



## EFFECTIVENESS OF MONITORING AND EVALUATION IN ENHANCING THE QUALITY OF NURSING CARE DOCUMENTATION IN INPATIENT

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### ABSTRACT

Effective nursing care documentation is a fundamental component of improving service quality, ensuring patient safety, and supporting professional accountability. This study aimed to evaluate the effectiveness of monitoring and evaluation in enhancing the quality of nursing documentation in an inpatient ward of a hospital in South Jakarta. This pilot study employed a management function framework, with activities conducted through planning, organizing, implementing, and controlling phases. Monitoring and evaluation interventions using digital tools were carried out by head nurses and primary nurses for 10 staff nurses. This study used a total sampling technique involving 10 nurses, with data analyzed through descriptive quantitative and qualitative methods to compare pre- and post-feedback documentation quality and identify factors influencing monitoring and evaluation effectiveness. The results showed an increase of 40.7% in the average documentation score after monitoring-evaluation feedback was provided. Significant improvements were found in the areas of nursing diagnoses and interventions. Structured monitoring and direct feedback were effective in improving documentation consistency and accuracy. Monitoring and evaluation should be institutionalized as a routine program supported by standard operating procedures, continuous training, and supervision to ensure the sustainability of high-quality nursing documentation.

Keywords: evaluation; head nurse; monitoring; nursing care documentation; nursing care quality; primary nurse

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### INTRODUCTION

Nursing care documentation plays a crucial role in improving the quality of patient care through effective communication. Numerous studies have shown that nurses who are well-trained and familiar with documentation protocols are more likely to record comprehensive information, which leads to improved patient outcomes and ensures continuity of care (Prasetyowati et al., 2023; Suryani et al., 2024; Tamir et al., 2021). Moreover, electronic documentation systems have been proven to enhance the quality of nursing records compared to traditional paper-based methods, although initial resistance to technology may hinder effective implementation (Hardiman et al., 2020; Khairunisa, 2023). Wahyuni et al. (2024) further concluded that electronic nursing documentation significantly improves the quality and efficiency of handovers, reduces the likelihood of medical errors, and saves time compared to conventional shift reports. Additionally, a supportive work environment and an adequate nurse-to-patient ratio are significantly associated with better documentation practices, indicating that organizational factors play an important role in the effectiveness of nursing documentation (Geta et al., 2023). Addressing these factors can improve documentation accuracy, which ultimately has a positive impact on patient safety and service quality (Cilović-Lagarija et al., 2020; Mansour, 2021).

In practice, various challenges remain in nursing documentation, particularly regarding completeness, consistency, and adherence to the nursing process. Incomplete documentation can significantly reduce the quality of patient care, as several studies have revealed the presence of documentation gaps across most clinical areas, hindering comprehensive patient assessment (Nantshev & Ammenwerth, 2022). This issue is often exacerbated by nurses' heavy workload and time pressure, leading to rushed or insufficient documentation that can negatively affect patient outcomes (Alodhialah et al., 2024).

Head nurses and primary nurses play a key role in improving the quality of nursing documentation through continuous monitoring, evaluation, and clinical supervision. Leadership functions include directing and evaluating nursing activities to ensure high-quality documentation practices, which ultimately enhance patient safety and satisfaction (Nopriyanto et al., 2020). Through ongoing educational interventions and mentoring programs, nursing managers can significantly improve documentation practices among nursing staff (Wang et al., 2024).

In hospitals, although nursing care standards have been established, monitoring and evaluation of documentation are not yet regularly implemented across all care units. Studies have demonstrated that effective nursing documentation is essential to ensuring continuity and quality of patient care (El Rahman et al., 2021). However, actual implementation in many clinical settings has not yet met these standards, as a comprehensive monitoring system is often lacking at the unit level, leading to variations in documentation quality across departments (Geta et al., 2023). Several studies emphasize that direct supervision and mentorship from head nurses are vital in reinforcing adherence to these standards by providing continuous evaluation and direct support to nursing staff (Tadese et al., 2024). Such efforts foster an environment conducive to consistent documentation practices, contributing to overall improvement in patient care quality within hospitals (El Rahman et al., 2021).

