# Legal Competence and Compliance with Nursing Documentation Standards Among Registered Nurses in Selected Government Hospitals in the City of Manila: Basis for a Quality Improvement and Legal Risk Reduction Program

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## ABSTRACT

This study examined the legal competence and compliance with nursing documentation standards among registered nurses in selected government hospitals in the City of Manila and used the findings as the basis for developing a Quality Improvement and Legal Risk Reduction Program. A quantitative, cross-sectional, predictive-correlational research design was employed among 129 registered nurses. Data were gathered using a researcher-developed questionnaire that assessed demographic and professional characteristics, seven dimensions of legal competence, seven dimensions of documentation compliance, and perceived barriers to proper documentation. Descriptive statistics, Pearson product-moment correlation, and multiple linear regression were used to analyze the data at the .05 level of significance. Findings showed that the respondents demonstrated an overall competent level of legal competence ($M = 4.04$, $SD = .42$) and a high level of compliance with nursing documentation standards ($M = 4.08$, $SD = .41$). Confidentiality, data privacy, and information security received the highest rating for legal competence, while confidentiality and data security ranked highest for documentation compliance. The most frequently reported barriers were heavy workload, insufficient time, staffing shortages, frequent interruptions or emergency demands, and fatigue, stress, or burnout. Legal competence was significantly and positively associated with documentation compliance ($r = .61$, $p < .001$). Moreover, the seven dimensions of legal competence collectively significantly predicted documentation compliance, $F(7,121) = 14.72$, $p < .001$, explaining 46.0% of the variance. Legally defensible documentation practices emerged as the strongest predictor, followed by confidentiality, data privacy and information security, professional accountability and scope of practice, and incident reporting and adverse events. The findings indicate that nursing documentation compliance is influenced by both nurses' legal competence and the organizational conditions in which documentation occurs. Accordingly, the CLEAR-DOC Quality Improvement and Legal Risk Reduction Program was proposed to strengthen legally defensible documentation, professional accountability, privacy protection, incident reporting, policy standardization, audit and feedback, workflow improvement, and organizational support.

**Keywords**: Legal Competence, Nursing Documentation, Documentation Compliance, Registered Nurses, Legal Risk Reduction, Quality Improvement, Government Hospitals

## INTRODUCTION

Patient safety, quality of care, and professional accountability remain major priorities of healthcare systems worldwide. Preventable harm continues to occur because of communication failures, medication errors, delayed interventions, incomplete transfer of information, and weaknesses in clinical systems. The World Health Organization (WHO, 2023) emphasizes that adverse events are often produced by the interaction of human, technological, procedural, and organizational factors rather than by a single healthcare worker alone.

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Consequently, improving professional competence, clinical communication, documentation processes, and organizational accountability has become central to contemporary patient-safety strategies.

Nursing documentation is an important component of these strategies because it provides a chronological and systematic record of the patient's condition, assessments, nursing interventions, communication, and response to care. Accurate documentation promotes continuity of care, facilitates interdisciplinary communication, and provides evidence of professional nursing practice. Mabunda et al. (2025) emphasized that quality documentation supports communication among healthcare professionals and records the nursing care planned and implemented for patients. Conversely, incomplete, inaccurate, delayed, or unclear records may contribute to omitted care, duplicated interventions, delayed treatment, ineffective handovers, and other threats to patient safety. Communication failures have been associated with adverse events, medication-related problems, and delays in care, highlighting the importance of reliable clinical records (Howick et al., 2024).

Beyond its clinical function, nursing documentation carries ethical, professional, and legal significance. Nursing records may be reviewed during quality audits, accreditation activities, administrative investigations, disciplinary proceedings, insurance claims, and legal cases. For documentation to serve as credible evidence of care, it should be accurate, complete, objective, timely, confidential, and properly authenticated. Missing information, retrospective entries, unauthorized disclosures, improper corrections, undocumented interventions, and records completed by persons who did not provide the care may expose nurses and healthcare institutions to professional and legal risks. Legal competence is therefore essential because nurses must be able to understand and apply legal principles related to professional accountability, scope of practice, informed consent, confidentiality, negligence, malpractice, incident reporting, patient rights, and the management of clinical records.

Compliance with nursing documentation standards, however, is influenced not only by legal knowledge but also by the clinical environment. Workload, staffing shortages, inadequate time, changing policies, documentation burden, insufficient supervision, limited training, and inefficient electronic systems may affect the quality and completeness of nursing records. Michl et al. (2023) found that nurses experienced tension between documentation requirements, direct patient-care responsibilities, time pressures, and the perceived administrative burden of audit systems. Similarly, Mabunda et al. (2025) reported that nurses recognized the importance of quality documentation but identified continuing training, supervision, self-auditing, and institutional support as necessary for sustained improvement. These findings indicate that documentation deficiencies may reflect both individual competency gaps and organizational-system weaknesses.

The increasing use of electronic nursing documentation also introduces new considerations for legal compliance and patient safety. Electronic records may improve accessibility, legibility, retrieval, and continuity of information, but they may also create risks associated with delayed data entry, inappropriate copying and pasting, unauthorized access, shared passwords, selection errors, and breaches of confidentiality. Akhu-Zaheya et al. (2024) reported that electronic nursing documentation can contribute to patient safety and quality of care, although its effectiveness depends on system design, staff preparation, implementation, and integration into clinical workflows. Therefore, documentation competence in contemporary nursing practice requires not only knowledge of proper charting but also an understanding of information security, confidentiality, and legally appropriate use of electronic health records.

In the Philippine setting, registered nurses are legally and professionally expected to maintain safe and accountable nursing practice. Republic Act No. 9173, or the *Philippine Nursing Act of 2002*, requires nurses to observe ethical standards and maintain accepted standards of safe nursing care (Republic of the Philippines, 2002). Nursing documentation is also closely connected with professional accountability, communication, record management, and quality improvement. Furthermore, Republic Act No. 10173, or the *Data Privacy Act of 2012*, requires healthcare professionals and institutions to protect personal and sensitive information from unauthorized collection, access, use, or disclosure (Republic of the Philippines, 2012). These legal provisions make accurate and secure nursing documentation an essential aspect of professional nursing responsibility.

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Despite the existence of national laws, professional standards, ethical guidelines, and institutional policies, limited empirical evidence is available on whether registered nurses who possess stronger legal competence also demonstrate greater compliance with nursing documentation standards. Existing studies frequently examine legal awareness, documentation quality, workload, electronic-record burden, or quality-improvement strategies separately. Variations in educational preparation, clinical experience, workload, documentation systems, legal training, supervisory support, and exposure to chart audits may further influence nurses' knowledge and practices. This gap is particularly important in government hospitals, where high patient volume and complex service demands may place additional pressure on nurses' documentation responsibilities.

Accordingly, this study will examine the legal competence and compliance with nursing documentation standards among registered nurses in selected government hospitals in the City of Manila. It will determine the respondents' levels of legal competence and documentation compliance and establish whether a significant relationship exists between these variables. The findings will serve as the basis for developing a Quality Improvement and Legal Risk Reduction Program that may include legal-literacy education, documentation competency enhancement, standardized guidelines, audit and feedback mechanisms, mentoring, policy reinforcement, and monitoring of documentation practices. Through these measures, the study seeks to contribute to patient safety, professional accountability, documentation quality, and legally defensible nursing practice.

The study is aligned with the Philippine Development Plan 2023–2028, which promotes the strengthening of healthcare services, health workforce capacity, governance, and information systems (National Economic and Development Authority [NEDA], 2023). It is also consistent with AmBisyon Natin 2040, the Harmonized National Research and Development Agenda 2022–2028, and the National Integrated Basic Research Agenda 2022–2028, which support health-system strengthening, workforce development, evidence-based policy, and responsible use of health technologies (Department of Science and Technology [DOST], 2022). At the international level, the study supports Sustainable Development Goal 3, which promotes health and well-being, and Sustainable Development Goal 16, which emphasizes accountable, effective, and transparent institutions (United Nations, 2015).

