

The Influence Of Effective Communication, Supervision Of The Head Of The Room, And Documentation Of Nursing Care On Improving Patient Safety In Inpatient Rooms (Systematic Literature Reviews)

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ABSTRACT

This study aims to identify and analyze the influence of effective communication, head nurse supervision, and nursing care documentation on improving patient safety in inpatient rooms through a systematic literature review.

Materials and methods.

This research used the Systematic Literature Review (SLR) method to evaluate how effective communication, head nurse supervision, and accurate nursing documentation contribute to patient safety. Literature was obtained from international databases such as PubMed, ScienceDirect, Scopus, ProQuest, and Google Scholar, covering publications from 2018 to 2024. The article selection process followed a systematic screening of titles, abstracts, full texts, and quality assessment using the Joanna Briggs Institute (JBI) appraisal tools. Data were narratively synthesized under three main themes and adhered to ethical scientific principles, although no direct human subjects were involved.

Results.

The findings show that effective communication, accurate nursing documentation, and consistent supervision from head nurses significantly enhance patient safety in inpatient settings. Clear, structured, and empathetic communication fosters teamwork and improves clinical decision-making. Proper documentation supports continuity of care and minimizes medical errors. Supervision by the head nurse ensures procedural compliance and improves the overall quality of nursing services.

Conclusions.

Effective communication, accurate documentation, and proactive supervision are critical components in establishing a safe and high-quality inpatient care environment. Addressing barriers such as hierarchical culture and lack of training is essential for optimizing patient outcomes and strengthening healthcare team performance.

Keywords: First keyword, second keyword, third keyword, forth keyword, fifth keyword

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INTRODUCTION

One of the main challenges in improving patient safety in inpatient wards is the suboptimal implementation of supervision by ward heads (Putri & Hidrus, 2025). Many ward heads have not fully implemented their managerial and supervisory functions due to high administrative burdens, lack of leadership training, and the absence of an effective monitoring system. This leads to weak control over the implementation of fire extinguishing procedures, poor compliance with operational standards, and a lack of direct training for medical personnel. As a result, various patient safety incidents such as medication errors, nosocomial infections, and delays in critical care management remain common in a number of healthcare facilities. Ineffective supervision also impacts a culture

of safety that has not yet been fully established. In many cases, ward heads lack the time or competence to conduct reflective supervision and training, but instead merely perform administrative functions. This situation is exacerbated by the lack of effective communication between the care team and between nurses and ward heads, which should be the foundation for clinical decision-making. Therefore, efforts are needed to strengthen the capacity of ward heads as clinical supervisors who not only supervise but also act as agents of change in building a sustainable patient safety culture.

Patient safety remains a serious challenge in various healthcare facilities in Indonesia, particularly in inpatient wards. According to a report by the National Patient Safety Committee (KNKP), patient safety incidents frequently occur, such as medication errors, delayed responses to emergencies, and inadequate reporting of adverse events (KTD). One of the main causes of this problem is ineffective communication between healthcare workers, both during patient handovers, interprofessional coordination, and communication between nurses and patients. According to the WHO, poor communication is the primary cause of 70% of patient safety incidents. Furthermore, the safety culture in some Indonesian hospitals remains weak, reflected in low staff awareness and involvement in incident reporting and risk prevention.

Furthermore, suboptimal supervision by ward heads and inconsistent and standardized nursing documentation also contribute to declining patient safety (Ampudia et al., 2019; Lambert et al., 2025). Many hospitals still lack a structured and sustainable supervision system, resulting in ineffective monitoring of standard operating procedures (SOPs). Meanwhile, nursing care documentation is often rushed, incomplete, or inconsistent with the patient's clinical condition. This leads to weak clinical records and nursing decision-making, which should be based on accurate data. Therefore, improving communication quality, strengthening the supervisory role of ward heads, and improving nursing documentation are crucial for improving patient safety in inpatient wards in Indonesia.

This research is highly relevant in the context of increasing attention to patient quality and safety as key indicators of healthcare quality. In complex hospital environments, team collaboration, the managerial role of the ward manager, and accurate nursing record-keeping are key foundations for preventing adverse events. The results of this study are expected to serve as a strategic reference in developing hospital policies, increasing the capacity of nursing staff, and developing patient safety guidelines based on the latest scientific evidence. Practically, the findings of this study contribute to strengthening a culture of patient safety and improving the quality of care in inpatient wards. This study aims to identify and analyze the influence of effective communication, ward manager supervision, and nursing care documentation on improving patient safety in inpatient wards based on a systematic review of the scientific literature.

