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The Lived Experiences of Nurses in the Documentation Process in the Clinical Practice

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ABSTRACT

This paper explores the lived experiences of nurses in the documentation process in clinical practice, aiming to clarify how they perceive, manage, and give meaning to documentation within busy hospital settings by highlighting both its essential role and the tensions it creates between patient care, workload, and professional accountability. Using a descriptive phenomenological design and Colaizzi's method applied to in-depth, semi-structured interviews with staff nurses from special units in a tertiary government hospital, the study systematically transformed rich first-person accounts into themes that reflect the core structure of nurses' documentation experiences. The findings show that nurses regard documentation as indispensable for patient safety, continuity of care, communication within the healthcare team, and legal protection, yet experience it as time-consuming, burdensome, and often in competition with direct bedside care, responding to heavy workloads and high patient acuity by prioritizing immediate care and safety while using practical strategies such as near-real-time charting, workflow organization, and structured formats to cope with documentation demands. The research is limited to one institution and a specific group of nurses, so the results are context-bound rather than statistically generalizable, but they carry important implications for policy and practice, suggesting that documentation systems, standards, and staffing patterns should be redesigned to better align with real clinical workflows and to protect both record quality and nurse well-being. The paper's original value lies in offering a phenomenological, context-specific understanding of documentation as a lived experience rather than as a purely technical task, illuminating how documentation embodies ethical responsibility, clinical judgment, and emotional labor, and thereby contributing nuanced insight to nursing scholarship and efforts to improve documentation practices.

Keywords: - *Nursing documentation, lived experience, descriptive phenomenology, Colaizzi method, workload and time pressure, patient safety, continuity of care, Philippine tertiary government hospital.*

INTRODUCTION

Nursing documentation remains a core component of clinical practice because it supports patient safety, continuity of care, professional accountability, and interprofessional communication. Despite its importance, nurses often experience documentation as burdensome due to excessive time demands, inefficient systems, staffing shortages, and workflow interruptions, especially in high-acuity hospital settings. The study addresses the limited phenomenological evidence on how nurses in the Philippine setting experience and interpret documentation in their everyday work.

Statement of the Problem

This study sought to examine and articulate the lived experiences of registered nurses assigned to special units in a selected tertiary government hospital in Quezon City in relation to the documentation process. It is guided by the grand tour question: What is the lived experience of nurses in the documentation process in clinical practice?

Scope and Delimitations

The inquiry focused on registered nurses in special units who provide direct bedside care and routinely perform documentation in the selected hospital. It excludes other health professionals, nursing students, administrative nurses without bedside duties, and any evaluation of chart accuracy, legal sufficiency, completeness, interventions, or institutional comparisons. The findings are intended to provide context-specific insight rather than statistical generalization.

Review of Related Literature

The literature in your revised draft shows that documentation is both essential and burdensome. Studies cited in the proposal describe documentation as vital for patient safety, continuity, and accountability, while also identifying usability issues, repetitive charting, workload, inadequate staffing, insufficient training, and hybrid documentation systems as sources of burden and error risk. The synthesis in your file also shows that much of the available evidence focuses on quality, barriers, and workload, while few studies use a phenomenological lens to explore nurses' holistic lived experiences, particularly in the Philippine context.

Theoretical Framework

This research uses Carper's Fundamental Patterns of Knowing in Nursing as the main theoretical framework. This framework positions documentation not only as an empirical and technical task but also as an ethical, personal, and aesthetic expression of nursing practice. The proposal also draws on a phenomenological philosophical underpinning, recognizing nurses' lived experiences as meaningful sources of knowledge and acknowledging the need for bracketing because the researcher is also a nurse in the study setting.

METHODOLOGY

The study uses a qualitative descriptive phenomenological approach because it seeks to understand nurses' subjective experiences, meanings, and interpretations of documentation rather than measure variables numerically. This methodology allows the study to generate rich, context-based descriptions of how nurses perceive and experience documentation in clinical practice.

Research Design

A descriptive phenomenological research design is adopted, with Colaizzi's method guiding the analysis. This design is appropriate because the study aims to describe the essential structure of nurses' lived experiences in documentation and to remain close to participants' own narratives.

Research Steps

The revised proposal outlines these major steps: securing ethics and institutional approval, coordinating with the Nursing Service Office and unit heads, identifying eligible participants, obtaining informed consent, conducting in-depth interviews, transcribing data

verbatim, and analyzing the narratives using Colaizzi's seven-step process. Selected participants may also be involved in member checking to validate the synthesized descriptions.

