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ER Checklist Utilization and Documentation Accuracy among Emergency Nurses in Private Hospitals in Quezon City

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ABSTRACT

Emergency care relies on timely clinical documentation for effective patient management. This study examined the use of Emergency Room (ER) checklists by nurses in private hospitals in Quezon City, focusing on their impact on documentation accuracy. A quantitative descriptive-correlational design was applied, surveying 133 emergency nurses. Results showed general agreement on the effectiveness of ER checklists in reducing documentation errors. However, perceptions of clarity and legibility varied. Statistical analysis found a moderate, significant relationship between checklist use and documentation quality. The study recommends a Documentation Optimization through Checklists for Reliable Emergency Decisions (DOC-READY) Program to enhance checklist utilization through staff training and workflow integration, ultimately improving emergency documentation standards.

Keywords: *Emergency Room checklists, checklist utilization, documentation accuracy, emergency nurses, clinical documentation, emergency care*

INTRODUCTION

Effective documentation is crucial in emergency departments, improving patient care and communication while mitigating liability risks. Despite the urgent and chaotic environment, inadequate documentation can lead to serious issues, including communication failures and delayed care. Standardized documentation tools, such as ER checklists, help improve the accuracy and completeness of records, as shown by studies highlighting their positive impact. However, challenges remain in utilizing these checklists effectively, often depending on organizational support and integration into workflows. In the Philippines, research on ER checklist usage in nursing documentation is limited, prompting a study to assess their effectiveness among emergency nurses in private hospitals in Quezon City. The findings aim to enhance documentation practices and ensure patient safety.

Statement of the Problem

This study evaluated the use and effectiveness of ER checklists among emergency nurses in private hospitals in Quezon City, focusing on several key areas: the demographic profile of respondents (age, sex, and experience), utilization patterns of checklists (frequency, ease of use, integration with documentation), and their effectiveness in reducing documentation errors, supporting accurate clinical decisions, and ensuring adherence to protocols. Additionally, it examines the impact of checklists on documentation quality (accuracy, completeness, clarity) and explores the relationships between checklist utilization and documentation outcomes. Finally, the study aims to propose program or policy

recommendations to enhance ER checklist utilization and improve documentation practices in emergency care.

Scope and Delimitations

This study investigated the usage of Emergency Room (ER) checklists and their effect on documentation accuracy among 133 licensed ER nurses in a private hospital in Quezon City. It excluded other health professionals, focusing solely on nursing personnel. Data were collected through a self-administered questionnaire using a five-point Likert scale to assess checklist utilization, effectiveness, and the accuracy of ER records. The research was descriptive-correlational and based on self-reported perceptions rather than direct audits, limiting its generalizability to other facilities or regions.

Review of Related Literature

The literature review highlights the critical role of Emergency Room (ER) checklists in enhancing patient safety, documentation accuracy, and standardized clinical practices in emergency care. ER checklists serve as cognitive tools, helping to reduce errors and improve communication among healthcare professionals under high-pressure conditions. Studies indicate that their effectiveness is influenced by factors such as frequency of use, simplicity, clarity, and organizational support. Regular use of ER checklists leads to better documentation practices, mitigates the risk of omissions, and helps nurses make informed decisions. However, challenges such as high workloads and environmental stressors often hinder their consistent application, underscoring the need for integration into existing workflows and ongoing education. Overall, while ER checklists are proven to improve documentation outcomes and patient safety, their successful implementation depends on a supportive organizational culture and structured processes.

Theoretical Framework

This study utilizes Avedis Donabedian's Structure-Process-Outcome (SPO) Model and Patricia Benner's Novice to Expert Theory to explore emergency nurses' compliance with ER checklist protocols in private hospitals in Quezon City. The SPO Model assesses healthcare quality by examining the structure (resources, policies), process (execution of nursing care), and outcome (quality documentation, patient safety). The findings suggest that effective use of the ER checklist improves workflow and patient care. Benner's theory outlines the development of nursing competence from novice to expert, indicating that experience influences adherence to protocols. Together, these frameworks provide insights into how training and structural factors affect nurses' compliance in emergency settings.

Conceptual Framework

This study explored the Input-Process-Output framework for emergency room (ER) checklists, assessing how factors such as staff profiles, checklist accessibility, and the clinical environment influence their use and effectiveness. It evaluates checklist accuracy, completeness, and effectiveness in capturing vital patient information in real-time. The input component assesses respondent characteristics and contextual factors that impact usage. The process analyzes implementation, compliance, data quality, and workflow contributions. The

output offers insights into checklist performance and actionable recommendations to improve training and integration into ER documentation, aiming to enhance patient care and documentation standards.

METHODOLOGY

In this study, a descriptive-correlational quantitative research design was employed to analyze relationships between variables through numerical data. The descriptive aspect presented the demographic profile of respondents and the use of ER checklists, while the correlational aspect examined the relationship between checklist use and documentation outcomes, including accuracy, completeness, and clinical effectiveness. This methodology is particularly suitable for healthcare settings, as it allows for the measurement of relationships without manipulating conditions. The results aimed to inform enhancements in documentation practices among emergency nurses in a private hospital in Quezon City.

