chart of nursing care that is organized and provided to individual patients by nurses, and it is a cornerstone of safe, accountable, and high-quality patient care [1–3]. Documentation in nursing is the primary source of clinical information that helps to satisfy legal standards of practice in patient care [4]. Nursing documentation that is clear, accessible, and accurate is an essential element of quality, safe, and evidence-based nursing care [5].

Nursing documents maintained in an effective, accurate, and dynamic manner also serve as a reliable source for medico-legal purposes, quality assurance activities, health planning, resource allocation, and research activities [6]. Poor nursing documentation is repeatedly related to patient safety incidents, disorganized care, and inability to evaluate nursing interventions [3, 7].

Inadequate communication between caregivers is associated with discontinuity of care, a factor that contributes to errors [8]. The consequences of discontinuity of care are linked to increased cost and length of hospital stay, readmissions, poorer patient satisfaction, adverse events, delays in treatment and diagnosis, inappropriate treatment, and omission of care [9].

Despite nursing documentation being critical to safe and effective patient care, it is often seen as less important than hands-on nursing care. Furthermore, evidence suggests that maintaining nursing documentation is viewed as burdensome and even as a distraction from direct patient care; hence, compromising the quality of those documents [10].

International studies report common problems of nursing documentation, such as incomplete records, inconsistency in recording vital signs and nursing interventions, and low use of standardized nursing formats. These documentation problems are factors that undermine consistent patient monitoring and the evaluation of outcomes [3, 11].

In Ethiopia, research similarly indicates gaps in routine documentation practice and identifies multiple factors associated with poor nursing documentation. Different studies have identified heavy workloads, limited training for nurses, absence of clear documentation guidelines, and shortages of essential documenting formats as factors of poor nursing documentation [12, 4].

A scoping review of qualitative literature identifies multi-level barriers to good nursing documentation practice, such as individual barriers, technical barriers, and organizational barriers. So far, these reviews consistently request focused, locally-grounded qualitative studies that capture vanguard nurses' perspectives to inform feasible and acceptable solutions in specific hospitals and regions [13, 14].

Existing studies often give emphasis to only what is documented and what is not documented, but do not include why documentation is incomplete or how nurses feel about the nursing documentation practice, which clearly shows the paucity of qualitative studies. Therefore, this study addresses these gaps qualitatively by exploring the motivators, barriers, and suggested improvement strategies from the perspective of nurses working at HUHFCSH.

Methods

Study area and study period

The study was conducted at Haramaya University Hiwot Fana Comprehensive Specialized Hospital (HUHFCSH) located in Harar, Eastern Ethiopia, 526 km from Addis Ababa. HUHFCSH is a teaching and referral hospital serving a wide catchment area that includes populations from Harari, Oromia, and Somali Regions, and the Dire Dawa city administration. The hospital has more than 400 inpatient beds and employs 371 nurses. The study was conducted from November 10 to November 21, 2025.

Study Design

A qualitative descriptive phenomenological study design was employed to provide insights into the perceptions of nurses regarding the barriers and motivators of nursing documentation among nurses working at HUHFCSH. To secure accurate and complete reporting of the study, the COREQ checklist [15] was used as a guideline.

Population

The source population consists of all nurses at HUHFCSH. The study population consists of all staff nurses who were actively involved in providing direct patient care in different wards and units at HUHFCSH during the study period.

Inclusion and Exclusion Criteria

Nurses who have been directly involved in patient care for at least one year at HUHFCSH were included, while nurses on leave/have been in a long leave, and nurses in administrative roles without direct patient care responsibilities were excluded from the study.

Sample size determination

The sample size was determined by the concept of data saturation [16]. The data saturation was reached after interviewing 8 nurses and confirmed by the 9th and 10th interviews, which reinforced existing themes without adding new information. In addition, three nurses (2 females and 1 male)

refused to participate, and the reasons were that they were not interested in the research and did not consent to be recorded.

Sampling technique

A purposive sampling technique was used to recruit participants from different clinical wards, including gender and with different levels of experience.