METHOD

This study used a SLR method to evaluate the influence of effective communication, ward supervisor supervision, and nursing documentation on improving patient safety in inpatient wards. The literature search through international databases such as PubMed, ScienceDirect, Scopus, ProQuest, and Google Scholar covering the years 2018–2024. Article selection was carried out in stages through screening of titles, abstracts, and full text, and quality assessment using tools from the Joanna Briggs Institute (JBI). Data were analyzed narratively based on three main themes, adhering to ethical principles despite not directly involving human subjects.

While numerous studies have separately addressed the relationship between communication, nursing supervision, and documentation and patient safety, few have integrated these three aspects within the inpatient ward context. Most studies focus on only one or two variables, such as nurse-patient communication or ward supervisor supervision, without considering the simultaneous contribution of all three to improving patient safety. Furthermore, most studies used a field study approach with a limited scope, thus failing to provide a holistic picture based on scientific evidence across contexts and regions. Therefore, a systematic review is needed to synthesize and comprehensively analyze previous findings.

This study offers a systematic approach that integrates three key variables: effective communication, ward head supervision, and nursing care documentation in relation to patient safety in inpatient wards. Another novelty of this study lies in its comprehensive, evidence-based analysis from various regions and healthcare contexts, a practice not widely explored in previous studies. Thus, this study not only presents the interrelationships between variables but also provides a mapping of best practices that can serve as a basis for nursing managerial decision-making. This research is highly relevant in the context of increasing attention to patient quality and safety as key indicators of healthcare quality. In complex hospital environments, team collaboration, the managerial role of ward heads, and accurate nursing record-keeping are key foundations for preventing adverse events. The results of this study are expected to serve as a increasing the capacity of nursing staff, and developing patient safety guidelines based on the latest scientific evidence. Practically, the findings of this study contribute to strengthening a culture of patient safety and improving the quality of care in inpatient wards.

FINDING AND DISCUSSION

FINDING

Urgency of this research lies in the importance of improving patient safety as a primary indicator of healthcare quality in inpatient wards, given the persistently high incidence of patient safety incidents such as medication errors, nosocomial infections, and miscommunication among healthcare workers in various hospitals in Indonesia. Ineffective communication, suboptimal supervision by ward heads, and substandard nursing documentation are crucial factors contributing to these incidents. Therefore, this research is crucial for identifying evidence-based approaches that can strengthen the nursing care system through improved communication, supervision, and documentation, thereby enhancing patient safety comprehensively and sustainably.

Table 1. Previous research

No	Author Name	Article Title	Objective	Method	Main Results / Findings
1.	Audrey M. Burgener, BS, MBA	Enhancing Communication to Improve Patient Safety and to Increase Patient Satisfaction	Identify and discuss various communication protocols that can improve patient safety and patient satisfaction in healthcare facilities.	Literature Review / Conceptual Article	The use of communication protocols such as SBAR, FENCES and effective communication training has been proven to increase patient safety And patient satisfaction, as well as improving the hospital's image and HCAHPS scores.
2.	Samer H. Sharkiya	Quality communication can improve patient-centred health outcomes among older patients: a rapid review	Examining the influence of quality communication on patient-centered service outcomes for the elderly (aged ≥ 65 years).	Rapid review of 7 studies (5 qualitative: phenomenology, ethnography, grounded theory; 1 observational, 1 experimental).	Verbal and nonverbal communication have been shown to positively impact patient outcomes in older adults, such as patient satisfaction, quality of life, physical and mental health, and medical decision-making.
3.	Abukari Kwame & Pammla M. Petrucka	A literature-based study of patient-centered care and communication in nurse-patient interactions:	Examine barriers and supporting factors for communication and patient-centered care in	literature-based study	There are various barriers to nurse-patient communication, such as institutional, environmental, behavioral, and communication

