Unsafe nursing documentation: A qualitative content analysis

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Unsafe Nursing Documentation: A Qualitative Content Analysis

Running title: Unsafe documentation

Abstract

Background: Nursing documentation as a pivotal part of nursing care has many implications for patient care in terms of safety and ethics.
Objectives: To explore factors influencing nursing documentation from nurses' perspectives in the Iranian nursing context.
Methods: This qualitative study was carried out using a qualitative content analysis of data collected from 2018 to 2019 in two urban areas of Iran. Semi-structured interviews (n = 15), observations and reviews of patients' medical files were used for data collection.
Ethical Considerations: This study was conducted in accordance with the ethical principles of research and regulations in terms of confidentiality of data, anonymity and provision of informed consent.
Findings: The main theme of this study was 'unsafe documentation'. Two categories of 'types of errors in reporting' and 'reasons of errors in reporting', and 12 subcategories were developed indicating factors influencing nursing documentation in the Iranian nursing context.
Conclusion: In general, individual, organizational and national factors affected nursing documentation in Iran. In this respect, hiring more nurses, application of reforms in the healthcare management structure, devising appropriate regulations regarding division of labor, constant education of healthcare staff, establishment of clinical governance, improvement of interpersonal relationships, development of hardware and software techniques for documentation, and provision of support should be done to improve the quality of nursing documentation. The above-mentioned suggestions can help nurses with a safe, ethical, lawful and reliable documentation in nursing practice.

Keywords: Content analysis, documentation, nursing, safe care

Background

Nursing documentation is an important aspect of safe and ethical nursing care (1, 2). Documentation of care is one of the professional responsibilities of nurses and is associated with their accountability in the healthcare system (3). Nursing regulatory bodies emphasize the importance of accurate, clear and current documentation by nurses within the legal, ethical and professional framework (4). Unrealistic and wrong information in the patient's medical file can disrupt the therapeutic process (5), because the documentation of care that patients receive helps facilitate collaboration between healthcare staff (6).

Provision of safe and high quality care is the basic principle of the healthcare system (7). Nurses are responsible to provide professional, ethical, and legal care to patients (8). Nurses are at the first

line of patient care and should be responsible to prevent practice errors, faulty diagnoses, wrong medicines and other related caring issues. In this respect, they need to transfer correct information to their colleagues in other work shifts to improve the process of healthcare (9). Nursing documentation is required to integrate clinical performance and improve safety of care (10). One out of every four negligence cases in patient care is attributed to mistakes in nursing documentation (11). Failure to properly document nursing care significantly affects the diagnosis and treatment of serious clinical conditions (12). Also, failure to document important caring issues, documentation at improper times, use of jargon or misleading information and presence of uncertainties in reports are the most common types of faults in documentation (13). Nursing shortages, ambiguities in physician's order, and lack of time for documentation can cause medication errors (14,15). In this respect, development of a reliable documentation system is required. However, documentation standards are not taken into account in most cases, and for instance, healthcare services offered to patients are not always recorded completely in the patient's medical file (16). However, electronic documentation can ideally reduce drug mistakes, support decision-making, and increase patient participation in the process of care (17).

Since nurses spend the most time with patients, documentation by nurses should be the most reliable. Considering challenges in the Iranian nursing context including lack of professional independence, inappropriate nurse-physician communication, nursing shortages, and high workloads and inadequate time for patient care, nursing documentation has many flaws in clinical settings. In addition to the financial consequences of wrong nursing documentation, it could have many consequences for nurses' professional reputation and ethical aspects of patient care, which can be explored for needs considerations. Therefore, by examining the process of nursing documentation using a qualitative method, a variety of factors affecting nursing documentation can be detected to improve the quality and safety of nursing care.

Objective

This study aimed to explore factors influencing the process of nursing documentation from nurses' perspectives in the Iranian nursing context.

Methods

Design

A qualitative design using a content analysis approach was used to conduct this study in two urban areas of Iran from 2018 to 2019. Qualitative research helps with an in-depth analysis of data and provides a cultural and contextual description and interpretation of social phenomena that may not

be achieved using the quantitative research tradition (18). Content analysis as a qualitative descriptive research approach is used for the condensation and abstraction of a large amount of textual data with the aim of gaining new insights into the study phenomenon (19).