Data collection instrument

Data was collected using in-depth interviews guided by a semi-structured interview tool prepared in English and translated into Amharic and Afaan Oromo accordingly. The semi-structured interview guide we used in this study was developed specifically for this research after performing an extensive review of relevant literature. The study objectives and previous clinical experiences, knowledge and qualitative expertise among the research teams also shaped the interview guide preparation. The English language version of the interview guide is provided as a Supplementary File 1.

The interview guide mainly included questions that addressed motivators and barriers of nursing documentation and suggested solutions for improvement of nursing documentation practice. The interview guide was pretested on 2 nurses who were not included in the final study sample to refine the clarity, relevance, and sequencing of the questions.

Data collectors and supervisors

All interviews were conducted by four PhD nursing students (bilingual) with previous experience in interviewing and clinical experience in the research settings, and one PhD holder was acted as supervisors as needed and accordingly. All authors previously taken qualitative research methodology training and have experience in previous qualitative study execution and publishing. Before joining the PhD program, the four authors were academicians at public universities in Ethiopia and had previous clinical experience.

Procedure of data collection

Data were collected using face-to-face, in-depth interviews guided by a semi-structured interview tool prepared in English and translated into Amharic and Afaan Oromo. In-depth interviews explored the barriers and motivators of nurses regarding nursing documentation. Data was collected at the hospital (head office and staff duty room). Each session of the interview lasted 30–45 minutes, alongside taking field notes and audio recording with participant consent. Field notes were taken both during and after the interview to capture non-verbal cues and contextual information. But no repeat interviews were required.

No prior relationship was established between the researchers and participants, but after approaching the participants, all authors have introduced themselves (they are all PhD in nursing students) and explained the purpose of the research.

Theoretical definitions

Nursing documentation is defined as a process in which the patient's experience from admission to discharge is recorded in a manner that enables all clinical staff involved in the patient's care to detect changes in the patient's condition and the patient's response to treatment and care delivery [17].

Motivation for nursing documentation

- is the internal and external drive and willingness that compels a nurse to thoroughly and accurately complete patient records [18].

Barriers to nursing documentation

- are obstacles preventing accurate, timely, and complete recording of patient care, and could be categorized as organizational (*staff shortages, workload, poor policies*), individual/behavioral (*lack of knowledge/skills, poor attitude, time perception*), technical (*EHR issues, lack of standards*), and legal (*fear of litigation*) factors [14].

Data Management

Audio recordings were transcribed verbatim and translated into the English language. Transcripts were reviewed multiple times to ensure accuracy. All transcripts were imported into MAXQDA Analytics Pro version (26.0.0) for systematic data management and analysis. All participant identifiers were removed to maintain confidentiality.

Trustworthiness of the Study

The trustworthiness of the study was maintained by applying Lincoln and Guba's [19]. The four dimensions of credibility, dependability, conformability, and transferability, were the foundation of the current study's validity and reliability. Maintaining strategies included prolonged engagement, audit trails, peer debriefing, reflexive journaling supported by participant quotes, and a thick description of the study context.

By following Lincoln and Guba's (1985) criteria [19], several strategies were used to enhance the trustworthiness of the study. Credibility was supported by including an adequate number of nursing staff, encouraging dialogue in the interview sessions, and by discussing the interpretation of data until a consensus on themes and subthemes was reached.

Providing descriptions of informants, data collection, analysis, and quotes from the in-depth interviews enabled each individual reader to assess the transferability of the study findings to other contexts.

Dependability and confirmability were achieved by using audio recording during the interviews and transcribing all interviews verbatim, and by having all authors discuss the data interpretations together.

Methods of Data Analysis

Data were analyzed thematically using Braun and Clarke’s six-step approach [20], and MAXQDA Analytics Pro v26 software was used throughout the analysis to facilitate systematic coding, retrieval, and organization of qualitative data.

The Braun and Clarke's method was selected because it provides a flexible yet rigorous framework for identifying, analyzing, and reporting themes (patterns) within the qualitative data. This step allows for an in-depth exploration of nurses' perceptions regarding motivators and barriers to nursing documentation.