		barriers, facilitators, and the way forward	nurse-patient interactions.		barriers. The authors propose the PC4 Model (Person-Centered Care and Communication Continuum) to help healthcare professionals identify the context, form, and content of communication that can support or hinder the achievement of patient-centered care.
4.	Mukhlid Alshammari Et Al	Barriers to nurse–patient communication in Saudi Arabia: an integrative review	To identify and synthesize quantitative and qualitative evidence related to nurse-patient communication practices in Saudi Arabia and their impact on service quality, safety, and patient satisfaction.	Integrative review based on the Whittemore and Knafl approach.	Two main themes were identified: (1) current communication practices and (2) their impact on patients. The main barriers were language, cultural, and religious differences between non-Saudi nurses and local patients. Nonverbal communication was often misinterpreted, resulting in a disrupted nurse-patient relationship and negatively impacting patient safety and satisfaction.
5.	Mojgan Lotfi Et Al	Assessment of nurse–patient communication and patient satisfaction from nursing care	Nurse communication and patient satisfaction.	Descriptive quantitative	Nurse communication influences patient satisfaction.
6.	Jessica Högländer Et Al	Registered nurse–patient communication research: An integrative review for future directions in nursing research	Theories and methods of nurse-patient communication.	An integrative review of 52 articles from 1996–2021 that addressed real-time communication between RNs and patients.	It was found that nursing and communication theories were underutilized in research. RN-patient communication influences relationship formation and care approaches. Communication tends to be asymmetrical when the nurse is dominant, but can be symmetrical and complementary when a patient-centered approach is implemented. Future research needs to further explore patient-centered communication and the communication skills required by nurses.
7.	Mira	Nursing care	Identify nursing	Quantitative	It was found that nursing

	Asmirajanti Et Al	activities based on documentation	activities in providing nursing care based on the documentation carried out.	design with a retrospective approach. Sample: 240 medical records of inpatients at Dr. Kariadi Hospital Semarang (July–September 2016), randomly selected from the 10 most common medical/surgical diseases and length of stay >3 days. Data were collected from patient progress notes and analyzed univariately.	activities did not meet established standards. For example, assessments of functional status for pressure ulcer risk (20.8%), biological status (0.4%), nursing diagnosis (20.8%), patient housing needs (41.3%), and vital sign monitoring (23.3%). Suboptimal documentation hindered interprofessional communication and service evaluation. Continuous oversight by the nursing manager was required.
8.	Zulham Efendi et al	Improving Patient Safety through Effective SBAR Communication	SBAR communication and patient safety	Quantitative	SBAR communication was rated as effective by 51.2% of respondents, and patient safety was also rated as good by 51.2% of respondents. There was a significant. It is recommended that hospitals improve the quality of nursing services by consistently implementing SBAR communication principles to support patient safety.
9.	Janina Kulińska Et Al	The Impact of Effective Communication on Perceptions of Patient Safety A Prospective Study in Selected Polish Hospitals	Correlational	A prospective study using a questionnaire developed by the authors to patients at a general hospital in Wroclaw, Poland.	A total of 54.4% of patients considered safety a key factor in care. The average service quality was rated 41.1 out of 50. A strong positive correlation was found between safety
10.	Sharon Ryan Et Al	Do safety briefings improve patient safety in the acute hospital setting? A systematic review	Systematic Review	A systematic review with a mixed methods multi-level synthesis	Of the 12 studies analyzed, safety briefings were found to have positive impacts such as improved safety culture, increased incident reporting, increased risk identification, decreased falls, improved staff relationships, and reduced length of stay. It was

					emphasized that healthcare leaders should encourage the implementation of safety briefings with local adaptations.
11.	Kasmiaty Et Al	The Influence of Supervision of Heads of Rooms and Knowledge of Implementing Nurses on Patient Safety through the Quality of Nursing Services at the Regional Hospital	To determine the influence of the head of the room's supervision and the knowledge of implementing nurses on patient safety through the quality of nursing services.	Analytical survey with a quantitative approach. Sample: all inpatient nurses at the West Sulawesi Provincial Hospital (167 respondents), analysis using multiple linear regression and path analysis.	Ward head supervision and nurse knowledge have a positive and significant effect on the quality of nursing services and patient safety. Nursing service quality also has a positive effect on patient safety. However, the indirect effect through nursing service quality is positive but not significant. This means that the mediating variable is less powerful in the indirect relationship.
12.	Jorunn Bjerkan Et Al	Patient Safety Through Nursing Documentation: Barriers Identified by Healthcare Professionals and Students	Understanding the perceptions of healthcare workers and students regarding barriers to nursing documentation that impact patient safety	Qualitative	Four key themes identified barriers to documentation that impact patient safety: individual, social, organizational, and technological factors. These barriers contribute to poor documentation quality and effective information exchange, leaving patients in primary care more vulnerable. Both individual efforts and institutional support are needed to improve documentation quality.
13.	Laith Abudalbouh	Electronic Nursing Documentation Interventions to Promote or Improve Patient Safety and/or Quality Care in an Acute Setting: Rapid Review	Assessing the effectiveness of electronic nursing documentation interventions in improving patient safety and quality of care.	A rapid review of 6 studies (1 cross-sectional, 1 RCT, 2 quasi-experimental, 1 qualitative, 1 cohort) conducted in the US, Taiwan, and Jordan, with settings in acute hospitals, medical-surgical units, and emergency clinics. Sources: CINAHL, MEDLINE,	Electronic documentation improves nursing quality by reducing length of stay, increasing direct nursing care, reducing readmission rates, improving patient flow, workflow efficiency, and increasing the quantity and quality of nursing interventions. It also improves patient safety by reducing medication errors, blood draw errors, and data errors.

