JURNAL RISET KESEHATAN
POLTEKKES DEPKES BANDUNG
Vol 17 No 2, Oktober 2025

e-ISSN: 2579-8103
p-ISSN:1979-8253

INTERNAL AND EXTERNAL DETERMINANTS OF NURSING CARE DOCUMENTATION: A SCOPING REVIEW IN INPATIENT SETTINGS

Scoping Review: Determinant Internal dan Eksternal Kelengkapan Dokumentasi Asuhan Keperawatan di Ruang Rawat Inap

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ABSTRAK

Dokumentasi asuhan keperawatan merupakan bagian penting dari pelayanan kesehatan, berfungsi sebagai sarana komunikasi antarprofesional sekaligus bukti hukum tindakan keperawatan. Kelengkapan dokumentasi berdampak langsung pada keselamatan pasien, mutu layanan, dan keberlanjutan proses asuhan. Scoping review ini bertujuan memetakan faktor internal dan eksternal yang memengaruhi kelengkapan dokumentasi keperawatan di ruang rawat inap serta mengidentifikasi strategi peningkatan kepatuhan. Review dilakukan dengan kerangka PRISMA. Pencarian literatur dilakukan melalui Scopus (n=85), PubMed (n=125), dan ProQuest (n=90), dengan total 300 artikel. Setelah menghapus duplikasi (n=60), penyaringan otomatis (n=30), serta mengecualikan artikel tidak lengkap atau tidak relevan (n=30), sebanyak 45 artikel dinilai kelayakannya. Sebanyak 15 artikel memenuhi kriteria inklusi (diterbitkan dalam lima tahun terakhir, berbahasa Inggris atau Indonesia, dan relevan dengan kepatuhan dokumentasi) untuk dianalisis secara naratif. Hasil menunjukkan tingkat kepatuhan dokumentasi berkisar 60–80%. Faktor internal meliputi latar belakang pendidikan, pengalaman kerja, pengetahuan, sikap, dan motivasi perawat. Faktor eksternal mencakup supervisi kepala ruang, beban kerja, pelatihan berkelanjutan, serta dukungan teknologi informasi. Strategi efektif untuk meningkatkan kelengkapan dokumentasi antara lain supervisi terstruktur, pembagian beban kerja proporsional, pelatihan berkesinambungan, dan penerapan sistem dokumentasi elektronik yang terintegrasi serta mudah digunakan dengan panduan jelas. Kesimpulannya, peningkatan kelengkapan dokumentasi keperawatan membutuhkan dukungan sistematis, bukan hanya upaya individu. Optimalisasi jumlah tenaga sesuai kapasitas ruang dan adopsi sistem elektronik terintegrasi dapat memperkuat akurasi, efisiensi, dan konsistensi, sehingga mutu pelayanan keperawatan tetap terjaga.

Kata kunci: *beban kerja, dokumentasi keperawatan, kepatuhan, ruang rawat inap, supervisi.*

ABSTRACT

Nursing care documentation is an essential component of healthcare, functioning as both a communication tool among professionals and as legal evidence of nursing practice. Its completeness directly impacts patient safety, service quality, and continuity of care. This scoping review aimed to map internal and external factors influencing the completeness of nursing documentation in inpatient settings and to identify strategies for improving compliance. The review followed the PRISMA framework. Literature searches were conducted in Scopus (n=85), PubMed (n=125), and ProQuest (n=90), yielding 300 articles. After removing duplicates (n=60), automated screening (n=30), and excluding incomplete or irrelevant articles (n=30), 45 were assessed for eligibility. A total of 15 articles met the inclusion criteria (published within the last five years, in English or Indonesian, and relevant to documentation compliance) and were narratively analyzed. Findings showed nursing documentation compliance ranged from 60–80%. Internal factors included educational background, work experience, knowledge, attitudes, and

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

motivation. External factors comprised head nurse supervision, workload, ongoing training, and support from information technology. Effective strategies to enhance documentation included structured supervision, proportional workload distribution, continuous training, and user-friendly electronic documentation systems with clear guidelines. In conclusion, improving the completeness of nursing care documentation requires not only individual effort but also systemic support. Optimizing staffing according to ward capacity and adopting integrated electronic systems can strengthen accuracy, efficiency, and consistency, thereby ensuring high-quality nursing care.