Optimizing monitoring and evaluation activities in nursing documentation is therefore crucial to ensure alignment with care standards, enhance patient safety, and support service accountability. Consistent monitoring also enables the identification of documentation gaps, facilitating targeted interventions to improve service quality (Nantshev & Ammenwerth, 2022). Head nurses bear a major responsibility in guiding and supervising nursing staff, directly influencing nurses' attitudes toward patient safety and quality of care (Suganda et al., 2023). By fostering a culture of accountability and continuous improvement, head nurses can ensure that documentation practices adhere to established nursing standards, positively impacting patient safety and continuity of care (Cui et al., 2024). Thus, the optimization of monitoring and evaluation processes can significantly strengthen the quality of nursing documentation, ultimately promoting better patient health outcomes (Fibriansari et al., 2023; Moldskred et al., 2021). Given the pivotal role of documentation in ensuring patient safety, legal accountability, and service continuity, research on optimizing monitoring and evaluation systems is essential to strengthen nursing management and improve care outcomes. This study is therefore conducted to analyze the implementation of monitoring and evaluation in nursing documentation, identify existing gaps, and formulate strategies to enhance compliance with established nursing standards for improved patient care quality.

## **METHOD**

This study employed a pilot study design with a practical implementation approach aimed at evaluating the effectiveness of monitoring and evaluation (M&E) activities in improving the quality of nursing care documentation in inpatient units. The activities were guided by a management function framework planning, organizing, staffing, actuating, and controlling to ensure systematic implementation. The study was conducted in the Inpatient Installation of a hospital located in South Jakarta from June 18 to June 28, 2025.

The subjects of this study were staff nurses, with the active involvement of Head Nurses and Primary Nurses (PPJA) as implementers of the monitoring and evaluation activities. Three inpatient wards (Floors 2, 3, and 6 South) were designated as intervention units. A total of 10 new patient medical records were assessed using a predesigned monitoring instrument. Among the 10 staff nurses, three nurses were observed in full for pre- and post-feedback evaluations based on the results of nursing documentation monitoring.

The Standard Operating Procedures (SOPs) and monitoring instruments were developed based on hospital-established nursing care standards, the Indonesian National Nursing Standards (SDKI, SIKI, SLKI) issued by PPNI, and professional nursing practice documentation quality criteria. The instrument was subsequently validated by experts, the Head of the Nursing Service Work Team, and the Chairperson of the Hospital Nursing Committee. It was then converted into a digital format using Google Forms, with output data integrated into spreadsheets to facilitate analysis and feedback dissemination.

The implementation consisted of several stages, including socialization sessions attended by Head Nurses, Primary Nurses, and representatives from the Nursing Committee to explain the purpose, objectives, and technical procedures of the monitoring activities. In accordance with the developed SOPs, Head Nurses monitored Primary Nurses, while Primary Nurses monitored staff nurses' documentation using the validated instrument. The monitoring scores were analyzed and compiled for each staff nurse based on their documentation of new patient records.

Direct feedback was provided individually to the assessed nurses. Nurses with satisfactory documentation were given positive reinforcement, while those with lower scores received guidance and mentorship focused on areas requiring improvement. Follow-up monitoring was conducted several days after the intervention to observe changes in documentation scores for the same nurses when handling subsequent new patients. Pre- and post-feedback score comparisons were used to evaluate the immediate impact of the monitoring and mentoring activities. Data were analyzed using descriptive quantitative methods, comparing the mean quality scores of nursing documentation before and after the intervention. Additionally, a descriptive qualitative analysis was performed to identify implementation barriers, managerial engagement dynamics, and recommendations for improvement based on field observations and participant feedback.

