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Survey on Nursing Documents in Use on Patients with Heart Diseases at the Regional Hospital Bamenda

Marceline Singam Foba*, Kenneth Navti Lifoter, Mary Bi Suh Atanga

Department of Nursing, Faculty of Health Science, The University of Bamenda, Bamenda, Cameroon
Email: *marcelinefoba30@gmail.com

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Abstract

Introduction: Nursing documentation is fundamental to clinical practice, ensuring patient safety, continuity of care, and fostering interprofessional collaboration. Documenting appropriately, thoroughly and accurately is a nurse's legal and ethical responsibility. Concerns about care can easily be brought into question if a nurse's documentation does not represent a comprehensive picture of care that was delivered to a client. Nursing documentation is central to clinical decision-making and continuity of care, particularly for chronic conditions like heart disease. Accurate documentation allows healthcare providers to track a patient's progress, adjust care plans, and ensure that all team members are aware of the latest updates in the patient's treatment. **Objectives:** The objectives were, to identify the existing documents used on patients with heart diseases, to assess the frequency of use of documents on patients with heart diseases, to identify the reasons for effective use of documents on patients with heart diseases and to identify the reasons for neglect in the use of nursing documents on patients with heart diseases at the Regional Hospital Bamenda (RHB). **Methods:** A cross-sectional descriptive study design was used for this survey. A purposive sampling technique was used to recruit the nurse supervisors, while a convenient sampling method was used to recruit staff nurses into the study population. A total of 161 nurses (50 supervisors and 111 staff nurses) were recruited. Data was collected using structured questionnaires as the primary instrument and a participant observation checklist to assess the use of documents on patients with heart diseases. Data was analyzed using SPSS version 26. **Results:** The demographic characteristics of 147 participants reveal a young, predominantly female, educated nursing workforce who are serving as staff nurses and nurse supervisors. Most of them have 6 - 10 years of experience. His study presents documents reported by nurses with inconsistencies and significant gaps in the availability of crucial nursing

documents, such as patient assessment documents, indicated as not available to 128 (87.1%) participants. The study revealed a generally positive perception among nurses regarding the routine use of nursing documents, with 81.6% of nurses indicating using them regularly for the care of patients with heart disease (HD). The study shows that 83% of participants indicated workload as one of the reasons for neglecting nursing documentation. **Conclusion:** The study concluded that documentation practices at the Regional Hospital Bamenda were poorly implemented, as there were no necessary documents available for documentation and a staff shortage. There is also an indication of a lack of follow-up on documentation practices by nurses at the hospital, which should ensure effective management and quality of care for patients with heart diseases.

Keywords

Nursing Documents, Documentation, Heart Disease, Effective Patient Care

1. Introduction

Nursing documentation is defined as the systematic recording of planned and implemented care for individual patients and serves as a cornerstone of clinical practice, enabling essential communication across healthcare teams. According to the American Nursing Association, it is pivotal for ensuring patient safety, continuity of care, and fostering interprofessional collaboration [1]. In heart disease management, especially in resource-constrained settings, documentation is invaluable, facilitating timely interventions and risk management in patient care [2].

Nursing documents include both physical and digital records, capturing patient assessments, care plans, and medical histories, which streamline the documentation and communication process, improving care for heart disease patients by providing clear, standardized data for healthcare teams [3]. The requirements for effective documentation in nursing are set by both regulatory bodies and institutional policies. Proper documentation mandates accuracy, timeliness, and accessibility, all of which directly impact effective patient care and safety [4]. The American Nursing Association further emphasizes that comprehensive documentation must be legally compliant and provide a verifiable account of all patient care activities, ensuring accountability among healthcare providers [1]. The documentation process in nursing involves systematic steps to capture patient data accurately and thoroughly, ensuring consistency and accessibility of information. In clinical settings, especially for high-risk groups like those with heart diseases, the process often includes electronic health records (EHRs) to streamline data entry and retrieval, enhancing efficiency and reducing errors [5]. The implementation of EHRs supports real-time access to patient information, which is essential for the rapid decision-making needed in cardiovascular care. The process typically includes assessments, intervention records, and evaluation notes, providing a full narrative of the patient's journey through the healthcare system [3].