## CONCEPTUAL FRAMEWORK

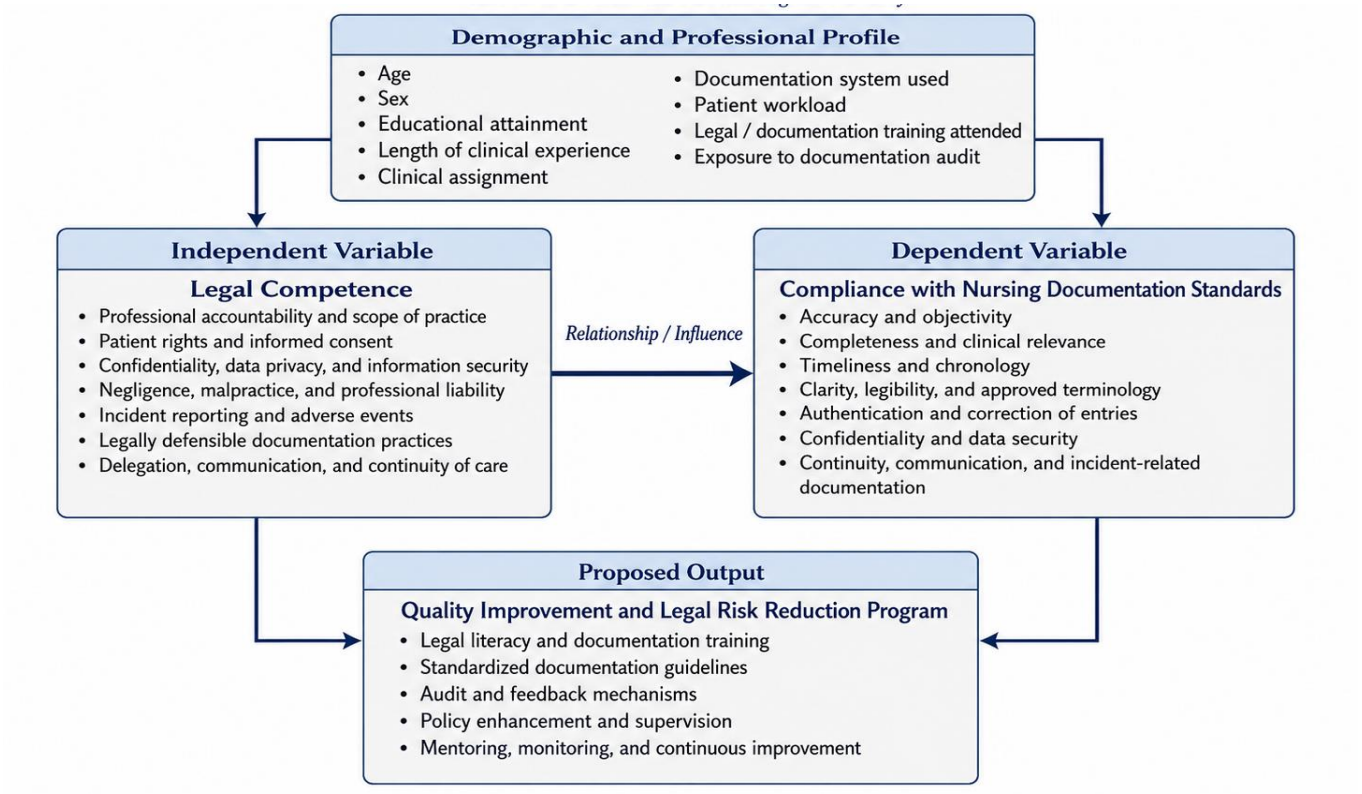


**Figure 1: Self-developed Conceptual Framework**

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The conceptual framework of this study is anchored in Bandura's Social Cognitive Theory, which explains behavior as the result of the interaction among personal factors, behavior, and environmental conditions. In this study, legal competence represents the personal or cognitive factor, while compliance with nursing documentation standards represents the behavioral factor. The demographic and professional characteristics of registered nurses, including clinical experience, educational attainment, workload, training, documentation system, and exposure to audits, provide the contextual conditions that may influence both variables.

Legal competence is examined in terms of professional accountability, patient rights, informed consent, confidentiality, data privacy, negligence, malpractice, incident reporting, legally defensible documentation, and professional communication. Compliance with nursing documentation standards is assessed through accuracy, completeness, timeliness, clarity, objectivity, authentication, confidentiality, and appropriate correction of records.

The framework assumes that nurses with stronger legal competence are more likely to demonstrate higher documentation compliance. However, this relationship may also be influenced by workplace conditions such as staffing, supervision, policies, technology, and organizational support. The findings from both variables will serve as the basis for developing a Quality Improvement and Legal Risk Reduction Program designed to strengthen legal literacy, documentation practices, monitoring, feedback, and institutional accountability.

**Statement of the Problem**

This study aims to determine the legal competence and compliance with nursing documentation standards among registered nurses employed in selected government hospitals in the City of Manila and to examine whether legal competence is significantly associated with and predicts compliance with nursing documentation standards. It also seeks to identify perceived barriers to proper nursing documentation. The findings will serve as the basis for the development of a Quality Improvement and Legal Risk Reduction Program designed to strengthen legal competence, documentation practices, professional accountability, and patient safety among registered nurses. Specifically, the study sought to answer the following questions:

1. What is the demographic and professional profile of the registered nurses in terms of:

1.1 age;
1.2 sex;
1.3 highest educational attainment;
1.4 length of clinical nursing experience;
1.5 current clinical assignment;
1.6 employment status;
1.7 type of nursing documentation system used;
1.8 usual number of patients handled per shift;
1.9 attendance in legal or medico-legal training;
1.10 attendance in nursing documentation training; and
1.11 frequency of exposure to documentation audits or chart reviews?

2. What is the level of legal competence of registered nurses in terms of:

2.1 professional accountability and scope of practice;

2.2 patient rights and informed consent;

2.3 confidentiality, data privacy, and information security;

2.4 negligence, malpractice, and professional liability;

2.5 incident reporting and adverse events;

2.6 legally defensible documentation practices; and

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2.7 delegation, communication, and continuity of care?

3. What is the level of compliance with nursing documentation standards among registered nurses in terms of:

3.1 accuracy and objectivity;

3.2 completeness and clinical relevance;

3.3 timeliness and chronology;

3.4 clarity, legibility, and approved terminology;

3.5 authentication and correction of entries;

3.6 confidentiality and data security; and

3.7 continuity, communication, and incident-related documentation?

4. Is there a significant relationship between legal competence and compliance with nursing documentation standards among registered nurses?

5. Which dimensions of legal competence significantly predict compliance with nursing documentation standards among registered nurses?

6. What are the perceived barriers encountered by registered nurses in complying with nursing documentation standards?

7. Based on the findings of the study, what Quality Improvement and Legal Risk Reduction Program may be developed to strengthen legal competence and compliance with nursing documentation standards among registered nurses?

**Hypothesis**

The following null hypotheses will be tested at the 0.05 level of significance:

$H_{01}$: There is no significant relationship between legal competence and compliance with nursing documentation standards among registered nurses in selected government hospitals in the City of Manila.

$H_{02}$: The dimensions of legal competence do not significantly predict compliance with nursing documentation standards among registered nurses in selected government hospitals in the City of Manila.

**Significance of the Study**

This study is significant because it will provide evidence on the legal competence of registered nurses and their compliance with nursing documentation standards. For nursing students, the findings may strengthen awareness that accurate documentation is essential to safe, ethical, and legally accountable practice. For nursing educators, the results may guide improvements in teaching nursing law, ethics, professional accountability, and documentation through case analysis, simulation, and competency-based activities. For nursing professionals, the study may identify strengths and gaps in legal knowledge and charting practices and support continuing professional development. Healthcare administrators may use the findings to improve policies, orientation programs, documentation systems, supervision, audit procedures, and feedback mechanisms. The proposed Quality Improvement and Legal Risk Reduction Program may also support patient safety and institutional accountability. Finally, future researchers may use the study as a basis for replication, instrument refinement, comparative research, and further investigations on documentation quality and legal-risk management.

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# METHODOLOGY

## Research Design

This study will employ a quantitative, cross-sectional, predictive-correlational research design. Quantitative research uses numerical data and statistical procedures to describe variables and examine relationships among them (Slater et al., 2025). The cross-sectional approach is appropriate because data on legal competence and documentation compliance will be collected at a single point in time, allowing the researcher to describe current conditions and examine associations without manipulating variables. Cross-sectional studies are efficient for describing populations and identifying relationships, although they do not establish causality (Mehta & Naveed, 2025). The correlational component will determine the strength and direction of the relationship between legal competence and documentation compliance, while the predictive component will identify which legal-competence dimensions significantly predict documentation compliance. Because the design is nonexperimental and cross-sectional, findings will be interpreted as associations and statistical predictions rather than evidence of cause-and-effect relationships.

## Locale of the Study

The study was conducted in selected government hospitals in the City of Manila, National Capital Region, Philippines. The setting was appropriate because government hospitals serve diverse patient populations and employ registered nurses in various direct patient-care areas, including medical-surgical, emergency, pediatric, operating and delivery, and critical care units. These areas require continuous documentation of patient assessments, medications, nursing interventions, endorsements, changes in condition, and patient responses. The government-hospital environment was especially relevant because high patient volume, time pressure, frequent interruptions, and resource limitations may influence the completeness, timeliness, and consistency of nursing documentation.