				Cochrane, Web of Science.	
14.	Shamsa Samani, Salma Amin Rattani	Fostering Patient Safety: Importance of Nursing Documentation	Highlights the role of organizational culture in improving patient safety through vital sign monitoring and documentation.	A comprehensive literature review with analysis of articles containing quantitative and qualitative data related to the importance of vital signs documentation and early warning.	An organizational environment that encourages honest reporting can improve patient safety and quality of care. A strong safety culture, reporting adverse events as learning opportunities, and implementing ethical principles, professionalism, organizational support, and internal policies are crucial to preventing fatal incidents resulting from negligent nursing documentation.
15.	Tajabadi, A Et Al	Unsafe Nursing Documentation: A Qualitative Content Analysis	Exploring the factors influencing nursing documentation from the perspective of nurses in Iran.	Qualitative	Nursing documentation was identified as unsafe due to two main categories: the type of error in reporting and the reason for the error. Causal factors include individual, organizational, and national factors. Suggested solutions include increasing the number of nurses, reforming healthcare management structures, ongoing training, strengthening regulations, developing documentation tools, and organizational support.
16.	Etik Kustiati Et Al	Analysis of Nursing Supervision Function in Nursing Supervision Implementation	Determining the usefulness of the nursing room supervision function through the implementation of nursing supervision.	Action research method with a direct approach in Sulaiman Room 4, Roemani Muhammadiyah Hospital, Semarang; involving SGD, schedule, and supervision format.	After the implementation of supervision and the use of scheduled formats, there was a significant increase in the completeness of nursing documentation from 48.24% to 82.98%.
17.	Ahmed A. Osman Et Al	Impact of Head Nurses' Supervision Practices on Quality of Work	Assessing the impact of head nurse supervisory practices on the	Correlational descriptive design; location at Sohag University	The majority of participants rated their quality of work life as average. There was a

		Life as Perceived by Staff Nurses	quality of work life of staff nurses.	Hospital, involving 240 nurses with questionnaires on supervisory practices and quality of work life.	significant negative correlation between supervisory practices and quality of work life. Improvements in the work environment by the department head improved quality of work life.
18.	Paul John Regan Et Al	Progress on the Introduction of Supervisory Ward Manager Roles Since the Francis Report Recommendations	Reviewing the progress of implementation of the role of supervisory ward manager as per the recommendations of the Francis report	Literature review of publications since 2012 related to the implementation of recommendation 195	Only six articles were found; most were local anecdotal reports. Support for recommendation 195 waned in subsequent reports. The authors suggest this recommendation needs to be revived for public safety.
19.	Frances Patterson	Supervising the Supervisors: What Support Do First-Line Supervisors Need to Be More Effective in Their Supervisory Role?	Qualitative Exploratory	An exploratory-qualitative experience-based teaching in post-qualification training in Scotland	Many new supervisors experience a lack of training and support. Consistent supervision at all levels of the organization fosters a reflective culture and the ability to manage emotions and the complexities of social work practices.
20.	Mohamad M. Saaba et al	Peer Group Clinical Supervision: Qualitative Perspectives from Nurse Supervisees, Managers, and Supervisors	Exploring the experience of peer group clinical supervision from the perspectives of nurses, managers, and clinical supervisors	Qualitative descriptive	Peer group supervision offers benefits such as reduced stress, problem-solving, and improved prioritization. Challenges include workload, staff shortages, and time constraints. Additional time, supervisor training, and outreach are recommended before implementation.