## **RESULT**

Based on root cause analysis using the fishbone (Ishikawa) diagram approach, it was found that the suboptimal quality of nursing care documentation was influenced by various factors across six main categories: Man, Machine, Materials, Method, Measurement, and Environment. From the Man (Human Resources) aspect, it was observed that some nurses tended to replicate documentation from others without conducting independent clinical evaluations. Furthermore, documentation practices were often performed merely as a formality or administrative requirement, rather than as an integral part of the nursing process. From the Machine aspect, the documentation system remains hybrid, combining paper-based and electronic medical records (EMR). This hybrid model created inconsistencies and incomplete documentation. Moreover, the absence of standardized nursing care plan templates within the EMR makes it difficult for nurses to formulate individualized care plans.

The Materials aspect also contributed to the problem, especially with the transition from printed forms to EMR, which required new adaptations but had not been accompanied by improved documentation efficiency. Some inpatient wards still faced limited access or technical issues that hampered the documentation process. In terms of the Method aspect, nurses had not fully implemented documentation according to the established Standard Operating Procedures (SOPs). From the Measurement aspect, supervision and evaluation of documentation by head nurses and Primary Nursing Care Managers (PPJA) were not conducted regularly, systematically, or well-

documented. As a result, there was no consistent monitoring data available to support documentation quality evaluation. From the Environment aspect, frequent interruptions from patients or other clinical situations during documentation activities disrupted nurses' concentration, increasing the likelihood of incomplete or delayed entries. Overall, this analysis revealed that the issues in nursing documentation were not solely rooted in individual nurse behavior but were instead the result of systemic interactions among multiple factors, as illustrated in Figure 1. Therefore, interventions to improve documentation quality should be comprehensive and cross-sectoral, encompassing training, supervision, system improvement, and strengthening of quality-oriented culture within nursing service units.

