RESEARCH REPORT

PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

By

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DISSERTATION

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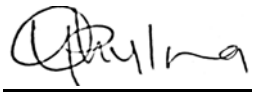
DECLARATION

I, Vhuthuhawe Phuluwa [redacted] hereby declare that the work confined to ”Perceptions of nurses on documentation of nursing care at selected public hospitals in Vhembe district, Limpopo Province” is my original work and that all the sources used in this study have been accurately indicated at the end of the list of references.

I declare that this work has been submitted to Turnitin for its originality check, and it has met the originality acceptance requirements of the University of Limpopo. I further declare that I am the only author of this work and that I have not previously submitted this work or a part of it to any other institution for any other qualification.

Signature :  Date: 2023/07/25

DEDICATION

I dedicate this dissertation to my darling supportive mother, Tshianeo Sylvia Phuluwa, who has instilled in me the desire to learn, and my two loving siblings, Zwivhuya Phuluwa and Zwiande Phuluwa, who have supported me throughout this study with their words of encouragement.

This dissertation is also dedicated to my late father, Humbulani Edward Phuluwa. You have laid a good foundation. May your soul continue to rest in peace, Dad.

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ABSTRACT

Introduction: Good nursing practice involves detailed documentation, which should be timely, appropriate, comprehensive, and accurate. Therefore, documents contain the who, why, how, where, what, and when of patient care. However, poor documentation practices among nurses have been identified and understood to have been influenced by numerous factors. Poor documentation practices have a negative impact on health care provision and clinical decision-making during patients' hospitalisations. The perceived challenges experienced by nurses during documentation of patient care are more evident in clinical practice; hence, this is an area that needs attention by health care management to ensure quality patient care.

Purpose of the study: The study aimed to determine the perceptions of nurses about nursing care documentation in selected public hospitals in Vhembe district, Limpopo Province.

Research setting: The study was conducted in a public regional hospital and a district hospital in Vhembe district, Limpopo Province.

Research method: A qualitative, exploratory, descriptive, and contextual research designs were used. A non-probability-purposive sampling technique was used to select the participants in the study. Data was collected through a semi-structured one-on-one interview using an interview guide. Tesch's open-coding method was used for data analysis, where themes and sub-themes were developed. Measures to ensure trustworthiness, credibility, dependability, transferability, and conformability were all taken into consideration. All ethical principles were adhered to throughout the study.

Findings: The findings of this study revealed that registered professional nurses perceive the documentation of nursing care as an essential practice that benefits patients, health care workers, and the health system as a whole. However, due to the numerous challenges they are faced with, such as lack of resources, shortage of staff, lack of time, workload, poor handling of patient documents, and ward allocation barriers, the documentation standards are poor. Such challenges place patients' health and safety at risk, and health care workers and the health care system are at risk of litigation.

Recommendations: This study recommends that hospital management advocate for more nurses to be hired to reduce the issue of a shortage of nurses and workload. Educated and well-trained clerks should be employed to promote good documentation management. There must be a supply of material resources, such as papers, to use for documenting patient care. Training workshops should be conducted to educate nurses on the importance of documenting nursing care. Hospital management must supply managers in the wards with documentation policy guidelines and must also elaborate on the actions that will be taken against people who do not comply with such guidelines.

Conclusions: The study concluded that there are evident challenges with documentation of patient care amongst nurses in public hospitals, and this affects the provision of quality patient care. The study findings revealed a need for continuous in-service training, commitment, and teamwork among all categories of nurses to improve nursing documentation practices.

Keywords: Nurse, Nursing care, Nursing care documentation, public hospital

DEFINITION OF KEY CONCEPTS

Nurse

A nurse is a person registered with the South African Nursing Council (SANC) under Section 31(1) in a category to practice nursing and midwifery (Nursing Act, No. 33, 2005). In this study, "nurses" refers to trained personnel employed in a hospital who are responsible for rendering and documenting the nursing care given to patients throughout their hospital stay.

Nursing care

Nursing care is the arrangement and performance of nursing actions carried out when rendering patient care, which includes admission and discharge processes, the giving of treatment, carrying out doctors' orders, and interacting with the doctors on patients' wellbeing (Smith, 2016). In this study, "nursing care" refers to all health care activities that will be rendered to patients to improve their quality of life when they are admitted to the hospital wards.

Nursing care documentation

Nursing care documentation is explained as all written information concerning health care services rendered to patients (Muhammad, 2018). Nursing care documentation is the writing down of all nursing care activities that were performed on the patient in order of their performance (Alhawri, Rampal, & Abdulla, 2021). In this study, "nursing care documentation" refers to all written documents relating to all nursing care activities rendered to patients by nurses from the period of admission in the hospital ward until discharge.

Public hospital

According to Freshwater and Maslin (2012), a "public hospital" refers to a state-owned entity that provides treatment, diagnosis, and rehabilitation for mentally and physically injured patients. In this study, a "public hospital" is any state-funded hospital at the tertiary and district levels that renders services that benefit and improve the health of all people in the country.

LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
ENA	Enrolled Nursing Assistant
FREC	Faculty of Research and Ethics Committee
HCW	Health Care Workers
KZN	Kwazulu-Natal
LDoH	Limpopo Department of Health
MDT	Multi-Disciplinary Team
RPN	Registered Professional Nurse
SANC	South African Nursing Council
SREC	School Research Ethics Committee
TREC	Turfloop Research Ethics Committee
WHO	World Health Organization

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CHAPTER ONE
OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Nursing care documentation is an essential aspect of nursing practice globally, but its effectiveness during patient care is still lacking in most public hospitals. Globally, nurses show inadequate knowledge about nursing care documentation practices, and their nursing care activities were not documented, while some were just poorly documented (Andualem, Asmamaw, Sintayehu, Liknaw, Edmealem, Bewuket, & Gedfew, 2018). A survey conducted on the documentation of nursing care revealed that poor documentation practices among healthcare workers (HCWs) result in medical errors (WHO, 2011; Tasew, Mariye, & Teklay, 2019). Nurses in Bangladesh perceive nursing care documentation as a critical task in their practice, which safeguards the quality of care patients receive in the ward (Akter, Anowar, & Latif 2020). Another perspective from the Danish nurses is that nursing care documentation is viewed as an administration demand that interferes with direct patient interaction in the ward (Olivares Bøgeskov & Grimshaw-Aagaard, 2019).

A study conducted in Yemen's Sana'a city by Alhawri, Rampal, and Abdulla (2021) indicate that nursing care documentation is the writing down of all nursing care activities that were performed on the patient in the order of their performance. Furthermore, the study indicated that documenting what was done to the patient facilitates continuity of care among HCWs (Alhawri et al., 2021). Another study conducted in Uganda by Nakate, Dahl, Drake, and Petrucka (2015) highlighted the importance of nursing care documentation practices when rendering patient care in health care institutions. The study further revealed that nursing care documentation was not continuously showing the nursing care that was rendered to patients, and patient outcomes were not documented (Nakate et al., 2015). According to Hardido, Kedida, and Kigongo (2023), nurses in Ethiopia perceived that documentation of nursing care is poorly supported and managed, despite its importance for quality and effective patient care.

According to Kebede, Endris, and Zegeye (2017), nursing care documentation is regarded as an important aspect of nursing practice. However, it is mostly left undone due to inadequate knowledge and a lack of in-service training among nurses (Kebede

et al., 2017). Quality documentation of nursing care includes timely, accurate, and complete documents consisting of all assessments done, formulated nursing diagnoses, nursing care plans, nursing interventions, and evaluated nursing care (Paendong, Suryati, Rudhiati, Mulyati, & Dew, 2019). The incompleteness of the nursing care documentation is due to the various perceptions among nurses: the educational background, workload, lack of understanding of documentation, and the perception that documentation does not affect their income (Saputra, 2018). In Ethiopia, nursing care documentation is perceived as part of the legal documents that reflect the nursing care rendered as well as patient's responses to the care rendered (Ayele, Gobene, & Birhanu, 2021). According to Saputra (2018), in cases of lawsuits, nursing care documents are used as evidence to prove that work was done because, in nursing practice, there is a saying that "what is not documented was not done" (Taiye, 2015; Mutshatshi, Mothiba, Mamogobo, & Mbombi, 2018). A study conducted by Tamir, Geda, and Mengisties (2021) revealed that nursing care documentation facilitates communication between members of the Multi-Disciplinary Team (MDT), leading to early recognition of patients' problems and ensuring standardized patient safety, thereby increasing patients' quality of life.

The majority of nurses in Ghana were confronted with lawsuits due to poor documentation practices; therefore, nurses should critically examine their documentation practices because such documents may be used to either accuse or liberate them during lawsuits (Asamani, Amenorpe, Babanawo, & Ofei, 2014). In South Africa, nursing care documents remain essential; however, there is a noted trend of poor documentation practices amongst nurses, and this leads to HCWs missing a patient's previous diagnosis, medication, and treatment history (Marutha & Ngoepe, 2017). In a study conducted in Kwazulu-Natal (KZN), poor nursing care documentation practices had a negative impact on the delivery of healthcare services in hospitals (Luthuli & Kalusopa, 2017). In the Northwest and Gauteng Provinces, millions of rands were forfeited when patient bills that were owed were written off due to incomplete patient documents (Luthuli & Kalusopa, 2017).

Another report by Nyasha (2014) in Sagwa (2022) revealed that Namibian women claimed to be victims of forced sterilization and won the case due to inadequate nursing care documentation to be used as evidence for defence by the government.

Nurses are required to maintain accurate and reliable documents that will be used as evidence during litigation because care that has not been reported through documentation has not been done (Agizew, 2021). Adequate nursing care documentation is the only legal evidence to prove that nursing care has been conducted (Tamir et al., 2021).

The South African Nursing Council (SANC) Rules and Regulation 387 stipulate that nurses should keep clear and accurate documents of the nursing care rendered, as failure can result in disciplinary action being taken against the nurse. In a South African study conducted by Nkoane (2023) in the Northwest province, nurses perceive that it is important to be mindful of the legal and ethical aspects of nursing care documentation in the healthcare setting, despite the challenges faced in public hospitals. Furthermore, in another instance, the Limpopo Department of Health (LDoH) was charged 1.7 million due to poor nursing care documentation practices for the nursing care rendered to patients (News 24, 2013).

The findings of the study conducted by Shihundla, Lebese, and Maputle (2016) in the Vhembe District indicate that nurses fail to document nursing care due to staff shortages, and such failures can result in the omission of crucial information. Nurses should document patients' nursing care immediately after it is rendered to prevent omitting crucial information (Shihundla et al., 2016). It is against this background that the current study seeks to investigate the perceptions of nurses regarding the documentation of nursing care at selected public hospitals in Vhembe district, Limpopo province.

1.2 PROBLEM STATEMENT

Nursing care documentation should be comprehensive, precise, and well-timed to ensure that quality nursing care is rendered (Hardido et al., 2023). According to Shihundla et al. (2016) and Nkoane (2023), nursing care documentation is regarded as a tool used to measure and detect a change in patients' health status. Therefore, registered professional nurses should document each nursing care activity and patients' needs and responses to the nursing care rendered (Hardido et al., 2023).

According to Mohammadi, Jafarjalal, Emamzadeh, Bahrani, and Sardashti (2017), nursing care documentation in various healthcare settings lacks quality and is of inadequate standards. Omissions of documentation of patient care result in the delay

of medical treatment as well as poor nursing care (Brima, Sevdalis, Daoh, Deen, Kamara, Wurie, Davis, & Leather, 2021). The South African Nursing Council's report analysis from 2003 to 2008 reflected that 769 RPNs were found guilty of occupational misconduct, whereas 587 who documented nursing care activities in patient documents were suspected of not doing so (Williams, Koen, & Van Graan, 2016).

In Zimbabwe, it was reported that nursing care lacks quality due to a shortage of storage areas for medical records; this results in patients keeping their medical records (Luthuli & Kalusopa, 2017). Furthermore, patients do not take their medical records when seeking healthcare services, which results in healthcare workers rendering poor services as they lack a baseline from the patient's history to make sound decisions (Luthuli & Kalusopa, 2017).

The researcher is a registered professional nurse (RPN) working in a public hospital and has experienced continuous concern from nursing management reports on inadequacy regarding nursing care documentation in hospital wards. Despite a continuous plea by the hospital nursing management to have quality documentation that enhances quality patient care, documentation of nursing care remains a challenge, as perceived by nurses in public hospitals.

The study thus seeks to determine the perceptions of registered professional nurses on nursing care documentation practices in selected public hospitals in Vhembe district, Limpopo province. Based on this background, this study aims to determine the perceptions of registered professional nurses on nursing care documentation practices in public hospitals in Vhembe District, Limpopo Province.

1.3 THE AIM OF THE STUDY

The aim of the study was to determine the perceptions of nurses on nursing care documentation in selected public hospitals of Vhembe district, Limpopo Province.

1.4 OBJECTIVES OF THE STUDY

To explore perceptions of nurses on documentation of nursing care in public hospitals of Vhembe district, Limpopo Province.

To describe perceptions of nurses on documentation of nursing care in public hospitals of Vhembe district, Limpopo Province.

To recommend measures to improve documentation of nursing care in public hospitals of Vhembe district, Limpopo Province.

1.5 RESEARCH QUESTION

What are the perceptions of nurses on documentation of nursing care in public hospitals of Vhembe District, Limpopo Province?

What recommendations can be done to improve documentation of nursing care in public hospitals of Vhembe district, Limpopo Province?

1.6 OVERVIEW OF THE RESEARCH METHODOLOGY

This study followed a qualitative, explorative, and descriptive research method. A qualitative, explorative, and descriptive research method was used for this study as it commonly explains and offers knowledge and understanding of different human and independent behaviours and experiences in various forms (Paendong et al., 2019).

The qualitative, explorative, descriptive, and contextual research design helped the researcher collect quality non-numerical data based on participants' past-lived experiences and opinions. The qualitative research methodology was used in this study to obtain in-depth information and determine nurses' perceptions on nursing care documentation in selected public hospitals in Vhembe district, Limpopo Province.

A non-probability purposive sampling technique was used in this study to select participants from the study population who were believed to have knowledge and information about the phenomenon under study using their judgment. This allowed the researcher to interview 18 registered professional nurses with insight and working experience in general wards. Data was collected through a semi-structured one-to-one interview using an interview guide that had open-ended questions. Registered professional nurses were interviewed until data saturation was reached. A voice recorder was used during the interview to capture information, and field notes were written after obtaining consent from the participants.

Recordings were transcribed verbatim; the researcher analysed the data and included an independent coder, where an agreement was made on the themes and sub-themes. Data was analysed using Tesch’s open coding method for qualitative research. All measures to ensure trustworthiness credibility, dependability, confirmability, and transferability were achieved. Ethical issues were all adhered to.

Permission to conduct the study was obtained from the Limpopo Provincial Department of Health Research Ethics Committee. The researcher had obtained informed consent from participants before the interview process. A detailed methodology will be discussed in Chapter 3.

1.7 THE THEORETICAL FRAMEWORK OF THE STUDY

According to Brink et al. (2012), a theoretical framework is a structure that helps a researcher arrange their study based on statements of hypothesis made in other theories. A theory is a set of assumptions and combined conceptions that show how a situation can be used to predict and explain a phenomenon (Grove et al., 2015). This study will be guided by Katie Eriksson's theory of caritative care, which was developed during the 1970s. Eriksson initially developed a nursing care process model in 1974, later formulated as a theory in her doctoral thesis in 1981. Katie Eriksson defined caritative care as using Caritas when rendering nursing care to human beings in terms of health and suffering. Eriksson further stipulated that caring communion and true caring come about when one renders nursing care in the spirit of Caritas, which reduces a patient's suffering. The major foundation of this theory focuses on human beings' health, environment, and nursing. The following are major assumptions in Ericksson's caritative caring theory:

1.7.1 The human being

According to Alligood (2014), the human being is an organisation of body, sound, and knowledge. Not all nursing beings have recognised a religious being. Human beings are fundamentally holy and exist for the sake of others. In this study, the human being is the suffering patient dependent on another (the nurse) and constantly becoming and changing. The term "human being" refers to the sick patient involved in a continued struggle for total health. Nurses should document everything done to patients (Alkouri et al., 2016) to continuously monitor patients' progress. Sick patients depend on nurses for the restoration of their health. MDT members should ensure critical patient care documentation to promote the continuity of quality patient care (Alhawri et al., 2021). A study conducted by Alhawri et al. (2021) revealed that poor communication between MDT members negatively affects the quality of nursing documentation. According to Mutshatshi et al. (2018), quality nursing care requires complete documentation that is accurate and precise. The sick person wants to experience love

and caring, faith and hope, and feel that his existence is important to others (Alligood, 2014).

1.7.2 Health

According to Alligood (2014), Ericksson defined health as being complete in body, spirit, and soul. When a patient's health status is disturbed, it requires seeking medical care. In this study, Eriksson saw health as a movement for change, which is determined by human beings' needs and desires. The sick patient desires to be in total health. A study by Okaisu et al. (2014) reported that deaths in hospitals and post-discharge were linked to poor documentation practices by healthcare workers.

When nurses render quality nursing care, they desire patients to be in total health. In a study by Lindo, Stennett, Stephenson-Wilson, Ann Barrett, Bunnaman, Johnson, Waugh-Brown, and Wint (2016), quality nursing care includes written documentation of nursing care that communicates about patient care and response to treatment. Eriksson described the three dimensions of health as doing, being, and becoming. In doing so, the patient focuses on living a healthy, balanced lifestyle for quality of life and good health promotion, thereby preventing illness. In doing so, patients fight to maintain a healthy lifestyle and become whole people by combining all three dimensions.

1.7.3 Environment

Eriksson described the environment as "ethos," which refers to a home. Ethos is the idea of love, charity, respect, and honour (Alligood, 2018). In this study, the environment is the hospital setting, where nurses treat patients with love, respect, honour, and dignity. The care will start with assessment, diagnosis, planning, implementation, and evaluation. All the necessary steps will be documented after their performance to ensure the continuity of quality nursing care. Eriksson believed that "ethos" refers to the task of being called for, which is patient care (Alligood, 2018). Nurses are called to render nursing care to the sick and have the responsibility to document the quality and continuity of care.

1.7.4 Nursing

In nursing, there is an act of caring, charity, and love. Caring comes about naturally. Generosity and joy should be the nurses' attitudes. Eriksson believed that natural

caring is composed of motherliness, cleansing, nourishing, and unconditional love. Eriksson distinguishes between caring nursing and nursing care, wherein she defines caring nursing as a form of care without harming patients and nursing care as a type of care based on the nursing process (Alligood, 2018). In this study, nurses follow the nursing process when rendering patient care and documenting nursing care, and patients are not harmed when cared for by nurses.