Nursing documentation is central to clinical decision-making and continuity of care, particularly for chronic conditions like heart disease. Accurate documentation allows healthcare providers to track a patient's progress, adjust care plans, and ensure that all team members are aware of the latest updates in the patient's treatment [2]. For cardiovascular patients in sub-Saharan Africa, where there are higher incidences of hypertension and other risk factors, comprehensive documentation helps monitor disease progression and detect complications early [4]. Standardized nursing documentation thus supports continuity and quality in patient care by offering a clear and accessible history of care provided. The primary functions of nursing documentation are to provide a legal record of care, ensure accountability, support communication, and maintain a continuous record of patient status. These functions are particularly significant in the context of heart diseases, where accurate tracking of symptoms and treatment responses is essential to prevent life-threatening events. Nursing documentation also facilitates coordinated efforts among interdisciplinary teams, allowing nurses, physicians, and specialists to share information that impacts effective patient care [3]. This collaborative function is especially valuable in managing complex cases, such as patients with multiple cardiovascular risk factors seen in settings like Cameroon, where proactive intervention can reduce mortality [6].

Heart diseases, a major category of non-communicable diseases (NCDs), are increasingly prevalent in sub-Saharan Africa due to rapid urbanization, westernization, and the rise in risk factors such as hypertension and diabetes [7]. In Cameroon, the health system faces significant challenges, including inadequate health insurance coverage and a shortage of healthcare professionals, contributing to high mortality rates from NCDs. Approximately 31% of all deaths in Cameroon are attributed to NCDs, with cardiovascular conditions accounting for 14%. There is limited evidence on the specific profile of heart diseases in Cameroon, as existing data mostly is derived from localized hospital-based studies [8]. These studies consistently identify heart disease (HD), and cardiomyopathies as predominant conditions. To contribute to the growing body of knowledge and inform better healthcare planning and nursing practice, particularly in documentation and patient management, this study investigates the nursing documents in use for patients with heart diseases at selected district and referral hospitals in Bamenda, Northwest Region of Cameroon [8].

Nursing documentation provides a rich source of data for research and health policy development, offering insights into patient demographics, disease prevalence, and treatment efficacy. In heart disease management, documentation data can be analyzed to assess the effectiveness of interventions, track disease trends, and guide resource allocation in healthcare [2]. This research utility makes documentation essential not only for clinical purposes but also for informing broader health policy decisions and preventive care strategies [6]. Patients with heart diseases are considered critically ill, with a heavy risk of crisis within the twinkle of an eye. Accurate reporting and timely communication by nurses will arrest crisis

situations and reduce complications/mortality rates in patients with heart disease. Despite its importance, nursing documentation faces challenges such as time constraints, limited resources, and a lack of standardized guidelines in some settings. In many sub-Saharan African countries, where Cameroon is part, resource limitations impact the implementation of electronic documentation, posing a barrier to efficient record-keeping in heart disease care [5]. Addressing these challenges is crucial for improving the quality and accessibility of documentation and, by extension, the quality of patient care.

Objectives

1) To identify the existing documents used on patients with heart diseases at the RHB.

2) To assess the frequency of use of documents on patients with heart diseases at the RHB.

3) To assess the reasons for the effective use of documents on patients with heart diseases at the RHB.

4) To identify the reasons for neglect of documents on patients with heart diseases at the RHB.

2. Methods

Study design:

This study adopted a cross-sectional descriptive study design to meet the objectives, which were aimed at exploring documents and documentation practices on patients with heart disease at the Regional Hospital Bamenda.

Study area:

The study was conducted at the Regional Hospital Bamenda, a 480-bed facility that includes multiple departments such as medical, surgical, pediatric, and intensive care units. As a teaching hospital affiliated with the University of Bamenda, it serves as a hub for advanced medical care and education. With 147 senior nurses, 16 midwives, and 56 nurse assistants, the hospital manages a high patient load, including 454 cases of congestive heart failure in 2022. This setting provided an ideal environment for evaluating nursing documentation practices for heart disease patients.