Research Design

This design is ideal for healthcare settings where control over conditions is limited, and real-world practices are observed. The quantitative approach also ensures that the data collected are measurable and objective, and can be statistically analyzed to validate the findings. This design was selected because it aligns with the study's purpose: to determine the use of ER checklists and their relationship to documentation accuracy among emergency nurses in a private hospital in Quezon City. The findings provided a strong evidence base for the proposed program enhancement to documentation practices in the private hospital setting.

Research Steps

The researcher obtained informed consent and institutional approval from a private hospital in Quezon City for a study involving ER nurses. Target participants included those with at least six months of ER experience and familiarity with the checklist. The questionnaire was distributed via Google Forms, through email or social media, with clear instructions and ethical safeguards provided. The researcher ensured understanding by being available for clarifications. Responses were collected electronically, reviewed for completeness, and stored securely to comply with data privacy regulations.

Data Collection and Sample Selection

The study targeted Emergency Room (ER) nurses involved in patient care and documentation. A sample of 133 ER nurses was determined using Slovin's Formula with a 5% margin of error, and purposive sampling was used to include only those with at least 6 months of ER experience who had used the ER checklist. Data were collected through a Google Forms questionnaire, which took 5 to 10 minutes to complete, and ethical considerations included obtaining informed consent via email.

Data Analysis Methods

The data were analyzed using SPSS and Excel, employing descriptive statistics to summarize demographics and agreement levels on ER checklists. Pearson’s r was used to assess relationships between checklist utilization and documentation outcomes, confirming

associations significant at the 0.05 level. These findings provided a basis for recommending improvements to documentation protocols and the ER checklist program in private hospitals.

Research Hypotheses and Validation

Two null hypotheses were tested at the 0.05 significance level: Ho_1 posits no significant relationship between Emergency Room (ER) checklists and documentation outcomes related to patient information accuracy, data completeness, and entry clarity. Ho_2 posits no significant relationship between ER checklists and their overall effectiveness.

Study Limitations and Ethical Considerations

This study examines the use of ER checklists and their impact on documentation accuracy among 133 licensed emergency room nurses in a private hospital in Quezon City. The research focused solely on nursing staff's experiences, excluding other health professionals. Data were collected using a Likert-scale questionnaire that addressed checklist utilization, effectiveness, and the accuracy of ER records, based on nurses' perceptions rather than direct audits. Key definitions include ER checklist as a standardized documentation tool; utilization as its integration into workflow; effectiveness in reducing errors; documentation accuracy as reliability; and clarity as the legibility of records. The findings are specific to one private institution and do not represent broader practices in public hospitals or other regions in the Philippines.

RESULTS AND DISCUSSION

The chapter's findings indicate that Emergency Room (ER) checklists are effective for clinical decision-making and protocol adherence, but their impact on documentation accuracy remains moderate. Statistical analysis reveals a marginally significant relationship between checklist use and documentation quality, which is hindered by inconsistent use and workflow challenges. While ER checklists enhance clinical effectiveness, their potential for improving documentation is not fully realized. The findings lay the groundwork for future programs and policy recommendations focused on training, workflow integration, and monitoring to ensure effective application, thereby enhancing patient safety and the quality of emergency care.

SUMMARY

The findings indicate that ER checklists support accurate recording of patient data with a neutral overall effectiveness (AWM = 3.09). They effectively document handoffs and follow-up plans but are less successful in filling all required fields. Clarity and legibility of entries received similarly neutral ratings (AWM = 3.08), with improved consistency in terminology but minimal gains in readability. The overall documentation outcomes also reflected a neutral composite mean. Notably, a slight but significant relationship exists between checklist utilization and accuracy, completeness, and clarity, although perceived effectiveness indicated workflow barriers (Pearson $r = -0.012$, $p = 0.000$).

CONCLUSIONS

ER checklists effectively aid clinical decision-making and protocol adherence, though their impact on documentation is moderate. Inconsistent real-time use limits their benefits,

evidenced by neutral ratings on accuracy, completeness, and clarity. While slight correlations suggest that use influences documentation outcomes, workflow challenges hinder effectiveness. Therefore, stronger institutional support, better integration into workflows, and ongoing staff training are needed to enhance their contribution to patient safety and care continuity.

RECOMMENDATIONS

Recommendations for improving documentation in emergency care include implementing the DOC-READY program, which focuses on mandatory training, simulation-based drills, regular audits, and mentorship by designated checklist champions. Policy recommendations advocate integrating checklists into electronic medical records, standardizing across facilities, linking performance-based incentives to staff evaluations, reinforcing checklist use during peak loads, and conducting an annual review of checklist content. These measures aim to enhance documentation quality and safety in emergency care.

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AI DECLARATION STATEMENT

The authors declare that artificial intelligence (AI)-assisted tools were used solely to support language editing, grammar checking, organization of written content, and improvement of clarity in the manuscript. AI tools were not used to generate, fabricate, manipulate, or alter research data, statistical results, participant responses, references, or study findings.

All research procedures, data collection, data analysis, interpretation of results, conclusions, and recommendations were conducted and verified by the authors. The authors accept full responsibility for the accuracy, originality, ethical integrity, and final content of this manuscript.

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