Step 1: Familiarization with the Data

The first phase involved immersion in the data to gain a comprehensive understanding of nurses' perspectives. All interviews were audio-recorded and transcribed verbatim. All researchers repeatedly read and re-read the transcripts while listening to the recordings to ensure accuracy and to become familiar with the depth and breadth of the data. During this process, initial ideas/impressions and potential meanings relevant to nursing documentation practices were noted, and reflexive notes were also maintained.

Step 2: - Generating Initial Codes

In this second phase, systematic coding was performed using MAXQDA Analytics Pro v26 software. All authors independently coded the data. Each transcript was examined line by line, and meaningful segments of text related to motivators, barriers, and suggestions for improving nursing documentation were assigned codes. Coding was data-driven, allowing codes to emerge inductively from the participants' narratives. Similar codes were applied across transcripts to ensure consistency, while remaining open to new codes as analysis progressed.

Step 3: - Searching for Themes

Following initial coding, similar/related codes were grouped together to identify broader patterns of meaning. Codes that shared conceptual similarities were clustered to form candidate sub-themes, which were then organized under three preliminary major themes. At this stage, the analysis focused on how different codes combined to present nurses' shared challenges and perceptions of nursing documentation.

Step 4: Reviewing Themes

In this phase, the preliminary themes were reviewed and refined to ensure internal coherence and clear distinctions between themes. Each sub-theme was examined in relation to the coded extracts and the entire dataset to confirm that it accurately reflected participants' accounts. Some sub-themes were merged, refined, or re-categorized to improve clarity and analytical depth. The iterative process ensured that the themes meaningfully captured nurses' perspectives and aligned with the study objectives.

Step 5: Defining and Naming Themes

Once the thematic structure was finalized, each theme and sub-theme was clearly defined and named using simple, descriptive, and practice-oriented language. The final analysis resulted in three major themes and seven sub-themes reflecting nurses' perceived motivators, barriers, and suggestions for improving nursing documentation. Detailed definitions were developed for each theme to explain their scope, focus, and relevance to the research question.

Phase 6: - Producing the Report

The final phase involved integrating the themes into a coherent analytical narrative. The findings were presented thematically, supported by verbatim quotations from participants to illustrate key points and enhance credibility. The analysis went beyond mere description by interpreting how organizational, individual, and system-level factors influence nursing documentation. The final report links the themes to existing literature and highlights implications for nursing practice management and policy within the context of HUHFCSH. All authors participated in the data analysis and jointly discussed possible approaches to each theme until a consensus was reached. Transcripts were not returned to participants, so they do not provide feedback on the findings.

Reflexivity Statement

Throughout the research process, reflexivity was carefully considered to enhance the credibility and trustworthiness of this study. The researchers acknowledged that their professional background in nursing could influence the overall research process, including data collection, interpretation, and analysis. Familiarity with nursing documentation practices and hospital environments may have shaped the way interview questions were posed and how participants' responses were understood.

The researchers adopted a reflexive stance to minimize potential bias, consciously reflecting on their assumptions, expectations, and prior experiences related to nursing documentation. Participants were encouraged to share both positive and negative experiences freely, and probing questions were used consistently to avoid leading responses throughout the data collection process.

Codes and themes were developed inductively from the data, throughout data analysis, rather than being imposed a priori. The use of participant quotations ensured that interpretations continued to be grounded in participants' perspectives. Regular reflection throughout the coding and theme development process helped the researchers distinguish between participants' views and their own interpretations.

We also used iterative re-reading of transcripts and returning to raw data during theme review. By maintaining reflexivity at each stage of the research process, the researchers sought to ensure that the findings realistically represent nurses' perspectives regarding nursing documentation.

Results

Socio-demographic characteristics

The results presented in the demographic characteristics were first followed by the findings of the study. The demographic characteristics of the interviewed participants are shown in Table 1. Accordingly, the participants' ages and experience ranged from 28 to 43 and 3 to 22 years, respectively. Half (5) of the study participants were females, while the majority (n = 8) of the participants' educational level was BSc.