Concepts of caritative caring are Caritas, caring communion, the act of caring, caritative caring ethics, dignity, suffering, the suffering human being, and caring culture (Alligood, 2018).

The suffering human being

Eriksson described the patient as a suffering human being who suffers and endures patiently (Alligood, 2018). Human suffering relates to the patient when the health status has been disturbed, and patients have suffered that nurses must alleviate. According to Hemberg (2017), suffering in humans refers to patients who lack freedom and strength. Furthermore, suffering makes patients feel worthless. In this study, the suffering human being, the patient, seeks medical attention from healthcare professionals to alleviate pain and suffering. When nurses do not document accurately, crucial patient information can be missed (Shihundla et al., 2016), leading to poor diagnosis and poor healthcare.

Caritas

Eriksson described Caritas as "love and charity." Caritas refers to caring, an attempt to meditate on faith, hope, and love (Alligood, 2018). In this study, caring will occur when nurses render daily patient care to sick patients, which is documented at the end of the performance. Nurses should always be available to care for patients and have a caring attitude towards sick patients (Holopainen, Nystrom, and Kasen, 2019). Furthermore, a nurse regarded as caring is competent in his or her work respects patients and shows concern about patients' wellbeing (Holopainen et al., 2019). Nurses should document all care rendered in totality to facilitate quality continuity of nursing care (Alhawril et al., 2021).

Caring Communion

Eriksson described caring communion as an intimate connection that is characterised by closeness, respect, honesty, and tolerance (Alligood, 2018). Nurses should form a

caring relationship with patients based on respect for one another and honesty. When nurses form close relationships with patients, patients become free to talk about their health and well-being easily, which results in nurses getting more information from the patients they will document.

In caring for patients, nurses perceive patients' possibilities as if they were their own. Nurses should be attentive to patients' needs when they express their feelings and be ready to understand them (Holopainen et al., 2019). Registered professional nurses are responsible for the safekeeping of patients' documents, which they do not share with unauthorised personnel, thereby respecting patients' rights to privacy. Nurses are responsible for documenting what they are told and what they see, not what they think (Alhawril et al., 2021).

The act of caring

The act of caring comes about when nurses make sick patients feel exceptional out of something less special (Alligood, 2018). When nurses render nursing care to patients, they should do it in a way that makes the patient feel welcomed and special. Patients should be made to feel free to express themselves while giving information that the nurse will need when documenting. Nurses should attend to the needs of their patients, showing respect. Patient care needs, which were rendered, should be documented for continuity of care (Tuinman, de Greef, Krijnen, & Paans, Roodbol, 2017).

Caritative Caring Ethics

This refers to the ethics to be followed by nurses when rendering patient care. Nurses should follow the caring ethics of privacy, confidentiality, and respect. Documentation of nursing care rendered is an ethical consideration to be met. In this study, "caritative caring ethics" refers to the interaction between the patient and the nurse and how the nurse approaches the patient (Alligood, 2018). When rendering nursing care, nurses inform patients about every procedure before they can perform it so that patients can give informed consent. Nurses are responsible for documenting their interactions with patients because the ethical principle of documentation states that what is not documented is not done (Taiye, 2015).

Ethical principles guide nurses in their decision-making processes. Nurses should assure patients about their right to privacy and confidentiality. Shared confidentiality

with other relevant staff members should be emphasised because of the importance of continuity in care. The patient’s right to privacy should be respected. When nurses fail to document, the statutory body governing nurses' ethical behaviour can punish them for such omissions. In cases of lawsuits, written documents can act as evidence to prove that nursing care was rendered to the patient (Newnham, Hine, Rogers, & Agwu, 2015).

Dignity

Eriksson viewed patient dignity as the right to be considered unique (Alligood, 2018). When patients are treated as unique human beings, they feel like somebody with unique needs. In this study, "patient dignity" refers to nurses involving patients in their nursing care and decision-making process, giving them a sense of belonging (Holopainen et al., 2019). Patient dignity is upheld when nurses respect patients' nursing care documents and decisions, thereby respecting their choice of treatment and care.

Caring culture

Eriksson defines a caring culture as the environment in which the patient receives nursing care, which is the hospital setting. Caring culture comprises traditions, rituals, and values (Alligood, 2018). In this study, caring culture refers to the hospital setting where the sick patient will be taken care of by nurses and other health care workers. Nurses will document the nursing care rendered after every action. Patients’ documents should be documented clearly and completely. A schematic presentation of the theory is shown below as Figure 1.1.

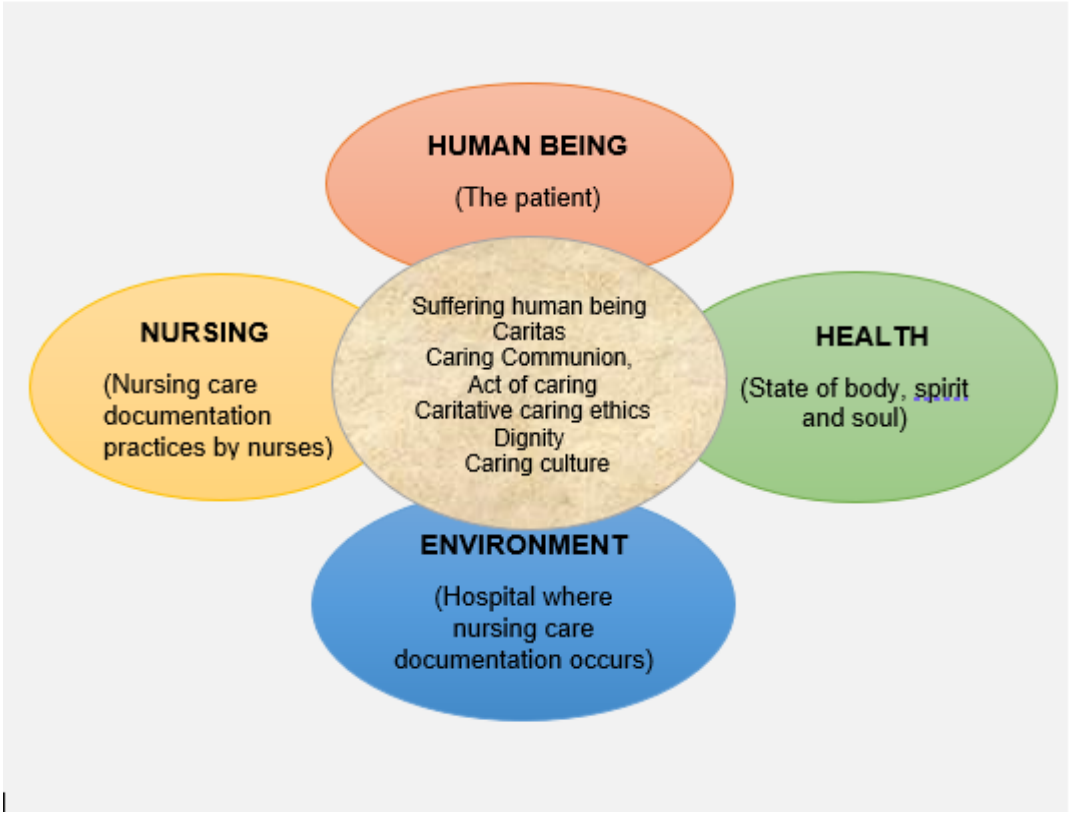

Figure 1.1 Schematic presentation of Eriksson's Caritative caring theory

1.8 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the Turfloop Research Ethics Committee (TREC), and the Limpopo Provincial Ethical Research Committee granted the researcher permission to commence with the study. The Vhembe District Office, the Chief Executive Officers, and the operational managers of the two selected hospitals permitted to commence the study at the hospital. Participants gave written consent after the research topic and the significance of the study were explained to them. All ethical considerations and measures to ensure trustworthiness were adhered to throughout the study.

1.9 SIGNIFICANCE OF THE STUDY

The findings of this study may benefit the following stakeholders:

The health research priority

Research must be conducted that addresses documentation issues as the core of nursing practice. It is important to research documentation studies because documentation is critical to nursing practice in hospitals. This research study will be

beneficial for other researchers who are willing to study nursing care documentation further.

The patients

Nursing care rendered will be documented due to improved nursing care documentation practices adopted from the study, improving quality service delivery to patients.

Nursing care

This study helped identify the challenges and gaps experienced by nurses in the nursing care documentation practices in the wards, and improvements will be made based on the study's findings.

Department of Health

The LDoH may experience fewer lawsuits relating to poor documentation practices, saving the department money and reducing the number of registered professional nurses being struck off the job. The department will be able to identify challenges and gaps that RPNs meet when documenting nursing care and will offer the necessary supportive measures to nurses to help them overcome such challenges and meet their gaps.

Nursing education and health research

The body of nursing education may adopt new ways of documenting nursing care in the wards based on these study findings and learn more from them, thereby improving the quality of nursing care documentation. This study may be a starting point for researchers using these findings in their study area.

1.10 DIVISION OF THE CHAPTERS

Chapter 1: The introduction and overview of the study
Chapter 2: Literature Review
Chapter 3: Research Methodology
Chapter 4: Presentation of findings, interpretation, and literature control
Chapter 5: Summary, limitations, recommendations, and conclusions of the study

1.11 SUMMARY OF THE CHAPTER

This study highlighted the introduction and background to nurses' perceptions of the documentation of nursing care at selected public hospitals in the Vhembe district, Limpopo province. This chapter discussed the study's problem statement, aim and objectives, research questions, research methodology, theoretical framework, and significance. The next chapter, Chapter 2, will discuss the detailed literature review of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 INTRODUCTION

According to Gray, Grove, and Sutherland (2017), a literature review is a written and organized explanation of sources for a research report by the study's author. A literature review is conducted to match the current study's findings with those of the existing study. The purpose of this chapter is to give a comprehensive discussion of the literature that has been studied, thereby giving the readers a deeper understanding of the perceptions of nurses with regard to nursing care documentation. In this chapter, the researcher used the following sources for a literature review: books, articles, and journals from databases such as Google Scholar, PubMed, Science Direct, and EBSCOhost. This literature review will cover the following aspects: description of nursing documentation, historical background of nursing care documentation, legislative framework on nursing care documentation, scope of practice for nursing documentation, importance of documentation in nursing practice, factors contributing to poor nursing care documentation practices in hospitals, strategies to improve nursing care documentation, and documentation challenges experienced by nurses during the COVID-19 pandemic.

2.2 DESCRIPTION OF NURSING DOCUMENTATION

Nursing documentation is the written plan of nursing care that is rendered to patients by nurses (Babu & Rajakumari, 2020). Nursing documentation should include the care rendered to patients, which is of high quality across the physical, psychological, and social aspects (Sjoberg, Edberg, Rasmussen, and Beck, 2021). According to Ali, Albashir, and Mariod (2020), quality nursing documentation should be clear, concise, specific, objective, comprehensive, complete, accurate, true, consistent, timely, confidential, legible, and permanent.

2.3 HISTORICAL BACKGROUND OF NURSING CARE DOCUMENTATION

According to Nakate, Dahl, Drake, and Petrucka (2015), nursing documentation was introduced by Florence Nightingale during the Crimean War when she indicated the causes of mortality using diagrams. Nightingale was the first to document her findings while caring for Britain's wounded soldiers (Michaels, 2020). Since the time of Florence Nightingale, documentation has been seen as an essential practice. Nightingale

stressed the need to document all nursing plans and care rendered to patients for quality patient management (Sum & Chebor, 2013).

Virginia Henderson came up with care plans in the 1930s as a means of communication between healthcare professionals (Sum & Chebor, 2013). In 1873, a newly graduated nurse named Linda Richards started reporting patients' health status to doctors through written documentation (Michaels, 2020). It was reported that reporting had been done verbally before. Linda Richards first invented a structure for charting and documenting nursing care in 1893. The charting structure was aimed at maintaining individual documents, which had sections that doctors and a section for nurses could use. This documenting structure is still being practised today, where doctors have their forms for documentation that are different from those of nurses. Previously, nursing documents about patient care were discarded after the patient was discharged, but now they are retained as evidence of the care rendered to patients (Sum & Chebor, 2013).

2.4. VIEWS OF REGISTERED PROFESSIONAL NURSES ON NURSING CARE DOCUMENTATION OF PATIENT CARE

The nurses' views on patient care documentation are discussed from a global, African, and South African perspective, as discussed in detail below.

2.4.1 Global views on documentation of nursing care

The World Health Organization conducted a survey that revealed that medical errors are caused by poor documentation among healthcare workers (O'Daniel & Rosenstein, 2008; Babu et al., 2020); hence, it is essential to keep legible and accurate records of the patient's health. According to a study conducted by Sjoberg (2020), good clinical nursing documentation will facilitate communication between healthcare workers, thereby facilitating continuity of patient care. Quality nursing documentation reflects that good patient care was rendered, whereas inadequate nursing documentation reflects poor nursing care (Mofiz, 2010; Barua et al., 2020).

In the United States of America, Cavin (2018) reported that nurses complained about the environmental setting where they conducted their nursing care documentation, stating that it was easy to get distracted by the noise and open space. The quality of nursing documentation in the country's hospitals was reported to be not satisfactory or insufficient (Vafaei, Manzari, Heydrai, Froutan, & Amiri Farahani, 2018). Another

study by Smith (2012) and Ayele et al. (2021) reported that nurses perceive nursing documentation as a burden, shifting them away from direct patient care.

According to a study conducted by Kamil, Rachmah, and Wardin (2018) in Indonesia, from the perspective of nurse leaders and their subordinates, it has been indicated that documentation of nursing care in numerous hospitals is far from ideal. Furthermore, nurses reported that they experienced documentation challenges such as inadequate supervision, competency issues, and a lack of confidence and motivation (Kamil et al., 2018).

In Bangladesh, the value of health care service delivery is influenced by nursing care documentation; therefore, improving the comprehensiveness of nursing care documentation is an essential step for enhancing the quality of healthcare services (Barua, Saha, Borua, Barua, Akhter, and Begum, 2020). Quality nursing documentation will improve the continuity of care among healthcare workers (Alhawri, Rampal, and Abdulla, 2021); therefore, patient care will be planned and organised, and good healthcare decisions will be made (Vafaei et al., 2018).

2.4.2 African views on documentation of nursing care

The nursing care documentation in Ethiopia includes the assessment, planning, and evaluation of patient care needs, which should be documented conspicuously; however, nurses' knowledge, attitude, and practices towards such tasks remain open to doubt (Hailu, 2017; Kebede, Endris, and Zegeye, 2017). Furthermore, nurses' little knowledge, attitude, and practice on documentation negatively affect healthcare standards, resulting in omissions or duplications of medication administrations and an increased risk of litigation (Hailu, 2017; Kebede et al., 2017).

Nurses from Ethiopia further reported that documentation practices remain a challenge due to a lack of in-service training, resources, comprehensive nursing education, a high nurse-to-patient ratio, and inadequate knowledge (Gizaw, Yimamreta, & Mamo, 2018). In Ghana, nurses reported that insufficient nursing care documentation was due to unclear guidelines for documentation, hospital policies, workload, time limitations, and differences in staffing resources (Agizew, 2021).

Nurses in Nigeria trust nursing care documentation to promote continuity of patient care, provide early diagnosis of patient problems, and advance medical standards (Taiye, 2015; Seidu, Abdulai, & Aninanya, 2021). However, nursing care

documentation remains incomplete and taken for granted, compromising patient care (Buunaaisie, Iddrisu, Letitia, Abass, Kyilleh, & Abdul-Malik 2018). Another study conducted in Winneba, Ghana, revealed that most nurses do not sign or write their initials after documenting patient care (Okine, 2017), which leads to the risk of duplication of patient care. Moreover, a signature at the end of a patient's progress note serves as proof and shows accountability and responsibility for a specific task (Hariyati, Malawat, Purwandari, & Afifah, 2018).

Healthcare workers from Zimbabwe described challenges in their health facilities in which patients' documents had no storage space, and as a result, patients were responsible for the maintenance and storage of their own documents (Chikuni, 2010; Luthuli & Kalusopa, 2017). Furthermore, health services rendered to patients became slow and poor because most patients could not carry their medical documents, which they reported was burdensome (Chikuni, 2010; Luthuli & Kalusopa, 2017).

2.4.3 South African view on documentation of nursing care

According to a study conducted by Olofinbiyi, Dube, and Mhlongo (2020) in Kwazulu Natal, South Africa, the study concluded that documentation is essential during patient care in all circumstances when nurses are performing their roles in cases such as triaging. Furthermore, the study also indicated that the role of a triage nurse includes assessment and proper documentation to provide efficient care.

In the healthcare facilities of the Vhembe district, Mutshatshi et al. (2018) revealed that nurses complained of a lack of time to document all the required documents as there were many documentation forms to be completed manually. Shihundla, Lebese, and Maputle (2016) also reported that patient nursing care documents in the Vhembe District were inadequate, and certain patient information was not documented regardless of documenting stationery being available.

2.5 LEGISLATIVE FRAMEWORK ON NURSING CARE DOCUMENTATION IN SOUTH AFRICA

The government of South Africa has set up legislative frameworks for health care services, which are used for developing health policies, procedural manuals, and nursing documentation (Marutha, 2019). Non-compliance with legislative frameworks results in inappropriate management of nursing care documentation, which produces non-quality data required by the healthcare system to provide knowledge and the

necessary support needed for organisational decision-making (Anova Health Institute, 2012; Marutha, 2019).

According to Luthuli and Kalusopa (2017), healthcare workers must know their responsibilities regarding documentation of patient care and documentation procedures for adequate documentation of patient care. Everyone has the right to access their medical documents to complain in cases of unfair treatment (Department of Health Limpopo, 2018). Nurses are strictly obligated by law to document nursing care that was rendered to patients to promote continuity of care (Abd El Rahman, Ibrahim, and Diab, 2021); failure to comply can result in legal actions taken against them, and nurses can also lose their practising license (Andrews & Aubyn, 2015; Sagwa, 2022). Inadequate nursing documentation puts nurses at risk for legal claims (Abid, Majeed, & Mohammed, 2018) because poor documentation means poor evidence for defence during litigation (Sagwa, 2022).

The South African Nursing Council (SANC) can take disciplinary measures against nurses who poorly document patient care and charge them with professional misconduct (Mutshatshi et al., 2018). An analysis report made by SANC from 2003 to 2008 showed that 769 nurses were found guilty of professional misconduct, with 587 professional nurses being charged with nursing care documentation negligence, as stated by Van Graan, Williams, & Koen (2016) in Mutshatshi et al. (2018).