## Population and Sampling of the Study

The study population consisted of licensed registered nurses employed in selected government hospitals in the City of Manila. Eligible respondents were nurses assigned to direct patient-care areas, directly involved in nursing documentation, and employed in their current institution for at least six months. Nurses working exclusively in administrative, educational, research, or other nonclinical positions were excluded, together with student nurses, nursing aides, and other healthcare professionals.

The required sample size was determined through an a priori power analysis using G*Power. For the predictive component, the computation was based on multiple linear regression with seven predictor variables, a medium effect size of ($f^2=.15$), a significance level of .05, and statistical power of .80. The minimum required sample was 103 registered nurses. To allow for possible nonresponse, withdrawal, or incomplete questionnaires, a 20% allowance was added, resulting in a target sample of 129 nurses. Proportionate stratified random sampling was used, with each participating hospital serving as a separate stratum. Respondents were proportionately allocated based on the number of eligible nurses in each hospital and selected through a computer-generated random procedure. A total of 129 registered nurses provided complete and usable responses and were included in the final analysis.

## Research Instrument

Data were collected using an author-developed structured questionnaire designed specifically for the study. The instrument consisted of five parts. Part I gathered the respondents' demographic and professional profile, including age, sex, educational attainment, length of clinical experience, current clinical assignment, employment status, type of documentation system, usual patient load, attendance in legal or medico-legal training, nursing documentation training, and exposure to documentation audits.

Part II measured legal competence through 35 items grouped into seven dimensions: professional accountability and scope of practice; patient rights and informed consent; confidentiality, data privacy, and information security;

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negligence, malpractice, and professional liability; incident reporting and adverse events; legally defensible documentation practices; and delegation, communication, and continuity of care. Responses were rated on a five-point scale from 5 – Highly Competent to 1 – Not Yet Competent.

Part III measured compliance with nursing documentation standards through another 35 items covering accuracy and objectivity; completeness and clinical relevance; timeliness and chronology; clarity, legibility, and approved terminology; authentication and correction of entries; confidentiality and data security; and continuity, communication, and incident-related documentation. Responses ranged from 5 – Always to 1 – Never.

Part IV contained a 15-item checklist of perceived barriers to documentation, including workload, staffing, insufficient time, limited training, system downtime, unclear policies, inadequate supervision, and fatigue. Part V contained one optional open-ended item for additional concerns or suggestions regarding institutional support.

The author-developed questionnaire underwent face and content validation before full administration. Five expert validators with backgrounds in nursing administration, nursing law and ethics, clinical documentation, quality and risk management, and research methodology evaluated the instrument for relevance, clarity, appropriateness, and alignment with the study objectives. The Item-Level Content Validity Index ranged from .80 to 1.00, while the overall Scale-Level Content Validity Index based on the average method was .96, indicating satisfactory expert agreement.

The revised instrument was pilot-tested among 30 registered nurses who were similar to the intended respondents but were not included in the final sample. Internal consistency was assessed using Cronbach's alpha. The Legal Competence Scale obtained an overall alpha of .94, with dimension coefficients ranging from .82 to .90. The Nursing Documentation Compliance Scale obtained an overall alpha of .93, with dimension coefficients ranging from .81 to .89. These results indicated satisfactory to excellent internal consistency.

**Data Gathering Procedure**

Data collection began only after approval from the research adviser, the appropriate Research Ethics Committee, and the participating government hospitals. The researcher coordinated with the nursing service offices to identify eligible nurses based on the inclusion criteria. Eligible participants were selected through the approved proportionate stratified random sampling procedure.

Selected nurses were informed of the purpose of the study, procedures, possible risks and benefits, confidentiality measures, and the voluntary nature of participation. Informed consent was secured before questionnaire administration. The validated questionnaire was distributed either in printed form or through a secure electronic platform, depending on institutional arrangements. Respondents were instructed not to provide names, employee numbers, professional license numbers, patient information, or other direct identifiers.

Completed questionnaires were retrieved using secure procedures and checked for completeness. Electronic responses were accessed only through a password-protected account. A total of 129 complete and usable responses were coded, entered into a protected database, checked for accuracy, and prepared for statistical analysis.

**Ethical Consideration**

The study observed established ethical principles for research involving human participants. Ethical clearance and institutional permission were obtained before data collection. Participation was voluntary, and informed consent was secured from all participants. Respondents were informed that participation or refusal would not affect their employment, duty assignment, salary, benefits, or professional standing.

Privacy, anonymity, and confidentiality were maintained throughout the study. No direct identifiers were collected, and each questionnaire was assigned a numerical code. Data collection, storage, analysis, and disposal were conducted in accordance with Republic Act No. 10173, or the Data Privacy Act of 2012. Printed and electronic records were stored securely, and only coded, de-identified information was used for analysis.

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Measures were also taken to minimize coercion and undue influence, particularly because the participants were hospital employees. Findings were reported only in aggregate form and were not used to blame, stigmatize, or identify individual nurses or institutions. Scientific integrity was maintained by ensuring that data were reported accurately without fabrication, falsification, inappropriate alteration, or selective omission.

### Data Management and Analysis

Completed questionnaires were reviewed, coded, and entered into a password-protected electronic database. The dataset was screened for missing values, data-entry errors, inconsistent responses, and potential outliers before analysis. Only complete and usable responses were retained.

Frequency and percentage were used to summarize the respondents' demographic and professional characteristics. Weighted mean and standard deviation were used to determine the levels of legal competence and compliance with nursing documentation standards, both by dimension and overall.

Before inferential testing, the assumptions of the planned statistical procedures were examined. Pearson's product-moment correlation coefficient was used to determine the relationship between overall legal competence and documentation compliance when assumptions were satisfied; Spearman's rho was considered as an alternative when appropriate. Multiple linear regression was used to determine which of the seven legal-competence dimensions significantly predicted overall documentation compliance. Regression results included the overall model significance, regression coefficients, confidence intervals, and the proportion of variance explained.

Perceived documentation barriers were summarized using frequency, percentage, and rank ordering. Responses to the optional open-ended item were grouped according to recurring concerns such as legal education, workload, staffing, technology, policies, supervision, audit, mentoring, and feedback. All inferential tests were evaluated at the .05 level of significance. The findings from the descriptive, correlational, predictive, and barrier analyses served as the basis for developing the proposed Quality Improvement and Legal Risk Reduction Program.

## RESULTS, ANALYSIS, AND DISCUSSION

### Profile of the Respondents

This section presents the demographic and professional characteristics of the 129 registered nurses included in the study. Specifically, the respondents were described according to age, sex, highest educational attainment, length of clinical nursing experience, current clinical assignment, employment status, usual documentation system, usual number of patients handled per shift, attendance in legal or medico-legal training, attendance in nursing documentation training, and exposure to documentation audits or chart reviews. These characteristics correspond directly to the 11 profile variables contained in Part I of the research instrument.

**Table 1:Demographic and Professional Profile of the Respondents (N = 129)**

| Profile Variable | Category | f | % |
|---|---|---|---|
| Age | 21–25 years | 22 | 17.1 |
| | 26–30 years | 38 | 29.5 |
| | 31–35 years | 28 | 21.7 |
| | 36–40 years | 18 | 14.0 |
| | 41–45 years | 11 | 8.5 |
| | 46–50 years | 7 | 5.4 |
| | 51 years or older | 5 | 3.9 |
| Sex | Female | 94 | 72.9 |
| | Male | 33 | 25.6 |
| | Prefer not to disclose | 2 | 1.6 |
| | Others | 0 | 0.0 |
| Highest Educational Attainment | Bachelor's degree in Nursing | 89 | 69.0 |

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| | | | |
|---|---|---|---|
| | Master's units | 25 | 19.4 |
| | Master's degree | 12 | 9.3 |
| | Doctoral units/degree | 2 | 1.6 |
| | Others | 1 | 0.8 |
| Length of Clinical Nursing Experience | 6 months–2 years | 22 | 17.1 |
| | 3–5 years | 34 | 26.4 |
| | 6–10 years | 31 | 24.0 |
| | 11–15 years | 20 | 15.5 |
| | 16 years or more | 22 | 17.1 |
| Current Clinical Assignment | Medical-Surgical | 34 | 26.4 |
| | Emergency | 20 | 15.5 |
| | Critical Care/ICU | 18 | 14.0 |
| | Pediatrics | 15 | 11.6 |
| | Obstetric/Delivery | 14 | 10.9 |
| | Operating Room/PACU | 13 | 10.1 |
| | Others | 15 | 11.6 |
| Employment Status | Permanent | 82 | 63.6 |
| | Temporary/Casual | 18 | 14.0 |
| | Contractual/Job Order | 27 | 20.9 |
| | Others | 2 | 1.6 |
| Usual Documentation System | Paper-based | 25 | 19.4 |
| | Electronic | 36 | 27.9 |
| | Hybrid paper-electronic | 68 | 52.7 |
| Usual Number of Patients Handled per Shift | 1–5 | 20 | 15.5 |
| | 6–10 | 41 | 31.8 |
| | 11–15 | 30 | 23.3 |
| | 16–20 | 14 | 10.9 |
| | More than 20 | 8 | 6.2 |
| | Varies by unit | 16 | 12.4 |
| Legal/Medico-Legal Training Within the Last 3 Years | None | 39 | 30.2 |
| | Once | 45 | 34.9 |
| | Twice | 27 | 20.9 |
| | Three or more times | 18 | 14.0 |
| Nursing Documentation Training Within the Last 3 Years | None | 24 | 18.6 |
| | Once | 41 | 31.8 |
| | Twice | 36 | 27.9 |
| | Three or more times | 28 | 21.7 |
| Exposure to Documentation Audit/Chart Review | Never | 7 | 5.4 |
| | Rarely | 19 | 14.7 |
| | Sometimes | 44 | 34.1 |
| | Often | 38 | 29.5 |
| | Very often | 21 | 16.3 |

Note. Percentages may not total exactly 100.0 due to rounding.