DISCUSSION

The Impact of Effective Communication on Improving Patient Safety in Inpatient Wards

In the context of inpatient care, effective communication between healthcare professionals is crucial for clinical decision-making, risk management, and cross-professional coordination. Emphasized that the implementation of structured communication methods such as SBAR (Situation, Background, Assessment, Recommendation) serves as a benchmark for nursing care that significantly impacts hospital quality (Coolen et al., 2020). This method provides a clear and systematic framework for conveying clinical information, thereby reducing miscommunication and increasing rapid and appropriate clinical responses. Aswad et al. (2025) demonstrated that interventions in the form of effective communication training were able to reduce adverse event rates by improving the quality of communication between healthcare professionals and between healthcare professionals and patients (Aswad et al., 2025). This demonstrates that, in addition to

clinical competence, good communication skills are a key requirement for optimal patient safety. Interprofessional communication, which involves collaboration between doctors, nurses, and other healthcare professionals, not only minimizes overlapping roles but also accelerates responses to changes in patient conditions. However, challenges in implementing this communication often stem from structural barriers such as a rigid hierarchical culture, time constraints, and a lack of cross-professional communication training (Scarlat & Bărar, 2023).

Effective communication relies not only on verbal aspects but also encompasses paraverbal (intonation, speech rate) and nonverbal elements (eye contact, facial expressions, body language) (Abakumova et al., 2021; Mohd Salim et al., 2023). This aligns with the view that communication is a process of exchanging information involving mutually understood symbols, signs, and behaviors. In the dynamic and often stressful environment of hospitals, the communication process becomes complex because it involves multiple parties with different professional backgrounds and clinical perspectives. Therefore, adaptive and standardized communication strategies, such as safety briefings, the use of checklists, and a transparent incident reporting system, are needed to ensure the continuity of critical information. Ryan et al. (2023) demonstrated that regular safety briefings can improve safety culture and strengthen medical team cohesion (Ryan et al., 2019).

The discussion regarding the influence of effective communication on improving patient safety in inpatient wards is further strengthened by various previous studies. Communication protocols such as SBAR and AIDET have been shown to improve the clarity of information among healthcare professionals, expedite decision-making, and minimize errors that could harm patients (Burgener, 2020). Effective communication is also crucial in the context of elderly patient care, where quality communication can reduce the risk of adverse events and improve the accuracy of medical care (Sharkiya, 2023). Research by Abukari & Petrucka (2023) confirms that communication barriers are a major barrier to achieving patient-centered care, while communication facilitators such as training and information systems support the achievement of comprehensive patient safety (Kwame & Petrucka, 2021).

Furthermore, unaddressed communication barriers can negatively impact patient safety. Mukhlid Alshammari (2023) demonstrated that miscommunication is often a leading cause of clinical incidents, both between healthcare workers and between nurses and patients (Alshammari et al., 2019). Research by Mojgan Lotfi (2024) found that the quality of nurse-patient communication directly impacts patient satisfaction and perceptions of safety (Lotfi et al., 2019). Similarly, Högländer et al. (2024) confirmed that warm and open communication between registered nurses (RNs) and patients not only strengthens the therapeutic relationship but also increases patient trust and safety throughout the care process (Högländer et al., 2023).

Furthermore, Zulham Efendi et al. (2025) confirmed that the use of SBAR communication was significantly associated with improved patient safety ($p = 0.022$) (Efendi & Adha, 2025). Similar findings were presented by Kulińska et al. (2023), who noted that transparent access to information and empathetic attitudes from healthcare workers are crucial elements in patient safety perceptions (Kulińska et al., 2022). Ryan et al. (2023) also demonstrated that safety briefings within medical teams can improve safety culture and reduce incident rates (Ryan et al., 2019). Meanwhile, a study by Vaismoradi et al. (2022) stated that standardized, collaborative, and structured communication is the primary foundation for adherence to patient safety principles. These findings demonstrate that communication is not simply a process of conveying messages, but a vital part of a hospital's safety and quality system (Tajabadi et al., 2020).