The following legislation guides nursing documentation in South Africa:

The Constitution of the Republic of South Africa, Act 108 of 1996

In South Africa, the Constitution is considered the highest and supreme rule of the country, and any violation is punishable by law. According to the Constitution of the Republic of South Africa (1996), Chapter 2 deals with the Bill of Rights. Section 27(1)(a) states that every person has the right to access quality health care services. This includes well-documented nursing interventions rendered to patients under the care of nurses. As such, nurses are expected to keep all documentation of care given to patients to ensure quality care.

The National Health Act, Act 61 of 2003

The Act provides a framework for a structured, uniform health system within South Africa. According to the National Health Act (NHA) (2003), sections 13 and 17 stipulate that public hospitals should create a medical document for every patient seeking health care, which must be kept safe. Public hospitals are responsible for producing patients' medical documents in cases where they have to protect against poor service delivery or unsafe care (South Africa, 2003).

The South African Nursing Council Rules and Regulations

The South African Nursing Council (SANC) is a statutory regulatory body that governs nurses' ethical behaviour in their practice. SANC has the power to implement disciplinary actions against nurses for any healthcare misconduct (SANC 2005, R387). According to SANC rules and regulations R387, nurses are responsible for keeping clear, accurate, and complete documentation of information for patients at all times. Therefore, the nurses must ensure that patients' details are documented thoroughly. According to SANC (R2598), the scope of practice of a professional nurse includes the acts or procedures applicable to health care practice, including, amongst others, the coordination of the health care regimens provided for the patient by other categories of health personnel. This implies that, as a professional nurse, to achieve coordination, documentation of the care given is also involved as a means to ensure continuity of care.

2.6 TYPES OF NURSING CARE DOCUMENTS

Healthcare practices such as patient assessment, medication and treatment administration, patient progress, care planning, and health education are some of the routine practices registered professional nurses perform on patients regularly (Demsash, Kassie, Dubale, Chereka, Ngusie, Hunde, Emanu, Shibabaw, & Walle, 2023). However, nurses have reported failure to document most activities on patients due to the increased workload in the wards (Demsash et al., 2023).

Nurses monitor vital signs and document findings on a critical sign monitoring chart to detect clinical deterioration in patients (Sun, Matsui, Watai, Kim, Kirimoto, Suzuki, & Hakozaki 2018). Furthermore, nurses routinely measure and document vital signs on all patients 2-3 times per day, focusing on body temperature and blood pressure, which ensures that a proper assessment of the patient's condition is done (Sun et al., 2018).

In a study by Orlov and Arora (2020), the four-hourly vital sign monitoring routine can result in unnecessarily excessive observations and has been suggested for de-implementation. According to Dall'Ora, Griffiths, Hope, Briggs, Jeremy, Gerry, and Redfern (2021), nurses have reported omissions in vital sign monitoring due to the high workload they experience regularly.

Nurses are obliged to document patients' progress on a progress note to reflect on the patient's change in condition (Demsash, Kassie, Dubale, Chereka, Ngusie, Hunde, Emanu, Shibabaw, & Walle, 2023). Moreover, documenting patients' progress has been perceived to be repetitive and time-consuming by nurses. According to Wondmieneh, Alemu, Tadele, and Demis (2020), medication administration is primarily the registered professional nurse's responsibility, and they are obliged to document the treatment chart after the administration of treatment. Thus adding to the workload.

2.7 THE IMPORTANCE OF DOCUMENTATION IN NURSING PRACTICE

In nursing practice, nursing care documentation is important for the continuity of quality patient care (Hassan et al., 2018). According to Steward, Doody, Bailey, and Moran (2017), nursing documentation as a means of communication between healthcare workers ensures ongoing patient care and patient response to treatment. Healthcare workers are required to maintain clear patient documentation. Nurses, as the front-liners of patient care, should maintain patient documentation that is safe, effective, and meets ethical nursing standards (Nakate, Dahl, Drake, & Petrucka, 2015). According to a study by Taiye (2015), nursing documentation ensures continuity of patient care, detects patient problems at their early stages, and facilitates communication on patients' wellbeing amongst members of the health care team.

Documentation of patient care enhances nurses' critical thinking skills, thereby developing nurses' professional knowledge (Tamir, Geda, & Mengistie, 2021). The maintenance of a good nursing document of care helps healthcare workers with tracking, investigating, and making informed decisions about patients' health based on patients' health documents (Kasaye, Beshir, Endehabtu, Tilahun, Guadie, Awol, Kalayou, & Yilma, 2021). Nursing care documentation helps to track the deterioration in patients' conditions, which assists healthcare workers in coming up with measures

on how to improve patient care, thereby reducing the mortality rate in hospitals (Alhawri et al., 2021).

Nursing care documentation is essential for the patient's present and future health care (Barua et al., 2020). According to Vafaei et al. (2018), nursing documentation assists health care workers with assessing, planning, implementing, and evaluating patients' health care. Furthermore, nursing care documentation is regarded as an effective tool for improving the quality of nursing care as it paves the way for preparing universal standards for care. Generally, nursing documentation also assists nurses in effectively implementing quality and individualised nursing care plans (Vafaei et al., 2018).

According to Abid, Majeed, and Mohammed (2018), nursing documentation has an equally practical and legal picture of patient care; therefore, this kind of documentation is essential in improving effectiveness and efficiency in patient care. Furthermore, nursing documentation is considered the patient's healthcare register, a solemn and legal record (Abid, Majeed, & Mohammed, 2018). The failure to keep accurate nursing care documentation is associated with poor quality nursing care rendered (Sagwa, 2021). The nursing documentation system is an essential element of safe, moral, ethical, and effective nursing practice as it can negatively impact the quality of nursing care and improve patient outcomes. It can also be significant in legal allegations against inpatient care and nursing staff. Thus, effective nursing care is always associated with the quality of available information (Rahkar Farshi, Jebreili, & Abdinia, 2015; Ahmed & Nimer, 2022).

2.8 FACTORS CONTRIBUTING TO POOR NURSING CARE DOCUMENTATION PRACTICES IN THE HOSPITALS

In the health care system, nurses disregard the importance of nursing documentation, which also serves as a reference point, due to inadequate knowledge about its quality. Alhawri et al. (2021) Furthermore, nurses fail to maintain legal nursing documentation because of poor attitudes towards patient care documentation, the workload, and inadequate time to complete the required documents. Nurses do not have some of the documents necessary to carry out documentation. According to Nakate et al. (2015), the lack of nursing leadership and multidisciplinary team support affects nursing documentation, resulting in poor documentation of patient records.

Head nurses together with their staff in Indonesia reported that lack of confidence and motivation in the documentation of nursing care, poor supervision from senior nurses, and incompetency of nurses were reasons for poor nursing care documentation (Kamil, Rachmah, & Wardani, 2018; Endale, 2021). A similar study conducted in Ghana revealed that keeping accurate documentation was affected by a lack of time, documentation guidelines, heavy workloads, specific hospital policies, and nurses' uncertainties towards documentation (Agizew, 2021). The abovementioned factors that contribute to poor nursing documentation are further explained below:

2.8.1 Shortage of staff

A study conducted by Mokoena (2017) in Limpopo revealed that nursing shortage is a global problem. South Africa is affected because nurses migrate to developed countries looking for better opportunities. Mokoena further said that most migrating nurses are highly skilled. The absence of the required nursing staff leads to work overload (Shihundla et al., 2016), and as a result, nursing services will be poorly documented. Participants who took part in a study by Nakate, Dahl, Petrucka, Drake, and Dunlap (2015) reported that they are overworked with patients and do not find time to document patient care.

According to a study conducted by Vafaei, Manzari, Heydari, Froutan, and Farahani (2018), the ratio of the number of nurses to the number of hospital beds is less; therefore, nurses will not be able to document everything as required. An overburdened nurse can report patient care on improper documents due to tiredness or lose the completed documents, thus leading to poor nursing documentation (Shihundla et al., 2016). According to Shihundla et al. (2016), increased nurse workload meant that one nurse had to perform the duties of many nurses; this caused nurses not to document the work in time, as it would be time-consuming.

2.8.2 Lack of knowledge and skills in documentation practices

Nurses' lack of knowledge about documentation can result in medico-legal hazards, such as omitting nursing care and duplicating procedures (Andualem et al., 2019). A study reported by Andualem et al. (2019) on documentation knowledge done in Ethiopia revealed that 85.4% of nurses knew nursing documentation from the guidelines, 65.2% got the knowledge from nursing school, and 44.6% and 40.2%

received documentation knowledge from friends and co-workers in the hospital (Andualem et al., 2019).

According to a study conducted by Andualem et al. (2019), nurses with good knowledge of documentation of nursing care showed good documentation practices compared to those without knowledge. Nurses lacking knowledge fail to maintain reliable and legal nursing care documentation, which results in poor quality documentation (Alhawri et al., 2021). Furthermore, a non-knowledgeable nurse will be less familiar with the nursing operational standards and guidelines and will fail to advocate for providing relevant documentation materials, resulting in poor documentation practices (Andualem et al., 2019).

2.8.3 Lack of managerial support

The lack of support from the management side also contributes to poor nursing care documentation practices in healthcare institutions. Local area managers must supervise and mentor nurses using relevant tools for better documentation practices (Shihundla et al., 2016). Furthermore, nurse managers are also responsible for teaching nurses the latest documentation guidelines, as monitoring and supervision are two of their leadership principles (Shihundla et al., 2016).

When nursing managers fail to supervise nurses on documentation policies, patient care documents are poorly done, resulting in an increased risk of medication errors, which puts patients' safety at risk.

2.8.4 Shortage of Material Resources

Lack of relevant documentation stationery will result in poor documentation practices. For instance, in a study conducted by Mutshatshi et al. (2018) in Vhembe district, it was reported that documentation forms can be unavailable, meaning that one has to ask from other wards while the patient waits for admission. Furthermore, nurses need documentation forms for effective documentation practices, but they are unavailable, which results in some activities not being documented. According to Mokoena et al. (2016), quality equipment is needed to render care. If a hospital, for example, has no blood pressure machine, nurses cannot document patients' blood pressure on the vital data chart, which leaves documentation gaps.

2.8.5 Covid 19 pandemic protocols

Nurses must take precautionary measures such as donning protective clothing and conducting decontamination procedures to prevent the spread of the COVID-19 virus from one patient to another (Lucchini, Lozzo, and Bambi, 2020). Moreover, all these precautionary measures increase the nurse's workload, resulting in less time to document patient care.

2. 9 STRATEGIES TO IMPROVE NURSING CARE DOCUMENTATION

Education is considered the top contributor to improving and maintaining quality documentation standards (Noorkasiani, Gustina, & Maryam, 2015; Kamil et al., 2018). In a study conducted by Kamil et al. (2018), education is an essential element in nursing documentation practices; therefore, education regarding nursing documentation should be continuous to ensure that nurses adhere to the nursing documentation procedures. Nurses should receive planned training sessions at a suitable time (Jebur & Mohammed, 2017); the hospital can organise planned training in the form of seminars and workshops (Kurniawandari et al., 2019).

According to a study conducted by Sagwa (2022), supervision by managers can increase staff skills with regard to the documentation of nursing care. Therefore, managers should ensure continuous supervision of nurses to improve the completeness and quality of nursing care documentation (Yuswanto, Ernawati, & Rajiani, 2018). Furthermore, managers' supervision should be regarded as an act that enhances nurses' performance through educational, motivating, supportive, and encouraging (Yuswanto et al., 2018).

According to Barbosa Maia, Barros Barbosa, Pessoa da Silva, Gomes Castelo Branco, de Carvalho Rodrigues, and Teles de Carvalho Melo (2017), for nursing care documentation to be of good standards, managers should ensure continuous audits of the nursing care documents to identify weaknesses and improve nursing care documentation practices. The health department is responsible for developing strategies and policies to enhance nursing care documentation among nurses, thus improving patient safety and reducing medical-legal hazards (Barua et al., 2020).

According to a study conducted by Ayele et al. (2021), it has been recommended that hospital managers should motivate the increase of nurses in the wards to reduce workload and recruit nurses until hospitals are saturated enough (Andualem et al.,

2018). Nurses in the ward should be provided with relevant and sufficient documentation materials to carry out nursing care documentation as required (Sagwa, 2022).

2.9.1 Electronic documentation as a means of improving nursing care documentation

Most nurses complained of a lack of time for documenting nursing care rendered to patients, which resulted in poor documentation practices for patient care rendered amongst nurses, thereby hindering the proper evaluation of the progress of care in patient care (Siokal, 2021). Furthermore, paper-based patient care documentation has disadvantages, which are that it can be challenging to read, easily misinterpreted by healthcare workers, and can only be accessed by one healthcare worker at a time, according to Bennett and Hardiker (2017). Therefore, paper-based documentation has been considered incomplete, expensive, time-consuming, and inadequate in terms of data validity (Bennett et al., 2017).

With an increased demand for patient care, the quantity of nursing care documentation data is also growing. Consequently, the use of computers has become more common for documenting patient care (Ranjbar, Sabetsarvestani, Oghlaee, Sarvestani, Dehghan, & Shirazi, 2021). The use of electronic documentation should be reinforced as it facilitates effective communication between healthcare workers, promotes better treatment services, and has better health outcomes (Jenkins & Davis, 2019).

The implementation of an electronic documentation system will provide healthcare workers with more time to render quality patient care, resulting in improved patient care, improved communication, reduced documentation errors, and reduced hospital spending on stationary (Olson, Rogers, & Stutzman, 2015; Siokal, 2021). Ranjbar et al. (2021) have recommended that electronic systems be introduced in nursing education for documentation purposes; this can be an effective move in the fourth industrial revolution to improve documentation challenges.

2.10 SUMMARY OF THE CHAPTER

This chapter highlighted the literature of the study, which addressed the main issues of the study based on the different perspectives of nurses worldwide. This literature revealed that there are challenges with regard to nursing care documentation worldwide; however, strategies to overcome such challenges have also been

discussed based on the literature studied. The next chapter, Chapter 3, will focus on the research methodology of the study.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, the researcher discusses the detailed research methodology used for the study. Research methodology is the step-by-step guide the researcher makes to show the reader how the research study was carried out (Brink and Van Rensburg, 2022). This chapter discussed the research approach, research design, population, sampling technique, sample size, inclusion and exclusion criteria, data collection, data analysis, pilot study, bias, measures to ensure trustworthiness, and ethical considerations of the study to explore and describe the perceptions of nurses regarding the documentation of nursing care at the selected public hospitals in Vhembe district, Limpopo province. These include the research setting, research design, population and sampling, data collection methods, data analysis, and ethical considerations.

3.2 RESEARCH APPROACH AND DESIGN

Research methodology refers to the instruments used to carry out the research study or investigation, as well as the methods used to solve and answer research questions (Brink, Van Der Walt, and Van Rensburg, 2018). According to a study by Mgodi (2017), "research design" refers to a plan outlining how a research study will be conducted. A study design is a blueprint for how a study will be carried out while focusing on controlling the elements that could interfere with the findings (Groove, Gray, & Burns, 2015).

3.2.1 Research approach

This study used a qualitative research method because this approach commonly explains and offers comprehension and interpretation of different human and independent behaviours and experiences in various forms (Paendong et al., 2019). The qualitative research method enables the researcher to understand participants' lived experiences, which helps the researcher collect quality non-numerical data

based on participants' past experiences and opinions. This research method was suitable for this study as it allowed registered professional nurses to describe their perceptions regarding nursing care documentation in selected public hospitals in the Vhembe district, Limpopo province.

3.2.2 Research design

In this study, exploratory, descriptive, and contextual designs were used because the researcher explored to get in-depth information about documentation practices and described the perceptions of registered professional nurses on the documentation of nursing care at selected public hospitals in Vhembe district, Limpopo province, in the actual context where patient documentation is taking place. Below is a detailed explanation of the research design.

Exploratory research design

Exploratory design inspects a problem that was not appropriately addressed to get a clear meaning of that existing problem (Grove et al., 2015). The researcher used an exploratory design to explore and describe nurses' perceptions of the documentation of nursing care in public hospitals in Vhembe district, Limpopo Province. The researcher gained insight and understanding of the phenomena under study as he got an opportunity to interact with the registered professional nurses in their respective workplaces.

Descriptive research design

According to a study conducted by Mokoena (2017), a descriptive study is designed to obtain more excellent data about the traits within a particular study area. The researcher accurately described a situation or population by observing that area's traits. This research study aimed to provide a picture of a situation as it naturally happens (Mokoena, 2017). The researcher used this design to describe the documentation of nursing care as experienced by registered professional nurses in public hospitals in the Vhembe district, Limpopo province. In this study, the researcher gained in-depth knowledge from registered professional nurses who spent most of their time documenting nursing care daily.

Contextual research design

A contextual research design refers to a structured, systematic, user-centred design process that provides methods to collect field data, interpret it, and consolidate it in a

well-structured manner (Holtzblatt & Beyer, 2014). In this study, the researcher went into the field and observed while communicating with the participants' ways of living in their workplace to get a deep insight into their work practices. In this study, the researcher used a contextual design by collecting data from the registered professional nurses in their selected public hospitals in the Vhembe district, Limpopo province. The researcher observed registered professional nurses while documenting nursing care in a natural ward setting and collecting data from the registered professional nurses as they experienced the phenomenon under study.

3.3.3 Study site

The study was conducted in the Vhembe District of Limpopo Province. Limpopo is one of the nine provinces in South Africa and is situated in the northern part of the country, which forms the border with Zimbabwe. Limpopo Province is further divided into five districts: Capricorn, Mopani, Vhembe, Waterberg, and Sekhukhune. Vhembe district has four municipalities: Thulamela, Musina, Collins Chabane, and Makhado. The Vhembe District has a total population of 1294,722. The study was conducted in Vhembe District, and the study site was in hospitals A and B, which were a regional hospital and a district hospital, respectively.

A regional and district hospital were chosen for this study because a district hospital is the first line of contact for the community. Then patients are transferred to a regional hospital for further management. Vhembe district has only one regional hospital with a bed capacity of 530 approved beds, but useable beds are currently 383, and registered professional nurses are 235. The nurse-patient ratio is 1:5 in the selected general wards of the regional hospital in Vhembe district. The district hospital has a usable bed capacity of 316 beds and 221 registered professional nurses. The nurse-patient ratio is 1:5 in the general wards of the district hospital in Vhembe district. The figure below shows a map of the Vhembe district.