- **Inclusion criteria**

All nurses (both senior and staff nurses) who have worked for at least a year at the Regional Hospital will be included in the study.

- **Exclusion criteria**

All nurses who did not consent for the study.

All nurses who did not completed the questionnaire.

Sample Size:

The study made use of sample size technique in a bit to achieve an acceptable and convenient population to represent the whole. Given the total study population of 270 nurses and nurse assistance the Slovin's formula (Slovin, 1967) was used to calculate the actual population of the study.

$$N = N \div \left(1 + Ne^2\right).$$

$$n = \frac{N}{1 + Ne^2}$$

where N = Population size.

e = Margin of error.

n is the sample size.

The margin of error is a percentage, is expressed as a decimal for Slovin's formula. In this formula, the 5% margin of error would be expressed as 0.05 (5/100).

$$N = 270 \text{ nurses}$$

$$E = 0.05$$

$$N = 270/(1 + 270 \times 0.05^2)$$

$$n = 270/1 + 270\ (0.0025)$$

$$n = 161$$

The study population considered was 161 nurses following Slovin's formula (Slovin, 1967) for population sample size determination. A total of 161 were administered and returned. A total of 147 questionnaires were completed, giving a respond rate of 91.3%. A purposive sampling technique was used for nurse supervisors (n = 50) and a convenient sampling technique was used for staff nurses where 97 completed the questionnaires.

Ethical and Administrative Considerations:

As concerns ethical and administrative considerations, after working with the supervisors on the proposal and receiving their approval, the proposal was defended before a jury at the University of Bamenda. After approval by the jury, ethical clearance was obtained from the University of Bamenda's Institutional Review Board with project identification number (2024/0020H/UBa/IRB). The researcher presented the institutional ethical clearance at the Regional Delegation of Public Health, where an authorization number (382/ATT/NWR/RDPH/BRIGAD) was issued, enabling research to be conducted in the Region. The authorization from the Regional Delegation was presented to the Regional Hospital Management, to obtain an authorization number (REF. NO. R005/MPH/RDPH/RHB/632) to carry out research at the Regional Hospital Bamenda, permission from the Head Nurses and individual informed consent from the staff nurses. The participants were identified by codes, confidentiality and anonymity were maintained, and they were assured that the findings would be used for the purpose of this study only. Participants were informed that they had a free hand to withdraw whenever they felt the need to. The participants were also assured that the research had no negative effects on them as individuals.

Data collection: Data were collected using a structured self-administered questionnaire with both open and closed-ended questions adapted from validated sources, covering demographic data and various dimensions of nursing documentation quality. The demographic characteristics of participants included age, sex, marital status, qualification, job position, work experience, and monthly income. It further outlined findings on institutional policy on implementation and follow-

up on the use of nursing documents. The study explored the use of current documents on patients with heart diseases. The pre-test was conducted to ensure clarity, relevance, and ease of use of the data collection tool (questionnaire). A pilot study was carried out at the Nkwen District Hospital-Bamenda involving 18 nurses who constitute 11% of the study population, with a test-retest method applied to assess reliability using Cronbach's alpha (0.895) which indicates a high level of internal consistency and reliability for the set of items used in the assessment as applied to the standard alpha value above 0.7 (acceptable). Necessary modifications were made to improve the instruments.

Data Analysis:

Data was categorized as primary or secondary and analyzed using SPSS version 25. Descriptive statistics summarize nursing documents and documentation practices. Inferential statistics, including Chi-square tests, were applied to variables determining the availability of nursing documents, the usage of those available, and the reasons for nurses not using documents effectively in patient care.

3. Results

- **Demographic Characteristics**

The demographic characteristics of the 147 participants in this study showed a predominantly young, female, educated nursing workforce. Table 1 shows that 89 (60.5%) of the participants were aged between 31 - 40 years. The majority were female, accounting for 102 (69.4%) of the sample. Most participants were unmarried, with 90 (61.2%) reporting this status. In terms of educational qualifications, the largest group held a Bachelor's degree in nursing, comprising 110 (74.8%) of participants. Regarding job position, the majority were staff nurses, totaling 122 (83.0%). Most participants had 6 - 10 years of work experience, representing 64 (43.5%) of the sample. In terms of income, the highest proportion, 78 (53.1%), earned between 51,000 and 100,000 CFA francs monthly. Additionally, 137 (93.2%) indicated that a policy was available in their institution. However, when it came to follow-up on policy implementation, the highest number, 64 (43.5%), reported that such follow-up did not exist.