Table 1 shows that the 129 registered nurses represented a relatively young but professionally diverse workforce. The largest age group was 26–30 years (29.5%), followed by 31–35 years (21.7%), while only 3.9% were 51 years or older. Most respondents were female (72.9%) and bachelor's degree holders (69.0%). In terms of

experience, the largest proportions had 3–5 years (26.4%) and 6–10 years (24.0%) of clinical practice. These findings indicate that the sample included a substantial number of early- to mid-career nurses who had already acquired meaningful clinical exposure but may still require continuing professional development in specialized areas such as nursing law and documentation. Kim et al. (2025) emphasized that legal educational needs persist among practicing nurses and may vary according to workplace demands and professional experience.

The respondents were also distributed across several clinical areas, with the largest proportions assigned to Medical-Surgical units (26.4%), Emergency units (15.5%), and Critical Care/ICU units (14.0%). These settings involve different levels of patient acuity, rapid clinical decision-making, and documentation requirements. The diversity of clinical assignments strengthens the contextual relevance of the study because documentation responsibilities may differ according to workflow, patient complexity, and urgency of care. Recent research has shown that nursing documentation is closely integrated with clinical workflow and may consume a substantial proportion of nurses' working time, particularly in acute and critical-care environments (Cho et al., 2025).

More than half of the respondents (52.7%) used a hybrid paper-electronic documentation system, while 27.9% used fully electronic systems and 19.4% relied primarily on paper documentation. This finding suggests that many nurses must navigate two documentation processes simultaneously, which may increase opportunities for repetitive recording, inconsistent entries, or workflow inefficiencies. Recent studies have identified redundancy, system usability, navigation, training, and documentation burden as continuing concerns among hospital nurses using electronic health records (Cho et al., 2025; Staggers et al., 2025). These findings reinforce the importance of considering the documentation system when interpreting nurses' compliance with documentation standards.

Patient workload was likewise substantial. Approximately one-third of the respondents handled 6–10 patients per shift, while 23.3% cared for 11–15 patients and some reported more than 20 patients. Although Table 1 does not establish whether workload directly affected documentation compliance, the distribution suggests that many respondents practiced under considerable documentation demands. Evidence from recent research indicates that electronic documentation and related administrative requirements may consume substantial portions of nurses' working hours, and limited training or inefficient systems can further increase documentation burden (Alharbi et al., 2026). Therefore, workload should be considered an important contextual factor when interpreting subsequent compliance findings.

Of particular relevance to the study, 30.2% of respondents reported receiving no legal or medico-legal training during the previous three years, while only 34.9% had attended such training once. This finding suggests a possible gap in continuing legal education. Hasan et al. (2025) similarly found only moderate levels of legal knowledge among emergency nurses and recommended targeted continuing education to strengthen nurses' ability to manage legal responsibilities. Kim et al. (2025) further reported that nurses experienced practice-related difficulties because of inadequate legal knowledge and highlighted the need for workplace-specific legal education.

In contrast, respondents reported greater exposure to nursing documentation training and chart audits, with most having received documentation training at least once and 79.9% experiencing audits at least sometimes. This may indicate that documentation quality receives more consistent institutional attention than legal education. Zhang et al. (2025) demonstrated that targeted training can improve nurses' knowledge, attitudes, and practices concerning nursing-document quality control, supporting the value of structured educational interventions. Overall, the demographic and professional profile reflects a heterogeneous nursing workforce exposed to varying clinical demands, documentation systems, workloads, training opportunities, and audit practices. These characteristics provide an important context for interpreting the subsequent results on legal competence and compliance with nursing documentation standards.

**Legal Competence of Registered Nurses**

Table 2 presents the respondents' level of legal competence across the seven dimensions measured by the 35-item Legal Competence Scale. The scale was interpreted as follows: 4.21–5.00 = Highly Competent; 3.41–4.20 = Competent; 2.61–3.40 = Moderately Competent; 1.81–2.60 = Slightly Competent; and 1.00–1.80 = Not Yet Competent.

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**Table 2: Level of Legal Competence of Registered Nurses (N = 129)**

| Legal Competence Dimension | Mean | SD | Interpretation | Rank |
|---|---|---|---|---|
| Confidentiality, Data Privacy, and Information Security | 4.18 | 0.48 | Competent | 1 |
| Professional Accountability and Scope of Practice | 4.12 | 0.50 | Competent | 2 |
| Legally Defensible Documentation Practices | 4.08 | 0.52 | Competent | 3 |
| Patient Rights and Informed Consent | 4.05 | 0.51 | Competent | 4 |
| Delegation, Communication, and Continuity of Care | 4.01 | 0.54 | Competent | 5 |
| Incident Reporting and Adverse Events | 3.94 | 0.57 | Competent | 6 |
| Negligence, Malpractice, and Professional Liability | 3.88 | 0.61 | Competent | 7 |
| **Overall Legal Competence** | **4.04** | **0.42** | **Competent** | — |

Note. 4.21–5.00 = Highly Competent; 3.41–4.20 = Competent; 2.61–3.40 = Moderately Competent; 1.81–2.60 = Slightly Competent; 1.00–1.80 = Not Yet Competent.

Table 2 indicates that the registered nurses demonstrated an overall competent level of legal competence, with a mean of 4.04 (SD = 0.42). All seven dimensions were rated within the competent range, suggesting that the respondents generally perceived themselves as capable of understanding and applying legal and professional principles relevant to nursing documentation. This finding is encouraging because legal competence is essential for protecting patient rights, maintaining professional accountability, and reducing legal risk in clinical practice. Hasan et al. (2025) similarly emphasized that nurses require adequate legal knowledge to manage work-related responsibilities and recommended continuing legal education to strengthen practice-based competence.

Confidentiality, Data Privacy, and Information Security obtained the highest mean of 4.18 (SD = 0.48). This suggests that respondents were particularly confident in protecting confidential patient information, applying privacy requirements, controlling access to records, and recognizing possible breaches. This strength is especially important in increasingly digital healthcare environments, where concerns regarding data security, unauthorized access, and accountability remain significant. Recent qualitative evidence among ICU nurses also identified data security and unclear responsibility as key ethical and professional concerns associated with technology use, reinforcing the importance of strong privacy competence in contemporary nursing practice (Yalçın et al., 2026).

Professional Accountability and Scope of Practice ranked second (M = 4.12, SD = 0.50), followed by Legally Defensible Documentation Practices (M = 4.08, SD = 0.52). These findings indicate that the nurses generally understood their responsibility for the accuracy and integrity of nursing records and recognized practices such as proper authentication, appropriate correction of errors, avoidance of backdating or pre-charting, and use of approved terminology. This is consistent with Wang et al. (2024), who found that nurses' legal roles and responsibilities require clearer practical application and continuing institutional support, particularly when legal expectations intersect with routine clinical work.

Patient Rights and Informed Consent (M = 4.05, SD = 0.51) and Delegation, Communication, and Continuity of Care (M = 4.01, SD = 0.54) also remained within the competent range. These results suggest generally adequate competence in documenting consent, refusal of care, patient education, referrals, endorsements, and delegated activities. Such areas are important because communication and documentation are closely linked to continuity, accountability, and patient safety.

The lowest-rated dimensions were Incident Reporting and Adverse Events (M = 3.94, SD = 0.57) and Negligence, Malpractice, and Professional Liability (M = 3.88, SD = 0.61). Although still interpreted as competent, these lower scores suggest comparatively less confidence in recognizing legal liability, distinguishing negligence from malpractice, and managing documentation related to errors, near misses, and adverse events. This pattern is important because uncertainty surrounding professional responsibility and accountability remains a recurring concern in current nursing practice. Recent evidence also shows that nurses may experience ambiguity regarding responsibility in complex clinical and technology-supported situations, highlighting the need for clearer policies, structured education, and practical legal guidance (Yalçın et al., 2026).