Keywords: compliance, inpatient ward, nursing documentation, supervision, workload

INTRODUCTION

Nursing care documentation is an integral part of the nursing process, serving as a communication tool between healthcare professionals and legal evidence of nursing actions taken. Complete and accurate documentation enables nurses to provide quality care, ensures continuity of care, and provides legal protection for nurses.[1]However, documentation practices in various health care facilities, particularly inpatient wards, still show various obstacles, such as incompleteness, delays, and non-compliance with standards in recording.[2] This has a direct impact on patient safety and the quality of nursing services.

The completeness of nursing care documentation in Indonesia is still relatively low. Research by Ferreira (2020) indicates that incomplete documentation can delay a patient's healing process and prolong the length of stay. When nurses fail to fully document assessments, diagnoses, interventions, and evaluations, vital information about the patient's condition is lost, which can lead to clinical errors such as inappropriate therapy.[3]In addition, incomplete documentation will make it difficult to track a patient's medical history when the patient is readmitted, and can hinder the achievement of hospital accreditation standards.[4]

Several studies have identified various factors that influence the quality of nursing documentation. Internal factors such as education level, work experience, knowledge, and attitudes significantly influence nurses' ability and willingness to systematically record patient information.[5,6]Nurses with higher education have a better understanding of the importance of standards-based documentation and are able to record patient data in greater detail and accuracy. Similarly, nurses with more than five years of experience tend to be more consistent and meticulous in documenting the nursing process because they are familiar with work standards and have stronger clinical intuition.

External factors also play a significant role. High workloads, especially during night shifts, make it difficult for nurses to document comprehensively due to time constraints and high work pressure. Situmorang et al. (2023) reported that only 40% of documentation was considered complete among nurses with high workloads, while nurses with normal workloads reported up to 75% completeness.[7]Furthermore,
supervision by the ward head is also a key determinant in improving documentation completeness. Mayenti et al. (2020) found that nurses who received regular supervision had a documentation completeness rate of 82%, compared to only 58% for nurses who did not receive supervision.[8]

Internal factors influencing the completeness of nursing care documentation include the nurse's age, length of service, education level, knowledge, and attitude. Older nurses tend to have greater psychological and intellectual maturity in completing tasks, including documentation.[9]Length of service or experience also plays an important role, where nurses who have worked for more than five years show a

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

higher level of completeness of documentation due to a better understanding of work standards.[6,10]In addition, the level of education also determines the quality of recording, where bachelor's graduates generally have more complete documentation skills than diploma graduates.[11,8]Adequate knowledge is essential for nurses to formulate diagnoses and develop care plans appropriately, while positive attitudes towards documentation, such as a sense of responsibility and awareness of the importance of recording, also contribute greatly to improving the completeness of nursing care documentation.[12]

This problem of incomplete documentation not only impacts patients but also nurses themselves. In medical disputes, documentation is the primary evidence used in legal proceedings. If documentation is incomplete, nurses can face serious legal risks. Therefore, efforts are needed to analyze and map the factors influencing nursing care documentation so that appropriate interventions can be designed to improve its quality.

Through Peplau and Henderson's theoretical approach, nursing documentation can be understood not only as a technical process, but also as part of the therapeutic relationship and the fulfillment of the patient's basic needs. Peplau's theory emphasizes the importance of therapeutic communication and supervision as part of the nurse's professional interaction with the patient, while Henderson's theory highlights the importance of systematically documenting the patient's basic needs.[11,13]Thus, understanding these two theories can be used to develop managerial and educational approaches to improving the quality of nursing documentation.

The aim of this study is to map the internal and external factors that influence the completeness of nursing care documentation in the ward through a scoping review approach, and to identify effective interventions to improve the completeness of this documentation.

METHODS

Study Design

This study employed a scoping review design guided by the PRISMA-ScR framework. Literature searches were conducted in Scopus, PubMed, and ProQuest between June and July 2025, using the keywords *"nursing care documentation"*, *"completeness"*, and *"inpatient"*, including relevant Indonesian terms. The study was not registered in PROSPERO because the focus was mapping the literature rather than conducting a systematic review.

PICOTS Framework

The review applied the PICOTS framework. The population (P) was nurses working in inpatient wards. The intervention (I) included internal factors such as education, work experience, knowledge, attitudes, and motivation, as well as external factors such as supervision, workload, training, and technology. The comparator (C) was variations across these factors or interventions. The outcome (O) was the level of completeness or compliance in nursing documentation. The time (T) frame was studies published between 2019 and 2024, and the setting (S) was healthcare facilities, particularly inpatient wards.