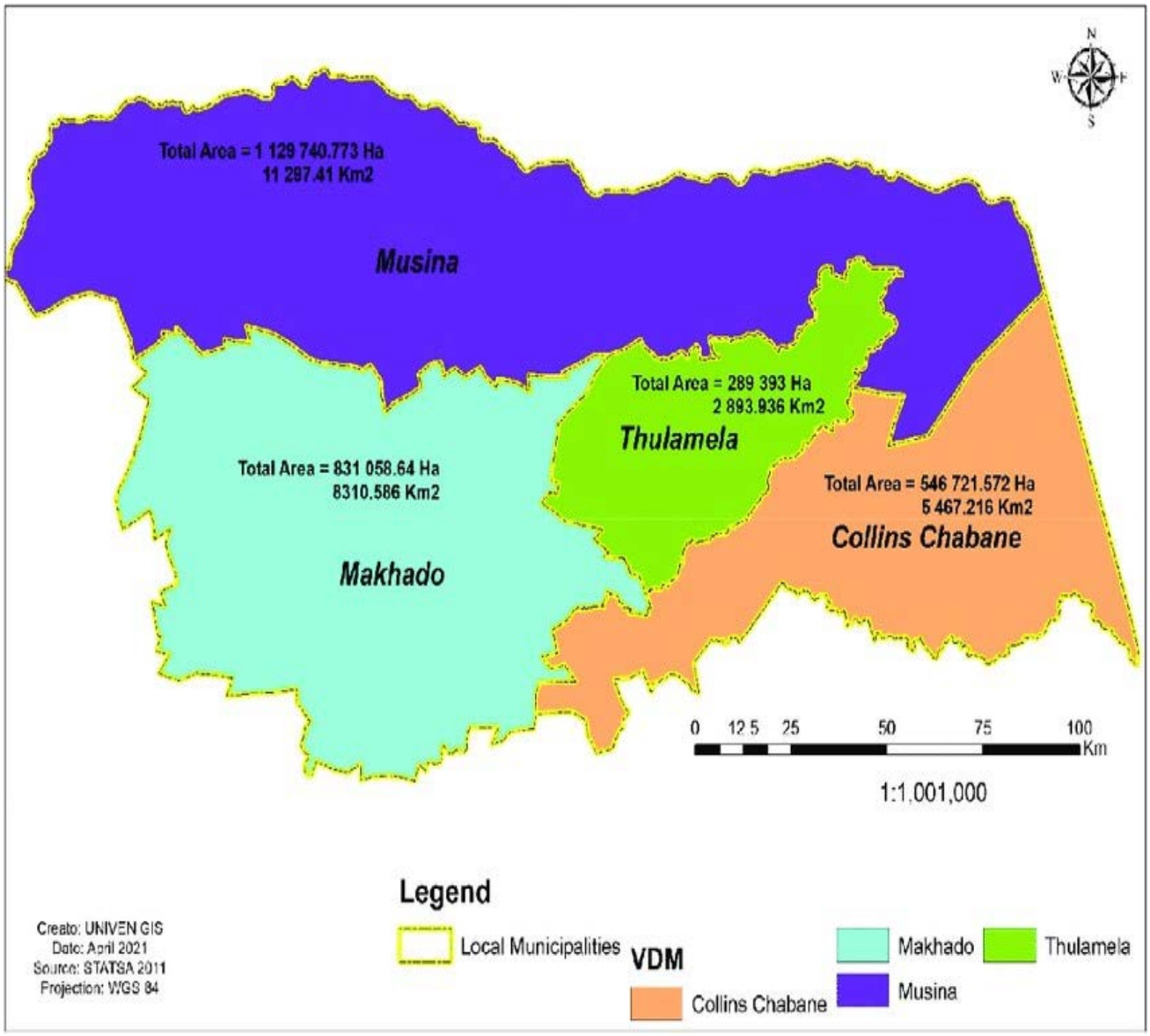

Figure1.1 Four local municipalities in Vhembe district Limpopo province. Source: Limpopo Province Spatial Development Perspective Map 2017 updated 2019.

3.3.4 Population

Population refers to the complete set of people that are of interest to the researcher and meet the criteria that the researcher is interested in studying (Burns & Groove, 2020). LoBiondo-Wood and Haber (2014) and Burns and Groove (2022) defined the target population as individuals or elements that meet the sampling criteria. According to Polit and Beck (2021), the "study population" refers to a group of people to whom the researcher has access and share the same standard attributes towards a study.

The study population was all nurses documenting nursing care at the selected public hospitals in Vhembe district, Limpopo Province. The targeted population was represented by registered professional nurses working at the two selected public hospitals in the Vhembe district of Limpopo province. Registered professional nurses were chosen because they lead nursing care documentation and supervise all the junior categories. The accessible population was recorded professional nurses working in medical, surgical, pediatric, and gynecological wards of the two selected public hospitals in Vhembe District, Limpopo Province. The population from the selected wards of the regional hospital had 113 registered professional nurses, and the district hospital had 65 registered professional nurses. This study's target population was 178 registered professional nurses working in the pediatric, medical, surgical, and gynecological wards of the two selected public hospitals.

3.3.5 Inclusion and exclusion criteria

The following inclusion and exclusion criteria were used in this study:

Inclusion criteria

Inclusion criteria refer to the characteristics or conditions that a participant, object, or study element has to meet the requirements and be eligible to form part of the research study (Gray et al., 2017). This study's inclusion criteria were all registered professional nurses working in the surgical, medical, pediatric, and gynaecological wards of the two selected hospitals in Vhembe district, Limpopo province. Thus, only those registered professional nurses who have two years or more of working experience because they have experience documenting nursing care. Therefore, only registered professional nurses who gave consent to participate were included in it.

Exclusion criteria

Exclusion criteria are the characteristics or conditions that make the participant or an object unqualified to participate in a study and, therefore, excluded from the target population (Grove et al., 2015; Gray et al., 2017). Those registered professional nurses working night duty were excluded from the study. Registered professional nurses who refused to give informed consent were excluded from the study because no one should be forced to participate in a study in which she or he does not want to take part. Registered professional nurses have less than two years of working experience because they lack experience in the documentation of nursing care.

3.3.6 Sampling method

Sampling is the process of selecting a sample from the population of the study to obtain data about a phenomenon (Brink et al., 2018). The sampling of the participating hospitals was done purposefully, and the regional hospital was selected because it is the only regional hospital in the district where all the district hospitals transfer their patients. The district hospital was chosen because of its accessibility to patient health care. The study was conducted in general wards, which are medical, surgical, pediatric, and gynaecological wards. The general wards were purposefully selected based on the fact that patients in general wards stay for more extended periods and extensive documentation is done by registered professional nurses over a more extended period than in other wards.

A non-probability purposive sampling technique was used in this study to select participants. Brink et al. (2018) define non-probability purposive sampling as a process where a sample is chosen from members of a population using non-random methods. In non-probability purposive sampling, the researcher selected those participants who were believed to have knowledge and information about the phenomenon under study using their judgment, as it allowed the researcher to choose registered professional nurses with insight and experience of nursing care documentation at the selected hospitals in Vhembe district, Limpopo province.

3.3.7 Sample size

The sample size was not predetermined in this qualitative study because it depended on data saturation when no additional information was received from participants. Data saturation occurs when the other sampling yields no new information but only a repetition of already collected information (Gray, Groove, & Sutherland, 2017). The researcher in this study conducted a one-on-one interview with the participants until the data was saturated and no additional information was given. Thus, the researcher stopped the interviews with the 18th participant since data saturation had been reached. Data saturation was born at one hospital, but the researcher continued to the other to get the perceptions of registered professional nurses at the regional hospital. Ten (10) registered professional nurses were interviewed at the district hospital, and eight (08) registered professional nurses at the regional hospital. Eighteen (18)

registered professional nurses participated in the study through one-on-one interviews.

3.3.8 Data collection

Data collection is when the researcher gathers information or facts from the selected participants during a research study (Brink et al., 2022). In this study, a pilot study was conducted before the main study's data collection.

3.3.9 Pilot study

A "pilot study" refers to a small study conducted by researchers using a limited number of participants from the same population to clarify the sampling processes, treatment, and measurement of variables in that study (Grove et al., 2015). The pilot study was done to explore the viability of the main survey and identify possible flaws in the research methodology of the proposed study (Brink et al., 2012). Thus, the researcher was also able to test their interviewing skills and the functionality of the voice recorder.

A pilot study was conducted at a district hospital, and five registered professional nurses were interviewed. The hospital and participants in the pilot study were not used in the main study. The researcher made an appointment with the nursing service manager at the hospital, went to the hospital on the agreed date and time, and selected registered professional nurses. Only registered professional nurses working in the surgical, medical, pediatric, and gynaecological wards with two or more years of working experience participated in this study because they have experience documenting nursing care. The research questions answered the research objectives. Themes that were picked up in the pilot study were similar to the themes that were obtained in the main study, which were nurses' perceptions of the importance of documentation of nursing care, nurses’ perceptions of environmental barriers to documentation of nursing care, and nurses’ perceptions of the consequences of inadequate documentation of nursing care. After the pilot study, no changes were made to the interview guide or demographic data.

3.3.10 Data Collection Preparation

The University of Limpopo granted the Turfloop Research and Ethics Committee (TREC) certificate; the research proposal, together with the TREC certificate, was submitted via the National Health Research Database (NHRD); and a permission letter was obtained from the Limpopo provincial department of health to collect data in the

selected hospitals. The researcher established a working relationship with the nursing managers of the two selected hospitals and discussed the data collection dates and the data collection process. The operational managers from the selected wards arranged a private cubicle where the interviews were conducted free from noise and distractions, and one registered professional nurse was interviewed at a time. The researcher explained the research topic to the registered professional nurses who met the selection criteria and requested permission to collect data before the one-on-one interview. Permission to use a voice recorder during the interview process was also obtained from the participants. All participants were given a chance to read through the consent form and were permitted to participate in the study. The registered professional nurses who met the selection criteria and gave informed consent in writing were included in the one-on-one interview.

3.3.11 Data collection

Data was collected using a semi-structured one-on-one interview. The interview guides, voice recorder, and field notes were the data collection tools. The researcher discussed the data collection tools and their methods in detail below:

Semi-structured interview

In semi-structured interviews, the participants are asked a number of questions using an interview guide, which is in English. The researcher used semi-structured interviews for data collection, and the interview guide had two sections: the demographic information section and a section for research questions. The demographic information section included data about the participant, such as gender, age, period of employment, and period of implementing nursing care documentation. The participant filled in the demographic information prior to the interview and was not presumed by the researcher; this section helped the researcher better understand the participant's employment background.

The other section of the interview guide was comprised of a series of questions that were asked of the participant. The research questions were open-ended, which allowed the researcher to obtain more in-depth information from the participants regarding their perceptions of the documentation of nursing care. The researcher opened the discussion with a question: "Can you share with me your perceptions about the documentation of nursing care in your ward?”

Additionally, the researcher asked the same series of research questions to participants as they appear in the interview guide (Appendix E), followed by probing based on the participants' manner of response, as a way to gain in-depth information from the registered professional nurses with regards to their perceptions of the documentation of nursing care at selected public hospitals in Vhembe district, Limpopo province. The interviews were conducted in a quiet cubicle free from noise and destruction, and one participant was interviewed at a time. The interviews lasted for about 30 to 45 minutes.

A voice recorder

A voice recorder was used to capture the interviews, and participants were asked to keep their cellphones silent during the interview process. Participants were aware of the voice recorder as the researcher asked for permission to voice record prior to the interview process, and informed consent was obtained from the participants. Each voice recording had a specific code to indicate a specific participant.

Field notes

Field notes were taken in between the semi-structured one-on-one interviews to capture the non-verbal cues. The participants were made aware of the field notes prior to the interview, and they gave informed consent. The field notes were written down in a notebook, and the researcher was taking note of the participants' non-verbal communication and emotions. The field notes assisted the researcher in noting down the non-verbal cues of the participants during the interview process.

3.3.12 Data analysis

It is a process of separating and analysing the data that was collected and assembling it again (Creswell, 2014). The researcher listened to the recorded audio repeatedly to understand the meaning. The researcher then transcribed what the participants were saying into writing and integrated that with the field notes. During the coding process, the themes and sub-themes were developed by the researcher, an independent coder assisted with the coding, and an agreement was reached between the researcher and the independent coder based on the themes and sub-themes developed. This study used Tesch's open coding method of qualitative data analysis by Creswell (2014). Tesch's steps of data analysis:

Transcription is the first step. The researcher read thoroughly through the transcripts, making notes of all ideas that came to mind.

The researcher chose one interview and went through it, reading line by line trying to get the meaning of the transcript. The researcher wrote down general notes.

The researcher categorized data after going through the transcripts and similar research studies.

The researcher went back to the data found from different sources, shortened the topics into codes, and wrote the codes next to the relevant section of the text.

The researcher observed the organisation of the data to check if new categories or codes emerged.

The researcher took the most descriptive wording for the topics and converted them into categories, the total list of categories was reduced by the aim, by grouping topics that relate to each other.

A final decision was made on the abbreviations for each category and the codes were arranged alphabetically.

The data material that belonged to each category was gathered in one place and kept track of.

3.4. MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness refers to the standards of trust in data, interpretation, and methods carried out to guarantee the quality of a study (Connelly, 2016). Lincon and Guba agreed to four measures to ensure trustworthiness, which are:

3.4.1 Credibility

According to Brink et al. (2012), credibility is trust in the truthfulness of the data collected and its interpretations. In this study, credibility was ensured by making use of a voice recorder during the interview process to ensure that the data was accurate and not missed. The researcher also ensured that data was collected over a period of one month, and probability sampling of the participants was used until data saturation was reached. The researcher interacted with the participants for a reasonable amount of time to obtain an in-depth understanding of their perceptions with regard to the documentation of nursing care. Prolonged engagement was ensured by spending sufficient time with the registered professional nurses in the field. Field notes were

made during the interview process. During the interview, the researcher asked the participants about their responses, and at the end of the interview, after the data had been collected and analysed, it was validated whether their responses were interpreted correctly. The researcher involved the supervisor and co-supervisor in verifying the interpretations from the participants' interviews to ensure member checking.

3.4.2 Dependability

Dependability is a way of proving that if a particular study were to be re-done using the same or similar participants in the same or similar circumstances, the results would be similar (Brink et al., 2012). In this study, dependability was ensured by detailed explanations of the methods that were used (Shelile, 2014). The researcher made use of audit trails, where all the tape-recorded interviews and field notes used for data collection are kept safe for auditing, and only the researcher and supervisor will have access to them. An independent coder assisted with the coding of the collected data.

3.4.3 Confirmability

Confirmability refers to the data being accurate, relevant, and having meaning as provided by the participants (Brink et al., 2012). In this study, confirmability was ensured by using more than one instrument for data collection. Tape recorders were used for audio recording and to ensure conformability by listening to the recorded audio for verification, and field notes were written during the interview process. The researcher asked more probing questions from participants until data saturation was reached.

3.4.4. Transferability

Transferability refers to the extent to which the study findings can be applied to other contexts and participants and give the same results (Brink et al., 2012). The information obtained from the participants was discussed, and the findings were formulated into quotes. Transferability was ensured by giving a clear, detailed description that involved the research setting, participants, and methods used to collect data.

3.5 ETHICAL CONSIDERATION

According to Mokoena (2017), ethics are the moral principles that guide researchers when carrying out their studies. Ethics helps researchers differentiate between right and wrong and determine acceptable and unacceptable behaviour.

3.5.1 Ethical clearance

Ethical clearance was obtained from the University of Limpopo, Turfloop Research and Ethics Committee (TREC).

3.5.2 Permission to conduct the study

Permission to collect data from registered professional nurses was obtained from the Limpopo Provincial Department of Health (LDoH), the Chief Executive Officer (CEO) of the regional and district hospitals, and the Operational Managers (OPM) of the selected wards at the selected regional and district hospitals to ensure that the research was conducted ethically.

3.5.3 Informed consent

The transfer of information from the researcher to the participants is enough to make the participants make informed decisions (Grove et al., 2015). In this study, the researcher ensured informed consent by explaining the research topic to the participants in detail, allowing them to make informed decisions. Informed consent was obtained verbally and in written form. Therefore, verbally, by using audio tape recorders, the researcher recorded the participant after agreeing to take part in the study. Participants also signed a consent form, indicating that they had agreed to take part in the study.

3.5.4 Anonymity

Anonymity occurs when the participants and the data collected from them are kept private in such a way that they cannot even be associated with their responses by the researcher (Grove et al., 2015). In this study, anonymity was ensured by naming participants using alphabets; for example, a participant was referred to as participant X, and calling participants by their real names was avoided throughout the interview.

3.5.5 Privacy and confidentiality

Privacy is the entitlement that people have to keep their private information private for the period they require until they decide to disclose or share it (Grove et al., 2015). Confidentiality is the researcher's promise to participants that shared data and

information during a study will be kept private from others (Grove et al., 2015). In this study, participants were reassured that the data collected would only be shared with the researcher, supervisors involved in the study, and the coders. Participants were interviewed in a private room that was free from noise and disturbances. The names of the participants who gave informed written consent did not appear on the document, but alphabets were used to refer to the participants.

3.5.6 Avoidance of harm

According to Maleka (2020), this is an ethical rule for research that states that all participants taking part in the study should cause no harm throughout the study, either emotionally, physically, or to their health. In this study, harm was avoided by conducting the study in a safe environment that was free from physical and emotional discomfort and followed COVID-19 regulatory measures. Participants were only asked questions that were relevant to the study and comfortable to answer. The researcher and participant wore surgical masks throughout the interview and maintained social distancing by 1.5 meters to prevent the risk of spreading COVID-19. The researcher and participant used hand sanitiser before and after the interview.

3.5.7 Principle of justice

In a study conducted by Shelile (2015), she defined the principle of justice as the participants' rights to fair treatment, confidentiality, and privacy. In this study, the principle of justice was ensured by giving participants an equal chance to participate, and the duration of time allocated was equal for all participants. Participants were not pressured to participate but were given the right to withdraw from the study whenever they wanted to do so (Shelile, 2015).

3.6. BIAS

According to Brink et al. (2018), bias refers to the actions that produce error and distortion in a study, which affect the quality of the evidence in the research study. In this study, bias was avoided by conducting a pre-test study in Siloam Hospital, which did not form part of the study. The researcher bracketed out preconceived ideas and beliefs. During the interviews, the researcher listened to the participants without adding any comments or making corrections. The research avoided asking participants leading questions. Even though purposive sampling is biased by nature,

the researcher took all measures to ensure that bias was minimised and avoided by following the methodology.

