Influence of Multidisciplinary Collaboration on the Quality of Documentation of Nursing Care in Selected County Referral Hospitals in Kenya

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Abstract

A multidisciplinary care team comprises a range of healthcare professionals whose coordinated efforts result in high-quality, patient-centered care. However, communication challenges frequently undermine multidisciplinary teams, compromising the success and quality of team activities. Research has shown that physicians and nurses focus on different aspects of patient care, and that synergy between them improves outcomes. For nurses' contributions to patient care to be fully realized, nursing care activities must be clearly documented. Without team synergy, healthcare professionals often work in silos, with minimal consultation on documentation and limited opportunities for improvement. This study examined the influence of multidisciplinary collaboration on the quality of nursing care documentation. The study was anchored on the service delivery pillar of health systems strengthening and was conducted in Nyeri, Nyandarua, and Isiolo County Referral Hospitals. A stratified sampling technique was used to select the three counties, and a census approach was applied to nurse managers. A descriptive research design was employed, using questionnaires and key informant guides for data collection. The study collected both qualitative and quantitative data. Thematic and content analyses were used for qualitative data, while regression analysis in SPSS version 26.0 was applied to quantitative data. Findings were presented using frequency tables and charts. From the study, only 22% of documented nursing care was categorized as good. Several multidisciplinary factors influencing nursing care documentation were identified, including joint setting of clinical outcomes, joint evaluation of patient progress, limited multidisciplinary consultation, and joint clinical meetings that provide nurses with opportunities to contribute to patient care. Regression analysis yielded p-values <0.05. Enhancing these factors is recommended to improve nursing care documentation.

Keywords: *Multidisciplinary team, Collaboration, Quality nursing care documentation, County Referral Hospitals, Kenya*

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1.0 Introduction

Healthcare practice is highly dynamic (Pierre et al., 2018) and can be complex, particularly when patients present with multiple pathologies. Additionally, healthcare provision often involves unpredictable situations that require a team-based approach (Zajac et al., 2021). Consequently, healthcare services are delivered by a multidisciplinary team of providers with diverse skills and competencies, all working toward restoring patients' health. Nurses, who spend 24 hours a day with patients, play a central role in the multidisciplinary team. Fowler et al. (2022) observed that other professionals, as well as patients and their relatives, frequently rely on nurses for support.

Nursing care documentation plays a crucial role in supporting healthcare professionals as they make clinical decisions about patient care. A well-coordinated multidisciplinary team enhances patient-centered care and improves healthcare outcomes (Australian Government, 2012). However, effective collaboration is not always achieved in practice (Hickman et al., 2015). Research has shown that effective multidisciplinary teams significantly improve healthcare quality in critical care units (Al Khalfan et al., 2021). Despite these benefits, some organizations have multidisciplinary interactions only in theory, and communication remains a major challenge (Licitra et al., 2016; Medakovic, 2020). This lack of collaboration can lead to fragmented patient care, increasing the risk of medical errors. Collaboration is especially critical within the healthcare team because healthcare is a multidisciplinary profession by design. For successful outcomes, the various specialties communicate frequently and work together to make a comprehensive assessment of the patient's situation, which they then use to develop a treatment plan. This calls for shared patient care outcomes and alignment of actions among team members toward the same goal.

Nurse managers and educators have discussed the documentation of nursing care and care planning since at least the mid-1960s. Walker and Selmanoff (1964) described behaviors and attitudes regarding the documentation and review of nurses' notes. They identified gaps in documentation and in the use of documented nursing notes, including inaccuracies and the fact that the notes were neither read nor valued. This indicates poor team effort and teams working in silos. In addition, studies have highlighted that physicians and nurses focus on different aspects of patient care, and that better care outcomes would be achieved if there were synergy between the two (Monica, 2018). Synergy cannot be achieved unless each party is committed to documenting the care they provide and also takes time to review what the other has documented. This would lead to improved documentation practices on both ends.