Participants

Nurses working at hospitals in two urban areas of Iran were recruited through a purposeful sampling method. After obtaining necessary permissions, the researcher referred to the nursing office at the research environment and requested the director of that office to help with the recruitment of participants using inclusion criteria as follow: having a bachelor's degree with at least 2 years of work experience in different wards and willingness to take part in the study. There were 23 eligible nurses, but after15 interviews data saturation was reached and no new data were collected to add to the variation and depth of findings. They were working in the intensive care unit (ICU) (n = 2), cardiac care unit (CCU) (n=1), internal medicine ward (2), infectious diseases ward (n=1), cardiac diseases ward (n=2), neurology ward (n=2), emergency department (n=2), neonatal care unit (n=2) and surgery ward (n=1). The participants' demographic characteristics were reported in Table 1.

Table 1. Demographic characteristics of the participants

Variable		N
Gender	Male	8
	Female	7
Age (year)	24-30	3
	30-40	9
	>40	3
Work experience (year)	2-10	3
	10-20	10
	>20	2
Education level		
	Bachelor of science	11
	Higher degree	4

Data collection

Semi-structured interviews, observations and reviews of patients' medical files were used for data collection. The interviews were conducted by the first author (AT) and each session lasted for 45-

75 min. The interviews began using an open-ended and general question about nursing documentation such as “during the work shift, what kind of care do you deliver and how do you document it?” Also, based on their responses, more questions were asked to gather in-depth data including “can you provide examples of recording a report that could have a contradictory identity with what actually happened in practice?”, “can you give an example of what you have changed or manipulated in reports?”. The interviews were audio-recorded and transcribed *verbatim*.

Observations helped with gathering more in-depth data and provided a realistic picture of the study phenomenon (20). After informing the nurses and patients, the main researcher (AT) as a non-participant observer considered verbal and non-verbal communications between healthcare providers and patients during the work shift that would be related to nursing documentation, recorded them as field notes, and used them during data analysis.

Also, reviews of patients’ medical files were performed in a systematic way on the nurses records in patients’ medical files to examine and evaluate what the nurses performed during documentation. Document analysis is recommended to be combined with data collection using other methods to improve the interpretation of data and close the gap between what is done and what is really done in practice (21).

Data analysis

Data analysis was carried out concurrently with data collection using the analysis method suggested by Graneheim and Lundman (22). The interviews were transcribed *verbatim* and read several time to ensure a general understanding of the participants’ statements. Next, meaning units were determined and related codes were assigned. Through a constant comparison of similarities and differences between codes, they were sorted and grouped to categories and subcategories. The main theme of the study as a thread to connect the categories and subcategories were developed (23). The MAXQDA version 10 software was used for data management during the data analysis process.

Rigor

The four criteria of transferability, dependability, credibility, and conformability were used in this study to increase rigor (24). Credibility was established using member and the peer-checking, prolonged engagement and maximum variance of participants techniques. For instance, for member-checking, a brief report of findings was given to two clinical nurses and were asked to ensure the researcher of the reflection of their experiences and perspectives to the analysis report. For peer checking, two qualitative researchers approved the primary codes and categorizing

process. Transferability was achieved through the provision of a rich description of data collection and analysis processes and findings, which allowed readers to match the findings with their own contexts.

Ethical considerations

This study was approved by the ethical committee of the faculty of Medical Sciences at Tarbiat Modares University (decree code: IR.MODARES.REC.1397.029). Participation was voluntary and the nurses could withdraw from the study without any consequence. The nurses were asked to give consent for audio-recording of the interviews, and observations during work shifts. Oral and written informed consents from the patients were received after introducing and explaining the purpose of the study. Before the study, the participants were informed of the study's purpose and method. All ethical measures including honesty in the provision of results, data confidentiality and anonymity were considered with care. Also, the nurses were asked to sign the written informed consent form indicating their willingness to take part in the study.

Findings

A main theme of unsafe documentation, and two categories of 'types of errors in reporting' and 'reasons of errors in reporting'. Also, 12 subcategories were developed indicating factors influencing nursing documentation in the Iranian nursing context (Table 2). The description and interpretation of the results using the participants' direct quotations were provided as follow.

