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# The Lived Experiences of Nurses in Documentation Process at Selected Hospital in Marikina City

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***ABSTRACT***

*Nursing documentation is an essential component of patient care that promotes effective communication, continuity of care, and patient safety. With the increasing adoption of Electronic Health Records (EHRs), nurses are required to adapt to new documentation systems while managing their clinical responsibilities. This study aims to explore and describe the lived experiences of nurses with the documentation process in a selected government hospital in Marikina City. Specifically, it seeks to examine nurses' perceptions of the documentation process, the challenges and barriers they encounter, the coping and adaptation strategies they employ, and the institutional support systems that influence their experiences. The study will utilize a descriptive qualitative phenomenological research design grounded in Edmund Husserl's philosophy. Purposive sampling will be employed to recruit ten (10) registered nurses who are directly involved in patient care and the use of Electronic Health Records. Data will be collected through semi-structured, face-to-face interviews and analyzed using Colaizzi's Seven-Step Method. The findings revealed that nurses experience documentation as both a professional responsibility and a systemic challenge. Major barriers included limited computer access, overlapping paper and electronic documentation systems, heavy workloads, and frequent workplace interruptions. Despite these challenges, nurses recognized documentation as essential for patient safety, continuity of care, communication, and legal accountability. They adapted through teamwork, time management, prioritization, continuous learning, and personal resilience. Although hospitals provide training and digitalization initiatives, persistent issues in staffing, equipment, and system improvements continue to affect documentation practices. The study concludes that nursing documentation extends beyond a technical requirement, serving as a professional, ethical, and legal responsibility that requires stronger institutional support. It recommends improving digital infrastructure, addressing staffing and workload concerns, strengthening documentation training, and implementing consistent policies to enhance patient safety, continuity of care, and healthcare quality.*

***Keywords:*** *Nurse, Documentation Process, Electronic Health Record, Marikina City, Lived Experiences*

## INTRODUCTION

Nurses in government hospitals face significant challenges in adapting to Electronic Health Record (EHR) systems while managing heavy workloads, limited staffing, and documentation demands. High patient loads, time constraints, complex EHR systems, and insufficient training can lead to incomplete or delayed documentation, affecting compliance

and continuity of care (Maghsoud et al., 2022; Kremlin, 2023). Despite the importance of accurate documentation, existing efforts often emphasize patient safety outcomes rather than nurses' experiences. This highlights the need to explore the lived experiences of nurses to better understand the challenges they encounter during the documentation process.

**Grand Tour Questions/Central Question**

How do nurses describe and make sense of their lived experience in the documentation process within Selected Hospitals in Marikina City?

**Probing Questions**

1. **Challenges and Barriers**

What difficulties do nurses encounter in completing documentation tasks, and how do these affect their workflow and patient care?

2. **Perceptions and Attitudes**

How do nurses perceive the importance of documentation in their professional practice, and what attitudes influence their engagement with the process?

3. **Coping and Adaptation**

What strategies do nurses employ to manage the demand of documentation while balancing clinical responsibilities?

4. **Institutional and Systemic Factors**

How do hospital policies, available resources, and administrative support shape nurses' experiences in the documentation process?

**Scope and Delimitations**

This study explores the lived experiences of nurses in the documentation process in a selected government tertiary hospital in Marikina City using a descriptive qualitative phenomenological design. Data will be gathered through semi-structured interviews with ten (10) purposively selected registered staff nurses (Nurse I–III) from the OPD, Medicine Ward, Surgery Ward, ER, and CD Ward who provide direct bedside care and use the Electronic Health Record (EHR) system. Nurses with primarily managerial or administrative roles, those not involved in nursing documentation, and those who decline or withdraw participation will be excluded. The findings are limited to the experiences of the selected participants in the chosen hospital and are not intended to be generalized to other healthcare settings.

**REVIEW OF RELATED LITERATURE**

The related literature emphasizes that nursing documentation is essential for effective communication, continuity of care, patient safety, and legal accountability. Although Electronic Health Records (EHRs) have improved documentation efficiency, nurses continue to face challenges such as heavy workloads, time constraints, inadequate training, and increased documentation burden, which may affect the quality of patient care. Most existing studies focus on documentation quality and EHR effectiveness using quantitative methods, with limited attention to nurses' lived experiences, particularly in Philippine government hospitals. This research gap provides the basis for the present study, which explores nurses'

perceptions, challenges, coping strategies, and adaptation to the documentation process using a phenomenological approach.

### Theoretical Framework

The study is anchored on **Patricia Benner's Novice to Expert Theory** and **Sister Callista Roy's Adaptation Model**. Benner's theory explains that nurses develop competence through clinical experience, enabling them to perform nursing responsibilities, including documentation, more effectively. Roy's model emphasizes that nurses continuously adapt to changing clinical environments by using coping strategies, particularly in responding to the demands of documentation and Electronic Health Record (EHR) systems. Together, these theories provide a framework for understanding nurses' experiences, competence, and adaptation in the documentation process.

## METHODOLOGY

### Research Design

This study employed a **descriptive qualitative research design using a phenomenological approach** to explore the lived experiences of nurses in the documentation process. Guided by **Edmund Husserl's phenomenological philosophy**, the study examined nurses' perceptions, challenges, coping strategies, and support systems. Through in-depth interviews, it aimed to capture the essence of nurses' experiences while setting aside the researcher's personal assumptions (Beck, 1994; Neubauer et al., 2019; Shefaly et al., 2022).