Table 1. Distribution of the participants according to demographic characteristics (N = 147).

	Frequency (n)	Percent (%)	χ^2-test
Every HD	120	81.6	
Terminally ill	8	5.4	$\chi^2 = 265.722$, $P < 0.0001$
ICU	18	12.2	
Never	1	0.7	
Readily available	12	8.2	
Costed	1	0.7	
Continuity of care	54	36.7	$\chi^2 = 68.466$, $P < 0.0001$
Care evaluation	68	46.3	
Follow up	12	8.2	

Continued

Not available	80	54.4	
No follow up	25	17	$\chi^2 = 74.164$, $P < 0.0001$
No motivation	33	22.4	
No continuity	9	6.1	
Quality care	117	79.6	
Outcome evaluation	12	8.2	$\chi^2 = 236.483$, $P < 0.0001$
Continuity of care	16	10.9	
Research	2	1.4	
Always	121	82.3	
Sometimes	25	17	$\chi^2 = 164.571$, $P < 0.0001$
Rarely	1	0.7	
Total	147	100	

- **Documents used on Patients with Heart Diseases at the RHB**

Table 2 shows that nurses' assessment documents were not available as reported by 128 (87.1%) participants. The fluid balance sheet was available, reported by 114 (77.6%) participants. The medication administration sheet was available, indicated by responses from 89 (60.5%), while the progress note sheet was reported by 88 (59.9%). Documents reported by less than half of the percentage of participants included: the informed consent form, 57 (38.8%); the weight monitoring sheet, 54 (36.7%); the discharge planning form and transfer form, 50 (34%); incident report sheet, 3 (20.4%). These findings highlight significant variation in the availability of essential nursing documentation, with vital signs being consistently used while the assessment form is absent for nurses.

Table 2. Distribution of participants according to current documents at the Regional Hospital Bamenda (N = 147).

Documents	Options	Frequency (n)	Percent (%)
Patient assessment form	Available	19	12.9
	Not available	128	87.1
Informed consent form	Available	57	38.8
	Not available	90	61.2
Medication administration sheet	Available	89	60.5
	Not available	58	39.5
Fluid balance sheet	Available	114	77.6
	Not available	33	22.4
Discharge planning form	Available	50	34
	Not available	97	66
Progress note sheet	Available	88	59.9
	Not available	59	40.1
Incident report sheet	Available	30	20.4
	Not available	117	79.6

Continued

Weight monitory sheet	Available	54	36.7
	Not available	93	63.3
Transfer form	Available	50	34
	Not available	97	66
Vital signs form	Available	144	98
	Not available	3	2
	Total	147	100

- **Nursing Documents According to field Assessment (Observation) per Unit**

Figure 1 presents the distribution of nursing documents across hospital units based on a checklist assessment, focusing on availability, adaptation, and usage. Medication administration sheets, incident report sheets, nursing care plans, discharge planning forms, and vital signs forms were available and used in all six units (100%). Informed consent forms were available and used in four units (Medical, Maternity, Surgical, and Intensive Care Units), representing 66.7% of units. The Intensive Care Unit adapted three additional documents: a transfer form, a flow chart, and a patient assessment form, all of which were in use. The Pediatric and T.B. units do not use informed consent forms, and no other unit besides the ICU had adapted documents.