Table 1
Socio-demographic characteristics of nurses who participated in the IDI at Haramaya University Hiwot Fana Comprehensive Specialized Hospital, Harar, Eastern Ethiopia (n = 10)

Participant	Age (years)	Gender	Education Level	Experience
P1	32	Female	BSc	10 years
P2	43	Female	BSc	21 years
P3	43	Female	BSc	22 years
P4	42	Male	MSc	22 years
P5	28	Male	BSc	6 years
P6	29	Female	BSc	6 years
P7	31	Male	BSc	10 years
P8	32	Male	MSc	6 years
P9	28	Male	BSc	3 years
P10	36	Female	BSc	15 years

In-depth Interview Findings

The findings of this study are reported in accordance with the COREQ (32-item) checklist for qualitative research. The results are derived from in-depth interviews with ten nurses working in different wards at

Hiwot Fana Comprehensive Specialized Hospital. Participants varied in age, sex, educational level, years of professional experience, and work units, allowing for diverse perspectives on nursing documentation practices.

Data were analyzed using thematic analysis. Through an iterative coding process, three major themes: barriers to nursing documentation, motivators for nursing documentation, and suggested recommendations to nursing documentation improvement, and six sub-themes emerged, reflecting nurses' perceived barriers, motivating factors, and recommendations related to nursing documentation. Illustrative verbatim quotations are presented to support the findings and enhance credibility (Table 2, Fig. 1).

Table 2
Table showing themes, sub-themes and sample illustrative quotes if the IDI result at HFCSH, Harar Ethiopia (n = 10)

SNo	Theme	Sub-theme	Illustrative quotes
1.	Barriers to nursing documentation	Workload and staffing barriers	“Today in this ward, I am the only one working.” (P1)
			“The barriers that prevent us from fully practicing nursing documentation are high workload and shortage of nurses in the ward.” (P2)
			“Staff may be on annual leave, and at that time due to overcrowding, I may not complete documentation immediately.” (P4)
		Institutional and administrative barriers	“There is no specific training focused solely on documentation; it was general training.” (P4)
			“When they evaluate us, what they look for is our fault, not to recognize or encourage the good work we have done.” (P2)
			“We do not get any support at all.” (P1)
			“I have not received formal training on documentation itself, but I have experience with electronic documentation systems” (P5)
2.	Motivators for Nursing Documentation	Professional and Legal Accountability Motivation	“Whether good or bad nursing care given, documentation is the evidence. If I do work and fail to record it, no one in the ward will know what I have done except myself.” (P1)
			“Whenever I document the care I provided, I feel happy and free.” (P2)
			“It also makes me happy when I record what I did because later it reminds me that I provided that service.” (P1)
			“If issues arise, proper documentation can protect staff and inform problem-solving.” (p8)
			“It is the nurse’s responsibility to document what they have done; no one else comes to document for them.” (P6)
		Patient Care and Organizational Motivation	“Documentation is very useful for continuity of care, apart from being time-consuming.” (P1)

			“Without documentation, I might mistakenly give the patient unnecessary or repeated treatment.” (P3)
			“However, if it is documented, the patient will understand that they have received adequate care.” (P6)
			“Yes, past time by saying top-5, I and another nurse were awarded certificates for good documentation work.” (P4)
			“Training is essential to update ourselves as currently we forgot so many information.” (P4)
3.	Suggested Recommendations for Improvement	Training and Resource Enhancement	“It would have been good if we were given support on the new formats.” (P2)
			“To improve nursing documentation, what is really needed is to fill the human resource gap.” (P1)
			“Improvements require continuous observation, rounds, alarms for missing items, and teamwork.” (P7)
		System and Administrative Actions	“Proper supervision by the case team leader and daily monitoring can improve documentation.” (P8)
			“Switching from hard copy to electronic documentation would reduce loss of records and improve overall quality. Electronic records would preserve information better and be more reliable.” (P5)

Theme 1: Barriers to Nursing Documentation

Several participants consistently described multiple barriers that hamper effective nursing documentation. These barriers were categorized into two sub-themes: workload and staffing barriers, and institutional and administrative barriers.