The importance of teamwork in healthcare cannot be overstated. Rosen et al. (2019) emphasized that high levels of coordination are essential for delivering patient services effectively. Fragmented healthcare delivery has been cited as a leading cause of medical errors (Kern et al., 2019). Moreover, collaboration among healthcare professionals is critical to clinical practice (Mboineki et al., 2019). Establishing shared patient care outcomes and aligning each team member's actions toward achieving these goals is essential for effective teamwork.

2.0 Materials and Methods

This study used a descriptive research design and was conducted at three County Referral Hospitals in Kenya: Isiolo, Nyeri, and Nyandarua. The target population consisted of nurses working in the medical and surgical wards of these hospitals. A sample of 8 nurses and 5 nurse managers was used. Data collection tools included: i) a questionnaire for nurses, ii) a key informant interview guide for nurse managers to assess institutional mechanisms supporting nursing care documentation, and iii) a checklist for auditing patient case files to evaluate the quality of nursing care documentation. The tools

were pre-tested to ensure reliability and validity. Data were analyzed using SPSS version 26.0.

"The findings highlight the importance of structured, collaborative interactions, such as clinical meetings, in enhancing the quality of nursing documentation"

3.0 Results and Discussion

Quality of nursing care documentation

The quality of nursing care documentation was assessed using a checklist comprising eleven items focused on completeness, relevance, and content quality.

The practice of nursing documentation was computed by summing all relevant Likert-type practice items from the self-administered questions. The results are outlined in Table 1 below.

Table 1

Quality of nursing care documentation

Phase/issue	N=158 (%)	
	Yes	No
Patient's details appear on every sheet of the nursing kardex	70(44.3)	88(55.7)
Detailed initial nursing assessment documented	20(12.7)	138(87.3)
Focused assessment during every shift, indicating the specific status of previous health issues and any new health issues.	28(17.7)	130(82.3)
Nursing interventions in line with issues identified are clearly documented per shift	36(22.8)	122(77.2)
Responses to the nursing interventions were documented	39(25.2)	116(74.8)
Instructions for the next shift indicated	34(21.7)	123(78.3)
The nursing kardex entries are specific	15(9.6)	142(90.4)
The nursing kardex entries are objective	20(12.7)	137(87.3)
The nursing kardex entries are complete	32(20.3)	126(79.7)
Timeliness of entries observed	49(31)	109(69)
Ownership of entries done by way of name and signature	18(11.4)	140(88.6)

According to the results, only 11.4% of entries included a name and signature, limiting traceability. A third (31%) of entries were made on time, while the rest were entered late, increasing the risk of errors. Only 20.3% of nursing kardex entries were complete, making it difficult to understand patient progress. 12.7% of entries were objective, while 9.6% were specific, reducing the clarity of recorded information. Objectivity allows nurses to record verifiable information, whether reported by the patient, observed, or reflected in investigative findings. It gives other health care providers room to make their own decisions regarding the documented findings. Few (21.7%) cases included instructions for the next shift, which is essential for continuity of care. These instructions are meant to communicate key, specific care and interventions that the incoming nurses are supposed to implement.

This could also be related to a lack of focused assessment per shift, where only 17.7% of case files contained focused assessments, which are crucial for monitoring patient progress. Lack of focused assessment leads to a failure to identify the direction of patient care interventions and compromises further care decisions. Similarly, only 22.8% of case files had interventions

aligned with identified issues, highlighting a gap in care planning. This can mean the nurses did not identify appropriate interventions or did not document them appropriately.