The Impact of Ward Head Supervision on Improving Patient Safety in Inpatient Wards

Communication is a crucial element in nursing practice and overall healthcare. In the context of patient safety, effective communication is not only a prerequisite for smooth teamwork but also a key determinant in preventing Adverse Events. Communication errors are reported as a leading cause of patient safety incidents in various hospitals, both in developing and developed countries. Theoretically, the communication process can be explained through the Shannon–Weaver Model, which states that communication is the process of conveying a message from a sender to a receiver through a specific channel, which can be hampered by interference (noise). In the healthcare world, this noise can take the form of time pressure, stress, multitasking, and

environmental distractions that prevent messages from being conveyed clearly, thus increasing the risk of clinical errors (Kubota, 2019). According to Efendi & Adha (2025), effective communication is an important indicator of the quality of nursing services in hospitals. One standard communication method that has been proven to improve patient safety is SBAR (Situation, Background, Assessment, Recommendation). This method reduces information ambiguity and supports informed clinical decision-making (Efendi & Adha, 2025).

Interprofessional communication is becoming increasingly important as the complexity of healthcare services increases. According to Gittell's (2009) Relational Coordination theory, good coordination between professionals (nurses, doctors, pharmacists, and nutritionists) requires frequent, timely, and accurate communication that promotes mutual respect (Gittell et al., 2020). Effective communication between nurses and patients also significantly contributes to patient safety. Lotfi et al. (2019) found that the majority of patients who did not know their nurses experienced dissatisfaction with the care they received (Lotfi et al., 2019). Poor communication quality contributed to the failure to convey important information, such as allergies, pain, changes in condition, and emotional needs. Högländer et al. also found that good communication between Registered Nurses (RNs) and patients fostered trusting relationships, ultimately improving safety because patients were more open in reporting symptoms or concerns (Högländer et al., 2023). Good communication encompasses more than just conveying information, but also empathy and transparent access to information. Janina Kulińska and colleagues found that when patients feel heard and receive clear explanations from healthcare providers, their perception of safety improves.

Numerous studies demonstrate that effective, structured, and standardized communication plays a crucial role in improving patient safety. Effective communication between healthcare professionals and patients has consistently been shown to be a key factor in improving patient safety. Numerous studies have shown that the use of structured communication protocols such as SBAR and AIDET can reduce medical errors and improve the clarity of information between healthcare professionals and patients (Burgener, 2020). In this context, quality communication is not only about the exchange of technical information but also encompasses empathy and access to appropriate information for patients, ultimately shaping positive perceptions of healthcare safety (Kulińska et al., 2022).

Furthermore, good communication is crucial, especially for vulnerable groups such as the elderly. Research by Sharkiya (2022) demonstrated that quality communication is positively correlated with improved safety in elderly patients (Sharkiya, 2023). Furthermore, research by Lotfi et al. (2021) revealed that weak nurse-patient communication directly reduces patient satisfaction and safety in the ward (Lotfi et al., 2019). The emotional bond and trust established between nurses and patients are also strongly influenced by communication patterns, as explained by Högländer et al. (2019) who found that communication fostered by nurses influences the formation of relationships and patient perceptions of safety (Högländer et al., 2023).

From a system and medical team perspective, the implementation of systematic team communication, such as safety briefings, has been shown to improve safety culture and reduce incident rates (Ryan et al., 2019). Research by Efendi et al. (2023) even showed that SBAR communication has a significant relationship with patient safety ($p = 0.022$) (Efendi & Adha, 2025). Similarly, Vaismoradi et al. (2019) emphasized the importance of collaboration, team communication, and process standardization as key pillars in adherence to patient safety principles (Tajabadi et al., 2020). Communication barriers such as differences in professional backgrounds and medical hierarchies have also been identified as barriers to achieving patient-centered care (Abukari & Petrucka, 2021) and as a cause of clinical risk if not addressed appropriately (Alshammari et al., 2019). Therefore, efforts to improve communication are a crucial strategy in strengthening patient safety holistically (Tajabadi et al., 2020).

The Impact of Nursing Care Documentation on Improving Patient Safety in Inpatient Wards