Workload and Staffing Barriers

Heavy workload and shortage of nurses were identified as the most reported barriers to nursing documentation. Nurses reported being responsible for a high number of patients in the wards during their shift, which limited the time for documentation. In such conditions, documentation was not fully or practically completed.

As one of the nurses says, *“Today in this ward, I am the only one working, so I have a heavy workload.” (P1, Female, 10 years’ experience).*

Similarly, another nurse highlighted the combined effect of workload and staff shortage:

“The barriers that prevent us from fully practicing nursing documentation are high workload and shortage of nurses in the ward.” (P2, Female, 21 years’ experience).

Several study participants acknowledged that delayed documentation increased the likelihood of forgetfulness, particularly in overcrowded wards and the absence of staff. *"Staff may be on annual leave, and at that time, due to overcrowding, I may not complete documentation immediately." (P4, Male, 22 years' experience).*

“Since nurses are busy, they may forget. So, the real problem is the shortage of nurses.” (P1, Female, 10 years’ experience).

Institutional and Administrative Barriers

In this institutional and administrative barrier sub-theme, lack of training, limited recognition, lack of an electronic system, and weak administrative support were frequently reported as barriers to effective nursing documentation. As most participants indicated, they had not received training specifically focused on nursing documentation.

As one participant stated: *“There is no specific training focused solely on documentation; it was general training.” (P4, Male, 22 years’ experience).*

Other participants also expressed their concern about the absence of recognition for good documentation practice: *“When they evaluate us, what they look for is our fault, not to recognize or encourage the good work we have done.” (P2, Female, 21 years’ experience).*

Another participant felt unsupported by the hospital administration. *“We do not get any support at all.” (P1, Female, 10 years’ experience).*

Furthermore, lack of an inclusive electronic documentation system was stated as a barrier: *“I have not received formal training on documentation itself, but I have experience with electronic documentation systems (HMIS).” (P5, Female, 28 years’ experience).*

Theme 2: Motivators for Nursing Documentation

Despite the challenges, nurses demonstrated strong professional, legal accountability, patient care, and organizational motivations toward documentation of nursing care.

Professional and Legal Accountability Motivation

Nurses demonstrated strong intrinsic and extrinsic motivation toward documentation rooted in professional responsibility and legal accountability. Also, documentation was viewed as tangible evidence of care and a personal duty.

One participant noted: *“Whether good or bad nursing care given, documentation is the evidence. If I do work and fail to record it, no one in the ward will know what I have done except myself.” (P1, Female, 10 years’ experience).*

One participant described personal satisfaction while she completed documentation: *“Whenever I document the care I provided, I feel happy and free.” (P2, Female, 21 years’ experience).*

Another participant also added: *“It also makes me happy when I record what I did because later it reminds me that I provided that service.” (P1, Female, 10 years’ experience).*

One participant described documentation as Legal protection: *“If issues arise, proper documentation can protect staff and inform problem-solving.” (p8, Male, 8 years’ experience).*

Another participant explained documentation as a strong sense of responsibility: *“It is the nurse’s responsibility to document what they have done; no one else comes to document for them.” (P6, Female, 10 years’ experience).*

Patient Care and Organizational Motivation

Participants strongly associated nursing documentation with improved patient care by ensuring continuity of patient care, avoiding unnecessary treatment, and improving communication among patients and healthcare providers.

As one nurse stated: *“Documentation is very useful for continuity of care, apart from being time-consuming.” (P1, Female, 10 years’ experience).*

Another participant highlighted the role of documentation in avoiding repeated treatment: *“Without documentation, I might mistakenly give the patient unnecessary or repeated treatment.” (P3, Female, 22 years’ experience).*

One nurse mentioned documentation improved communication with patients: *“However, if it is documented, the patient will understand that they have received adequate care.” (P6, Female, 10 years’ experience).*

Past recognition for good documentation also emerged as a motivator for documentation: *"Yes, past time by saying top-5, another nurse and I were awarded certificates for good documentation work." (P4, Male, 22 years' experience).*

Theme 3: Suggested Recommendations for Improvement

Several participants suggested several strategies to improve nursing documentation, including refresher training, increasing staffing, providing formats, strengthening supervision, and system-level improvement actions.