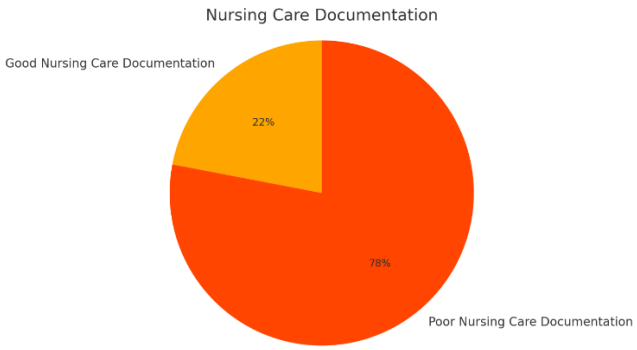
Only 12.7% of case files included detailed initial nursing assessments, which are critical for continuity of care. Failure to conduct this assessment can result in critical findings being omitted, thereby negatively affecting the care provided. Regarding patient details, 44.9% of patient case files lacked patient identification information. This can lead to mix-ups in care and patient information, delaying care or resulting in interventions performed on the wrong patient.

A review of the nursing kardex revealed that only 20.3% were complete. With incomplete information, the incoming nurse and other multidisciplinary team members struggle to understand the patient's progress, which, in turn, influences clinical decisions. 12.7% and 9.6% of the kardex were objective and specific, respectively. Objectivity allows nurses to record verifiable information, either as verbalized by the patient, as observed, or as reflected by investigative findings (Nursing Council of Kenya, 2024). It gives other health care providers room to make their own decisions regarding the documented findings. Each patient responds to illness and health care interventions uniquely. When documenting care, the nurse should pay attention to each patient's uniqueness to demonstrate patient-centeredness (Kuipers et al., 2019). Statements such as 'fair general condition' could mean different things for different patients and are neither objective nor specific. Thematic areas identified from the interview with the nurses' managers included the recognition of a gap and the challenge of enhancing nursing care documentation, with barriers such as nursing workforce challenges and individual factors, including limited experience among nurses, attributed to the emigration of experienced nurses. Overall, the managers positively identified apt nursing care documentation as closely linked to patient care outcomes.

Nursing documentation practice was calculated by summing all relevant Likert-type items from the self-administered questions. The total score for both self-administered questions and the checklist was dichotomized into good and poor practice using a mean score cutoff point. Levels of the total score for nursing care documentation practice were measured using a 75th percentile cutoff point. The results revealed 22% as good and 78% as poor nursing care documentation, as depicted in the figure below.

Figure 1

Results of quality of nursing care documentation



Regression analysis was conducted, and the results are outlined in Table 2 below.

Table 2

Regression analysis results

Phase/issue	Baseline N=158 (%)		Chi square	P-value
	Yes	No		
Patient's details appear on every sheet of the nursing kardex	70(44.3)	88(55.7)	43.95	3.37
Detailed initial nursing assessment documented	20(12.7)	138(87.3)	5.53	0.02
Focused assessment during every shift, indicating the specific status of previous health issues and any new health issues.	28(17.7)	130(82.3)	0.68	0.41
Nursing interventions in line with issues identified are clearly documented per shift	36(22.8)	122(77.2)	0.22	0.64
Responses to the nursing interventions were documented	39(25.2)	116(74.8)	1.34	0.25
Instructions for the next shift indicated	34(21.7)	123(78.3)	0.02	0.89
The nursing kardex entries are specific	15(9.6)	142(90.4)	10.81	0.00
The nursing kardex entries are objective	20(12.7)	137(87.3)	5.38	0.02
The nursing kardex entries are complete	32(20.3)	126(79.7)	0.01	0.94
Timeliness of entries observed	49(31)	109(69)	8.23	0.00
Ownership of entries done by way of name and signature	18(11.4)	140(88.6)	7.49	0.01

Regression analysis results were statistically significant for several aspects of nursing documentation, including initial assessments ($p = 0.02$), specificity ($p = 0.00$), objectivity ($p = 0.02$), timeliness ($p = 0.00$), and ownership ($p = 0.01$). These findings highlight areas of strength and gaps in documentation practices.