3.7 SUMMARY OF THE CHAPTER

This chapter highlighted the research methodology used throughout the study. A qualitative research method was applied to the study to determine the perceptions of nurses regarding the documentation of nursing care at the selected district hospitals in Vhembe district, Limpopo province. The study site, the data collection processes, and the tools for data collection were discussed. The data was analysed using the tech's method of data collection. Measures to ensure trustworthiness and ethical considerations were taken into consideration throughout the study. The next chapter, Chapter 4, will focus on the research findings.

CHAPTER FOUR
PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter depicts and discusses the findings of the study, which was collected using semi-structured one-on-one interviews with eighteen registered professional nurses and literature control. Five themes and twenty-one sub-themes were developed from the semi-structured one-on-one interview, as indicated in table 4.1 below.

4.2 PARTICIPANTS DEMOGRAPHIC INFORMATION

Table 4.1: Demographic information of participants

Participant	**Gender**	**Age range**	**Period of employment**	**Period implementing nursing care documentation**
Participant 1	Female	50-59	10-19 years	10-19 years
Participant 2	Male	20-29	2-9 years	1-9 years
Participant 3	Female	50-59	20-29 years	10-19 years
Participant 4	Female	40-49	20-29 years	10-19 years
Participant 5	Female	50-59	20-29 years	10-19 years
Participant 6	Female	20-29	2-9 years	1-9 years
Participant 7	Female	20-29	2-9 years	1-9 years
Participant 8	Male	50-59	20-29 years	20-29 years
Participant 9	Female	40-49	10-19 years	10-19 years
Participant 10	Female	40-49	10-19 years	10-19 years

Participant 11	Female	40-49	10-19 years	1-9 years
Participant 12	Male	20-29	2-9 years	1-9 years
Participant 13	Female	40-49	10-19 years	10-19 years
Participant 14	Female	20-29	2-9 years	1-9 years
Participant 15	Male	40-49	10-19 years	10-19 years
Participant 16	Female	50-59	20-29 years	20-29 years
Participant 17	Female	20-29	2-9 years	1-9 years
Participant 18	Female	50-59	20-29 years	20-29 years

The findings discussed below contain information about the registered professional nurses who took part in the semi-structured one-on-one interview. It was necessary to discuss the registered professional nurses who took part in this study, as this helped to assess the influence that each characteristic of the participants had on the research findings. In the demographic data, the researcher included the participants' gender, age, period of employment, and period of implementing nursing care documentation.

4.2.1 Gender

In this study, out of the 18 participants who took part in the semi-structured one-on-one interview, only four were male and fourteen were female. This revealed that female registered professional nurses comprised the majority of respondents in this study. Christensen and Knight (2014) indicated that males still have the sensitivity of being like outsiders in nursing because the nursing profession is alleged to be a female-dominated profession. Andualem et al. (2018) stated that female nurses had

better knowledge than male nurses in documenting patient care; thus, more females dominated the study as compared to males.

4.2.2 Age

In this study, most participants who took part were young and between the ages of 20 and 29, whereas we had seven participants who were between the ages of 20 and 29, six participants between the ages of 40 and 49, and five participants between the ages of 50 and 59. Participants between the ages of 30 and 39 and 60 and above did not take part in this study. The majority of young nurses showed an interest in participating in the study as compared to older nurses; this was also seen in a study conducted by Alhawri et al. (2021).

4.2.3 Period of employment

Eighteen participants who took part in this study have been employed for 29 years and below, whereas participants who were employed between 2 and 9 years were six, between 10 and 19 years were six, and 20 to 29 years were also six. Therefore, a total of 18 registered professional nurses who took part in this study were employed for a period of 2 to 29 years in the field. The researcher needs to know the participants' period of employment because the longer the period of employment, the more experience the registered professional nurses will have in nursing care documentation. According to Feleke, Mulatu, and Yesmaw (2015), nurses’ education, training, and experience in performing the work affect documentation errors.

4.2.4 Period of implementing nursing care documentation

In this study, out of the 18 registered professional nurses who took part, seven have been implementing nursing care documentation for a period of 1–9 years, eight for a period of 10–19 years, and only three for 20–29 years. The researcher needs to use participants who have been implementing nursing care documentation for two years or more because they have more knowledge and experience about nursing care documentation. More experienced nurses can be more knowledgeable about patient safety and documentation challenges (Ahmed & Nimer, 2022).

4.3 RESEARCH FINDINGS

This section presents the research findings from participants' perceptions of nursing care documentation. Five themes and sub-themes were developed during the data analysis. Each theme is presented and discussed in detail and supported by

participants' direct quotes presented in italics from individual interview transcripts to support the conclusion indicated by the researcher and also give meaning. The data analysed were grouped into five (5) themes with their sub-themes. Table 4.1 below presents the themes and sub-themes that were developed during data analysis using Tesch's open coding method.

Table 4.1 Themes and Sub-themes

Main themes	**Sub-themes**
1. Nurses' perceptions of importance of documentation of nursing care	1.1 Provides a record of the acts of caring. 1.2 Facilitates nursing communication for continuity of care. 1.3 Monitors patients' needs, condition, progress, and care. 1.4 Prevents litigations and errors.
2. Nurses' perception of environmental barriers(Work setting) to documentation of nursing care	2.1 Human resource barriers 2.2 Workload and work pressure 2.3 Logistical barriers 2.4 Organisational barriers (Ward allocations) 2.5 Interprofessional barriers
3. Nurses' perception of nursing practice barriers to documentation of nursing care	3.1 Compromised care related to documentation demands. 3.2 Nursing omissions in documentation
4. Nurses' perceptions of consequences of inadequate documentation of nursing care	4.1 Consequences for the patient (Compromised care) 4.2 Consequences for the hospital (litigations)
5. Nurses' recommendations for documentation of nursing care	5.1 Adequate resources to reduce risk. 5.2 Effective logistics for documentation 5.3 Nursing commitment to documentation 5.4 Nursing teamwork and support 5.5 Nursing education and supervision

4.3.1 THEME 1: NURSES' PERCEPTIONS OF IMPORTANCE OF DOCUMENTATION OF NURSING CARE

In this study, the findings revealed that registered professional nurses perceive nursing documentation as important in inpatient care if quality patient care is to be achieved. Participants perceived that documentation provides a record of the acts of caring, facilitates nursing communication for continuity of care, monitors patients' needs, progress, and care, protects nurses' integrity, and prevents litigation related to documentation errors.

Registered professional nurses have insight with regards to the importance of nursing care documentation; however, they fail to apply what is required due to the challenges that they are faced with on a day-to-day basis, such as a shortage of staff and resources and a lack of time to carry out the required task. Participants expressed that nursing care documentation consumes their time and is mostly just a repetition of acts.

4.3.1.1 Sub-theme: Provides a record of the acts of caring

The study findings revealed that registered professional nurses are aware that nursing care documentation is important in nursing practice as it provides a record that care has been given to the patient. Nurses are familiar with the fact that they have to document each act they render to the patients immediately after care because, in nursing practice, it is believed that "what is not documented has not been done." This is supported by a quote from participant 1, who said:

"Yes, otherwise we have to bear in mind that whatever we do should be documented to prove that we have done something to the patients, because if you didn't record, nobody would know that such a patient has been taken care of or what has been done to the patient." "In my ward, we document everything, e.g., when we are giving the treatment, we document it in the patient's bed letter." "And when we are taking patients anywhere or we are taking the patient to X-ray, we must document that the patient is going to X-ray, or the person is going to a psychologist or physiotherapist."

Participant 13 also reported, "Yes, otherwise we have to bear in mind that whatever we do should be documented in order to prove that we have done something to the patients because if you didn't record, nobody would know that such a patient has been taken care of or what has been done to the patient."

Participant 5 also reported that "*in my ward we document everything, e.g., when we are giving the treatment, we document it in the patient's bed letter." "And when we are taking patients anywhere or we are taking the patient to X-ray, we must document that the patient is going to X-ray or the person is going to a psychologist or physiotherapist*."

Participant 08 added that "*the good part about it is that we document everything that we do to the patient, which includes the assessment, the nursing care that we provide to the patient, and the continuity of care and the progress of the patient."*

This study's findings are similar to those of a study conducted by Taiye (2015) and Mutshatshi et al. (2018), which states that work not documented is considered work that has not been done since there is no evidence to show that care has been rendered to the patient. Another study conducted by Sagwa (2022) revealed that clear, complete, and adequate nursing care documentation facilitates the continuity of proper and quality nursing care. According to Erickson's theory, during the act of caring, nurses render nursing care to patients in such a way that the patient feels welcomed and special (Alligood, 2018). Thus, patients should be made to feel free to express themselves while giving information that the nurse will need when documenting.

4.3.1.2 Sub-theme: Facilitates nursing communication for continuity of care

The study findings revealed that the documentation of nursing care serves as a means for communication amongst nursing staff about the care rendered to the patient. Documented care also promotes continuity of care, which is aimed at improving the health status of the patient. Promoting care that is continuous and shared results in a speedy recovery for the patient and reduces the length of the hospital stay. Therefore, this means that for nurses to render continuous patient care, they need to communicate with each other through patient care documentation, which, if inadequate, will negatively impact the patient's improvement. The findings of this study are supported by the following direct quotes:

Participant 2 said, "*So it's important for us to document, so that the next person who comes and takes the bed letter should see what is going on with the patient." You cannot explain. If they find out that you are nursing a patient and you are no longer there, they want to see something. "And if you are not there to explain it to yourself, the bed letter should explain it to you*."

Participant 7 indicated that "some of the things are that because nursing is a continuation, we just give a report to others so that they continue where we left." "Because if it's not there on the file, they won't know what was happening to the patient."

This was evidenced by Participant 14, who added that "it also helps in communicating between nurses since if you write down and then you are not able to tell the person in verbal communication, it will help the patient to see; some people even use communication books in the wards, so even that thing, they use it; it's important because the document is also on that."

The study findings correspond with those of the study conducted by Stewart et al. (2017), who also indicate that nursing care documentation serves as a means of communication amongst health care members, which facilitates the continuity of care, thereby improving patient care. Registered professional nurses are accountable for quality nursing care documentation, as this will facilitate communication amongst health care members and continuity of care, thereby promoting good service delivery and health care decisions (Bizimana & Bimerew, 2021). The findings of the study concur with those of Stevens and Pickering (2010) and Bizimana and Bimerew (2021), who stressed that accurate documentation of patient care will provide precise treatment and care to patients, resulting in good communication between nurses in their daily patient care activities, making evidence-based decisions, and improving healthcare delivery. The caring theory indicates that a caring culture is the environment in which the patient receives nursing care, which is the hospital setting, and that the caring culture comprises traditions, rituals, and values, of which communication through nursing documentation is another value that is important during nursing practice (Alligood, 2018).

4.3.1.3 Sub-theme: Monitors patients' needs, condition, progress and care

The findings of the study revealed that when registered professional nurses document patient care in the ward, it reflects the care rendered to the patient as well as the progress in the patient's condition. The findings of the study further revealed that documentation of patient care enables registered professional nurses and other members of the health care team to observe the change in patients' condition and evaluate the care plan carried out. The findings of this study suggest that nursing care

documentation serves as a point of reference for health care members, assisting registered professional nurses and all health care members with patient care monitoring and progress. This is evidenced by Participant 15, who reported that “the importance of nursing care documentation during patient care is that I’ll be able to see my patient’s progress." "And then, if there is no progress, I’ll be able to notify the doctor immediately.”

Participant 18 said, “I will say it helps us with the history of the patient because there are those patients who have so many conditions that are related, so it does help us when it comes to rendering the service.”

Participant 03 reported that “as regards documentation, writing down how a patient is and writing down the progress of the patient is very important because it alludes to people who are going to be reading the file that the patient is changing and getting better to avoid re-writing the same thing over and over again.”

Participant 03 also added to say, “So that we can see what the patient is getting, for instance, if it’s a dietician, we can see the patient is getting this type of food, this type of diet, this type of meal or drink, everything so that we can nurse the patient properly.”

In support of these findings, Kurniawandari, Fatimah, and Listiyanawati (2019) expressed that documentation of nursing care is a vital means of communication between health care workers. Furthermore, without clear and accurate documentation of nursing care, the nursing care service rendered to patients cannot be accounted for (Kurniawandari et al., 2019). Therefore, registered professional nurses should accurately document the nursing care services that have been rendered or that will be rendered to patients (Asmirajanti, Hamid, & Hariyati, 2019). Accurate patient documents will enable health care workers to monitor patients' progress and response to interventions conducted, as well as enable registered professional nurses to understand nursing care rendered to patients (Elsayed Mansour, 2021).

Abdallah, Ebraheim, and Aziz Elbakry (2020) reported that the risk management and quality assurance officers use nursing care documents to evaluate the care that has been rendered to patients and assess if there should be any improvements made. According to Eriksson's theory, caring for sick patients can be expressed in various ways through love and kindness, with a view to improving suffering and serving the

patient's life and health (Alligood, 2018). When registered professional nurses continually monitor patients' progress and address their daily needs, they alleviate the suffering of patients while improving their health.

4.3.1.4 Sub-theme: Prevents litigations and errors

Registered professional nurses who took part in this study verbalised that documenting nursing care throughout patients' hospital stays protects nurses from lawsuits by patients and relatives. They also reported that medical errors were often associated with the omissions made during the documentation of nursing care rendered. This implies that registered professional nurses are aware that documenting nursing interventions during patient care helps to serve as legal evidence in court in cases of lawsuits and also protects health care workers from duplicating nursing care. This finding was confirmed by Participant 09, who said that *"I think documentation is important because it prevents us from things like litigation, and it also prevents the institution from being sued because some other people are looking for money from the institution."*

Participant 03 indicated that *"If, let's say, a patient has been in the ward for a certain time and then you have inserted a drip and then it stops running and then the child's or patient's hand gets swollen over time and it leads to a point whereby it becomes cyanosed or necrosed... "Ja, you run at a risk of being sued because you didn't take care of the patient, so as time goes by, you are going to need records that the drip site has been checked, you have documented that the medication has been given, it's been given on which hand, those kinds of things."*

Participant 16 reported that *"Okay, let's just say, for example, that the patient had a bed sore and we didn't see it; when the patient was at, or during admission, the patient came with a bed sore and we didn't document it; later, the patient wants to sue the hospital that the patient got the bed sore here in the ward, so if we had documented it, they will know that the patient came with the bed sore, and the family won't win that case. I think it's, ja". Participant 03 indicated that "if, let's say, a patient has been in the ward for a certain time and then you have inserted a drip and then it stops running and then the child's hand or patient's hand gets swollen over time and it leads to a point whereby it becomes cyanosed or necrosed... "Ja, you run at a risk of being sued*

because you didn't take care of the patient, so as time goes by, you are going to need records that the drip site has been checked, that you have documented that the medication has been given, that it's been given on which hand, those kinds of things."

Participant 08 verbalised that "*Because in lawsuits, it's obvious that there will be a problem that is being raised, or maybe it's negligence or something." "So, when we take that file of the patient and we have documented everything that has been happening to the patient, it can save us because we have done our part." Participant 05 described that "we should write so that we can cover ourselves if the patient can complicate." What did you do? "What did you do with the patient because the doctor was not there but you were present? You can do one, two, or three when you are waiting for the doctor to come and write it down*."

Abdullah et al., (2020),supports this point of view that registered professional nurses are legally responsible for documenting patient care and hence should accurately document the nursing care rendered to the patients to promote continuity of care in health settings (Akter, Anowar, & Latif, 2020). Evidence has revealed that nursing care that has not been documented can be easily forgotten, which negatively affects the continuity of patient care (Bizimana et al., 2021). In cases of litigation, registered professional nurses have no evidence to prove that work was done if they have incomplete patient documents (Sagwa, 2022). Nursing care documents serve as evidence whenever health care workers are accused of negligence, malpractice, or fraud (Ngwenya, 2020). Thus, according to Erickson, sick patients depend on nurses for the restoration of their health, and this can only be achieved through proper documentation of care rendered to patients. The theory thus implies that nurses should ensure serious documentation of patient care to promote continuity of quality patient care (Alhawri et al., 2021).

4.3.2. THEME 2: NURSES' PERCEPTION OF ENVIRONMENTAL BARRIERS TO DOCUMENTATION OF NURSING CARE

The findings of this study revealed that registered professional nurses are affected by a wide variety of environmental barriers, which include human resource barriers, workload and work pressure, logistical barriers, organisational barriers (ward allocations), and interprofessional barriers. The identified sub-themes are discussed in detail below:

4.3.2.1 Sub-theme: Human resource barriers

The findings of this study reveal that there is a shortage of human resources, which refers to the nurses required to render quality patient care in the wards and document nursing care rendered. This implies that the lack of adequate nursing staff in the wards affects the nursing care documentation of the patients and the care that we render to them. This was supported by the following quotes listed below:

Participant 4 said, “So I think the main problem that I'm sure of is the shortage of staff." If we are few and then we are nursing so many patients, it's not easy for us to document. We focus more on attending to the patients than documenting them. "We end up forgetting that we have to document."

Participant 7 said, “*According to my knowledge, we must document every procedure done to the patient." So, the challenges we experience are that we are short-staffed, so we do not have enough time to document every step. Whether the patient has gone to the X-ray, to psychology, to the doctors, or whatever, "So, due to a shortage of staff, we experience that some of the things are not documented well*.”

Participant 17 said, “Ja, at times you find that you are very busy in the unit because, as you see, there is always a shortage of personnel, nursing personnel, and you find that you are doing too much; you are expected to do too much in a very limited space of time, and you find that you are unable to document everything that you have done, and at times you find that you haven’t documented that which you have documented on the patient’s file." "That is the main challenge we face as healthcare providers.”

Participant 1 verbalized that “*you may find that some gaps are being left because the night staff is short staffed." So, you can find that some bed letters will not contain any documentation of the patient's care.*

The findings of this study correspond with those of a study conducted by Sagwa (2022), who revealed that registered professional nurses reported that they have no time to document patient care accurately due to a shortage of nurses. Another study conducted by Bizimana et al. (2021) indicated that heavy workloads, increased rates of inpatient admissions, and a shortage of nursing staff were categorised as barriers to poor quality nursing care documentation. Furthermore, Ali et al. (2020) reported that

the tendency for registered professional nurses to make documentation errors was more likely due to a shortage of nursing staff. Erickson's theory indicates that health is the act of being complete in body, spirit, and soul. When the health status of a patient is disturbed, it requires seeking medical care, and there needs to be adequate staff to render quality patient care.