Training and Resource Enhancement

Participants recommended refresher training that targets all nurses rather than any other action. One participant indicated: *"Training is essential to update ourselves as currently we forget so much information." (P4, Male, 22 years' experience).*

Another participant stated: *“It would have been good if we were given support on the new formats.” (P2, Female, 21 years’ experience).*

Increased staffing shortages were identified by several participants as a critical issue: *“To improve nursing documentation, what is really needed is to fill the human resource gap.” (P1, Female, 10 years’ experience).*

System and Administrative Actions

Several participants recommended that strengthening supportive supervision, improving feedback mechanisms, and introducing electronic documentation systems be considered to enhance the efficiency and accuracy of nursing documentation.

Participants described supervision and feedback: *“Improvements require continuous observation, rounds, alarms for missing items, and teamwork.” (P7, Female, 13 years’ experience).*

"Proper supervision by the case team leader and daily monitoring can improve documentation." (P8, Male, 6 years' experience).

Another suggested improvement was system-level reform: *“Switching from hard copy to electronic documentation would reduce loss of records and improve overall quality. Electronic records would preserve information better and be more reliable.” (P5, Female, 28 years’ experience).*

Discussion

This qualitative study explored nurses’ lived experiences of nursing documentation practices at Hiwot Fana Comprehensive Specialized Hospital. Guided by COREQ reporting standards, the discussion interprets participants’ accounts within their institutional context and integrates them with existing evidence. The findings reveal a clear contrast between nurses’ strong professional commitment to documentation and the practical constraints imposed by their working environment.

Across interviews, workload and staffing shortages were raised as the major barriers influencing nursing documentation practices, and they spoke candidly about the weight of responsibility they carry during each shift. Caring for many patients at once, often with insufficient staffing, forced nurses into difficult decisions about how to allocate their time and energy. During clinical urgency, documentation was frequently delayed, focusing on patient care, due to the direct patient care being felt morally inevitable.

This finding is consistent with study findings that high patient-to-nurse ratios compromise nursing documentation practices [21, 22, 23].

Participants represented their documentation practice completed retrospectively after caring for many patients, which increases the risk of recall bias and inaccuracies. From a patient safety perspective, such delayed documentation practice threatens continuity of care and alters communication among care teams. These findings align with a study that demonstrates documentation performed under fatigue or time pressure is more prone to error and recall bias [24, 25]. Besides participants with varying roles and years of service included in this study, their experiences were consistent, which enhances confidence in the findings and reflects thematic saturation, supporting dependability as outlined by COREQ.

Beyond staff shortage and high workload, participants reported limited access to training on nursing documentation. These institutional and administrative barriers further influenced nursing documentation practices, which is consistent with evidence that indicates inadequate continuing professional development weakens documentation quality [26]. In addition, supervision was commonly perceived as punitive rather than supportive, which discouraged intrinsic motivation. This aligns with a previous study that demonstrated unsupportive leadership and fault-focused supervision negatively affect nurses' motivation and compliance with professional standards [27, 28].

Other challenges, such as reliance on hard copy documentation systems and frequent unavailability of patient charts, further affect timely and accurate nursing documentation. According to earlier research, paper-based records are susceptible to loss, damage, and delayed access, especially in healthcare facilities with limited resources [29]. These results underscore that documentation issues primarily depend on organizational effort rather than individual effort.

Despite the several obstacles to nursing documentation noted, participants demonstrated a strong desire for nursing documentation practice. Participants widely considered that nursing documentation was a professional and ethical obligation as well as a legal safeguard. This result is consistent with general nursing standards that consider documentation as integral to professional accountability and legal protection [30, 24]. Participants demonstrated a clear understanding of medico-legal principles by pointing out that any undocumented activity is considered as not done or as not providing care. This outcome is in line with the results of several studies [30, 31].