Responses on Multidisciplinary Collaboration on Nursing Documentation Practices

This section presents responses regarding the relationship between multidisciplinary collaboration and the quality of nursing care documentation. The influence of multidisciplinary collaboration was assessed using 10 items and through interviews with nurse managers. The findings highlight key areas where collaboration affects documentation practices, including communication effectiveness, teamwork dynamics, and shared responsibilities in patient care documentation. The results are shown in Tables 3 and 4 below.

Table 3

Summary of themes from the interview with nurse managers

Issue	Findings
Audit of nursing care documentation	Carried out irregular
Any system in place to ensure the quality of nursing care documentation	Identified as part of the general quality improvement effort in the facilities
What role does the multidisciplinary team play in maintaining the quality of nursing care documentation?	Identified as critical

Table 4

Responses on Multidisciplinary Collaboration on Nursing Documentation Practices

Statement	Agreed		Disagreed		Total	
	n	%	n	%	n	%
We often set health care outcomes for the patients jointly with the multidisciplinary team	56	63.7	32	36.3	88	100
The multidisciplinary team often jointly evaluates patients' progress	61	69.4	27	30.6	88	100
I often receive consultations from the multidisciplinary team regarding the care and progress of the patients	52	59.1	36	40.9	88	100
We often conduct nursing rounds in my unit	77	89.5	9	10.5	86	100
We often hold clinical meetings in my unit	66	77.6	19	22.4	85	100
We often carry out joint ward rounds with the multidisciplinary team in my unit	60	69	27	31	87	100
The nurse contributes to the patient's management during the joint ward rounds	76	87.4	11	12.6	87	100
There are set parameters to check out while receiving the report at the commencement of a shift	76	86.4	12	13.6	88	100
I often encounter situations where the nursing kardex is not appropriately documented	70	79.6	18	20.4	88	100
I always act when I encounter a nursing kardex that has not been appropriately documented	77	87.5	11	12.5	88	100

Responses from participants regarding multidisciplinary collaboration in nursing documentation practices reveal significant insights into how healthcare teams work together to improve patient care records. Most respondents (63.7%) agreed that patient care outcomes are often set jointly with the multidisciplinary team, while 36.3% disagreed. Similarly, 69.4% of participants indicated that patient progress is jointly evaluated within the multidisciplinary team, suggesting strong interprofessional collaboration in decision-making. Consultation within the multidisciplinary team remains a key component of nursing documentation practices, with 59.1% of respondents stating that they often receive consultations regarding patient care and progress. However, 40.9% of respondents disagreed, indicating a need for more structured, frequent communication within healthcare teams. Nursing rounds were reported to be a common practice in most units, with 89.5% of respondents affirming that they conduct nursing rounds. Clinical meetings also emerged as a frequent occurrence, with 77.6% of respondents confirming that these meetings are held in their units.

Joint ward rounds with the multidisciplinary team were reported by 69% of respondents, highlighting a collaborative approach to patient care. A large majority (87.4%) acknowledged that nurses actively contribute to patient management. Additionally, 86.4% of respondents confirmed the presence of established parameters for reviewing reports at the beginning of a shift, supporting consistent documentation and handover practices. Despite these strengths, 79.6% of respondents reported encountering cases where the nursing Kardex

was not properly documented, indicating ongoing concerns about the accuracy and completeness of nursing records. Positively, 87.5% of respondents indicated that they consistently take corrective action when faced with poor documentation, reflecting a proactive commitment to improving nursing documentation standards.