4.3.2.2 Sub-theme: Workload and work pressure

Registered professional nurses revealed that, due to their workload and work pressure, they fail to document nursing care rendered to patients. This increased workload and pressure, which negatively impact documentation practices during patient care, is often reflected as if the work has not been done because they do not find time to document after performing an activity. This finding denotes that registered professional nurses do perform their nursing activities as planned in their nursing care plan; however, there is poor documentation due to increased workload and pressure.

This was seen in a quote from Participant 5, who stated, "*But at the end, we've done all the procedures." The doctors are giving orders. Almost everyone on the team will be giving us nurses' orders. So, we focus too much on carrying those orders instead of documenting, forget to document, and find out we don't have enough time to sit down or sit with the patient and document. "I think those are some of the things that I know hinder documentation*."

Participant 3 also mentioned that "*it's kind of putting pressure on us, and at the end of the day I might feel like I'm going to make a mistake if I don't do this correctly, so most of the time you take too much time with a patient, and then the work just piles up and up and up."*

Participant 18 reported, "Let's say I'm working in the female medical ward; we are swamped; we have a lot of patients." "I have a lot to do, and I end up doing a lot; I implement a lot in my patients, but then, because I have a lot of patients, I end up not getting enough time to go back to the patient's file and write everything that I did."

The findings of this study agree with those of a study conducted by Abdallah et al. (2020), who reported that registered professional nurses are expected to conduct an inclusive patient assessment during admission, obtain medical histories, conduct orders, and draw up a nursing care plan with interventions and evaluation at some

point. Additionally, they are obliged to provide patients with health education and insight into their condition and to care about the complete and continuous physical and emotional wellbeing of patients (Asmirajanti et al., 2019). However, due to workload and work pressure in the wards, registered professional nurses reported that they do not document most of the nursing care they have rendered to the patients (Elsayed Mansour, 2021). Numerous studies have disclosed that the action of nursing care documentation for patient care remains a challenge due to a high nurse-to-patient ratio demand (Agizew, 2021). The sick human being wants to experience love, care, faith, and hope and feels that his existence is important to others (Alligood, 2014); thus, it is the responsibility of registered professional nurses to ensure that patients experience love, care, and hope, which increases workload.

4.3.2.3 Sub-theme: Logistical barriers

The study findings revealed that registered professional nurses are faced with several barriers, which are poor management and storage of patients' files in the filing department, a shortage of stationery to utilise for patient care, and relatives having the patients' files. This means that registered professional nurses perceive that nursing care documentation of the care that they have rendered to patients in the wards is hindered by such logistical barriers, resulting in poor nursing care documentation and a risk of legal harm.

Participant 1, who verbalised that "*Like on the weekends, we find that on the weekends, the clerks are absent," So, if the charts to document the patient's problems or care are not enough, the forms will be finished, so through the weekend the wards cannot, and the computers have no toner, so we should print a new chart to record the patient's needs. " So that's a challenge*."

Participant 04 also reported "*And then the other thing is that when you are nursing so many patients, you find that the patients there will come to the hospital admitted, and then after a week, the patient will go back." And then we'll find that when the patient comes back again, the files have already been taken to OPD or the file station. So, you find that the files are missing. So, we will not be able to retrieve the old files or the old notes.*

Participant 08, with the same point of view, reported that "*the challenge that we have is, I mean, we have OPD where we keep the patients' files." You may find out that*

every time the patients come back to the hospital, maybe it's a chronic illness or whatever, they give them new files every day because the old ones are lost. Participant 16 further reported that "Also, as everything about the patient is written in the file, when the patient is discharged and is going to collect the medication from the pharmacy, we give the patient their file or their relatives' file to collect the medication, so they can take photos of whatever is written in the file to post on Facebook or for lawsuits and all sorts of other things as they are on hold of the patient's files, ja, thank you."

In support of these findings, Mutshatshi et al. (2018) reported that registered professional nurses cannot document complete nursing care rendered when there is a shortage of charts for documentation, which impacts nursing care documentation. The study conducted by Luthuli et al. (2017) described that the effective availability of patient documents will always promote the continuity of quality patient care. Furthermore, quality nursing care documents are important for safe and effective health care provision for patients. It is vital that nursing care documents are kept safe to make a proper patient diagnosis based on the patient's health history, reducing litigation and deaths associated with incorrect diagnoses (Marutha & Ngoepe, 2017).

Nursing care documents provide health care members with patient histories when making decisions in the future (Marutha et al., 2017). Therefore, these documents must be kept safe to ensure easy retrieval when needed. Ericksson believes that, when the health status of a patient is disturbed, it requires seeking medical care (Alligood, 2018). Hence, patients require health documents during consultation, which should be kept safe for future referral purposes.

4.3.2.4 Sub-theme: Organisational barriers (Ward allocations)

The findings of this study revealed that registered professional nurses perceived nursing care documentation as a difficult task to complete due to the layout of the ward, which cares for different kinds of patients with different health-related conditions in one ward. Registered professional nurses further reported that completing documents for short-stay patients was a difficult task for them to complete as they perceived it as time-wasting. This means that the ward layout, which renders nursing care to patients with different health care-related conditions and has short-stay patients in the ward, serves as a barrier for registered professional nurses to

accurately perform their task of documenting nursing care. This was supported by participant 1, who said that:

“Oh. The problem in this ward is that it has four divisions, which burdens us because we have a gynecological group, a surgical group, an orthopedic group, and a gynecological group. So, all is mixed here. So it's difficult for us to care for them well because when we see that someone will need the plasters of Paris when we attend to the plasters, the other group also needs help. So that gives us a burden, and we find that the staff is not too busy to participate in this with both patients. You see.”

Participant 15 also verbalised, “Because today we admit the patients, and then tomorrow we are discharging, and then you find that the papers we have here, the documents, are so many, and we get too tired." "And then, with a shortage of staff, we cannot be able to fill them up.”

The findings of this study are congruent with a study conducted by Fatmawati et al. (2018), which states that an increased number of patients increases the amount of work to be carried out, which negatively impacts the quality of nursing care to be rendered. Another study by Andualem et al. (2019) reported that registered professional nurses fail to document precisely due to an overcrowded ward with patients requiring care from nurses who are already short-staffed. Furthermore, registered professional nurses are burdened with implementing the planned patient care by health care members since they are obligated to document the care provided.

Unfavourable working environmental conditions and workload were viewed as barriers to accurate documentation of nursing care (Alhawri et al., 2021). Erickson's theory supports the findings of this study, wherein Eriksson believed that ethos refers to the task of being called upon to accomplish a purpose within a specific environment, which is patient care (Alligood, 2018). Therefore, registered professional nurses, regardless of their workload and unfavourable working environment, must maintain accurate documents to facilitate the continuity of nursing care.

4.3.2.5 Sub-theme: Interprofessional barriers

Registered professional nurses in this study revealed that they perceived that other members of the multi-disciplinary team did not work hand in hand with them to ensure that quality patient care was rendered to patients. This implies that the care rendered to patients will not be of good quality due to poor communication among members of the multi-disciplinary team. This perspective was seen from participant 03, who reported that:

“Okay, when it comes to our multi-disciplinary team, sometimes they come and see the patient, and they leave the ward without even documenting anything on the patient’s records. "So, it makes it hard for us to work together in that instance because if you left the ward without writing anything, how would we know the progress of the patient or where to go after that?”

Participant 04 added to say that “I think the challenge is all about the shortage of staff and that thing that we are many who are nursing the patient; we are not only nurses, so some other people would not be able to control or guide them because they do not fall under the same category or same, I do not know. They are not nurses; they are doctors. "Some people, when you try to guide them, will take you somehow or won't be able to listen to you. "So, I think that is the thing.”

Participant 05 further elaborated that “*So, the other thing is that we are dealing with orthopaedics and all other stuff, so we find that we will also need the physiotherapies, we will need other multidisciplinary teams, so we are so many, using the same file, and those papers can get lost at any time." Some other multidisciplinary team might end up losing some papers from the file. So, you find that some information is missing. So, you find that there are some important notes on the file that are missing due to those kinds of problems that we're having.*

The findings of this study are consistent with those of Tasew et al. (2019), who highlighted that poor communication with regard to patient care amongst health care workers leads to medical errors. Patient care documents include health-related information complied by members of the healthcare team, which includes medical assessments and evaluations, which enable health care members to make judgments for the provision of patient care (Kasaye et al., 2022). Therefore, there should not be

a communication breakdown to promote continuity of quality care. A study conducted by Adegboyega and Saâ (2019) further explained that health care members depend upon patient documents for continuity of care. Consequently, a breakdown in documentation as a means of communication among healthcare workers places patients at health risk. Thus, according to Eriksson's theory, there is a distinction between caring nursing and nursing care, wherein caring nursing is a form of care without harming patients either through improper documentation or nursing care as a type of care based on the nursing process, which involves documentation throughout all the steps of the nursing process.

4.3.3. THEME 3: NURSES' PERCEPTION OF NURSING PRACTICE BARRIERS TO DOCUMENTATION OF NURSING CARE

Registered professional nurses who took part in this study expressed their perspectives on barriers that hinder accurate documentation of nursing care in the wards. This study revealed that registered professional nurses perceived documentation as a time-consuming task that is repetitive and shifts their focus away from rendering quality patient care. The researcher formulated two sub-themes from this theme, which are compromised care related to documentation demands and nursing omissions in documentation.

4.3.3.1 Sub-theme: Compromised care related to documentation demands

The findings revealed that patient care was compromised due to the nursing care documentation demands. Registered professional nurses reported that they spent more time documenting patient care rendered than rendering care to the patients or caring for the next patient in need of care. This means that the standards of nursing care rendered to patients will be poor, and patients will suffer the consequences of increased demands for documentation of patient care.

This was supported by participant 14, who said, "Okay, because it shifts focus from the patients, and then let's say you have to give care at 10 o'clock and then you are still busy writing and documenting about the first patient, it delays you from going to the next patient, so yeah, that's why I'm saying it's time-consuming." Participant 11 also said, "Sometimes time cannot allow you to do all those things, those recordings,

because it mostly takes you away from bedside nursing, and then you will focus much more on the patient than when you write about some of the things you miss."

Participant 16 highlighted that "*we have to fill out lots of forms, so it takes our time; we're focusing on one patient that we are admitting and neglecting those other ones in the ward, and we have to carry the doctor's round and write those progress reports and implementations; it needs a lot of focus and lots of time." So that is why it is demanding.*

Participant 16 further verbalized that "*Okay, the challenges that we have, documenting patient care, it's a lot of work as we have to document, like sometimes when we are writing the implementation we talk about giving the health education to the patient and also we have a separate health education form on the side, then we have to write the same thing that we have already written, so it's taking our time, and also when we write the care plan, we have to replan if the patient didn't progress well, so things like that, it takes our time, we are repeating the same things every time*."

In support of these findings, McKenney, Shanahan, Dowd, and Elkbuli (2019) revealed that health care workers have reported that they give more attention to documenting patient care than rendering patient care. Furthermore, patient health care needs are compromised due to the demands of documentation, which shifts the focus of health care workers away from patient care (McKenney et al., 2019). Another study with the same point of view described nursing care documentation as a devastation and burden that hinders health care workers from rendering patient care (Ayele et al., 2021).

A study by Olivares Bogeskov and Grimshaw-Aagaard (2019) reported that documentation of patient care is comprehensive and requires patient information from admission until discharge; thus, it takes time to complete all required patient information due to a shortage of staff and a lack of time. Caritative caring ethics by Erickson refers to the interaction between the patient and the nurse and how the nurse approaches the patient (Alligood, 2018). Documentation of nursing care rendered is an ethical consideration to be met, which requires nurses to have good interaction with the sick patient.

4.3.3.2 Sub-theme: Nursing omissions in documentation

Registered professional nurses revealed that they omit to document some of the nursing care rendered due to the amount of work they are required to do in a short

time. This means that communication among healthcare workers will be poor, which will also affect the continuity of patient care. This was supported by a quote from participant 06, *who reported that "sometimes we just do things without documenting them because we don't have time to document, and other times we document before implementing." We might find that the patient is very sick, and then I have implemented that I already gave medication at 12. When the patient passes away at half past 11, it becomes a problem. "That's my view*."

Participant 09: "*Challenges that we face" One of the challenges that we face is that for some people, their handwriting is not legible. As you know, a document is a form of communication within the nurses, so we can't see what the other nurses have written in that document. Yes."*

Participant 11: *"What I've realised is that we do document all the information; sometimes you just miss, and when you look at it, you say, "I should have written this down, but you find that you did not*."

The findings of this study are supported by the findings of a study conducted by Khrais, Alsadi, Oweidat, and Ahmad (2023), who explained that registered professional nurses render comprehensive care to numerous patients in the ward, which leads to omissions in nursing care documentation due to the workload they are faced with. Omissions in patient care impact negatively on patients' health, resulting in long stays in the wards and patients' being frustrated by slow health progress (Janatolmakan & Khatony, 2022). Thus, registered professional nurses absent themselves from work to avoid the workload.

Another study with similar findings reported that quality patient care is compromised due to omissions in nursing care documentation, resulting in poor patient outcomes (Diab & Ebrahim, 2019). Katie Eriksson defined caritative care as the use of caritas when rendering nursing care to human beings in terms of health and suffering. Eriksson further stipulated that caring communion and true caring come about when one renders nursing care in a spirit of Caritas to reduce the suffering of a patient, which involves nurses rendering quality patient care with no omissions in care that might hinder the patient's progress.

4.3.4. THEME 4: NURSES' PERCEPTIONS OF THE CONSEQUENCES OF INADEQUATE DOCUMENTATION OF NURSING CARE

Participants who took part in this study revealed that failure to document the nursing care that they rendered to patients has consequences for the hospital, the nursing profession, and most importantly, the patients. They indicated that it was impossible to render quality health care to patients without proper documentation because all members of the multi-disciplinary team rely on documents to make proper patient assessments and diagnoses. The following sub-themes were identified: consequences for the patient's compromised care and consequences for the hospital's litigation.

4.3.4.1 Sub-theme: Consequences for the patient (Compromised care)

Registered professional nurses reported that when nursing care documents are left with gaps and are incomplete, it affects the flow of patient care, which delays patients' receiving quality patient care. They further revealed that it exposes patients to the risk of medical hazards because of the risk of duplication in work done as a result of omitting some of the actions carried out.

This was evidenced in a quote by Participant 03, who said, "Let's say, for example, I've given medication and I didn't document it; when the next person comes, the next person is going to say the medication has not been given and they are going to give double the dose, which means it's increasing the toxicity of the medication to the patient."

Participant 06 added to say, "*The importance of documenting is to firstly ensure that another person doesn't come and repeat the same thing; for instance, if you are giving medication, you have injected the patient with the medication, and then another person comes and injects the same medication, which becomes an overdose, and it puts the patient in danger because you didn't show that you actually did this by documenting*."

Participant 08 mentioned that "*it affects it because we cannot continue where we left with the patient." It means if we have done some investigations, we have to redo them, like blood tests, X-rays, and whatever. "We have to start afresh*."

Participant 04 reported that "so, because we must nurse the patient, we are forced to open a new file." So, when we open the new file, which means the old documents or

the old information are no more, so we are starting new things, we will not be able to have the history of the patient.

Poor nursing care documentation leads to a misdiagnosis of patients' conditions, omissions in patient care, and prolonged patient hospital stays, which compromise the quality of health care rendered to the patients (Nakate, Moleki, Sarki, and Fleming, 2022). Another similar study conducted by Elsayed Mansour (2021) reported that failure to accurately document the nursing care that was rendered to patients would affect the quality of the nursing care to be rendered, thereby affecting the patients' progress.

Akter et al. (2020) further reported that poor nursing care documents are a leading cause of medical legal hazards, such as medication errors, which can be fatal for the patient. Hence, registered professional nurses are obligated to document precise patient reports regarding nursing examinations conducted, the identified patient problems, care plans drawn, and progress report writing (Delnavaz, Sahebihagh, Valizadeh, Jasemi, & Bostanabad, 2018). Erickson's theory denotes that human suffering relates to the patient when the health status has been compromised, and patients have suffering that has to be alleviated by nurses through proper documentation of care.

4..3.4.2 Sub-theme: Consequences for the hospital (litigations)

The findings of the study revealed that when patients' documents are incomplete, there is a high possibility that the hospital can be sued. Registered professional nurses reported that patients' documents serve as evidence during times of litigation, so incomplete documents place the hospital and registered professional nurses at risk of being sued for negligence of care. This was supported by a quote from Participant 06, who said, "*Another thing, let's say something bad happens to the patient, and then the relatives come back and they want to sue the hospital, and they go through the file, and they find out that something was not done, or maybe it was done but it was not recorded in the file, and then they take it as if the patients were not given the care that was due." " So I think that could also lead to litigation."*

Participant 07 said that "*the department is losing a lot of money due to litigation because there must be some lawyers appointed to stand for the department." "The upside and down mean that the department is losing a lot of money."*

Participant 11 also explained that "*sometimes you might find that when maybe there is something that went wrong during the nursing provision of service, then maybe the patient might come back to sue the hospital or the personnel that was helping him or her." That's when you go to audit the file, and you might find that, "Yeah, there is something that I should have written*."

The findings of this study are supported by the findings of a study conducted by Tamir et al. (2021), which states that documentation of nursing care rendered to patients is the only source of patient care information that serves as proof of the care rendered and could expose health care members to lawsuits. Additionally, nursing care documents must adhere to the organisational policies and standards of care as well as the required organisational guidelines for them to be of legal value and provide for defense in court (Nkechi, 2021). Registered professional nurses are obligated to account for all their actions and omissions while rendering patient care (Fatmawati, Ismawati, & Suriawanto, 2018). Thus, accurately written documents will serve as evidence during litigation to prove that the work was done. Eriksson described Caritas as love and charity in the care of patients. Caritas therefore refers to caring, which is an attempt to meditate on faith, hope, and love based on the information the patient obtained in nursing documentation to provide holistic care (Alligood, 2018).

4.3.5. THEME 5: NURSES' RECOMMENDATIONS FOR DOCUMENTATION OF NURSING CARE

Registered professional nurses who took part in this study revealed that they were faced with many challenges concerning documenting nursing care and, however, came up with recommendations that can better the challenges of nursing care documentation, which are adequate resources to reduce risk, effective logistics for documentation, nursing commitment to documentation, nursing teamwork and support, nursing education, and supervision.

4.3.5.1 Sub-theme: Adequate resources to reduce risk

The findings of this study revealed that participants feel like there is a need to hire more nurses in the wards for the better provision of health care services. They further revealed that they think the provision of more nurses will improve health care

standards. Some participants also recommended the hiring of ward clerks to improve the means of filing and storing patients' medical documents in the ward.