The emotional fulfillment and sense of relief gained from completing documentation further demonstrate the internalized professional values that guide nurses' behavior. Participants also acknowledged nursing documentation as a tool crucial for preserving continuity of care, proper communication across the team, effective handover, and minimizing duplication of interventions. Beyond these, improving the quality of care, patient outcomes, and supporting the organization through feeding, reporting, and auditing procedures. These results are in line with research showing that efficient nursing documentation can improve coordination and quality of care [32, 33].

Participants provide practically applicable and contextually grounded recommendations for nursing documentation practice improvement. Regular, inclusive, and practice-focused training was identified as essential for improving documentation competence. Participants also clearly indicated that training alone is insufficient without addressing issues of workload and staff shortages. This finding is in line with the report of a study that workload management is important to documentation quality and patient safety [34]. Supportive supervision and constructive feedback were emphasized as critical administrative interventions for nursing documentation practice. This result is consistent with the results from a study showing that leadership approaches that emphasize encouragement and mentoring enhance motivation and adherence to professional standards [27].

Regarding reliability and COREQ conformity of this study, credibility was enhanced through extended engagement and interaction with participants, use of verbatim quotations, and inclusion of nurses with a range of experiences. Transferability was supported by a thorough explanation of the study's participants and environment, which encouraged transferability. Whereas, peer debriefing, reflexive journaling, and iterative coding all enhanced the dependability and confirmability of the findings. In addition, a balanced and thorough analysis was ensured by reflexively taking into account both similar and divergent participant experiences.

Conclusions and Recommendations

Conclusions

This study reveals a clear disconnect between nurses' professional values regarding documentation and the realities of their working environment. While nurses are motivated and ethically committed to documentation, different systemic constraints significantly hinder documentation practice. To address these challenges, integrated, system-level interventions encompassing human resource strengthening, supportive leadership, and sustainable training mechanisms are required. Thus, improving nursing documentation should be positioned as a patient safety, care quality, legal, and organizational priority rather than merely an individual performance issue.

Recommendations

Based on the present study findings, the following recommendations were suggested:

Hospital administration should encourage nurses to comply with the standard of nursing documentation by applying nursing documentation policies to guide nurses' performance. The hospital administration should address the barriers to adequate nursing documentation practices identified by the nurses and provide all needed resources, including human resources and materials.

In addition, the hospital should provide opportunities to attend training on documentation to refresh their knowledge about nursing documentation and motivate the nurses by preparing different principles, such

as rewarding the department that achieves a good nursing record in a regular manner, to develop a harmonious relationship among departments.

For researchers, future research should expand in exploring stakeholders' and patients' perspectives on how documentation affects patient care and trust between patients and nurses.

Abbreviations

DDU IRB	Dire Dawa University Institutional Review Board
HUHFCSH	Haramaya University Hiwot Fana Comprehensive Specialized Hospital
COREQ	Consolidated Criteria for Reporting Qualitative Research

Declarations

Ethics approval and consent to participate

The study was implemented in accordance with the Declaration of Helsinki (World Medical Association, 2001). An ethical approval letter was obtained from Dire Dawa University institutional review board (DDU IRB) with protocol number DDU-IRB-0234 to ensure full protection of the rights of study subjects. Following the approval, HUHFCSH nursing directorate wrote an official letter of co-operation for all ward head nurses of the hospital. After getting permission from the nursing directorate and ward head nurses, data collectors informed the study subjects about the study.

Informed consent to participate was obtained from all of the participants prior to their participation in the study for both interviews and audio recordings. Confidentiality was maintained through anonymization of transcripts by removing personal identifiers and securing data storage. Participants who were unwilling to participate in the study and those who wished to quit their participation at any stage of the interviews were informed to do so without any restrictions or consequences.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare no competing interests.

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Authors' contributions

[YS]: Conceptualization, Formal Analysis, Data curation, Methodology, Writing – original draft, Writing – review & editing. [AT]: Conceptualization, Data curation, Methodology, Writing – original draft, Writing – review & editing. [SJ]: Conceptualization, Formal Analysis, Methodology, Data curation, Writing – original draft, Writing – review & editing. [ZR]: Conceptualization, Formal Analysis, Data curation, Software, Writing – original draft, Writing – review & editing. [MD]: Conceptualization, Methodology, Software, Writing – review & editing. All authors reviewed and approved the final manuscript.