Rosen et al. (2019) indicated that a high level of coordination is required for a patient to receive services in a health facility. Fragmented healthcare delivery has been reported as a cause of medical errors (Kern et al., 2019). Furthermore, multidisciplinary collaboration has been cited as critical in clinical practice (Mboineki et al., 2019). Setting healthcare outcomes jointly is an important component of this collaboration. This is reaffirmed by Reese et al. (2021) who indicate that the healthcare team shares the common goal of providing high-quality, safe patient care. That collaboration is the vehicle through which they can achieve this. Schot et al. (2019) stated that for multidisciplinary teams to be effective, contributions from each involved team member are critical. Multidisciplinary collaboration can be enhanced or hindered by various factors, such as communication and how different cadres perceive each other's contributions to the team (Meyer-Kühling et al., 2015). This hampers the attainment of healthcare goals. Reducing professional weaknesses should encompass different aspects, including how each cadre documents their care. However, as critical as this is, it remains problematic (Mboineki et al., 2019), with professional boundaries dominating the healthcare spectrum, even though teams share the same objective of restoring patients' health. From the nurse managers' perspective, the setting of healthcare objectives often occurs in silos, with minimal multidisciplinary consultation, and the convergence point was that each team set goals aligned with patients' healthcare problems.

Nursing rounds were reported to be a common practice across most units, with 89.5% of respondents affirming that they conduct them. Nursing rounds have been highlighted as critical for identifying and modifying unsatisfactory patient conditions Suleiman (2021), thereby enhancing patients' experience and quality of care (Azhari & Sukartini, 2021).

According to interviews with nurse managers, nursing rounds were reported to occur during shift handovers but in an unstructured manner without clearly outlined goals. One manager reported that "The rounds often follow the handover report and are basically for confirmation of the physical presence of the patient rather than for care improvement purposes." However, nursing ward rounds provide an opportunity for nurses to learn from each other and exchange ideas about nursing interventions and their impact on patient care. The rounds could be made more productive if nurses also focused on and discussed documented nursing care.

Clinical meetings also emerged as frequent, with 77.6% of respondents confirming that they are held in their units. Clinical meetings have been defined as assemblies of healthcare teams aimed at addressing clinical issues of the patients under their care and identifying ways to address weaknesses in the healthcare system to improve patient outcomes (Rosell et al., 2018). These meetings have been cited as contributing to improved quality of care and teamwork within the multidisciplinary team (Opia, 2018). Given the importance of clinical meetings, their absence can compromise the quality of care, leaving no

room to share ideas for care improvement. Additionally, such meetings provide an opportunity for different cadres to understand each other's perspectives (Kyte et al., 2020). Without this, discord can arise regarding care provision, potentially compromising the quality of patient care. These meetings, as avenues for addressing weaknesses and improving healthcare systems, offer opportunities to scrutinize care documentation for gaps and areas needing improvement.

Joint ward rounds with the multidisciplinary team were reported by 69% of respondents, reinforcing the collaborative nature of patient management. A significant proportion (87.4%) of respondents indicated that nurses contribute to patient management during joint ward rounds, while 12.6% disagreed. Furthermore, 86.4% of respondents reported using set parameters to check reports at the start of a shift, ensuring consistency in documentation and handover processes. Nurse managers' responses aligned with this but also highlighted that most nurses are passive during ward rounds, contributing only when prompted by multidisciplinary team members. As such, they fail to assert themselves and to occupy their space in this important activity, despite possessing valuable information about patient care and treatment responses. Merriman and Freeth (2022) described ward rounds as complex social processes where discussions and decisions contribute to effective, safe, timely, and progressive patient care. Joint ward rounds have been documented as crucial for improving interprofessional communication and collaboration (Mboineki et al., 2019; Redley et al., 2018).

During joint ward rounds, crucial information is exchanged among healthcare providers, facilitating shared decision-making to enhance patient safety (Kallen et al., 2021). The ward round is a vehicle for coordinating care (Moleyar et al., 2020). Joint evaluation of how well healthcare outcomes are achieved is crucial because it enables a collective review of care plans. Coordination of patient care is a globally documented challenge, with information gaps and limited resource sharing leading to siloed approaches across different cadres within the same health system (Jepkosgei et al., 2022). Contrary to these findings, however, Agom (2015) opined that nurses often remain imperceptible during ward rounds. However, as Ndie et al. (2015) asserted, nurses, being present with patients throughout their care, have a unique and vital role to play in ward rounds. This aligns with the findings of Kvande et al. (2017) who, observed that collaboration between nurses and physicians was not without challenges, as nurses often felt undervalued. Despite this, studies report that interactive, pedagogical, multidisciplinary collaboration is enhanced when nurses actively participate in ward rounds (Kallen et al., 2021). This is because nurses bring a broad health perspective to patient care.