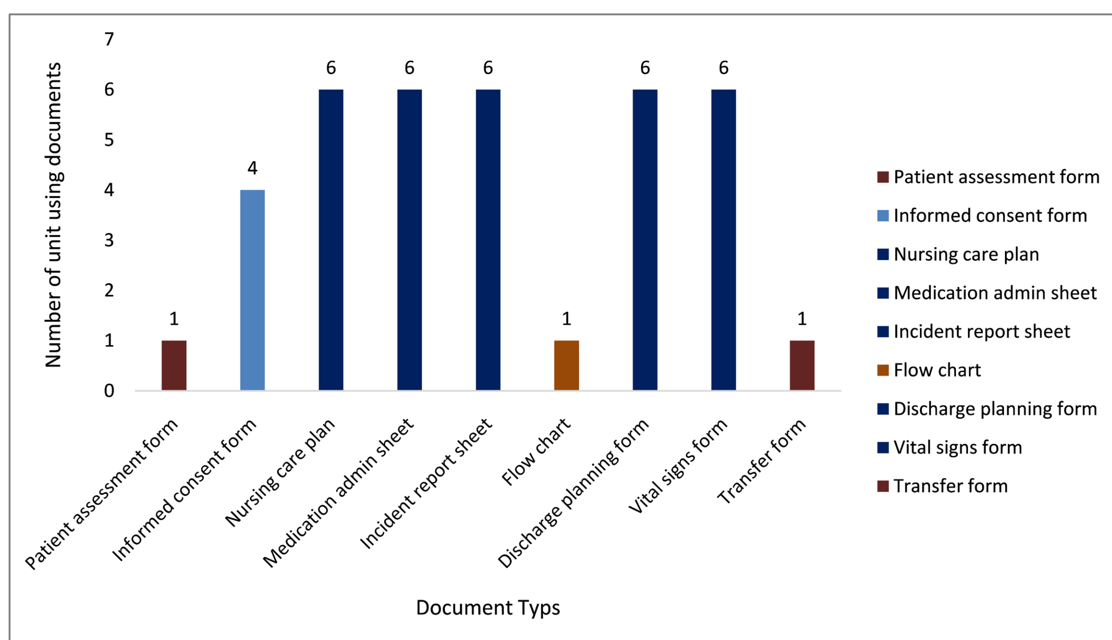

Figure 1. Distribution of nursing documents according to field assessment per unit.

- **Responses on When Documents Were Instituted**

Figure 2 shows responses on when documents were instituted. The distribution of participants based on when nursing documents were instituted shows that the majority, 70 (47.6%) of participants indicated that nursing documents were im-

plemented as of 3 years ago. Another proportion, 41 (27.9%), of participants indicated it existence dating 5 years ago.

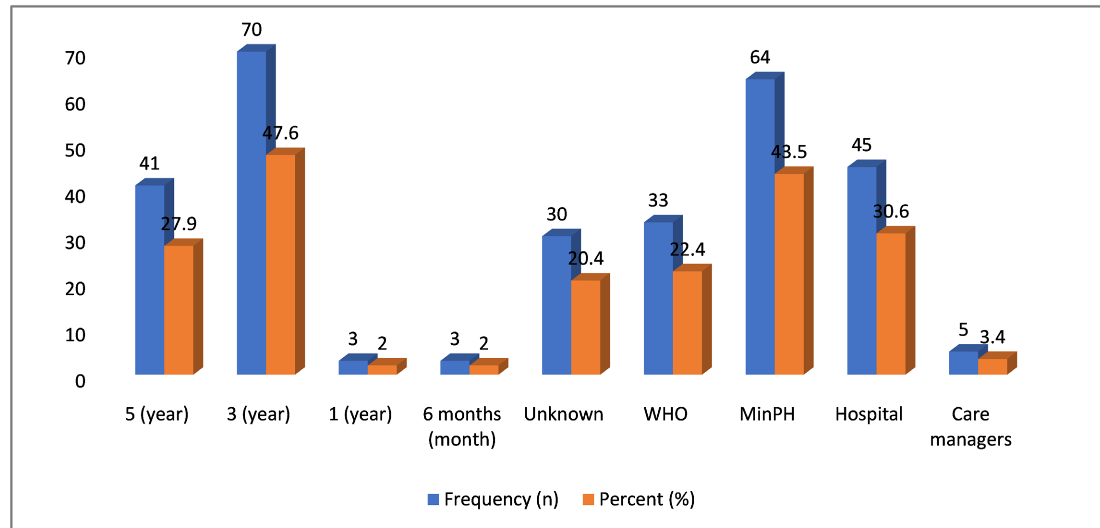

Figure 2. Distribution of participants according to when documents were instituted and who instituted the documents.