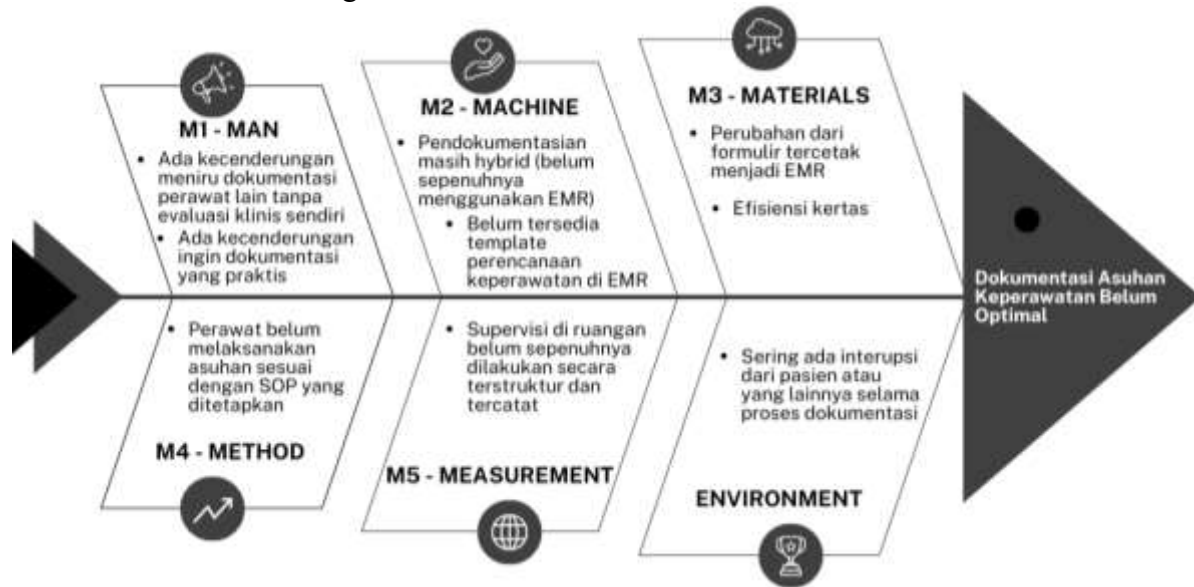


Figure 1. Ishikawa Diagram of Suboptimal Nursing Care Documentation

Monitoring and evaluation activities for nursing care documentation were carried out in three inpatient wards: maternity, pediatric, and medical-surgical units. A total of 10 new patient medical records, managed by actively assigned staff nurses during the implementation period, were assessed and analyzed using a digital monitoring and evaluation (Monev) instrument.

The monitoring results indicated variations in documentation quality, both between wards and among individual nurses. Out of the ten nurses evaluated, three were specifically monitored to analyze changes before and after feedback was provided. The assessment results showed an overall improvement in documentation scores among all nurses who received direct feedback. The most significant improvements were observed in the areas of nursing diagnosis formulation, intervention planning, and SOAPI-based CPPT (Continuous Patient Progress Notes) documentation.

Table 1.

Comparison of R average Nursing Care Documentation Values Before and After Evaluation

Documentation Aspects Assessed	Average Grade (Before Evaluation)	Average Grade (After Evaluation)	Percentage (%) Increase in Value
Nursing Assessment	82.2	97.8	19%
Nursing Diagnosis	40.0	80.0	100%
Nursing Interventions	41.7	83.3	99.8%
Nursing Actions	33.3	50.0	50.2%
Nursing Evaluation	58.3	91.7	57.3%
Overall Value	61.5	86.5	40.7%

The evaluation of nursing care documentation revealed a significant improvement following the implementation of monitoring and evaluation activities. Overall, the average documentation score increased by 40.7% after nurses received feedback and guidance. This improvement indicates that direct observation and individualized evaluation were effective in promoting better documentation quality. When analyzed by aspect, the most notable improvements occurred in the areas of Nursing Diagnosis and Nursing Intervention, which increased by 100% and 99.8%, respectively. These findings suggest that these components were previously the weakest areas but were highly

responsive to feedback and mentoring. The Nursing Evaluation component also showed a 57.3% improvement, reflecting that after being provided with guidance on the standards of CPPT (Continuous Patient Progress Notes) documentation, nurses were better able to adapt their notes according to the SOAPI framework.

Meanwhile, Nursing Assessment, which initially scored high (82.2), still showed a 19% increase, demonstrating enhanced consistency in already professional areas. Nursing Actions increased by 50.2%, indicating a continuing need for attention to ensure timely and complete reporting of nursing procedures. Overall, these findings reinforce that structured monitoring and evaluation, combined with direct feedback and mentoring, are effective strategies to improve the quality of nursing documentation and can serve as a foundation for replicating similar interventions in other units on an ongoing basis.

In addition to the quantitative findings, several qualitative insights emerged from the implementation process. Limited time resulted in only a small number of nurses being monitored repeatedly. Some wards lacked a systematic patient documentation tracking system, which made evaluation difficult. Head nurses and primary nurses (PPJA) expressed concerns regarding the additional workload of preparing monitoring reports and suggested the need to simplify the monitoring instrument. Adjustments were also recommended for the monitoring tool, particularly in the sections related to CPPT evaluation and nursing diagnosis validation. Despite these challenges, the initiative received positive feedback from head nurses, primary nurses, and staff nurses, and demonstrated strong potential for sustainable replication across service units.

## **DISCUSSION**

The Ishikawa (fishbone) analysis revealed that suboptimal nursing documentation practices are influenced by multiple interconnected factors—personnel, system, method, materials, measurement, and work environment. Among these, personnel factors, such as knowledge and attitude gaps, play a critical role in determining documentation quality. Previous studies have shown that insufficient education and limited understanding among nurses often lead to negative attitudes toward documentation, resulting in incomplete or inaccurate records (Jeanifer et al., 2023; Prasetyowati et al., 2023). Additionally, time pressure and heavy workloads contribute to rushed documentation, making it difficult for nurses to meet quality standards (Bibi et al., 2023; Tadese et al., 2024).