Regarding documentation challenges, 79.6% of respondents reported instances in which the nursing Kardex was not properly documented, raising concerns about the quality and accuracy of nursing records. Encouragingly, 87.5% of respondents stated that they always take action when they encounter inappropriate documentation, indicating a proactive approach to improving nursing documentation practices.

The nurse managers confirmed this. One manager reported that

"... nursing care documentation is basically in the ICU. It is a chronic problem that really messes up nurses' image. Other healthcare

providers gauge the capacity of the nurse from what they document, and it is basically bad…"

This indicates that nurses, though informally, audit each other's documentation. This is important because, as Ramukumba and Amouri (2019) opined, every nurse has an obligation to enhance quality within the system in which they operate. Such audits provide nurses with opportunities for improvement, leading to an overall enhancement in the quality of care delivered. Inappropriate documentation can lead to miscommunication among the multidisciplinary team regarding patient status, thereby hindering appropriate clinical decisions. This aligns with the findings of Tasew et al. (2019) who observed a 47.8% inadequacy in nursing care documentation. As part of safe, quality, and ethical care, gaps in documentation can significantly impact the entire healthcare system. Indeed, Asmirajanti et al. (2019) concluded that nursing care delivery was insufficient, based on what nurses documented. On a positive note, 34 (38.6%) and 43 (48.9%) of respondents strongly agreed and agreed, respectively, that they take action when they encounter an inappropriately documented Kardex. This presents an opportunity for improvement, ensuring nursing notes meet professional standards and ultimately enhancing the quality-of-care documentation and patient safety. Key thematic issues following interviews with the nurse managers included limited multidisciplinary collaboration, mainly attributed to a health professional shortage. As such, each cadre is key to accomplishing its activities, with collaboration taking a back seat.

Comparison between the three health facilities, and Influence of multidisciplinary collaboration on quality of nursing care documentation

A comparison was conducted across the three facilities, and the influence of multidisciplinary collaboration on the quality of nursing care documentation was estimated using multivariable logistic regression. The findings are shown in Table 5 below.

Table 5

Comparison of findings in the three hospitals

Statement	Total (n=86)	Nyeri (n=34)	Isiolo (n=27)	J.M. Kariuki (n=25)	Stats
	Agree/ Disagree	Agree/ Disagree	Agree/ Disagree	Agree/ Disagree	Chi squire (p)
Jointly set patient outcomes	56 (65.1%)/ 30 (34.9%)	23 (67.6%)/ 11 (32.4%)	17 (63.0%)/ 10 (37.0%)	16 (64.0%)/ 9 (36.0%)	4.02 (0.045)
Jointly evaluate progress	61 (70.1%)/ 25 (29.1%)	24 (70.6%)/ 10 (29.4%)	17 (63.0%)/ 10 (37.0%)	15 (60.0%)/ 10 (40.0%)	7.88 (0.005)
Receive consultations	52 (60.5%)/ 34 (39.5%)	23 (67.6%)/ 11 (32.4%)	16 (59.3%)/ 11 (40.7%)	13 (52.0%)/ 12 (48.0%)	0.90 (0.168)
Conduct nursing rounds	77 (89.5%)/ 9 (10.5%)	29 (85.3%)/ 5 (14.7%)	25 (92.6%)/ 2 (7.4%)	23 (92.0%)/ 2 (8.0%)	31.86 (<.001)
Hold clinical meetings	66 (76.7%)/ 20 (23.3%)	25 (73.5%)/ 9 (26.5%)	23 (85.2%)/ 4 (14.8%)	18 (72.0%)/ 7 (28.0%)	13.25 (<.001)
Joint ward rounds	60 (69.8%)/ 26 (30.2%)	22 (64.7%)/ 12 (35.3%)	20 (74.1%)/ 7 (25.9%)	18 (72.0%)/ 7 (28.0%)	6.99 (0.008)