Eligibility Criteria

The inclusion criteria were original research articles, using quantitative, qualitative, or mixed methods, that discussed factors influencing completeness or compliance in nursing documentation in inpatient settings and were available in full text. Exclusion criteria were duplicates, editorials, commentaries, conference abstracts, weak or irrelevant study designs, and articles not available in full text.

Data Management and Selection Process

Reference management was conducted with Mendeley, and Microsoft

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

Excel was used for data charting. Article selection was independently performed by two reviewers through title and abstract screening, followed by full-text reading, with disagreements resolved through discussion. Data extraction was carried out using a standardized form including article identity, study design, sample, investigated factors, analysis methods, measurement tools, and quantitative results.

Data Analysis

Narrative thematic analysis was applied by categorizing findings into internal and external factors. Risk of bias assessment was not used as a reason for exclusion but was acknowledged as a limitation. Out of 300 initially identified articles, duplicates and ineligible studies were excluded, resulting in 15 articles that met the final criteria. These studies were synthesized narratively to map internal and external factors influencing nursing documentation completeness and to highlight interventions proven effective.

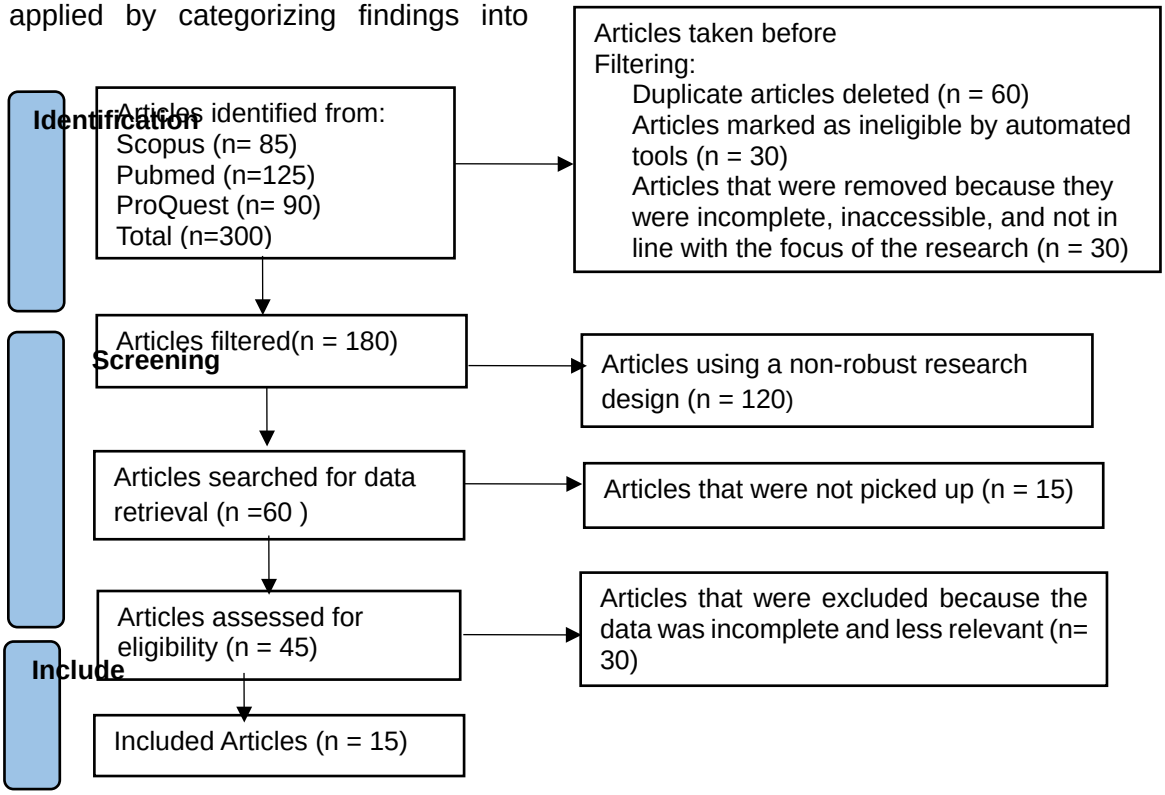

Figure 1. PRISMA diagram

RESULTS

The analysis of 15 articles revealed varying levels of compliance in nursing care documentation, both in inpatient wards and in other care settings. Generally, compliance rates ranged from 60–80%, although there were differences between countries. Articles 3, 4, 5, 6, 7, and 12 highlighted the influence of ward manager supervision and workload on documentation completeness. Findings indicated that structured supervision increased compliance to above 80%, while high workloads decreased documentation completeness to below 50%.