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Overall, the findings show that the respondents possessed a generally competent level of legal competence, with particular strength in confidentiality and data privacy. However, the comparatively lower ratings in negligence, malpractice, professional liability, and incident reporting identify priority areas for continuing education and institutional support. These findings support the inclusion of focused medico-legal training, case-based discussions, adverse-event reporting exercises, and policy reinforcement in the proposed Quality Improvement and Legal Risk Reduction Program.

**Compliance with Nursing Documentation Standards**

Table 3 presents the level of compliance with nursing documentation standards across the seven dimensions measured by the 35-item Nursing Documentation Compliance Scale. The scale was interpreted as follows: 4.21–5.00 = Very High Compliance; 3.41–4.20 = High Compliance; 2.61–3.40 = Moderate Compliance; 1.81–2.60 = Low Compliance; and 1.00–1.80 = Very Low Compliance.

**Table 3: Level of Compliance with Nursing Documentation Standards among Registered Nurses (N = 129)**

| Documentation Compliance Dimension | Mean | SD | Interpretation | Rank |
|---|---|---|---|---|
| Confidentiality and Data Security | 4.20 | 0.46 | High Compliance | 1 |
| Accuracy and Objectivity | 4.16 | 0.47 | High Compliance | 2 |
| Authentication and Correction of Entries | 4.13 | 0.50 | High Compliance | 3 |
| Clarity, Legibility, and Approved Terminology | 4.09 | 0.49 | High Compliance | 4 |
| Completeness and Clinical Relevance | 4.05 | 0.52 | High Compliance | 5 |
| Continuity, Communication, and Incident-Related Documentation | 4.00 | 0.55 | High Compliance | 6 |
| Timeliness and Chronology | 3.91 | 0.58 | High Compliance | 7 |
| **Overall Documentation Compliance** | **4.08** | **0.41** | **High Compliance** | — |

Note. 4.21–5.00 = Very High Compliance; 3.41–4.20 = High Compliance; 2.61–3.40 = Moderate Compliance; 1.81–2.60 = Low Compliance; 1.00–1.80 = Very Low Compliance.

Table 3 shows that the registered nurses demonstrated an overall high level of compliance with nursing documentation standards, with a mean of 4.08 (SD = 0.41). All seven dimensions were rated within the high-compliance range, indicating that respondents generally reported consistent adherence to accepted documentation practices. This finding is consistent with Mabunda et al. (2025), who emphasized that quality nursing documentation is essential for continuity of care, patient safety, and communication among healthcare professionals.

Confidentiality and Data Security obtained the highest mean (M = 4.20, SD = 0.46), suggesting that respondents were particularly consistent in protecting patient information, limiting access to authorized persons, and securing paper and electronic records. This strength is important because contemporary documentation systems increasingly depend on electronic platforms, where privacy, access control, and secure handling of information are integral to professional accountability.

Accuracy and Objectivity ranked second (M = 4.16, SD = 0.47), followed by Authentication and Correction of Entries (M = 4.13, SD = 0.50). These findings suggest that nurses generally documented verified clinical information, avoided speculative language, authenticated their entries appropriately, and corrected documentation errors according to accepted procedures. Such practices contribute to the reliability and legal defensibility of nursing records. Zhang et al. (2025) found that focused quality-control training significantly improved nurses' knowledge, attitudes, and practices related to nursing documentation, supporting the importance of continued institutional education and monitoring.

Clarity, Legibility, and Approved Terminology (M = 4.09, SD = 0.49) and Completeness and Clinical Relevance (M = 4.05, SD = 0.52) also demonstrated high compliance. These results indicate that respondents generally provided understandable and clinically relevant records containing important patient assessments, interventions, changes in condition, referrals, and follow-up actions. Mabunda et al. (2025) similarly noted that complete and

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meaningful documentation supports continuous clinical communication and provides evidence of the nursing care delivered.

Continuity, Communication, and Incident-Related Documentation ranked sixth (M = 4.00, SD = 0.55). Although still high, the comparatively lower score may reflect the complexity of documenting endorsements, physician notifications, incidents, and communications occurring during busy clinical shifts. These activities often require coordination across multiple professionals and documentation systems.

Timeliness and Chronology obtained the lowest mean (M = 3.91, SD = 0.58). While still within the high-compliance category, this finding suggests that completing documentation promptly may be the most challenging aspect for respondents. Cho et al. (2024) found that documentation burden among acute and critical-care nurses was influenced by patient-to-nurse ratios, patient acuity, limited time, redundant data entry, and poor alignment between electronic systems and clinical workflow. These factors may similarly help explain why timely documentation received the lowest rating in the present study, although the current descriptive findings alone cannot establish causation.

Overall, the respondents reported high compliance with nursing documentation standards, particularly in confidentiality, accuracy, and authentication. However, the relatively lower ratings for timeliness and incident-related communication indicate areas that may benefit from workflow improvement, continuing documentation training, audit and feedback, and better integration of documentation systems into clinical practice.

**Perceived Barriers to Compliance with Nursing Documentation Standards**

Table 4 presents the barriers perceived by the respondents as interfering with consistent compliance with nursing documentation standards. Respondents were permitted to select more than one barrier; therefore, the total frequencies exceed the number of respondents and the percentages do not total 100%. The questionnaire identifies barriers related to workload, staffing, interruptions, institutional policies, training, supervision, documentation systems, technology, organizational practices, fear of blame, and fatigue or burnout.

**Table 4: Perceived Barriers to Compliance with Nursing Documentation Standards (N = 129)**

| Perceived Barrier | Frequency (f) | Percentage (%) | Rank |
|---|---|---|---|
| High nurse-to-patient ratio or heavy patient workload | 91 | 70.5 | 1 |
| Insufficient time during the shift | 86 | 66.7 | 2 |
| Shortage of staff or unplanned staff absence | 79 | 61.2 | 3 |
| Frequent interruptions or emergency demands | 74 | 57.4 | 4 |
| Fatigue, stress, or burnout | 69 | 53.5 | 5 |
| Complex, lengthy, or repetitive documentation forms | 58 | 45.0 | 6 |
| Electronic system downtime, slow connectivity, or technical problems | 54 | 41.9 | 7 |
| Unclear or inconsistent documentation policies | 47 | 36.4 | 8 |
| Insufficient computers, devices, forms, or supplies | 43 | 33.3 | 9 |
| Differences in documentation practices among units or supervisors | 41 | 31.8 | 10 |
| Limited training on legal and documentation requirements | 39 | 30.2 | 11 |
| Poorly designed electronic record interface or difficult navigation | 35 | 27.1 | 12 |
| Inadequate supervision, coaching, or feedback | 32 | 24.8 | 13 |
| Fear of blame, punishment, or legal consequences when reporting errors | 29 | 22.5 | 14 |
| Other barriers | 8 | 6.2 | 15 |

Note. Multiple responses were allowed; therefore, percentages do not sum to 100%.

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Table 4 shows that the leading barriers to compliance with nursing documentation standards were primarily workload- and staffing-related. Heavy nurse-to-patient workload was the most frequently reported barrier (70.5%), followed by insufficient time during the shift (66.7%), staff shortages or unplanned absences (61.2%), frequent interruptions or emergency demands (57.4%), and fatigue, stress, or burnout (53.5%). These findings indicate that documentation difficulties may arise not only from nurses' knowledge or competence but also from the competing demands of direct patient care. Cho et al. (2024) similarly found that patient-to-nurse ratios, patient acuity, and limited time contributed substantially to documentation burden among acute and critical-care nurses.

Documentation-process barriers were also evident, with 45.0% identifying complex, lengthy, or repetitive forms. Brown et al. (2025) reported that duplicate and unnecessary documentation increased documentation burden and reduced nurses' and midwives' satisfaction, emphasizing the need to eliminate nonessential recording requirements. More recent qualitative evidence likewise shows that nurses frequently perceive repetitive and non-value-added documentation as competing with direct patient care (Cho et al., 2026).

Technology-related concerns were also substantial. System downtime or poor connectivity was reported by 41.9%, insufficient devices or supplies by 33.3%, and difficult electronic-record navigation by 27.1%. Cho et al. (2024) identified data redundancy, cumbersome data entry, poor workflow navigation, and inadequate alignment between EHR systems and nursing workflows as important contributors to documentation burden. These findings suggest that technology can facilitate documentation only when systems are reliable, accessible, and designed around nurses' clinical workflow.