Table 2. The products of data analysis in this study

Theme	Main category	Subcategory
Unsafe documentation	Types of errors in reporting	• Changing and manipulating reports • Deliberate ambiguity • Incompatibility between the task performer and the recorder • Routinized recording without critical thinking • Concealment of incidents
	Reasons of errors in reporting	• Conflict of individual interests • Conflict of organizational interests • Personal and other limitations or obligations • Legal precaution • Imposing subjectivity on the report • Compulsory recording of non-performed action

	• Subjective reporting without patterns or outlines

Main theme: Unsafe documentation

Safety and accuracy were the most important principles of nursing documentation. However, for some reasons the nurses' reports were non-compliant with patient safety standards and high-quality care, and were questioned by law and morality, and even compromised the nurses' job security. It was consisted of two categories of 'types of errors in reporting' and 'reasons of errors in reporting'.

Category 1: Types of errors in reporting

Nursing documentation should contain factual records to play a significant role in the treatment process, but some nurses were in a situation in which such a criterion was violated. This category contained the subcategories of 'changing and manipulating reports', 'deliberate ambiguity, 'incompatibility between the task performer and the recorder', 'routinized recording without critical thinking', and 'concealment of incidents'.

Subcategory 1: Changing and manipulating reports

The nurses tried to remain committed to their job and follow the rules of lawful nursing documentation. However, mutual relationships and cooperation with other healthcare staff, legal consequences, or coercion imposed by clinical supervisors at the work place encouraged them to change or manipulate reports instead of writing an exact reporting of incidents happened during patient care. In addition to undermining patient rights, it made the follow up of the treatment process difficult. Also, the nurses were accused of distorting reality and endangering job security.

"Once my colleague at the emergency department came to the ward, fabricated something in the patient's file and went away. However, the fabricated data was not anything important to the patient care, from my perspective." (Participant No. 6, BSc in nursing)

"In the neonatal ward, a colleague mistakenly recorded ceftriaxone instead of cefotaxime in the patient's medical file, and I recorded the same as I was copying his writing, yet, it brought up complications later on. When the child was transferred from the neonatal ward to the children ward, the nurses in charge realized the mistake, returned all the records to us, and asked for an urgent correction." (Participant No. 1, MSc in nursing)

"A patient used a high dose of narcotics, and it was ordered to administer naloxone drips. We reported the patient's condition at midnight and based on the physician's order the medicine was discontinued. The next morning, the patient fell asleep and immediately after that had an apnea, and was intubated. The patient's caregiver told us to report that the patient had continued to take the drips and the medicine was not stopped at any point. I had to report it according to the physician's order" (Participant No. 9, BSc in nursing)

Subcategory 2:Deliberate ambiguity

The nurses stated that they tried to write their reports ambiguously so that there would be loop holes to avoid legal issues especially when they were under time limitations or had heavy workloads.

"The patient had a respiratory distress from the beginning of the work shift, but it was not much severe to call the physician. If the physician would be called, a lot of orders would be given. I would rather do whatever is necessary and keep an eye on him. To avoid being held responsible, I vaguely wrote down that the patient had a better work condition, but it would not conceal the fact that he was in such a condition." (Participant No. 2, MSc in nursing)

Observation: The nurse was called by a colleague at the beginning of the work shift, that the MRI report would be ready in two hours. The nurse wrote down that 'it was not ready' and needed to be followed up'. She had a high workload and never followed it. (Nursing record of participant No. 7)

Subcategory 3: Incompatibility between the task performer and the recorder

Heavy workloads, time limitations, pattern of job division, being inexperienced, staff shortages, lack of interests in recording and reporting incidents, fear of legal prosecutions, respecting patients' privacy encouraged provided the ground that a nurse did the task, but another nurse documented it.

"Sometimes when a patient is admitted, there is a heavy workload. Therefore, I do the task and ask my colleague to document it simultaneously." (Participant No. 2, MSc in nursing)

Observation: The patient was admitted. Monitoring, vital signs and laboratory test were performed by a nurse, while at the same time another nurse documented them and signed them under his/her own name. (Nursing record of participant No. 14)

"As the number of patients is considerably high, tasks are divided between different nurses so that one would just do the practical part and examination, and another document them." (Participant No. 15, MSc in nursing)

Subcategory 4: Routinized recording

The nurses often recorded their reports by following the patterns suggested by their experienced colleagues. Routinized documentation during the task performance sometimes disrupted the careful follow-up of the patient's problems and resulted in faulty documentation, which would hamper the follow-up of patient care.