International studies in articles 1, 2, and 11 emphasize the importance of nursing audits and training programs in improving documentation quality. Articles 8 and 9 highlight the link between patient compliance and documentation quality and emphasize the importance of implementing standards-based protocols. Meanwhile, articles 13, 14, and 15 demonstrate that a supportive work environment, protocol-based education, and effective

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

team communication can significantly improve documentation completeness.

Overall, it can be concluded that internal factors such as nurses' knowledge, attitudes, motivation, education level, and experience play a significant role in the quality of record-keeping. External factors, on the other hand, include workload, supervision, technological support, and the documentation system used. The most frequently reported effective interventions include ongoing training, documentation audits, and the implementation of integrated electronic medical records (EMR).

Table 1. Mapping Journal

No	Article title	Country	Methodology	Results
1.	*Nursing audit conducted to gauge the documentation compliance* Varghese & RekhaS, 2020[14]	India	Design: Descriptive. Sample: 120 inpatient nurses at Sagar Hospital. Analysis: Descriptive test (%). Instrument: Standard Nursing Documentation Protocol and Audit Checklist (measuring compliance with clinical standards).	Initial compliance was 62%, increasing to 78% after the audit; the largest improvement was in recording nursing interventions (+20%).
2.	*Strategies to Improve Compliance with Clinical Nursing Documentation Guidelines* De Klerk, 2020[15]	Afrika Selatan	Design: Quasi-experimental. Sample: 80 inpatient nurses. Analysis: Paired t-test. Instrument: Clinical Nursing Documentation Guideline Review Form (assessing completeness of care records).	The average compliance score increased from 70% to 85% ($p<0.05$) after routine training.
3.	*Nurse Compliance of Electronic Nursing Care Documentation in Inpatient Rooms* Prasetyowati et al., 2023[16]	Indonesia	Design: Cross-sectional. Sample: 102 inpatient nurses. Analysis: Descriptive percentage. Instrument: Electronic Patient Education Audit Tool (assessing completeness of patient education documentation).	Compliance with patient education documentation was 82%, assessment documentation 75%, and evaluation 70%.
4.	*Overview of Nurse Compliance Level on Documenting Educational Provision* Diwa Agus S & Haryati., 2019[17]	Indonesia	Design: Descriptive. Sample: 60 inpatient nurses. Analysis: Proportion difference test. Instrument: Supervision Checklist (measuring documentation completeness before and after supervision).	Completeness of documentation increased from 68% to 83% after head nurse supervision.
5.	*Head Room Supervision to Completeness of Note Nursing Care Documentation* Saputra *et al*., 2018 [18]	Indonesia	Design: Cross-sectional. Sample: 75 inpatient nurses. Analysis: Pearson correlation. Instrument: Nursing Care Documentation Completeness Checklist (assessing completeness of all nursing care stages).	A significant positive correlation was found between supervision frequency and documentation completeness ($r=0.64$; $p<0.001$); average completeness was 78%.
6.	*Utilization of Online Learning Modules to Increase Nurse Capacity* Irawan *et al*., 2022[19]	Indonesia	Design: Quasi-experimental. Sample: 50 inpatient nurses. Analysis: Paired t-test. Instrument: Nurse Capacity Pre–Post Test (assessing ability to document care before and after training).	The average compliance score increased from 68% to 82% after training ($p<0.05$).
7.	*The Analysis of Nurse Compliance in Documenting of Nursing Care* Saputra & Alkhusari.,	Indonesia	Design: Correlational. Sample: 40 inpatient nurses. Analysis: Pearson correlation. Instrument: Patients' Rights-Based Documentation Checklist.	Compliance with patient rights documentation reached 78%; a significant positive correlation was found with checklist use

