



**NURSING  
COUNCIL  
OF KENYA**

# **POLICY BRIEF**

## **DOCUMENTATION OF CARE IN NURSING AND MIDWIFERY PRACTICE**

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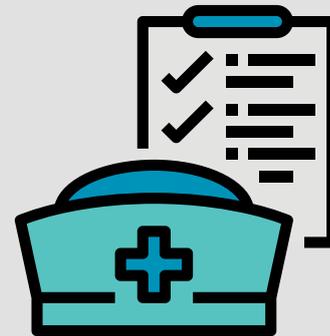
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## KEY MESSAGES

- **Core to practice** - documentation ensures care continuity, accountability, and decision-making.



- **Quality standards** - Must be accurate, timely, clear, and objective.



- **Value of good documentation** - Promotes professionalism, patient safety, and quality care.



- **Risks of poor documentation** – leads to miscommunication, harm, and litigations.



# 1. BACKGROUND

The **Nursing Council of Kenya (NCK)** and other regulatory bodies emphasize that documentation of care is not just a record but a reflection of the quality of care provided. It supports communication among multidisciplinary teams, facilitates audits, and serves as evidence in legal or ethical reviews.

In its *Documentation of Care Handbook for Nurses and Midwives*, NCK outlines that good documentation is essential for:

- **Demonstrating accountability and professionalism.**

- **Ensuring patient safety and continuity of care.**

- **Supporting ethical and legal standards.**

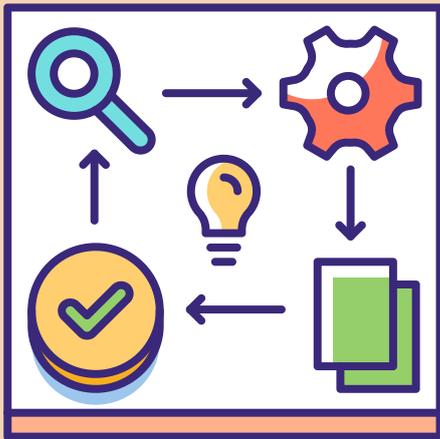
- **Facilitating education, research, and quality improvement.**

Poor documentation can lead to miscommunication, compromised patient safety, and legal consequences. Therefore, nurses and midwives are trained to document care accurately, contemporaneously, clearly, and comprehensively, using standardized terminologies and avoiding ambiguous language.

# 3. EXECUTIVE SUMMARY

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Effective nursing and midwifery care documentation is a cornerstone of quality healthcare delivery, patient safety, and professional accountability. In Kenya, while nurses and midwives form the majority of the health workforce and are often the first point of contact for patients, documentation practices remain inconsistent and challenged by :



## 1. SYSTEMIC

## 2. TECHNOLOGICAL



## 3. HUMAN RESOURCE FACTORS

This policy brief highlights the critical role of comprehensive nursing and midwifery documentation in ensuring continuity of care, facilitating clinical decision-making, protecting patients' rights, and providing legal evidence of care delivered. It also underscores how robust documentation supports data-driven health planning, performance monitoring, and achievement of Universal Health Coverage (UHC) goals.

Key gaps in this practice include:

- ***high nurse/midwife-to-patient ratios leading to incomplete records***
- ***weak enforcement of existing guidelines***
- ***Lack of consistency stemming from the absence of a standard operating procedure***

These gaps compromise **communication within the multidisciplinary team**, **the quality and safety of patient care** and **ultimately affecting patient care outcomes**.

To address these challenges, the brief proposes targeted policy actions:

- **Standardization** 
- **Capacity Building** 
- **Workforce Support** 
- **Monitoring** 
- **Accountability** 

By investing in nursing care documentation, Kenya can enhance the quality and safety of patient care, improve health data for decision-making, protect healthcare providers legally, and align nursing practice with global best standards.

# 2. KEY ISSUES



**1. Incomplete or Inaccurate Documentation;** Missing details or vague entries e.g., “appears” or “seems” can lead to misinterpretation of care and legal risks. Inaccurate documentation is responsible for electronic health record-related risk issues.

**2. Lack of Timeliness;** Delayed entries compromise the continuity of care and may be viewed as falsification.



**3. Documentation Burden;** high nurses/midwives to patient ratios with a huge workload and limited time on documentation. This contributes to burnout, job dissatisfaction, and increased risk of errors.

**4. Legal and Ethical Implications;** Poor documentation can result in disciplinary action due to negligence and malpractice allegations. Legal defense often hinges on the quality of documentation i.e. “*If it wasn’t documented, it didn’t happen.*”



**5. Low Adherence to Standards;** Studies show that only 50% of nurses consistently follow proper documentation practices (Dafer Ali Dafer Albahri, et al, 2023). Factors include lack of training, motivation, and standardized formats.

**6. Insufficient Capacity and Support;** Some nurses and midwives lack adequate education on documentation standards and legal implications. Continuous professional development is essential but often overlooked.



**7. System and Technological Evolution and Challenges;** Electronic health records (**EHRs**) can be complex and unintuitive. Poor interface design and excessive data entry requirements hinder effective documentation and subsequent quality of care.



## 4. TARGET GROUP

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1. **Nurses and Midwives** 
2. **Health Managers & Administrators** 
3. **Educators and Students** 
4. **Council of Governors** 
5. **Ministry of Health** 
6. **Researchers and Policy makers** 
7. **Legal and Ethical Reviewers** 
8. **Health Regulatory Bodies**

## 5. RECOMMENDATIONS

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1. Utility of the NCK Documentation of Care Handbook to guide Nurses and Midwives in consistent, professional documentation.
2. Improve nurse-to-patient ratios to ensure nurses have adequate time for both direct patient care and comprehensive documentation.
3. Continuous Professional Development (CPD) sessions to reinforce documentation skills and ethical standards.

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# 7. REFERENCES

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