" I have learned over the years that my colleagues usually record data based on her own routine". (Participant No. 14, BSc in nursing)

"As a routine I write in the report from the patients' admission, the level of consciousness, serum therapy, nutrition, digestive system condition, cardiovascular follow up, and other procedures based on the cardex." (Participant No. 11, BSc in nursing)

Review of the patient medical file: The routinized pattern of documentation in many patients files was as follow: "the patient is conscious and follows the diabetic diet. The Foley catheter is fixed and patient has diuresis. The patient is at the bed rest condition, and blood sugar is checked every 4 hours using a glucometer. The vital sign is controlled. The patient bedside is up and is constantly checked. "

Subcategory 5: Concealment of incidents

Due to heavy workloads, avoiding legal issues, partial job performance and not taking the full responsibility of tasks, and to support by colleagues, the nurses concealed incidents whose accurate recording would not be considered significant.

"It was at the very beginning of my job when I mistakenly administered warfarin to a patient. As the patient's condition in general was very important, I verbally reported it to the physician, but never wrote it down as to document it in the patient's medical file". (Participant No. 4, BSc in nursing)

Observation: The student injected 40 mg of Lasix to a patient instead of 20 mg. The nurse carefully controlled the patient's clinical condition, but never documented it. (Nursing record of participant No. 6)

Category 2: Reasons for errors in reporting

For appropriate documentation, incidents should be reported accurately and without ambiguity. Sometimes the nurses turned to unsafe and unethical documentation to conceal near misses, evade legal problems, manage time and patient's affairs, and consider the patient's health condition. Identifying the causes of reporting errors from the participants' perspectives helped with

understating potential causes of harm and shortcomings in the healthcare system. This category consisted of the subcategories of ‘conflict of individual interests’, ‘conflict of organizational interests’, ‘personal and other limitations or obligations’, ‘legal precaution’, ‘imposing subjectivity on the report’, ‘compulsory recording of non-performed action’, and ‘subjective reporting without patterns or outlines’.

Subcategory 1: Conflict of individual interests

Sometimes the nurses attempted to change the reports of incidents due to workloads, being scared to become responsible for mistakes, fear of losing job and reputation, and unpleasantness of the nursing procedure. This led to impairments and various expenses in the patient’s treatment process.

"It happened that a patient suffered from bradycardia and staff administered atropine, which improved the patient’s cardiac condition. However, they [nurses] did not record this, because the patient’s condition needed to follow the CPR protocol, which had to be ordered by the doctor and go through all the process.” (Participant No. 14, BSc in nursing)

Subcategory 2: Conflict of organizational interests

The community expects the healthcare system to provide the best care and support all patients. Therefore, if the patient is deprived of healthcare services or is not treated on time, it is considered some type of neglect. Occasionally, work conditions might occur where the protection of validity and reputation of the hospital and the healthcare system in the society became so important that the nurses were enforced to carry out unsafe and unethical activities.

"Once a bed in the ICU ward was required to admit a young patient. Therefore, it was asked to discontinue another patient’s drips, who was tagged as a no resuscitation as his blood pressure was being controlled using dopamine and norepinephrine and had a low consciousness level. It was done, but the CPR code was announced, that was unsuccessful and the patient died.” (Participant No. 8, BSc in nursing)

Subcategory 3: Personal and other limitations or obligations

Fear of being accused of not working enough, fatigue and laziness, lack of interest in job, high workloads, time limitations, and lack of facilities made the nurses to document activities that were not performed, which could impose additional costs to healthcare and disrupted the therapeutic process.

"The physician ordered that the patient should undergo hemodialysis for four hours. Accordingly, the patient’s clinical condition showed that s/he could not tolerate it for a long time. So, I recorded the doctor’s order, but I performed the hemodialysis only for less than 4 hours.” (Participant No. 12, BSc in nursing)

"Sometimes, due to time limitations, I could not measure the patient’s temperature using a thermometer and just guessed it by touching his/her hand and reported my guess.” (Participant No. 7, BSc in nursing)

Observation: The patient was transferred from the CCU with a wheelchair and a nurse without appropriate admission checking. The patient's temperature and other important vital signs were not measured and documented. (Participant No. 12, BSc in nursing)

Subcategory 4: Legal precaution

While the nurses accurately followed ethical codes of patient care, lack of facilities, the incompatibility between the type of department in which the patient was admitted into, a negative attitude toward the order of 'no resuscitation' given by the physician, and possibility of harm to patients, nurses turned to unsafe recording of incidents to avoid legal prosecutions.