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Figures

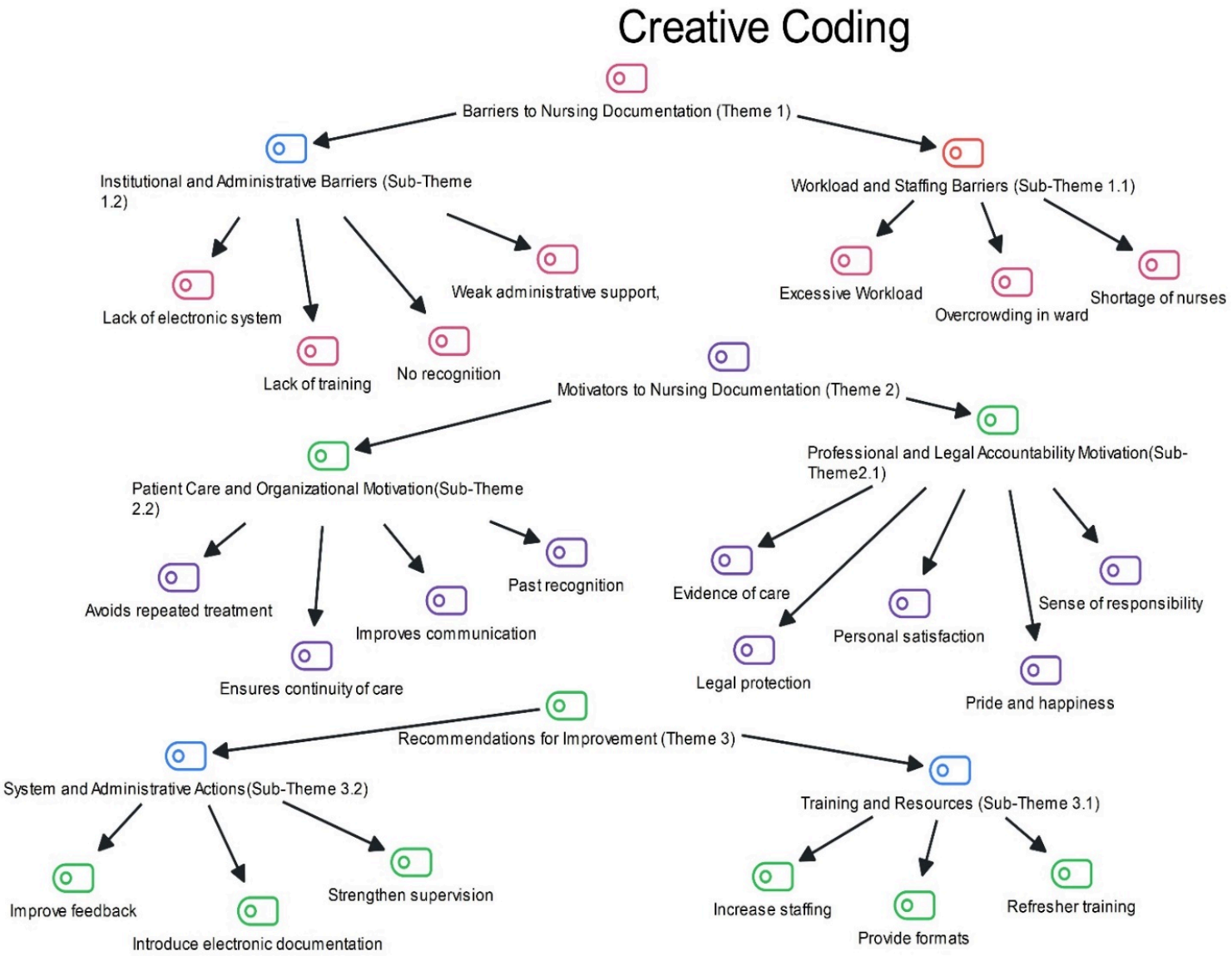


Figure 1

Schematic presentation of coding tree; main themes, sub-themes, and codes

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