Institutional concerns included unclear policies (36.4%), inconsistent practices among units or supervisors (31.8%), limited legal and documentation training (30.2%), and inadequate supervision or feedback (24.8%). These findings indicate that organizational support remains necessary even when nurses demonstrate generally high documentation compliance. Alobayli (2024) found that documentation workload, system usability problems, and insufficient organizational support contributed to stress associated with electronic health-record use among nurses.

Overall, the results demonstrate that the major obstacles to documentation compliance were predominantly systemic rather than purely individual. Heavy workload, time pressure, staffing limitations, interruptions, fatigue, repetitive documentation, and technology problems were the most prominent concerns. Therefore, interventions should extend beyond individual training and include adequate staffing, protected documentation time, streamlined forms, reliable electronic systems, clear institutional policies, supportive supervision, and constructive audit and feedback mechanisms.

**Relationship Between Legal Competence and Compliance with Nursing Documentation Standards**

Preliminary examination of the composite scores indicated an approximately linear relationship between legal competence and documentation compliance, with no serious violations that would preclude the use of Pearson's product-moment correlation. Pearson's correlation coefficient was therefore used to determine whether the respondents' overall legal competence was significantly associated with their overall compliance with nursing documentation standards.

**Table 5: Relationship Between Legal Competence and Compliance with Nursing Documentation Standards (N = 129)**

| Variables | r | 95% CI | p-value | Interpretation | Decision on $H_{01}$ |
|---|---|---|---|---|---|
| Overall Legal Competence and Overall Documentation Compliance | .61 | [.49, .71] | < .001 | Significant positive relationship | Reject $H_{01}$ |

Note. Statistical significance was evaluated at $\alpha = .05$.

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Table 5 shows a statistically significant positive relationship between overall legal competence and compliance with nursing documentation standards, $r = .61$, $p < .001$. The coefficient indicates a moderately strong positive association, meaning that nurses who reported higher legal competence also tended to report greater compliance with documentation standards. The 95% confidence interval, .49 to .71, remained entirely above zero, further supporting the reliability of this positive relationship.

This finding is consistent with recent evidence showing that nurses' knowledge and professional competence are associated with better documentation practices. Zhang et al. (2025) reported that improvements in nurses' knowledge, attitudes, and practices following intensive training were accompanied by better quality-control practices in nursing documentation. Similarly, a recent study of medical-surgical nurses found that greater knowledge was significantly associated with better electronic documentation practice, although the strength of the relationship was weaker than that observed in the present study (Electronic Documentation Practice and Its Correlated Factors, 2026).

The result is also conceptually supported by Hasan et al. (2025), who found that greater legal knowledge among nurses was significantly associated with more favorable attitudes toward legal issues and less difficulty in managing legal responsibilities. This suggests that stronger legal understanding may help nurses translate professional and legal expectations into safer and more consistent practice behaviors, including documentation.

Accordingly, the null hypothesis stating that there is no significant relationship between legal competence and compliance with nursing documentation standards was rejected. However, because the study used a cross-sectional, nonexperimental design, the relationship should be interpreted as an association rather than evidence that legal competence directly causes better documentation compliance. Other factors such as workload, staffing, supervision, documentation systems, training, and organizational support may also contribute to documentation behavior.

**Legal Competence Dimensions as Predictors of Compliance with Nursing Documentation Standards**

Multiple linear regression analysis was conducted to determine which dimensions of legal competence significantly predicted overall compliance with nursing documentation standards among registered nurses. The seven dimensions of legal competence were entered simultaneously into the regression model.

Preliminary diagnostic examination indicated no serious violation of the assumptions of multiple linear regression. The relationships between the predictors and outcome were approximately linear, residuals were reasonably normally distributed and homoscedastic, and no highly influential outliers were observed. Multicollinearity was also not considered problematic, with variance inflation factor values remaining within acceptable limits. These diagnostics supported interpretation of the regression model.

**Table 6: Multiple Regression Model Summary Predicting Compliance with Nursing Documentation Standards (N = 129)**

| R | $R^2$ | Adjusted $R^2$ | Standard Error of Estimate | F | df | p-value |
|---|---|---|---|---|---|---|
| .678 | .460 | .429 | .31 | 14.72 | 7, 121 | < .001 |

Dependent variable: Overall Compliance with Nursing Documentation Standards.

Table 6 shows that the seven dimensions of legal competence significantly predicted compliance with nursing documentation standards, $F(7, 121) = 14.72$, $p < .001$. The model explained 46.0% of the variance in documentation compliance ($R^2 = .460$), while the adjusted $R^2$ of .429 indicates that 42.9% of the variance remained explained after accounting for the number of predictors. This represents substantial predictive utility and suggests that legal competence is meaningfully associated with how consistently nurses adhere to documentation standards.

This finding is consistent with recent evidence showing that nurses' knowledge, attitudes, professional preparation, and documentation-related competencies contribute to documentation quality. Zhang et al. (2025) found that intensive training significantly improved nurses' knowledge, attitudes, and documentation practices, while regression analysis identified professional experience and position as factors associated with documentation performance. Similarly, recent evidence on electronic documentation found that nurses' knowledge and attitudes significantly predicted documentation practice, although the amount of explained variance differed across predictors.

The present $R^2$ of .460 also indicates that legal competence does not fully explain documentation compliance. Approximately 54.0% of the variance was attributable to factors outside the regression model. This is consistent with Gligor et al. (2025), who found that documentation quality was influenced by multiple clinical and organizational factors, including characteristics of the documentation process and the number of nurses involved. Recent qualitative evidence likewise identifies workload, time constraints, inconsistent practices, insufficient training, and weak handovers as important influences on documentation quality.

Overall, the findings support legal competence as an important predictor of documentation compliance, but they also reinforce the need for a broader organizational approach. Thus, the proposed Quality Improvement and Legal Risk Reduction Program should combine legal education with interventions addressing workload, staffing, documentation systems, training, supervision, and audit-feedback mechanisms.

**Individual Predictors of Documentation Compliance**

**Table 7: Multiple Regression Coefficients for the Dimensions of Legal Competence Predicting Documentation Compliance (N = 129)**

| Legal Competence Dimension | B | SE | β | t | p | 95% CI for B | Interpretation |
|---|---|---|---|---|---|---|---|
| Professional Accountability and Scope of Practice | .17 | .073 | .19 | 2.33 | .021 | [.03, .31] | Significant |
| Patient Rights and Informed Consent | .08 | .066 | .09 | 1.21 | .228 | [-.05, .21] | Not significant |
| Confidentiality, Data Privacy, and Information Security | .22 | .077 | .24 | 2.86 | .005 | [.07, .37] | Significant |
| Negligence, Malpractice, and Professional Liability | .06 | .058 | .08 | 1.03 | .305 | [-.05, .17] | Not significant |
| Incident Reporting and Adverse Events | .13 | .062 | .16 | 2.10 | .038 | [.01, .25] | Significant |
| Legally Defensible Documentation Practices | .27 | .075 | .30 | 3.60 | < .001 | [.12, .42] | Significant |
| Delegation, Communication, and Continuity of Care | .09 | .061 | .11 | 1.48 | .142 | [-.03, .21] | Not significant |

Note. B = unstandardized regression coefficient; SE = standard error; β = standardized regression coefficient. Statistical significance was evaluated at $\alpha = .05$.

Table 7 shows that four dimensions of legal competence significantly predicted compliance with nursing documentation standards. Legally Defensible Documentation Practices emerged as the strongest predictor ($\beta = .30$, $p < .001$), indicating that nurses who were more competent in accurate, objective, complete, timely, properly authenticated, and legally appropriate documentation also demonstrated higher overall compliance. This finding is supported by recent evidence emphasizing that nursing documentation is closely linked with professional accountability, legal protection, continuity of care, and patient safety (Alghamdi et al., 2026).

Confidentiality, Data Privacy, and Information Security was the second strongest predictor ($\beta = .24$, $p = .005$). This suggests that competence in protecting patient information and managing authorized access and disclosure contributes independently to documentation compliance. Recent literature likewise emphasizes that privacy and confidentiality remain major ethical and professional responsibilities as nursing documentation becomes increasingly digital (Abuhammad, 2025).

Professional Accountability and Scope of Practice also significantly predicted compliance ($\beta = .19$, $p = .021$). This supports the view that nurses who clearly understand responsibility, transparency, professional boundaries, and institutional expectations are more likely to demonstrate consistent documentation behavior. Recent work on nursing accountability similarly identifies responsibility, transparency, and answerability as important components of safe and quality professional practice (Tisinli, 2026).

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Incident Reporting and Adverse Events was also a significant predictor ($\beta = .16$, $p = .038$), although its contribution was smaller. This finding highlights the importance of legal competence in documenting errors, near misses, notifications, and adverse events appropriately. Current professional guidance emphasizes that timely and accurate incident reporting is essential for preventing recurrence, protecting patients, and supporting organizational learning.