This was evidenced by Participant 1, who said that *“they must employ more staff; they must employ more staff to reach the level of patient care here.”*

Participant 6 also reported that *“I think if more nurses are hired and we have enough staff, I think we can improve."*

Participant 18 said that *“I think if we had enough staff, we would be able to do everything." "You will be able to take care of your patients and actually write what you did."*

Participant 13 said that *“even we can also encourage the Department to hire some ward clerks so that they see all the documentation is up-to-date and is kept safe.”*

The findings of this study concur with the findings of a study conducted by Ayele et al. (2021), who recommended that hospital management should hire more nurses in the wards to promote proper nursing care documentation, thus reducing the nurse’s workload associated with the shortage of staff. Another study with comparable findings suggested that hospital management should have adequate nursing staff that will meet the documentation standards required by the hospital (Diab et al., 2019). There is also a need to hire more knowledgeable ward clerks for the safe storage and retrieval of patients’ health documents (Luthuli et al., 2017).

4.3.5.2 Sub-theme: Effective logistics for documentation

Participants verbalised that the filing system in our healthcare facility is failing. They raised concerns about how the papers are easy to get lost, the files can be lost in the outpatient department, and how some healthcare professionals even write things that are not visible. Registered professional nurses came up with suggestions on how such issues can be dealt with; some participants suggested the use of electronic documentation using laptops and digital tablets. Some participants suggested that documents should be kept under lock and key and that they should come pre-written in the sense that registered professional nurses will fill in some of the patient's

information that is needed. The findings of this study were supported by the following quotes from the participants:

Participant 4 said that *“I think the other thing is how we file things. If we can be able to have, I do not know, but someone may be able to come with something better, unlike the papers which can get lost at any time, so they might provide us with something that will stay forever in the file. And then also the filing method. If they can improve the way they file things at OPD or the other departments, that is where we can be able to manage our documents.”*

Participant 08 suggested that “things that can improve nursing documentation Maybe if we can get an electronic system where we document on laptops or tablets, because that is where the patient's information will be kept forever. "It will never get lost.”

Participant 18 verbalised, “Let’s say you know what kind of questions you ask when it comes to a certain condition." Let us say a patient has diabetes. You know you are going to ask about her diet, you are going to ask about blurriness, you are going to ask stuff like that, so if we had documentation that already has those questions and then you just tick there if the patient has them, I think it would make it extremely easy. "So, I feel like if we also had that kind of documentation, in other words, it would be easy.”

The findings of this study also agree with the study conducted by Kutney-Lee, Sloane, Bowles, Burns, and Aiken (2019), who reported that the use of electronic documentation systems has been observed as a way of improving quality patient care documentation. Another study conducted by Erezina, Gift, Odipe, Raimi, Abaya, and Kakwi (2023) reported that electronic documentation for patient care provides easy retrieval of documents and ensures information retention. Similarly, Afolabi, Oladipo, and Popoola (2022) also reported that members of the multi-disciplinary team can easily share patient information electronically by using electronic health documentation.

4.3.5.3 Sub-theme: Nursing commitment to documentation

Registered professional nurses revealed that regardless of the challenges they have faced daily concerning documenting nursing care, they do work hard to improve the

documentation standards in their facility. This was evidenced by a quote by Participant 6, who said "*We try to make as much time as we can after doing whatever it is that we have to do to the patient; we try to sit down immediately after implementing it; we write it because if you can schedule it for later on, you might end up forgetting*."

Participant 09 confirmed that "*I think the documentation of nursing care is very good in my ward." Since I'm working in male medical, we share work amongst ourselves, and we make sure that every document is fully completed. "And then even the next morning, we audit the file that you admitted the previous day to ensure that everything is complete."*

Participant 09 further revealed that "suggestions The one I have mentioned is auditing in the morning. Every file should be taken in the morning. and we go through each file. We read everything. And also, monthly auditing is especially important to check. "Some documents are not fully completed, so check everything."

Azzolini reinforces the findings of this study, Furia, Cambieri, Ricciardi, Volpe, and Poscia (2019), reported that file auditing improves patient care documentation, thus improving the quality of patient care and health care standards. A commitment to the nursing profession promotes quality patient care and safety (Garca-Moyano, Altisent, Pellicer-Garca, Guerrero-Portillo, Arrazola-Alberdi, & Delgado-Marroqun, 2019). Similar study findings by Sadeghnezhad, Nejatmohammad, Safari, Jamali, and Varzeshi (2020) conveyed that when nurses show more commitment to the tasks they perform in their profession, there is an improvement in the quality of patient care. Eriksson described caring communion as an intimate connection and commitment that is characterized by closeness, respect, honesty, compassion, and tolerance (Alligood, 2018). Thus, when nurses address patients with empathy and consideration, proper documentation will also be performed to provide quality patient care.

4.3.5.4 Sub-theme: Nursing teamwork and support

The findings of this study revealed that teamwork and support among registered professional nurses would help improve some of the omissions made during the documentation of nursing care. This was evidenced in a quote by Participant 3 who said that *"Teamwork. We help each other. If I give medication, you just check for me if I did this, and did that. If you are opening the files and you see that I've left something out, you should just come back to me and say hey, you didn't sign for this or can you*

please sign for this document that you did this and that because some people can see that you did this but you didn't sign in and they ignore the whole thing."

Participant 03 further said that *"We really try to have a conversation about working together, teamwork. If you came to see the patient, just try, and write everything that you did down and sign for it. Just write the date and time, write everything that you did, everything that you have given to the patient and sign for it."*

Participant 12 said that *"We delegate work among ourselves, so that we can get things done at the end of the day."*

Participant 03 *"Working together and just double checking on the things you do. If you give medication, just double check after you are done with it, If I really signed for this."*

The findings of this study agree with those of Costello, Russell, and Coventry (2021), who indicated that teamwork among nurses is essential for effective communication among healthcare members. Furthermore, the findings reported that teamwork reduces errors and miscommunication among healthcare members while rendering patient care, thereby promoting patient safety. Appropriate teamwork amongst nurses in the workplace has been contended to have good nurse and patient results (Bragadóttir, Kalisch, Flygenring, & Tryggvadótti, 2023), although improper teamwork among nurses has been reported to be associated with omissions in patient care that threaten patients' safety (Soliman and Eldeep, 2020).

The Caritative Caring Ethics, according to Erickson (Alligood, 2018), refers to the ethics to be followed by nurses when rendering patient care, and this caring ethics enables nurses to render ethically sensitive care through adequate and proper documentation.

4.3.5.5 Sub-theme: Nursing education and supervision

Participants reported that there is no training being done in the ward regarding nursing care documentation. They also raised concerns about not being supervised in the documentation that they produce. Therefore, they came up with suggestions on how to improve the concerns they had, wherein they made suggestions on in-service training in the wards and that the registered professional nurses must supervise the junior categories. This was seen in a quote by Participant 4, who said that "*And also,*

as nurses, there are different categories of nurses; as sisters or a shift leader, you must make sure that you supervise your staff about the documentation."

Participant 4 further alluded to the fact that “you make sure that everyone documents, and then also the in-service." You must make sure that you educate your staff about documentation, its importance, and how to document. Because some of us do not know exactly what is needed in the documents, "we just write, not knowing if it's the correct way.”

Participant 08 said that “And also, we can do training on staff about the importance of documentation because some people forget; they just do their work." They just work, and they do not record anything on the file. "So, the in-service is important to revive that skill of documentation.”

Participant 12: “We need to be educated about documentation." "We really need workshops to be done so that at the end of the day, even we as old nurses and the students must be sure that what we’re doing is correct.”

The findings of this study are similar to the findings of a study conducted by Tasew et al. (2019), who outlined that registered professional nurses should be provided with workshop training on how to effectively document patient care. A study conducted by Kasaye et al. (2021) recommended that registered professional nurses be supervised in the documentation of patient care to enhance their documentation knowledge. Comparable findings further explained that in-service trainings on documentation will improve the documentation standards in the wards (Kasaye et al., 2022). Thus, nurses will be knowledgeable about what is required of them when conducting nursing care documentation.

4.4 SUMMARY OF THE CHAPTER

This chapter emphasised the themes and sub-themes that were developed during data analysis. Each theme and sub-theme were established from the interviews that were conducted with the participants and were strengthened by a quotation from a participant. The five themes that were established are as follows: nurses’ perceptions of the importance of documentation of nursing care; nurses’ perceptions of environmental barriers to documentation of nursing care; nurses’ perceptions of nursing barriers to documentation of nursing care; nurses’ perceptions of the

consequences of inadequate documentation of nursing care; and nurses' recommendations for documentation of nursing care. The next chapter, Chapter 5, will focus on the summary, limitations, recommendations, and conclusion of the study.

CHAPTER FIVE

SUMMARY, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSIONS

5.1 INTRODUCTION

This chapter concludes the study findings on the perceptions of nurses regarding the documentation of nursing care at selected public hospitals in Vhembe district, Limpopo province. It entails the summary, recommendations, conclusion, and limitations of the study. The recommendations of this study were obtained from the study findings during the data collection process, and such recommendations will benefit the Department of Health, the district, nursing education, administration, and research. The limitations of the study were also discussed.

5.2 SUMMARY OF THE STUDY

The objectives of the study were to:

To explore perceptions of nurses on documentation of nursing care in public hospitals of Vhembe district, Limpopo Province

To describe perceptions of nurses on documentation of nursing care in public hospitals of Vhembe district, Limpopo Province

To recommend measures to improve documentation of nursing care in public hospitals of Vhembe district, Limpopo Province

The perceptions of nurses on the documentation of nursing care were explored and described by means of a qualitative research method, and accordingly, the two objectives of the study were achieved. An explorative, descriptive, and contextual research design was used to explain the perceptions of nurses about the documentation of nursing care. A non-probability-purposive sampling technique was used to select the participants. The total population of the study was eighteen registered professional nurses from the two selected hospitals in the Vhembe district, Limpopo province. One-on-one interviews were conducted using semi-structured interviews. Data was analysed by the researcher and an independent coder using the Tech's coding method, and with the help of an independent coder, themes and sub-themes were developed based on the findings from the interviews. Measures recommended to improve the documentation of nursing care were identified after the one-on-one interviews were conducted and are discussed below.

The study identifies five themes with sub-themes, which were fully discussed in the previous chapter, and the findings were integrated with the theory that guided the study. The findings of the study, as expressed by registered professional nurses who participated in this study, revealed that documentation of nursing care is a fundamental practice in nursing, as it serves as a means of communication amongst health care workers, which promotes the quality of patient care and serves as proof that the care was rendered to the patient. However, registered professional nurses highlighted that they are faced with challenges such as a shortage of staff, workload, ward allocation barriers, poor handling and filling of patient documents, a lack of in-service training, and a shortage of documentation material. The participants expressed that such challenges hinder the completion and quality of documentation of patient care, which results in poor quality patient documentation. Registered professional nurses emphasise that poor-quality patient documents can lead to litigation against the responsible registered professional nurse as well as the department of health, whereas the affected patient will receive poor health care and treatment.

5.3 LIMITATION OF THE STUDY

This research study was limited to two public hospitals that are located in the Vhembe district of Limpopo Province; therefore, the study findings cannot be generalised to the other hospitals or primary health care facilities of the Vhembe district or the opinions of registered professional nurses working in the private sector.

5.4 RECOMMENDATIONS OF THE STUDY

The recommendations in this study were developed based on the themes and sub-themes that emerged from the one-on-one interviews that the researcher conducted with the registered professional nurses at the selected public hospitals in Vhembe District, Limpopo Province.

5.4.1 Recommendations for Theme 1: Nurses' perceptions of importance of documentation of nursing care

The theme had the following recommendations:

5.4.1.1 Recommendation to nursing practice and administration

There must be effective communication about patient care amongst members of the multi-disciplinary team, and this can be achieved through in-service trainings in the

wards. More research must be conducted on the benefits of working together as a team and how it benefits the patient to educate health care members on the benefits of working together as a team. Managers in the wards should ensure that there is enough nursing staff to be able to document patient care accurately. In-service training with regards to the importance of documenting patient care and the consequences of not documenting patient care should be rendered to nursing staff in the wards. The hospital management and ward managers should ensure continuous supervision of the documentation practices to be adhered to.

5.4.1.2 Recommendations to nursing education

Nursing schools should work with the Department of Health to introduce short courses that will educate nursing students on the importance of documenting nursing care in the wards.

5.4.1.3 Recommendations to research

Further research needs to be conducted on the nurse's perception of the importance of documentation in nursing care.

5.4.2 Recommendations for Theme 2: Nurses' perception of environmental barriers to documentation of nursing care

The theme proposed the following recommendations:

5.4.2.1 Recommendation to nursing practice and administration

The human resources office management needs to review the staff establishment and consider hiring more staff until all wards have enough nursing staff to render quality documentation of patient care. Hospital management and ward managers should work together to motivate more nursing staff to be hired in the wards. Managers in the wards should ensure that there is enough provision of material resources to use while documenting patient care, such as the relevant papers, and must ensure that nursing staff are provided with enough to meet their documentation demands. The ward managers, together with the hospital management, should advocate for a conducive working environment for patients in order to ensure patient safety and the provision of quality documentation of patient care. Nursing managers must ensure that members of the multi-disciplinary team work hand in hand with each other and must also educate all healthcare members on the benefits of working together as a team.

5.4.2.2 Recommendation to nursing education

Nursing managers, together with hospital management, should advocate for ward clerks to receive short training programs on effective documentation filling and handling skills to improve the filling strategies of patient documents in OPD.

5.4.2.3 Recommendations to nursing research

More research ought to be conducted on how a shortage of nurses, workload, and work pressure in the ward can affect the documentation of nursing care.

5.4.3 Recommendations for Theme 03: Nurses' perception of nursing barriers to documentation of nursing care

The theme yielded the following recommendations:

5.4.3.1 Recommendations to nursing practice and administration

Managers in the ward must ensure that the patient-to-nurse ratio is well balanced to avoid burnout and patient mortality, which will also ensure that patient care rendered is documented completely and accurately. Regular in-service trainings should be conducted on the acts and omissions in respect of which disciplinary actions may be taken against nursing staff by the South African Nursing Council (SANC) to ensure accurate and complete documentation of patient care. There must be a policy that guides nursing staff on how to effectively document patient care in the wards.

5.4.3.2 Recommendations to nursing education

The department of health must work together with nursing schools to develop short courses that will be added to the curriculum on documentation of nursing care, which stipulate the principles to be adhered to and the consequences of documentation omissions and errors, in order to equip nursing students with the necessary and basic documentation skills before they can be registered professional nurses.

5.4.3.3 Recommendations to research

Further research studies on barriers that hinder the proper documentation of nursing care should be conducted, paying particular attention to how compromised care related to documentation demands and nursing omissions can hinder the documentation of patient care.

5.4.4 Recommendations for Theme 04: Nurses' perceptions of consequences of inadequate documentation of nursing care

The following recommendations emanated from the theme:

5.4.4.1 Recommendations to nursing practice and administration

The hospital management and the quality assurance managers at the hospital and district levels should reinforce the consequences and disciplinary measures taken against registered professional nurses who do not accurately and completely document patient care rendered. Ward managers should educate nurses on the requirements of documenting patient care and should supervise all nursing care documents on a regular basis to impart the skills of documentation of nursing care to their subordinates.

5.4.4.2 Recommendations to nursing education

Ward managers registered professional nurses, and nursing tutors who facilitate clinical practical's should impact their documentation of nursing care skills on nursing students during their exposure (clinical practical's) in the wards to train nursing students on nursing care documentation practices.

5.4.4.3 Recommendations to research

This study recommended that more research be performed on how inaccurate or incomplete nursing care documentation can be addressed in nursing practice to avoid hospital litigation that exhausts department funds and leads to compromised patient care.

5.4.5 Recommendations for Theme 05: Nurses' recommendations for documentation of nursing care

The study findings recommend the following:

5.4.5.1 Recommendations to nursing service and administration

Ward managers should ensure that there is enough resource material to ensure accurate and complete patient care documentation on a regular basis. Ward clerks should be encouraged to supply the ward with enough resource materials and to make enough to use even on weekends and holidays. The management of the hospital, together with the ward managers, should advocate for nursing staff so that they can implement the use of electronic documentation in the wards and ensure that all nursing staff and other members of the multi-disciplinary team are well trained on how to use tablets and laptops for documenting patient care. Managers should encourage team building amongst all members of the multi-disciplinary team, with the aim of Ward managers should ensure that there is enough resource material to ensure accurate

and complete patient care documentation regularly. Ward clerks should be encouraged to supply the ward with enough resource materials and to make enough to use even on weekends and holidays. The management of the hospital, together with the ward managers, should advocate for nursing staff so that they can implement the use of electronic documentation in the wards and ensure that all nursing staff and other members of the multi-disciplinary team are well-trained on how to use tablets and laptops for documenting patient care.

Managers should encourage team building amongst all members of the multi-disciplinary team, to create team spirit between members, which will facilitate continuity of care amongst patients. Continuous support should be rendered to members of the multi-disciplinary team and guidance on the challenges they face when trying to improve the documentation challenges members experience. Hospital management should give praise where it is due to keep nursing staff motivated. Ward managers should continually supervise nursing staff concerning nursing care documentation and support those with challenges where necessary. creating team spirit between members, which will facilitate continuity of care amongst patients. Continuous support should be rendered to members of the multi-disciplinary team and guidance on the challenges they face to improve the documentation challenges members experience. Hospital management should give praise where it is due to keep nursing staff motivated. Ward managers should continually supervise nursing staff concerning nursing care documentation and support those with challenges where necessary.

5.4.5.2 Recommendations to nursing education

Nursing institutions for undergraduate students should be advised to introduce short courses on nursing care documentation practices to instil knowledge in students before implementing documentation of nursing care. Ward managers and hospital management should encourage nurses to further their studies and acquire more knowledge on documentation skills. Managers should empower nursing staff through training workshops and motivate staff members to establish themselves through learning. Outpatient Department (OPD) personnel should receive training workshops on their roles and responsibilities as document handlers to give them insight into what is required of them, thereby ensuring good documentation practices.

5.4.5.3 Recommendations to research

Further research should be undertaken based on the findings of the study and its recommendations, which can further improve the documentation of nursing care practices in hospitals to improve patient care.