The use of electronic documentation systems has been shown to improve documentation quality; however, initial resistance and inadequate training often hinder effective implementation (Khairunisa, 2023; Saumalina et al., 2023; Wahyuni & Hariyati, 2024). This highlights the need for comprehensive training to build confidence and familiarity among nurses. The documentation method also plays a key role—traditional documentation habits may limit effectiveness, especially when nurses are reluctant to adopt new standards (Thu et al., 2020). Furthermore, supporting materials, such as standardized forms and clear guidelines, are essential to promote comprehensive and protocol-compliant documentation (Mabunda et al., 2025).

Routine monitoring and evaluation are essential for strengthening accountability and identifying areas for improvement. Suboptimal documentation often results from a lack of effective supervision systems to guide and assess nursing performance (Nopriyanto et al., 2020; Saumalina et al., 2023). The work environment, including staffing levels and organizational culture, also significantly influences documentation practices. Studies have reported that stressful environments and staff shortages can overwhelm nurses, leading to lower documentation quality (Bibi et al., 2023; Seidu et al., 2021).

The results of this study demonstrated a significant increase in nursing documentation scores after structured monitoring and evaluation, particularly in the areas of diagnosis, intervention, and

evaluation. Similar findings were reported by Cocchieri et al. (2022), emphasizes that structured supervision and the use of specific models can improve the accuracy of nursing documentation. Moreover, ongoing evaluation and continuous feedback have been found to positively affect nurses' documentation practices and enhance compliance with established standards (Cilović-Lagarija et al., 2020).

Effective leadership by head nurses and primary nurses plays a critical role in improving documentation quality through the implementation of managerial functions—planning, organizing, implementing, and controlling monitoring and evaluation activities. Nopriyanto et al. (2020) emphasizes that head nurses have a strategic role in guiding nursing documentation through continuous supervision, which significantly influences compliance with documentation standards. Similarly, Suryani et al. (2024) found that structured supervision significantly improves documentation quality, reinforcing the need for head nurses to actively participate in training and mentoring to maintain consistent documentation practices.

Structured monitoring and evaluation are vital components for improving nursing documentation quality, patient safety, and continuity of care. Evidence from the literature indicates that systematic M&E processes enable comprehensive assessment of documentation practices, significantly reducing errors and increasing adherence to standards (Mabunda et al., 2025; Piol, 2023). Mabunda et al. (2025) also emphasized that self-audits conducted by nurses can identify documentation gaps and highlight the serious implications of poor documentation for patient safety and care continuity. Therefore, structured and continuous monitoring and evaluation are essential strategies to drive quality improvement initiatives and strengthen patient safety within healthcare settings (Mihdawi et al., 2020).

## **CONCLUSION**

Nursing care documentation serves as a fundamental component in ensuring patient safety, continuity of care, and professional accountability. The findings of this pilot study demonstrated that systematic monitoring and evaluation conducted by head nurses and primary nurses (PPJA) had a significant positive impact on improving the quality of nursing documentation, particularly in the areas of nursing diagnosis, intervention formulation, and patient evaluation records aligned with professional standards. Structured monitoring not only enabled the identification of documentation gaps but also encouraged behavioral changes among nurses toward more accurate, complete, and standardized documentation practices. The success of this intervention was supported by the implementation of direct feedback, clinical mentoring, and the use of practical digital evaluation tools. Therefore, hospitals are encouraged to institutionalize regular monitoring and evaluation of nursing documentation, strengthen clinical leadership through managerial and supervisory training for head nurses, and foster a culture of quality and accountability within nursing services. Optimizing monitoring and evaluation processes can serve as an effective strategy to enhance documentation quality, improve patient safety, and support the overall performance of healthcare systems.

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