In contrast, Patient Rights and Informed Consent, Negligence and Malpractice, and Delegation and Communication did not contribute significant unique variance after the other dimensions were considered. Their non-significance does not imply that they are unimportant; rather, their effects may overlap with stronger predictors in the regression model.

Overall, the findings led to the rejection of $H_{02}$. They indicate that legally defensible documentation, confidentiality and data privacy, professional accountability, and incident-reporting competence are the most influential legal dimensions associated with documentation compliance. These areas should therefore receive priority in the proposed Quality Improvement and Legal Risk Reduction Program.

**Proposed Quality Improvement and Legal Risk Reduction Program**

Based on the findings, the study proposes the CLEAR-DOC Quality Improvement and Legal Risk Reduction Program, an institution-based intervention designed to strengthen nurses' legal competence, improve compliance with nursing documentation standards, reduce documentation-related legal risks, and address organizational conditions that interfere with accurate, complete, timely, and legally defensible nursing documentation.

CLEAR-DOC stands for Clinical Legal Education, Accountability, Risk Reduction, and Documentation Optimization for Compliance. The program recognizes that improving nursing documentation cannot depend solely on increasing nurses' knowledge. Although respondents demonstrated competent legal knowledge and high documentation compliance, the findings indicated comparatively weaker areas involving negligence and professional liability, incident reporting, timeliness, and incident-related documentation. Moreover, respondents identified workload, insufficient time, staffing shortages, interruptions, fatigue, documentation complexity, and technological limitations as important barriers. Consequently, the proposed program combines education, policy strengthening, workflow improvement, documentation audit and feedback, technological support, and organizational risk management.

**General Objective**

The CLEAR-DOC Program aims to strengthen legal competence and improve sustained compliance with nursing documentation standards among registered nurses while reducing institutional and professional risks associated with incomplete, inaccurate, delayed, insecure, or legally indefensible documentation.

**Specific Objectives**

Specifically, the program aims to:

1. strengthen nurses' knowledge and application of legal and professional requirements related to nursing documentation;

2. enhance competence in legally defensible documentation, confidentiality and data privacy, professional accountability, and incident reporting;

3. improve the accuracy, completeness, timeliness, authentication, confidentiality, and continuity of nursing documentation;

4. standardize documentation policies, procedures, and expectations across participating clinical units;

5. establish a regular documentation audit, feedback, coaching, and monitoring system;

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6. address modifiable organizational, workload-related, and technological barriers to documentation compliance;

7. promote a supportive and nonpunitive culture for incident reporting, documentation correction, and continuous improvement; and

8. establish measurable indicators for evaluating improvements in documentation quality and legal-risk reduction.

**Proposed CLEAR-DOC Program Matrix**

| Program Component | Basis from the Findings | Major Strategies/Activities | Responsible Persons/Units | Time Frame | Proposed Indicators of Success |
|---|---|---|---|---|---|
| **1. Clinical Legal Documentation Education** | Legal competence was generally competent, but negligence, malpractice, professional liability, and incident reporting were comparatively weaker dimensions. | Conduct structured learning sessions on the Philippine Nursing Act, professional accountability, negligence and malpractice, patient rights, informed consent, confidentiality, Data Privacy Act, incident reporting, and legal implications of nursing records. Use case-based exercises and documentation scenarios. | Nursing Service Office, Nursing Education/Training Unit, Legal Office, Risk Management, Nurse Educators | Initial intensive training; annual refresher | ≥90% of nurses complete training; ≥80% post-test competency; measurable improvement between pre- and post-assessment |
| **2. Legally Defensible Documentation Skills Enhancement** | Legally defensible documentation emerged as the strongest predictor of documentation compliance. | Conduct skills workshops on factual and objective charting, late entries, correction of errors, authentication, approved abbreviations, avoidance of pre-charting/backdating, documentation of refusals, changes in condition, physician notification, and continuity of care. | Nursing Education Unit, Clinical Supervisors, Quality Management | Quarterly workshops | Improvement in documentation audit scores; reduction in incomplete, unsigned, improperly corrected, or delayed entries |
| **3. Privacy, Confidentiality, and Information Security Reinforcement** | Confidentiality/data privacy was among the strongest dimensions and a significant predictor of compliance. | Provide periodic Data Privacy Act refresher sessions; reinforce secure password use, record access, electronic documentation, handling of printed records, disclosure procedures, and breach reporting. Include privacy reminders in unit orientation. | Data Protection Officer, Nursing Service, IT Department, Quality/Risk Management | Semiannual; continuous reminders | ≥95% compliance with privacy-related audit indicators; reduction in inappropriate access or handling of patient information |
| **4. Documentation** | Respondents reported | Review and harmonize documentation policies, | Nursing Administration, | Initial review within 3 months; | Approved standardized |

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| | | | | | |
|---|---|---|---|---|---|
| **Policy Standardization** | unclear/inconsistent policies and differences in practices among units and supervisors. | approved abbreviations, correction procedures, incident documentation, late-entry rules, handoff documentation, and electronic-record practices. Develop a concise Documentation Standards Manual or quick-reference guide. | Quality Management, Legal/Risk Office, Clinical Unit Heads | annual review thereafter | policy; 100% of units receive updated guidelines; reduced variation in audit findings across units |
| **5. Documentation Audit, Feedback, and Coaching System** | Audit exposure varied, and continued monitoring is necessary to sustain compliance. | Conduct structured monthly or quarterly documentation audits using standardized criteria. Provide confidential individual/unit feedback, coaching, and corrective education. Track recurring deficiencies and improvement trends. | Quality Assurance, Nursing Supervisors, Nurse Auditors, Unit Heads | Monthly/quarterly | ≥90% documentation audit compliance; progressive reduction in repeated deficiencies; documented feedback provided after each audit cycle |
| **6. Workload and Workflow Optimization** | Heavy patient workload, insufficient time, staffing shortages, interruptions, and fatigue were the most commonly perceived barriers. | Review nurse-to-patient assignments, identify peak documentation periods, minimize unnecessary interruptions during documentation, improve shift-end documentation workflow, streamline redundant forms, and integrate protected documentation time where feasible. | Nursing Administration, Human Resources, Unit Managers, Quality Improvement Team | Continuous; initial workflow review within 3 months | Reduction in late or incomplete entries; improved staff perception of documentation time; reduction in repetitive documentation processes |
| **7. Technology and Documentation System Support** | System downtime, connectivity problems, insufficient devices, and poor electronic-record usability were reported barriers. | Assess hardware availability, connectivity, EHR usability, system downtime, and technical support. Establish rapid-response IT support and identify opportunities to simplify electronic templates and remove unnecessary duplication. | IT Department, Nursing Informatics, Nursing Administration, Quality Management | Initial assessment within 3 months; ongoing | Reduced downtime; improved device accessibility; fewer technology-related documentation delays; improved user satisfaction |
| **8. Safe Incident Reporting and Just-Culture Initiative** | Incident reporting significantly predicted documentation compliance; fear of blame and legal consequences was also reported. | Reinforce distinction between clinical documentation and incident reports; conduct case simulations; clarify escalation and reporting procedures; promote nonpunitive reporting of near misses and adverse events consistent with just-culture principles. | Risk Management, Patient Safety Office, Nursing Administration, Legal Office | Quarterly and during orientation | Increased appropriate incident reporting; fewer incorrectly documented incident references in clinical notes; improved staff confidence in reporting |

| | | | | | |
|---|---|---|---|---|---|
| **9. Nurse Support and Fatigue-Risk Reduction** | Fatigue, stress, and burnout were among the leading perceived barriers. | Review scheduling practices, encourage appropriate breaks, provide psychosocial support and referral pathways, integrate fatigue awareness into patient-safety education, and monitor units with high workload-related documentation deficiencies. | Nursing Administration, HR, Employee Wellness/Occupational Health | Ongoing | Reduction in reported fatigue-related documentation problems; improved staff perception of organizational support |
| **10. Continuous Quality Improvement and Program Evaluation** | Sustained improvement requires systematic evaluation rather than one-time training. | Apply a Plan–Do–Study–Act cycle. Compare baseline and follow-up documentation audits, training results, reported barriers, incident-related documentation deficiencies, and compliance indicators. Revise interventions based on results. | CLEAR-DOC Committee, Quality Management, Nursing Administration | Every 6 months | Documented PDSA cycles; measurable improvement in agreed indicators; program revisions based on evaluation data |

## Implementation Framework

The CLEAR-DOC Program may be implemented through a Plan–Do–Study–Act (PDSA) quality-improvement cycle.