The distribution of participants with respect to who instituted the documents indicates most participants 64 (43.5%) reported that the Ministry of Public Health (MinPH) accounted for the highest proportion while 45 (30.6%) of participants indicate that the hospitals was responsiple for instituting the nursing documents and the World Health Organization (WHO) accounted for by 33 (22.4%) of participants.

- **Routine Use of Existing Nursing Documents**

Table 3 shows a generally positive perception regarding the routine use of nursing documents. The distribution of participants according to how documents were being used shows that 120 (81.6%) participants reported usage in every congestive heart failure (CHF), and 18 (12.2%) of the participants indicated usage in Intensive Care Units (ICU).

- **The Reasons for Effective Use of Existing Nursing Documents and Documentation**

Table 3 also shows the reasons for effective use of documents. A total of 68 (46.3%) participants stated that the primary reason for the effective use of nursing documents was for care evaluation, while 54 (36.7%) of the participants indicated that it was to ensure continuity of care.

- **Reasons for Ineffective Use of Existing Documents and Documentation**

Table 3 shows the various reasons for ineffective use of nursing documents. The majority of participants, 79 (54%), reported that the primary reason for the ineffective use of nursing documents was their unavailability. About 33 (23%) of the participants indicated that a lack of motivation among healthcare staff contributed to the ineffective use of these documents, while 25 (17%) of the partici-

pants stated that the absence of follow-up mechanisms was a key factor.

- **Responses on How Often Nursing Documents Are Used**

Table 3 further shows how often nursing documents were used. The majority of participants, 121 (82%), reported that nursing documents were always used in patient care, while 25 (17.0%) of the participants stated that the documents were used only sometimes.

Table 3. Distribution of participants according to reasons for effective and ineffective use and the frequency of use of documents.

	Frequency (n)	Percent (%)
Every HD	120	81.6
Terminally ill	8	5.4
ICU	18	12.2
Never	1	0.7
Readily available	12	8.2
Costed	1	0.7
Continuity of care	54	36.7
Care evaluation	68	46.3
Follow up	12	8.2
Not available	80	54.4
No follow up	25	17
No motivation	33	22.4
No continuity	9	6.1
Quality care	117	79.6
Outcome evaluation	12	8.2
Continuity of care	16	10.9
Research	2	1.4
Always	121	82.3
Sometimes	25	17
Rarely	1	0.7
Total	147	100

- **Documents Often Used and Documents Often Neglected**

Table 4 presents the distribution of participants based on the documents they frequently used or neglected. The informed consent form was used by 67 (45.6%) participants, while 80 (54.4%) neglected it. The changing position of patient format was rarely used (27, 18.4%), with most neglecting it (120, 81.6%). The medication administration sheet was used by 84 (57.1%), but 63 (42.9%) neglected it. The fluid balance sheet was frequently used (101, 68.7%), though 46 (31.3%) neglected it. Most participants used the patient assessment form (111, 75.5%), while only 36 (24.5%) neglected it. The nursing care plan was used by 87 (59.2%), with 60 (40.8%) neglecting it. The discharge planning form was neglected by 89

(60.5%), compared to 58 (39.5%) who used it. The progress note sheet was rarely used (33, 22.4%), with 114 (77.6%) neglecting it. Similarly, the incident report sheet, digitalis/digoxin monitoring chart, and report algorithm sheet were each neglected by 120 (81.6%), 120 (81.6%), and 125 (85.0%) participants, respectively. The pain assessment form was used by 90 (61.2%), while 57 (38.8%) neglected it. The heparin administration form was neglected by 115 (78.2%), and the weight monitoring sheet by 92 (62.6%). The transfer form was used by 88 (59.9%), and the flow chart by 91 (61.9%). Nearly all participants (145, 98.6%) used the vital signs form, with only 2 (1.4%) neglecting it. These findings suggest varying levels of document utilization, with some being widely adopted while others are frequently overlooked.

Table 4. Distribution of participants according to documents often used/neglected.