### Research Steps

The study began with a review of related literature to establish the research foundation and identify knowledge gaps. Following approval from the research adviser, Ethics Review Board (ERB), and the participating hospital, participants were selected through purposive sampling. Data were collected using semi-structured interviews and analyzed through **Colaizzi's Seven-Step Descriptive Phenomenological Method** to identify significant statements, develop themes, and describe the essence of participants' lived experiences. The findings were then interpreted in relation to existing literature and nursing theories to formulate conclusions and recommendations.

### Data Collection and Sample Selection

The study will use **purposive sampling** to recruit ten (10) registered staff nurses from a selected hospital in Marikina City. Eligible participants are nurses directly involved in bedside patient care and the use of the Electronic Health Record (EHR) system. Data will be collected through face-to-face semi-structured interviews after obtaining written informed consent. Interviews will be audio-recorded with participants' permission, transcribed verbatim, and kept confidential for research purposes.

### Data Analysis Methods

The collected data will be analyzed using **Colaizzi's Seven-Step Method of Descriptive Phenomenology**. Interview transcripts will be reviewed to identify significant statements, formulate meanings, and develop themes that describe the essence of nurses' lived

experiences with the documentation process. To ensure credibility, member checking will be conducted by validating the interpreted findings with the participants.

**Research Hypotheses and Validation**

This study is guided by the assumption that participating nurses will provide honest and accurate accounts of their lived experiences with the documentation process. It also assumes that their experiences may vary based on their clinical roles, level of experience, and use of electronic documentation systems, providing meaningful insights into the documentation process.

**Study Limitations and Ethical Considerations**

Ethical approval will be obtained from the Ethics Review Board and the participating hospital before data collection. Participation will be voluntary, with written informed consent secured from all participants. Confidentiality will be maintained through participant codes, and data will be stored securely. Participants may withdraw from the study at any time without penalty.

## RESULTS AND DISCUSSION

The study found that nurses in selected hospitals in Marikina City experience documentation as both a professional responsibility and a systemic challenge. Participants identified barriers such as limited computer access, overlapping paper and electronic systems, heavy workloads, and frequent interruptions, with one participant describing the situation as "*kakulangan sa gamit… naghihiraman lang.*" P1

Despite these challenges, nurses recognized documentation as essential for patient safety, continuity of care, communication, and legal accountability, emphasizing that "*if it's not documented, it didn't happen.*" P6

To cope, they relied on teamwork, time management, prioritization, continuous learning, and personal resilience, with one participant highlighting "*teamwork… guidance of Lord.*" Although hospitals provided support through training and digitalization initiatives, participants stressed the need for "*more equipment, training, [and] audits*" to improve documentation practices. P10

## CONCLUSIONS

From these findings, it can be concluded that documentation is both a **professional anchor and a systemic burden**. Nurses construct it as a vital duty that validates care, upholds accountability, and protects them legally, yet it is consistently challenged by institutional resource gaps, overwhelming workloads, high-acuity demands, and workflow inefficiencies. Their lived experiences portray documentation as a **balancing act** a practice that embodies professional identity and ethical responsibility, but one that requires stronger institutional support to be sustained effectively. Documentation is therefore not only a technical requirement but also a moral and emotional responsibility, deeply tied to nurses' sense of professionalism and patient-centered care.

## RECOMMENDATIONS

To address the identified challenges, the study recommends strengthening institutional support through improved digital infrastructure and standardized documentation systems, addressing staffing and workload concerns, providing regular documentation training, promoting teamwork and resilience, and implementing consistent documentation policies with regular audits and feedback. Overall, the findings highlight that nurses view documentation as both a professional responsibility and a systemic challenge. Strengthening institutional support and documentation practices can improve workflow efficiency, patient safety, continuity of care, and the quality of healthcare delivery.

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## AI DECLARATION STATEMENT

AI-supported tools helped with grammar and structure in creating this article. No AI tools were used to collect, analyze, or interpret data; all authors are credited for their academic contributions.

## REFERENCES

Beck, C. T. (1994). Phenomenology: its use in nursing research. *International Journal of Nursing Studies, 31*(6), 499–510. https://doi.org/10.1016/0020-7489(94)90060-4

Benner, P. (1984). From novice to expert excellence and power in clinical nursing practice. *The American Journal of Nursing, 84*(12), 1479. https://doi.org/10.1097/00000446-198412000-00025

Kremlin, E., Maria N., (2023). Lived Experiences of Nurses on Utilization of Electronic Health Records on Patients' Safety and Quality Care. *Asia Pacific Journal of Allied Health Sciences*,6(2),

Maghsoud, F., Rezaei, M., Asgarian, F. S., & Rassouli, M. (2022). Workload and quality of nursing care: the mediating role of implicit rationing of nursing care, job satisfaction and emotional exhaustion by using structural equations modeling approach. *BMC Nursing, 21*(1), 273. https://doi.org/10.1186/s12912-022-01055-1

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

Roy, C. (1984). *Introduction to nursing: An adaptation model* (2nd ed.). Appleton & Lange.

Shefaly, M., Shanbehzadeh, M., Nassari, Z., & Kazemi-Arpanahi, H. (2022). Development and evaluation of an electronic nursing documentation system. *BMC Nursing, 21*(1), 15. https://doi.org/10.1186/s12912-021-00790-1