"I reported that the patient should be monitored using the pulse oximetry. The number of pulse oximetry devices in the ward was not enough to carry out monitoring for all patients. Legally, I recorded it to show that it was done." (Participant No. 13, BSc in nursing)

Review of the patient medical file: It was found that 11 patients had a monitoring order by the physician, but it was not performed for all of them.

"Sometimes for a patient a resuscitation code is announced, but resuscitation is not fully performed due to the presence of 'no code' order for that patient. However, I am obliged legally to document the resuscitation process to avoid possible legal problems that may follow." (Participant No. 3, BSc in nursing)

Subcategory 5: Imposing subjectivity on the report

The more the work experiences of a nurse, the more his/her self-confidence and sense of authority during documentation, which affects chooses about how to document. Due to the patients' clinical conditions, the nurses decided not to perform some procedures, but recorded them as if they were performed.

"Sometimes, when the patient's dressing is still clean, I do not change it, because less I tamper with it, less the possibility of infection. However, I record it as if it has been done." (Participant No. 12, BSc in nursing)

Observation: The nurse stated verbally that the patient's eyes were clean and did not need to be washed, but it was reported that the patient's eyes were washed. (Nursing record of participant No. 5)

"An hour ago, the patient had to take a sedative drug, but since he was already asleep, I did not give it to him and reported that he received it." (Participant No. 11, BSc in nursing)

Observation: The patient had to be administered 5 mg methadone at 10 PM, but the patient did not want to get it. Therefore, I did not inject the medicine, but reported that it was done. (Nursing record of participant No. 13)

Subcategory 6: Compulsory reporting of non-performed actions

Legal accreditation forced the nurses to record performing interventions that were not taken place.

"There are some routines that I need to record for the validation of my documentations, but I may not actually carry out all of them." (Participant No. 5, BSc in nursing)

"Sometimes there is a vebal order that a patient does not need to be resuscitated, but legally, a thorough report on it is recorded." (Participant No. 15, MSc in nursing)

Review of the patient medical file: The patient's consciousness level was low as the patient was at the end stage of the disease and had a 'no code' order. Resuscitation was announced, but it was never performed. The nurse recorded a full report of the resuscitation process in the patient's medical file.

Subcategory 7: Subjective reporting without patterns or outlines

Various hospitals had their own style and routines for documentation. The content, number and time of documentation differed based on the type of ward. However, there was no constant pattern or outline shared between all, that led to the numerous cases of either subjective recordings by nurses or imposed opinions of supervisors, which resulted in unsafe and unethical documentation.

"I am told here to finalize documentation until the end of the work shift. but in another hospital, I was told that it would be okay to do it during the work shift. Everyone acts based on his/her own opinion and there is no shared pattern or outline for this, I am afraid." (Participant No. 4, BSc in nursing)

Discussion

The purpose of this study was to explore the perspectives and experiences of nurses on safety and ethical aspects of nursing documentation. Overall, our findings indicated shortcomings and insufficiencies in the documentation process due to various individual and system factors. Careless documentation can have negative consequences for both the caregiver and the care provider and endanger patient safety in terms of legal and moral issues.

Two main categories developed in this study were types of errors in reporting and reasons of error in reporting. Hospital errors are the major challenges of the healthcare system mainly due to negligence during documentation (25).

Distortion of facts and changing reports occurred when the nurses changed the documentation of what actually occurred due to personal or organizational interests. Such a dishonesty in documentation and recording of fabricated or untrue events by nurses happen due to conflicts of personal and organizational interests (26). Avoiding legal prosecutions and fear of punishment are two reasons that motivated the nurses in this study to distort reality and perform unsafe documentation. It is believed that nurses feel vulnerable and threatened by disciplinary and legal consequences, and they do not report errors or avoid recording them publicly (27). Additionally, the nurses sometimes tried to avoid future disciplinary follow-ups through down grading the severity of the patient's condition in their reports. Sometimes, the nurses delayed documentation due to heavy workloads, lack of time and/or work experiences. This is in consistent with the findings of the Warren's study indicating that unfavorable performances attributed to a lack of

experience, and unfamiliarity with the work pattern. Fatigue also hinders nurses from providing appropriate care and subsequently lead to poor documentation (28).