During the Plan phase, Nursing Administration, Quality Management, Risk Management, Legal Services, Information Technology, and representatives of the clinical nursing units would review the baseline findings and identify priority documentation problems. Unit-specific baseline indicators would be established using documentation audits and staff feedback. During the Do phase, the planned interventions would be implemented, including legal-documentation education, documentation skills workshops, standardized policies, audit and coaching mechanisms, workflow improvements, and technological support. During the Study phase, post-intervention data would be compared with baseline indicators. Particular attention would be given to documentation completeness, timeliness, authentication, correction of errors, confidentiality, incident-related documentation, and recurring audit deficiencies. During the Act phase, interventions that demonstrated improvement would be institutionalized, while components that produced limited improvement would be modified and subjected to another quality-improvement cycle.

## Suggested Program Evaluation Indicators

Evaluation should occur at three levels. At the learning level, pre-test and post-test scores can determine whether nurses' legal-documentation knowledge improved. At the practice level, periodic chart or documentation audits can assess changes in accuracy, completeness, timeliness, authentication, confidentiality, and continuity of documentation. At the organizational level, the institution can monitor recurring documentation deficiencies, privacy incidents, incident-reporting practices, workflow concerns, technological problems, and staff perceptions of documentation barriers. A reasonable six- to twelve-month target would be to achieve at least 90% compliance with key documentation audit indicators, reduce recurrent documentation deficiencies by at least 20% from baseline, ensure that at least 90% of eligible nurses complete the legal-documentation training, and demonstrate measurable improvement in the specific documentation areas identified as comparatively weak. These figures should be presented as program targets, not as findings of the present study.

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**Proposed Governance Structure**

The program should preferably be overseen by a multidisciplinary CLEAR-DOC Quality and Legal Risk Reduction Committee chaired by Nursing Administration or Quality Management. Membership may include representatives from Nursing Education, Risk Management, Patient Safety, Legal Services, Data Privacy, Information Technology/Nursing Informatics, Human Resources, and selected clinical-unit representatives. Such an arrangement is important because the findings indicate that documentation compliance is not exclusively an individual nurse responsibility. While nurses' legal competence is associated with their documentation behavior, institutional conditions such as staffing, workload, policies, systems, supervision, and technology may facilitate or hinder consistent documentation.

## CONCLUSIONS

Based on the findings of the study, it can be concluded that the registered nurses in selected government hospitals in the City of Manila generally possessed an adequate level of legal competence and demonstrated a high level of compliance with nursing documentation standards. This indicates that the respondents were generally knowledgeable about the legal and professional responsibilities associated with nursing documentation and were able to translate much of this competence into appropriate documentation practices. However, the comparatively lower ratings in negligence, malpractice, professional liability, incident reporting, timeliness, and incident-related documentation suggest that specific areas still require focused improvement.

The significant positive relationship between legal competence and documentation compliance further indicates that nurses who possess stronger legal competence tend to demonstrate more consistent compliance with documentation standards. Legal competence therefore appears to be an important factor in supporting appropriate documentation behavior. At the same time, the relationship was not absolute, which means that documentation compliance is influenced by other factors beyond legal knowledge and competence alone.

The regression findings further support this conclusion. Legally defensible documentation practices, confidentiality and data privacy, professional accountability, and incident reporting emerged as significant predictors of documentation compliance. These dimensions appear to have particular importance because they are directly linked to the day-to-day legal and professional responsibilities involved in nursing documentation. However, the proportion of unexplained variance also suggests that other organizational and environmental factors remain relevant.

The barriers identified by the respondents confirm that documentation compliance is not solely an individual responsibility. Heavy workload, insufficient time, staffing shortages, frequent interruptions, fatigue, documentation burden, and technological limitations may hinder nurses from consistently applying what they know. Thus, improving documentation quality requires both individual competency development and organizational support.

Overall, the study concludes that strengthening nursing documentation compliance requires a combined approach that develops nurses' applied legal competence while also improving the work environment in which documentation occurs. The proposed CLEAR-DOC Quality Improvement and Legal Risk Reduction Program is therefore appropriate because it addresses both dimensions through education, policy standardization, audit and feedback, workflow improvement, technology support, incident-reporting enhancement, and continuous quality-improvement strategies.

The findings further support the use of Bandura's Social Cognitive Theory in explaining nursing documentation behavior. The results demonstrate that legal competence, documentation behavior, and environmental conditions are interrelated, reinforcing the view that professional practice is shaped by the interaction of cognitive, behavioral, and organizational factors.

## RECOMMENDATIONS

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Based on the findings of the study, it is recommended that ***nursing administrators*** in selected government hospitals in the City of Manila strengthen institutional efforts to improve both legal competence and compliance with nursing documentation standards. Particular attention should be given to the areas that emerged as comparatively weaker or more vulnerable, including negligence and professional liability, incident reporting and adverse events, timeliness of documentation, and incident-related documentation. Since legally defensible documentation practices, confidentiality and data privacy, professional accountability, and incident reporting significantly predicted documentation compliance, these areas should be prioritized in continuing professional development and quality-improvement initiatives.

**Hospitals** may implement the proposed CLEAR-DOC Quality Improvement and Legal Risk Reduction Program as a structured intervention for strengthening documentation practice. Training should move beyond lecture-based orientation and include case analysis, documentation simulations, correction-of-entry exercises, adverse-event scenarios, privacy and confidentiality cases, and guided application of institutional policies. Regular competency assessment may also be incorporated to determine whether nurses are able to apply legal principles appropriately in actual documentation situations.

**Nursing service offices** and quality-management units are likewise encouraged to strengthen documentation audit and feedback mechanisms. Regular chart reviews may be used to identify recurring deficiencies in accuracy, completeness, timeliness, authentication, confidentiality, communication, and incident-related documentation. Feedback should be constructive and educational, with coaching and corrective interventions provided when recurring concerns are identified. The literature reviewed in the study likewise supports repeated audit, intervention, feedback, and reassessment rather than one-time improvement activities.

**Hospital administrators** should also address the organizational barriers identified by the respondents. Heavy workload, insufficient time, staffing shortages, interruptions, fatigue, and documentation-system difficulties suggest the need to review staffing patterns, patient assignments, workflow, documentation requirements, and availability of resources. Where feasible, redundant documentation processes should be reduced, forms and procedures standardized, and nurses provided with adequate opportunities to complete documentation without unnecessary interruption. Documentation deficiencies should therefore be approached not only as individual performance concerns but also as possible indicators of system and workflow problems.

**Information technology and nursing informatics personnel** should periodically evaluate the usability, accessibility, reliability, and efficiency of electronic or hybrid documentation systems. Issues involving system downtime, connectivity, availability of devices, repetitive data entry, and difficult navigation should be addressed because technological limitations may interfere with timely and complete documentation. Data privacy and information-security safeguards should likewise be continuously reinforced in both electronic and paper-based systems.

**Hospital policies** concerning documentation should be reviewed regularly and communicated consistently across clinical units. Clear guidelines should be maintained for late entries, correction of errors, authentication, confidentiality, patient refusal, physician notification, incident documentation, adverse-event reporting, and escalation procedures. Supervisors and unit managers should apply these policies consistently to minimize variation in documentation practices among units.

**A supportive approach to incident reporting** is also recommended. Healthcare institutions should maintain accountability while promoting a culture in which nurses can appropriately report errors, near misses, and adverse events without unnecessary fear of blame. Clear differentiation between clinical documentation and incident-reporting processes should be reinforced to improve both patient safety and legal-risk management.

**For nursing education and continuing professional development providers**, legal competence should be strengthened through applied and scenario-based learning rather than relying solely on theoretical instruction. Particular emphasis may be placed on legally defensible charting, professional accountability, privacy and data protection, professional liability, and management of adverse events. Such approaches may help strengthen not only knowledge but also nurses' judgment and confidence in applying legal principles in clinical practice.

**Future researchers** are encouraged to replicate the study in other government and private hospitals, other cities or regions, and larger populations to determine whether the findings are consistent across different healthcare settings. Studies may also incorporate direct chart audits or objective documentation measures to complement self-reported compliance. Longitudinal or intervention studies may be conducted to determine whether improvements in legal competence lead to sustained improvements in documentation behavior. Future research may also examine additional factors such as organizational culture, leadership, burnout, staffing adequacy, electronic health-record usability, and continuing professional education, which the manuscript itself identifies as potentially relevant influences on documentation compliance.

### Limitations of the Study

This study is limited by its cross-sectional and nonexperimental design, which prevents causal conclusions from being drawn from the observed relationships. The use of self-reported data may introduce recall and social-desirability bias, while actual documentation practices were not independently verified through chart audits or direct observation. The study was also limited to selected government hospitals in the City of Manila, which may restrict generalizability. Moreover, other organizational and technological factors were not included in the regression model. Finally, the proposed CLEAR-DOC Program has not yet been pilot-tested; therefore, its feasibility, effectiveness, and sustainability should be evaluated using baseline and follow-up indicators before wider institutional adoption.

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