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

No	Article title	Country	Methodology	Results
	2019[20]			(r=0.59; p<0.01).
8.	*Compliance of Nurses with Patients' Rights* Rashdan *et al*., 2023[21]	Arab Saudi	Design: Descriptive correlational. Sample: 150 inpatient nurses. Analysis: Spearman correlation. Instrument: Patients' Rights Compliance Checklist.	Average compliance was 81%; significant positive correlation between patient compliance and documentation completeness (ρ=0.48; p<0.01).
9.	*Faktor yang berhubungan dengan kualitas dan kelengkapan dokumentasi keperawatan* Saputra *et al*., 2019[9]	Indonesia	Design: Quantitative, cross-sectional. Sample: 152 nurses. Analysis: Chi-square test. Instrument: Tools to test association between variables and documentation quality/completeness.	Most nurses had high knowledge (59.9%) and low workload (57.2%), but the majority (59.2%) were unable to utilize health information technology. Age, education, work experience, knowledge, workload, and IT use were significantly associated with documentation quality and completeness (p<0.05).
10.	*Implementation Of Nursing Care Documentation in Inpatient Room* Rahman *et al*., 2019[2]	Inggris	Design: Descriptive. Sample: 65 inpatient nurses. Analysis: Pre–post descriptive comparison. Instrument: Standard Nursing Documentation Checklist.	Completeness increased from 60% to 75% after standard implementation (p<0.05).
11.	*Improving the Quality of Nursing Documentation at a Residential Care Home* Moldskred *et al*., 2021[22]	Norwegia	Design: Descriptive with clinical audit. Sample: 30 nursing home nurses. Analysis: Pre–post descriptive test. Instrument: Clinical Documentation Audit Tool.	Completeness increased from 55% to 80% after training.
12.	*Analysis of Factors Related to Nurse Compliance* Pradana., 2019[23]	Indonesia	Design: Cross-sectional. Sample: 120 nurses (various units, not only inpatient). Analysis: Chi-square and logistic regression. Instruments: Work Environment Questionnaire & Nursing Documentation Checklist.	Compliance rate was 76%; work environment was significantly associated (p=0.02).
13.	*Quality of Nursing Documentation and its Effect on Continuity of Patient Care* Rahman *et al*., 2021[24]	Malaysia	Design: Descriptive correlational. Sample: 110 inpatient nurses. Analysis: Pearson correlation. Instrument: High-Quality Nursing Documentation Checklist.	Average completeness was 82%; significant association with continuity of care (r=0.52; p<0.001).
14.	*Nursing Methods for Improving Medication Compliance of Diabetic Patients* Yang *et al*., 2019[25]	Cina	Design: Quasi-experimental. Sample: 60 nurses treating diabetes patients (not general inpatient). Analysis: Paired t-test. Instrument: Protocol-Based Patient Education Assessment.	Compliance with medication education documentation increased from 65% to 85% (p<0.05).
15.	*Compliance Communication in Home Health Care* Vivian & Wilcox., 2020[26]	Amerika Serikat	Design: Observational. Sample: 25 home care staff (multidisciplinary team, not only inpatient nurses). Analysis: Descriptive and correlation tests. Instrument: Home Health Care Team Communication & Documentation Checklist.	Documentation completeness increased by an average of 30% after communication training.

DISCUSSION

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

The results of this scoping review identified various factors that influence the completeness of nursing care documentation by nurses in inpatient wards. These factors can be grouped into two main categories: internal factors (education, work experience, knowledge, attitudes, and motivation) and external factors (supervisor supervision, workload, training, and documentation systems).

1. Internal Factors

a. Education Level

Education level has been shown to significantly influence the completeness of documentation. Nurses with a bachelor's degree/nursing degree tend to have more complete documentation than those with a diploma.[27] This can be explained because nurses who have higher education tend to understand documentation standards based on nursing theory, are able to think critically, and are more skilled in clinical record-keeping.

b. Work Experience

Longer work experience is also an important factor. Nurses with more than five years of experience demonstrate better documentation completeness than newer nurses.[28,6] This was associated with improved clinical skills and better time management in experienced nurses.[28,27]

c. Knowledge and Attitude

Good knowledge of nursing documentation, including understanding of standards such as SDKI, SIKI, and SLKI, is consistently associated with more complete documentation.[29,30] However, there is one study that states that knowledge does not have a significant effect on documentation,[31] which is likely due to differences in the quality of training or nurses' perceptions of the importance of documentation.

d. Motivation

Nurses' intrinsic and extrinsic motivation plays a significant role in documentation compliance. Nurses with high motivation are more likely to complete documentation completely and accurately.[32,33] Factors such as appreciation, positive supervision, and a supportive work climate are known to increase work motivation.