In this study, some nurses performed the intervention and other nurses documented them. It is believed that separation of performance and documentation can be a most common cause of nursing errors (29). The nurses sometimes created ambiguous reports due various reasons and later changed them to avoid possible legal consequences. Since there was no single pattern for documentation in healthcare settings, most nurses used the routinized pattern of reporting suggested by experienced nurses. It has been stated that none of the current documentation models are fully suitable and of high quality, because they often fail to consider key concepts and nurses perspectives. Also, reports are written using stereotyped and routinized sentences (30).

Sometimes the nurses refused to document actual events and errors, and tried to conceal them. Reporting errors is important in the nursing profession to prevent endangering the patient's life. Responsible individuals report mistakes to those who have the power to stop them, but many others easily walk away and remain silent (31). Revealing and reporting mistakes and errors is the cornerstone for maintaining and improving patient safety. Some healthcare professionals do not record mistakes as they may believe that their efforts are futile. Some others are afraid of the potential revenge by patients and the organization (32).

Failure to provide high quality care resulted in nurses being less than honest in their reports to avoid threatening their job reputation. It is believed that fear of losing professional and social credibility, fear of economic and legal consequences, fear of losing the patient trust, damage of the nurse-patient relationship, and the nurse's own personal characteristics such as dishonesty and lack of courage to accept mistakes could lead to the distortion of events and reluctance in revealing them during documentation (33). Distortion of events and facts can cause dissatisfaction with care and impose additional costs to the patient due to the costs of unsafe practice. However, according to the international literature, proper recording of events not only shows the nurse's honesty, but also it can decrease the patient's suffering and improve his/her satisfaction, trust, and positive emotional reaction toward disclosure of mistakes by healthcare providers (34). Honesty in documentation can improve treatment results, reduce organization's expenses, and help identify weaknesses in the organizational and individual levels (35).

The results of this study showed that senior nurses or clinical supervisors hindered the nurses in recording actual facts to maintain the credibility and reputation of the hospital and the healthcare

system. However, some nurses did not change their reports, which might threaten their job position for not obeying orders, but they tried to keep a clear conscience and cooperated with their seniors and supervisors as long as such style of documentation did not endanger patient safety. A clear conscience protects nurses' integrity, beliefs and values, that are required for practicing with commitment (36).

Personal and environmental limitations and obstacles encouraged the nurses to fabricate documentation. It is believed that a lack of interest in conducting a procedure motivate nurses to fabricate documentation. Perhaps it could be related to their feeling of being experienced and independent as that they are tired of performing the same tasks routinely. Also, human resources inefficiencies and lack of a proper program for division of labor can also lead to fabricated documentation. Strong leadership and guidance of collaborations in the interdisciplinary environment of hospital that depends on mutual reports between healthcare providers are required (37).

Lack of adequate facilities was one reason for inappropriate documentation. It has been stated that organizational factors can cause nurses to document interventions that have not actually been performed and are directly associated with the hospital's administrative system such as lack of facilities and management issues (38).

The nurses mentioned how they documented interventions that were not actually performed based on their own judgment and willingness. Nurses' judgments were not included in decision making whether these judgments were recorded or not. Factors such as not acknowledging the significance of nurses' role as a profession in the care process, redundant praising of other healthcare disciplines, considerable differences in job benefits and salaries between physicians and nurses, and the negative attitude of the society toward nurses can influence nurses' attitudes toward interdisciplinary collaborations (39).

Conclusion

Various individual and organizational factors led to unsafe and unethical nursing documentation. Removing staff shortages, improvement of the hospital management structure, provision of education on ethical and legal effects of inappropriate documentation, establishment of clinical governance, creation of changes in the management process, establishment of an appropriate professional communication between physicians and nurses, and appropriate distribution and

adjustment of nursing staff in different sectors help with the improvement of nursing documentation. Other solutions could be the electronic documentation system, which is missing in the majority of Iranian healthcare settings. It is clear that policies surround do not resuscitation orders and practices need to be addressed and that will include but not be limited to the Nursing Department. Those might be brought forward as ways to create an environment that supports nurses in practicing ethically.

The findings of this study have implications for management, education, research and clinical practice. As a limitation, the participants might have concealed some important data due to the sensitivity of the study topic and the fear of putting their job into risk. To overcome this, the researcher ensured the participants of confidentiality of data and their anonymity throughout the study process. Future research is needed to understand the perspectives of other healthcare professionals regarding nursing documentation and how it can be improved.

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Conflict of interest

The author(s) declare that there are no potential conflicts of interest.

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