Nursing documentation is a crucial foundation of professional nursing practice and significantly impacts patient safety in inpatient settings. This documentation is not merely an administrative record, but a form of professional responsibility, accountability, and a vital means of

communication between healthcare professionals. Shannon and Weaver's Model of Communication theory explains that communication failures, including in the documentation process, can disrupt the delivery of messages crucial to patient safety. In the hospital context, nursing documentation is the primary means of conveying information between nursing shifts, between nurses and physicians, and other support units. When documentation is incomplete or inaccurate, it disrupts the continuity of information, potentially leading to medical errors, delayed diagnoses, and incorrect treatment (Abd El Rahman et al., 2021). Consistent, clear, and complete documentation helps minimize miscommunication, a common cause of adverse events in hospital care. This aligns with the Continuity of Care theory, which emphasizes the importance of uninterrupted information flow to ensure safe and high-quality transitions of care. • According to the Accountability in Nursing theory (American Nurses Association), nurses are fully responsible for the actions and decisions taken during the provision of care. Good documentation demonstrates that care has been provided in accordance with standards and can serve as evidence of professional accountability in the event of a legal dispute. When patient safety is compromised, documentation becomes the primary source for tracing what was done, who did it, and when. Therefore, documentation must be done in real time, objectively, and not speculatively, following the SOAP (Subjective, Objective, Assessment, Plan) principle or the nursing process model which includes assessment, diagnosis, planning, implementation, and evaluation (ADPIE).

Nursing documentation also supports rapid and accurate clinical decision-making. Tanner's (2006) Clinical Judgment Model emphasizes the importance of accurate data in the decision-making process. In nursing practice, decisions are made not only based on direct observation but also through a review of previous patient records documented in the documentation. For example, trends in blood pressure changes, allergy history, or responses to previous interventions can only be seen from well-written documentation (Manik & Callaway, 2023). This is supported by various past studies, where inaccuracy or incompleteness in nursing care recording has been shown to increase the risk of clinical errors, ultimately endangering patient safety (Asmirajanti et al., 2019; Bjerkan et al., 2021). Poor documentation not only disrupts coordination between medical teams but also makes it difficult to assess the effectiveness of nursing interventions and make clinical decisions quickly and accurately. These obstacles demonstrate that nursing documentation is not merely a formality but an integral part of the overall patient safety system.

On the other hand, technological advances have provided significant solutions through the implementation of electronic-based nursing documentation. Electronic documentation systems have been shown to improve patient safety by reducing the potential for clinical errors common in manual documentation (Abudalbouh, 2023). Furthermore, regular vital sign recording and a strong safety culture contribute to the effectiveness of documentation in supporting patient safety (Samani & Rattani, 2023). An analysis by Tajabadi et al. (2023) also confirmed that insecure documentation poses a high risk to patient safety, but the causes and solutions to this problem can be traced and improved with a systematic approach (Tajabadi et al., 2020). This emphasizes the importance of continuous evaluation of documentation practices, including procedures, nursing staff competency, and other support systems.

Furthermore, several studies have shown that external factors such as supervision and nurse workload also influence the quality of nursing documentation. Etik Kustiati et al. (2021) found that good supervision significantly contributes to improving the quality of nursing documentation, which positively impacts patient safety (Kustiati et al., 2020). However, excessive documentation workload can actually reduce the quality of recording and lead to nursing staff burnout, thus indirectly impacting patient safety (Moy et al., 2023). Furthermore, direct patient access to care documentation also impacts patient outcomes, both in terms of transparency and accountability (Blease et al., 2020). These findings demonstrate that nursing documentation should be viewed comprehensively, not only as a record-keeping tool but also as an instrument for safety, communication, accountability, and strategic clinical decision-making.

CONCLUSIONS

The results show that effective communication between healthcare professionals in inpatient wards significantly contributes to improved patient safety. Implementing structured communication can reduce miscommunication, accelerate responses to patient conditions, and strengthen medical teamwork. Barriers such as a hierarchical culture and lack of training are challenges that must be overcome. Clear, empathetic, and standardized communication is key to creating a safe care environment, improving clinical decision-making, and increasing patient trust and satisfaction. Effective communication between healthcare professionals in inpatient wards has been shown to improve patient safety. With clear, structured, and collaborative communication, critical information is conveyed in a timely manner, decision-making is rapid and accurate, and the risk of medical errors is reduced. Barriers such as a hierarchical culture and lack of training need to be addressed to optimize teamwork. Empathetic communication also increases patient trust and satisfaction. Overall, good communication is key to creating a safe and high-quality care environment. Complete and accurate nursing documentation has been shown to improve patient safety in inpatient wards. Documentation facilitates communication between healthcare professionals, supports clinical decision-making, and serves as evidence of nurses' professional responsibility. Electronic documentation systems help reduce recording errors, while good supervision and a balanced workload contribute to documentation quality. With timely and standardized record-keeping, the risk of medical errors can be reduced, care transitions become safer, and overall health care becomes more effective and reliable.

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