2. External Factors

a. Supervision of the Head of Room

Most articles show that supervision has a significant relationship with the completeness of documentation.[27,32] Regular supervision can improve nurses' adherence to documentation standards, provide feedback, and correct erroneous recording habits. Mardianti et al., 2024, found no significant association, possibly due to ineffective or inconsistent supervision.

b. Workload

High workloads were consistently found to be a barrier to complete documentation.[28,7] Nurses who care for many patients in one shift tend not to have enough time to record all interventions in detail, especially during night shifts or when there is a shortage of staff.

c. Training and Documentation System

Several studies have shown that training and the availability of structured documentation systems (both manual and electronic) can improve the quality and efficiency of documentation.[31] User-friendly electronic systems and ongoing training have been shown to improve nurses' compliance with record-keeping standards.

Limitations

This study has several limitations that should be considered when interpreting the results. First, the number of articles analyzed in this scoping review was limited, with only 15 articles out of a total of 300 identified, thus narrowing the scope of the findings and potentially creating a high level of selection bias. Second, most of the articles were from the Indonesian context, which may limit the generalizability of the results to nursing documentation practices globally, as healthcare systems and nursing work cultures differ across countries. Third, differences in methodological approaches among the

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

articles, such as descriptive, quasi-experimental, and correlational designs, make it difficult to synthesize the results thoroughly, particularly for drawing quantitative conclusions. Furthermore, not all articles presented comprehensive and comparative numerical data, limiting the depth of analysis of intervention effectiveness. Finally, the study focused on commonly studied factors such as supervision and workload, without delving further into other factors such as organizational culture, reward systems, or artificial intelligence-based technology that may play a significant role in improving nursing documentation.

Superiority

Despite several limitations, this study also demonstrates several significant strengths. The use of a systematic scoping review approach guided by PRISMA strengthened the validity and transparency of the literature review process. The topics raised are highly relevant to actual challenges in the field, particularly regarding the quality of nursing care documentation, which directly impacts patient safety and hospital accreditation. This study also successfully categorized factors influencing documentation completeness into two main categories: internal factors (education, work experience, knowledge, attitudes, motivation) and external factors (supervisor supervision, workload, training, documentation systems), thus providing a comprehensive understanding. Furthermore, this study was able to identify several interventions proven effective in improving documentation quality, such as ongoing training, nursing audits, and the use of electronic documentation systems. The findings also provide clear policy direction for nursing managers and healthcare institutions in designing strategies for continuously improving the quality of nursing documentation.

Practical Implications

The practical implications of this scoping review's findings indicate that improving the completeness of nursing care documentation requires comprehensive managerial policy support. Hospitals need to provide effective and structured supervision to ensure nurses' compliance with record-keeping standards. Furthermore, proportionally managing nurses' workloads is crucial to ensure nursing staff have sufficient time to complete documentation. Routine documentation training should also be provided on an ongoing basis to update nurses' knowledge and skills in line with evolving standards and technology. Furthermore, hospitals are encouraged to develop and implement user-friendly, technology-based documentation systems to accelerate, improve accuracy, and integrate with other healthcare services.

CONCLUSION

This scoping review identified that the completeness of nursing care documentation in inpatient wards is influenced by various internal and external factors. Internal factors include nurses' education level, work experience, knowledge, attitudes, and motivation, while external factors include ward head supervision, workload, training, and documentation systems. Effective supervision and a manageable workload are the two external factors that most consistently influence documentation quality. Nurses with higher education and sufficient experience are also more likely to complete documentation according to standards.

The results of this scoping review provide lessons learned that improving the quality of nursing documentation is not enough only through improving individual competencies, but must be accompanied by supporting managerial policies. Policies that can be taken include: Establishing standard operating procedures (SOPs) for documentation that refer to the SDKI, SIKI, and SLKI.

https://doi.org/10.34011/juriskesbdg.v17i2.2943

e-ISSN: 2579-8103
p-ISSN:1979-8253

Requiring structured and regular supervision by ward heads with direct feedback to nurses. Arranging nurses' workloads proportionally to ensure adequate time for the recording process. Organizing ongoing training related to documentation techniques and standards, both manual and electronic. Integrating a user-friendly electronic documentation system connected to the hospital's medical records for efficiency and accuracy of recording.

The implementation of this policy is expected to improve compliance and completeness of documentation, maintain the quality of nursing care, and strengthen legal evidence and hospital accreditation.

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