5.5 CONCLUSION

The main aim of the study was to investigate the perceptions of nurses regarding the documentation of nursing care at selected public hospitals in Vhembe district, Limpopo province. The nurses are responsible for the documentation of nursing care to improve the quality of patient care in hospitals; however, the study findings revealed the perceived challenges associated with the documentation of patient care. Based on the study findings, documentation practices can be improved through the support of nurses by management, continuous in-service training and teamwork, the provision of adequate material resources, and nurses' commitment to documentation. If nurses continue to work as a team with effective logistics for documentation maintenance, patients will be provided with continuous care, resulting in quality patient care in public hospitals.

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APPENDIX A: CONSENT FORM

DEPARTMENT OF NURSING SCIENCE ENGLISH CONSENT FORM

Statement concerning participation in research

Name study: PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE PRACTICES AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE**.**

I have read the information and the aims and objectives of the proposed study and was provided with the opportunity to ask questions and was given adequate time to re-think the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in this study in any way.

I am aware that this material may be used in scientific publications, which will be electronically available throughout the world. I consent to this if my personal information such as names and surname will not be revealed.

I understand that participation in this study is voluntary and that I may withdraw from it at any time and without reasoning.

I know that the Turfloop Research Ethics Committee (TREC) has approved this study. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this provided my privacy will be guaranteed.

Access to the records that pertain to my participation will be restricted to persons directly involved in the research.

Any questions that I may have regarding the research or related matters, will be answered by the researchers.

I indemnify the University of Limpopo and all persons involved with the above study from any liability that may arise from my participation in the above study or that may be related to it, for whatever reasons including negligence on the part of the mentioned persons.

I hereby give consent to participate in this study.

Signature of participant……

Signature of researcher…….

Signed at……on the…… of……20

Contact no: ……

APPENDIX B: REQUEST FOR PERMISSION TO CONDUCT RESERCH AT TSHILIDZINI HOSPITAL

University of Limpopo
Nursing Department
Private Bag X1106
Sovenga
0727

To the Chief Executive Officer
Tshilidzini Hospital
Private Bag X924
Shayandima
0945
Dear sir/Madam

Request for permission to conduct research at Tshilidzini hospital

I am a student at the University of Limpopo, studying towards a master's degree in nursing science. I hereby request permission to conduct a research study at Tshilidzini hospital.

The title of my study is, PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE PRACTICES AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE**.**

The study aims to determine nursing care documentation practices as experienced by Nurses in public hospitals. I have enclosed my research proposal which includes the consent form the research study**.** Participation is voluntary and consent forms will be signed by nurses (RPN) who give consent to participate.

Hope my request will be taken into consideration

Contact Numbers of Researcher: 0724636737

Yours Sincerely,

Phuluwa V

APPENDIX C: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT DONALD FRASER HOSPITAL

University of Limpopo
Nursing Department
Private Bag X1106
Sovenga
0727

To the Chief Executive Officer
Donald Fraser Hospital
Private Bag X1172
Vhufuli
0971

Dear sir/Madam

Request for permission to conduct research at Donald Fraser hospital

I am a student at the University of Limpopo, studying towards a master's degree in nursing science. I hereby request permission to conduct a research study at Donald Fraser hospital.

The title of my study is, PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE PRACTICES AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE**.**

The study aims to determine nursing care documentation practices as experienced by Nurses in public hospitals. I have enclosed my research proposal which includes the consent form of the research study**.** Participation is voluntary and consent forms will be signed by nurses (RPN) who give consent to participate.

Hope my request will be taken into consideration

Contact Numbers of Researcher: 0724636737

Yours Sincerely,

Phuluwa V

APPENDIX D: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT ELIM HOSPITAL

University of Limpopo
Nursing Department
Private Bag X1106
Sovenga
0727

To the Chief Executive Officer
Elim hospital
Private Bag X312
Elim
0960

Dear Sir / Madam

Request for permission to conduct research at Elim hospital

I am a student at the University of Limpopo, studying towards a master's degree in nursing science. I hereby request permission to conduct a research study at Elim hospital

The title of my study is, PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE PRACTICES AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE**.**

The study aims to determine nursing care documentation practices as experienced by Nurses in public hospitals. I have enclosed my research proposal which includes the consent form of the research study**.** Participation is voluntary and consent forms will be signed by nurses (RPN) who give consent to participate.

Hope my request will be taken into consideration

Contact Numbers of Researcher: 0724636737

Yours Sincerely,

Phuluwa V

APPENDIX E: INTERVIEW GUIDE

Part 1

Demographic Information

Gender	Male		
	Female		

Age	20-29	
	30-39	
	40-49	
	50-59	
	60 and above	

Period of employment in the category	2 – 9 years	
	10 – 19 years	
	20 – 29 years	
	30 – 39 years	
	40 years and longer	

Period of implementing nursing care documentation	1– 9 years	
	10– 19 years	
	20– 29 years	
	30– 39 years	
	≥ 40 years	

Interview questions

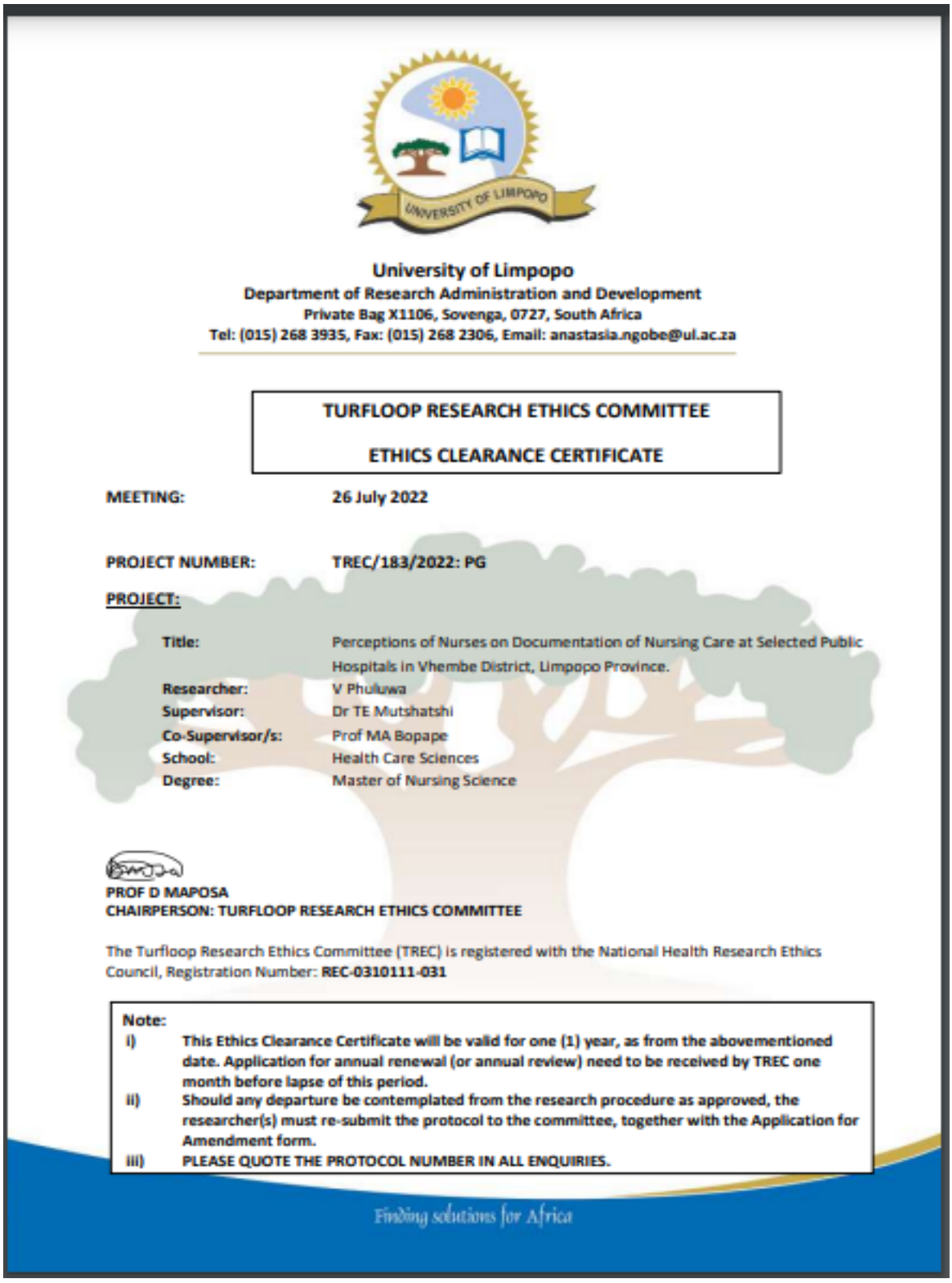
Can you share with me your perceptions about documentation of nursing care in your ward?

Can you share with me the importance of nursing care documentation during patient care?

What challenges do you have with regard to nursing care documentation?

What suggestions do you think can improve nursing care documentation challenges?

APPENDIX F: ETHICAL CLEARANCE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: **26 July 2022**

PROJECT NUMBER: **TREC/183/2022: PG**

PROJECT:

Title:	Perceptions of Nurses on Documentation of Nursing Care at Selected Public Hospitals in Vhembe District, Limpopo Province.
Researcher:	V Phuluwa
Supervisor:	Dr TE Mutshatshi
Co-Supervisor/s:	Prof MA Bopape
School:	Health Care Sciences
Degree:	Master of Nursing Science

PROF D MAPOSA
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

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APPENDIX G: PROVINCIAL PERMISSION LETTER

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP_2022-08-008
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

Vhuthuhawe Phuluwa

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;
PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. Present this letter of permission to the Office of District Executive Manager a week before the study is conducted.
    b. This permission is ONLY for the following institution's i.e. **DONALD FRASER HOSPITAL; ELIM HOSPITAL; TSHILIDZINI HOSPITAL**
    c. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
    d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    f. The approval is only valid for a 1-year period.
    g. If the proposal has been amended, a new approval should be sought from the Department of Health
    h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

pp **Head of Department** 01/09/2022 **Date**

APPENDIX H: VHEMBE DISTRICT PERMISSION

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
VHEMBE DISTRICT

Ref: S5/4/2/3
Enq: Gertrude Baloyi
Date: 26 September 2022
TO: University of Limpopo
Attention: Vhuthuhawe Phuluwa

SUBJECT: REQUEST TO CONDUCT A STUDY (RESEARCH) AT DONALD FRASER HOSPITAL, ELIM HOSPITAL, TSHILIDZINI HOSPITAL

Your study topic: Perceptions of nurses on documentation of nursing care at selected public hospitals in Vhembe District, Limpopo Province, South Africa.

1. The above matter has reference
2. The Department of Health has acknowledged your communiqué received on the 14th September for the above mentioned.
3. Kindly be informed that permission has been granted to conduct a research at **Donald Fraser Hospital, Elim Hospital,Tshilidzini Hospital from 27 September 2022–27 September 2023.**
4. You are also advised to comply or adhere with the Departmental Policies, rules and regulations during your operations.

Hoping that you will find this in order

.....
CHIEF DIRECTOR: HEALTH SERVICES

26/9/2022
Date

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623

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APPENDIX I: TRANSCRIPTION

NAME OF AUDIO	**:**	**participant H (08)**		
DATE OF AUDIO	**:**	**11/01/2023**		
TRANSCRIPTION CODE	**:**	**RESEARCHER**	**-**	**R**
	:	**INTERVIEWEE**	**-**	**I**

R Good day.

I Hello.

R How are you?

I I am good and you?

R I am good, my name is Vhuthuhawe, I am a master's student from the University of Limpopo, I am conducting research under the topic “Perceptions of nurses on documentation of nursing care at selected public hospitals in Vhembe District, Limpopo Province.” Please be assured that my research has been approved by the Limpopo Department of Health, Vhembe District and also Tshilidzini has granted me the permission to collect data and bear in mind that the information that we share here together is between me and you, and I will only share it with my supervisor for academic purposes only. So, as we have agreed to meet at this time, do you still agree to participate in this interview?

I Yes.

R Okay, thank you very much. This is the consent form. You can read it and sign it at the back. There is also a demographic data attached to it so if you have any questions with regards to the consent form, feel free to ask. You can return it back to me once you are done. Okay, thank you very much. Please bear in mind that this interview will take a maximum of 30 to 45 minutes. I will not mention your name throughout the interview. I will only refer to you such, I will only refer to you as Participant X to keep you anonymous. Do you understand?

I Okay.

R Okay can I also please voice record you, because I want to capture everything that you say to me can I also write down also some few notes because I do not want to miss anything that you have said to me?

I Yes.

R If ever you feel emotional or you feel like you do not want to continue with the interview anymore, please feel free to tell me. I will stop the recording. If it is something that we can talk through, we can resume again recording. But if you no longer want to participate, you can withdraw at any time. No penalties will be raised against you. Is there any question?

I No.

R Okay can you start?

I Yes.

R Okay. Can you share with me your perceptions about documentation of nursing care in your ward?

I In my wards, the documentation is good. Sometimes it is bad.

R Okay. Can you please share with me the good part about it?

I The good part about it is because we document everything that we do to the patient, which includes the assessment, the nursing care that we provide to the patient, and the continuity of care and the progress of the patient.

R Okay, thank you very much for that. Can you please share with me the bad part about it?

I The bad part of it is because sometimes we miss some documentation, some things we do not document. Maybe because sometimes they ward is busy and you find that we are short staffed, like always, you do not have time to sit down and record everything. You are busy caring for the patient, and then you forget to document some of the things or miss some of the things that you have done to the patient or that need to be recorded.

R Okay, so how do you manage such situations wherein you are busy and short staffed but still need to document? How do you go about it?

I Some of the things is that because nursing is a continuation, we just give a report to others so that they continue where we left. Because if it is not there on the file, they will not know what was happening to the patient and also do the file audit daily. The following day when we come in again to check where we missed something so that we can add.

R Okay, thank you very much. So, can you share with me the importance of nursing care documentation during patient care?

I The importance of nursing care documentation is for continuity of care because in nursing we have shifts. So, we, when you are collaborating with the patient during the day, you need to document everything that has been happening to the patient. If you are admitting the patient, the next person who is going to take care of that patient will be able to know what is supposed to be done to the patient. Also, it helps in terms of maybe when there are lawsuits at the hospital because it does happen.

R Okay, so with regards to lawsuits, why do you think documentation is important. How do you think it can save you during lawsuits?

I Because in lawsuits, obvious there will be a problem that is being raised or it is negligence or something. So when we take that file of the patient and we have documented everything that has been happening to the patient, it can save us or we have done our part. But if we did not record anything, that can be a problem, and we have to pay for that just because we did not document anything.

R Okay, thank you very much. Is there something else that you would like to add with regards to nursing care documentation, with regards to its importance?

I You can also prevent like, errors, like medication errors, nursing care errors? Yes.

R Okay. How does it prevent errors?

I The patient is getting certain medication and then it is not documented that you did not document that you have given the patient medication. The next person can come because you do not work alone. The next person can come and give the patient medication and you gave the medication, but you didn't document down. So, the next person can come and give the very same medication, which is a disaster to the patient.

R Okay, thank you very much for that point. So, is there anything else that you would like to add, or can we move to the next question?

I No you can move.

R Okay. What challenges do you have with regards to nursing care documentation?

I The challenge that we have is, I mean we have OPD where we keep the patients files. You may find out that every time when the patients comes back to the hospital, maybe it's a chronic or whatever, they give the patients new files every day because the files are lost and then we have to start afresh by collecting the information of the patient and we missed some of the things that had been done before for the patient, so we lost information of the patient.

R Okay. And how does that affect rendering health care to that patient? When you lost the patient's file, when you lost patient's information, how does it affect rendering service care to the patient?

I It affect it because we cannot continue where we left with the patient. It means if we have done some investigations, we have to redo them, like bloods, X-rays and whatever. We have to start afresh.

R Okay, thank you very much. Is there any other challenge?

I The other challenge? No.

R Okay. Let us move on. So with regards to the challenges that you have shared with me, what suggestions do you think can improve nursing care documentation?

I Things that can improve nursing documentation. Maybe if we can get an electronic system where we document on the laptops or tablets because that is

where the information of the patient will be kept forever, for a long time. It will never get lost like those papers that are on the file. Some they even fall off and whatever, and also, we can like in the ward, because that electronic can take longer. We can like if it is a medical ward, they are admin clerks in each and every ward. So we can have our small room where we keep the patient's files so that when they come back we just search for the files there and then give to the patient instead of going to the main OPD, where there are many files, and they could not find them there.

R Okay thank you very much.

I And also, we can do training on staff about the importance of documentation because some people, they forget, they just do their work. All the work, they just work, and they do not record anything on the file. So, the in-service is important to revive that skill of documentation.

R Okay. Is there anything else that you would like to add?

I No, thank you.

R Thank you very much for your time. Please be assured that the information that you have shared with me will only be shared with my supervisor at school, as I have mentioned before. So, thank you for the information that you have shared with me. Have a nice day.

I Thank you.

RECORDING ENDED.

APPENDIX J: CODING CERTIFICATE

Dr Annatjie van der Wath (M Cur, PhD) annavdw@mweb.co.za

CODING CERTIFICATE

Qualitative Data Analysis

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: 18 interviews for the study:

PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

I declare that the candidate, Phuluwa Vhuthuhawe, and I have reached consensus on the major themes and categories as reflected in the findings during a consensus discussion.

Annatjie van der Wath (M Cur, Ph D) annavdw@mweb.co.za

APPENDIX K: EDITING CERTIFICATE

Phuluwa Vhuthuhawe

University of Limpopo

Sovenga

O727

Unit C Mankweng 0727
081 5666 755
rightmovemultimedia@gmail.com
Researcheditors882@gmail.com
karabokonyani@gmail.com

14 August 2023

TO WHOM IT MAY CONCERN

This editing certificate verifies that this dissertation was professionally for Phuluwa Vhuthuhawe.

Thus, it is meant to acknowledge that I, Mrs K.L Malatji and Dr E.J Malatji professional Editors under a registered company RightMove Multimedia, have meticulously edited the dissertation from the University of Limpopo. Title: "PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE ".

Sincerely,

Mrs K. L Malatji

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UNIT C, MANKWENG
081 746 8032
Karabokonyani@gmail.com
rightmovemultimedia@gmail.com

Editing CertificationS
07 December 2023

TO WHOM IT MAY CONCERN

This editing certificate verifies that this Research was professionally edited for Phuluwa V.

Thus, it is meant to acknowledge that I, Mrs K.L Malatji, a professional Editor under a registered company, RightMove Multimedia, have meticulously edited the manuscript from the University of Limpopo. Title: "PERCEPTIONS OF NURSES ON DOCUMENTATION OF NURSING CARE AT SELECTED PUBLIC HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE".

Mrs K. L Malatji