Nurse contribution in rounds	76 (88.4%)/ 10 (11.6%)	29 (85.3%)/ 5 (14.7%)	25 (92.6%)/ 2 (7.4%)	22 (88.0%)/ 3 (12.0%)	29.70 (<.001)
Shift report parameters	76 (88.4%)/ 10 (11.6%)	28 (82.4%)/ 6 (17.6%)	25 (92.6%)/ 2 (7.4%)	23 (92.0%)/ 2 (8.0%)	29.70 (<.001)
Inappropriate Kardex docs	70 (81.4%)/ 16 (18.7%)	27 (79.4%)/ 7 (20.6%)	23 (85.2%)/ 4 (14.8%)	20 (80.0%)/ 5 (20.0%)	18.81 (<.001)
Act on poor Kardex docs	78 (90.7%)/ 8 (9.3%)	30 (88.2%)/ 4 (11.8%)	26 (96.3%)/ 1 (3.7%)	22 (88.0%)/ 3 (12.0%)	34.14 (<.001)

The chi-square test results and associated p-values indicate statistical significance across various aspects of multidisciplinary collaboration and nursing documentation practices. Participation in clinical meetings was significantly associated with better nursing documentation. Nurses who engaged in clinical meetings were more likely to produce high-quality documentation than those who did not. The crude odds ratio (COR) was 2.969 (p = 0.024), and the adjusted odds ratio was 3.740 (95% CI: 0.984-14.211), suggesting that clinical meetings were positively associated with documentation practices. Nurses who participated in joint clinical meetings were 2.969 (95% CI [1.155, 7.628]) times more likely to have quality nursing documentation practices than those who did not. Joint clinical meetings are indicators of teamwork and can influence and shape each team member's behavior. The meetings can also lead to improved care coordination and communication within the team, both written and verbal, and thus are an important ingredient to patient safety. Densash et al. (2023) noted that care documentation is not only an obligation of health care providers but is also crucial for patient safety. WHO (2023) on the other hand, recognizes a lack of patient care coordination and poor communication within multidisciplinary teams as factors that compromise patient safety.

Joint ward rounds also showed a potential positive impact on the quality of nursing documentation, although the association was not statistically significant. The adjusted odds ratio was 1.588 (95% CI: 0.55-4.585), with a p-value of 0.070. While this suggests a possible trend toward improved documentation, further investigation is needed to establish a stronger relationship. The analysis revealed that setting healthcare outcomes jointly did not have a statistically significant influence on the quality of nursing documentation. The adjusted odds ratio (AOR) was 0.503 (95% CI: 0.139-1.823) with a p-value of 0.359, indicating that this factor was not strongly associated with improvements in documentation quality.

4.0 Conclusion

Among the multidisciplinary collaboration practices examined, participation in clinical meetings showed the strongest positive association with high-quality nursing documentation. While joint ward rounds showed some potential benefit, the joint setting of healthcare outcomes did not appear to have a significant impact. These findings highlight the importance of structured, collaborative interactions, such as clinical meetings, in enhancing the quality of nursing documentation.

5.0 Recommendations

The study recommends the following to help healthcare institutions enhance the quality of nursing documentation by leveraging multidisciplinary collaboration.

i. Institutionalize regular clinical meetings to improve nursing documentation and provide structured training.

ii. Standardize and enhance ward rounds to improve communication and documentation.

iii. Re-evaluate the Joint Setting of Healthcare Outcomes by integrating nurses more actively into outcome-setting processes and ensuring documentation standards are included.

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