Data Collection and Sample Selection

Participants are selected through purposive sampling from registered nurses who work as staff nurses or charge nurses in clinical units, have at least one year of experience in the institution, and actively perform nursing documentation. The target sample size is about 8–14 nurses, with the final number determined by data saturation. Data are gathered through individual semi-structured in-depth interviews, lasting around 30–60 minutes, conducted in English or Filipino, audio-recorded with consent, and supplemented by field notes.

Data Analysis Methods

The study uses Colaizzi's seven-step descriptive phenomenological analysis. This includes repeatedly reading transcripts, extracting significant statements, formulating meanings, clustering themes, producing an exhaustive description, identifying the fundamental structure of the phenomenon, and returning findings to selected participants for validation.

Research Question and Validation

Your revised draft no longer uses a hypothesis, which is appropriate for a qualitative phenomenological study. Instead, it is driven by a central research question and supported by trustworthiness criteria: credibility, dependability, and transferability. Credibility is supported through probing and member checking, dependability through an audit trail and consistent interview procedures, and transferability through thick description of the locale and participants.

Study Limitations and Ethical Considerations

The study is limited to one tertiary government hospital in Quezon City and to nurses in selected units, so findings are context-specific. It does not quantify outcomes or evaluate documentation accuracy, legal sufficiency, or institutional performance. Ethical safeguards in the proposal include autonomy, beneficence, non-maleficence, justice, veracity, fidelity, data privacy, informed consent, secure storage of recordings and transcripts, use of codes or pseudonyms, and five-year data retention before secure disposal

RESULTS AND DISCUSSIONS

The study found that nurses experience documentation as both essential and burdensome in daily clinical practice. Documentation is viewed as a core professional responsibility that safeguards patient safety, ensures continuity of care, supports communication within the healthcare team, and provides legal protection. At the same time, nurses reported that documentation is time-consuming, difficult to complete promptly under high workload and patient acuity, and often competes with time for direct bedside care and meaningful interaction.

The discussion highlights how nurses prioritize patient safety and urgent care over immediate charting, leading to delayed documentation, overtime work, fatigue, and reliance on memory. It explains how these experiences reflect ethical commitment and structural pressures in the clinical environment, and it interprets nurses' coping strategies (such as real-time charting, workflow organization, and structured formats) in relation to the literature on documentation burden, system usability, and nursing workload.

SUMMARY

This study explored the lived experiences of nurses regarding the documentation process in a tertiary hospital setting using a descriptive phenomenological approach. Ten nurses from special units participated in in-depth interviews, and their narratives were analyzed using Colaizzi's method. The findings showed that nurses consider documentation indispensable for safe, continuous, and accountable patient care, but they also experience it as demanding and sometimes exhausting, especially in high-acuity and understaffed environments.

Across participants, recurring themes included the essential and legal role of documentation, the burden of time pressure and workload, the prioritization of direct patient care over immediate charting, the personal and professional costs of delayed documentation, the impact on nurse–patient interaction, and the use of adaptive strategies and reflection to manage documentation demands. These results provided a comprehensive picture of how documentation is integrated into, and sometimes in tension with, everyday nursing practice.

CONCLUSIONS

The study concludes that nursing documentation is a central, non-optional component of professional practice that nurses deeply value for its contributions to patient safety, continuity of care, and legal accountability. However, the way documentation is currently organized and required within clinical settings can create significant tension, as nurses must continuously balance charting responsibilities with the priority of responding to immediate patient needs.

It is further concluded that documentation burden is shaped by contextual factors such as staffing levels, patient acuity, interruptions, and institutional standards. Nurses respond to these pressures with practical strategies and ethical judgment, but their efforts do not fully resolve the conflict between documentation demands and bedside presence. Therefore, improving documentation experiences requires system-level changes, not only individual adaptation.

RECOMMENDATIONS

The study recommends that hospital administrators and nurse leaders review documentation policies, forms, and electronic systems to reduce unnecessary repetition and to better align documentation requirements with actual clinical workflows. Staffing and workload distribution should be adjusted where possible to prevent documentation tasks from consistently encroaching on direct patient care time.

In education and practice, it is recommended that nursing curricula and continuing professional development place greater emphasis on documentation skills, legal and ethical considerations, and time management within high-acuity settings. Nurses are encouraged to continue using effective coping strategies—such as documenting close to real time, organizing their workflow, and reflecting on their practice—while future research is suggested to evaluate interventions that streamline documentation and support nurse well-being and patient safety.

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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.

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