		Frequency (n)	Percent (%)	χ^2-test
Informed consent form	Used	67	45.6	$\chi^2 = 1.959$, $P = 0.1616$
	Not used	80	54.4	
Changing position of patient format	Used	27	18.4	$\chi^2 = 115.156$, $P < 0.0001$
	Not used	120	81.6	
Medication administration sheet	Used	84	57.1	$\chi^2 = 5.442$, $P = 0.0197$
	Not used	63	42.9	
Fluid balance sheet	Used	101	68.7	$\chi^2 = 39.673$, $P < 0.0001$
	Not used	46	31.3	
Patient assessment form	Used	111	75.5	$\chi^2 = 74.503$, $P < 0.0001$
	Not used	36	24.5	
Nursing care plan	Used	87	59.2	$\chi^2 = 9.197$, $P = 0.0024$
	Not used	60	40.8	
Discharge planning form	Used	58	39.5	$\chi^2 = 12.245$, $P = 0.0005$
	Not used	89	60.5	
Progress note sheet	Used	33	22.4	$\chi^2 = 87.075$, $P < 0.0001$
	Not used	114	77.6	
Incident report sheet	Used	27	18.4	$\chi^2 = 115.156$, $P < 0.0001$
	Not used	120	81.6	
Pain assessment form	Used	90	61.2	$\chi^2 = 13.932$, $P = 0.0002$
	Not used	57	38.8	
Heparin administration form	Used	32	21.8	$\chi^2 = 91.483$, $P < 0.0001$
	Not used	115	78.2	
Digitalis/digoxin monitoring chat	Used	27	18.4	$\chi^2 = 115.156$, $P < 0.0001$
	Not used	120	81.6	
Report algorithm sheet	Used	22	15.0	$\chi^2 = 141.551$, $P < 0.0001$
	Not used	125	85.0	
Weight monitory sheet	Used	55	37.4	$\chi^2 = 17.633$, $P < 0.0001$
	Not used	92	62.6	

Continued

Transfer form	Used	88	59.9	$\chi^2 = 10.667$, P = 0.0011
	Not used	59	40.1	
Flow chart	Used	91	61.9	$\chi^2 = 15.728$, P < 0.0001
	Not used	56	38.1	
Vital signs form	Used	145	98.6	$\chi^2 = 274.340$, P < 0.0001
	Not used	2	1.4	
	Total	147	100.0	

- **Reasons for Neglect**

Table 5 shows the reasons for the neglect of nursing documents. A majority 122 (83.0%) of the participants indicated workload as the reason for neglect. Other reasons included lack of knowledge for use as indicated by 9 (6.1%) participants, document not available as indicated by 8 (5.4%) participants and no follow-up as reported by 6 (4.1%) of the participants.

Table 5. Distribution of participants according to reasons for neglect.

	Frequency (n)	Percent (%)
Work load	122	83.0
Document not available	8	5.4
Lack of knowledge for use	9	6.1
No follow-up	6	4.1
Unknown	2	1.4
Total	147	100.0

- **Discussion of Findings**

The study shows a young, predominantly female, educated nursing workforce and serving as staff nurses and nurse supervisors with most of them having 6 - 10 years of experience. Despite high awareness of institutional policy availability (93.2%), follow-up on implementation was lacking (43.5%). Most of the nurses serving in this study hospital, earned minimal incomes not commensurate to their qualifications per the countries official pay roll. This may directly influence work output among the nurses. Most of the nurses hold bachelor's degrees in nursing, indicating a skilled workforce which is poorly motivated.

- **Existing Documents Used on Patients with Heart Diseases at the RHB**

This result present documents reported by nurses and confirmed using an observational checklist to have inconsistencies and significant gaps in the availability and use of important nursing documents. Nurses in the study population reported the presence of fluid balance documents. The findings suggested a fragmented documentation system that undermines continuity of care and comprehensive patient assessment. The substantial variation also points to a disconnect between documentation expectations and actual practice, possibly due to systemic challenges in provision of nursing documents separate from medical documents, pol-

icy enforcement, resource allocation, poor knowledge on nursing document and documentation.

Nurses' reported that many essential documents were not always available. For example, the nurses' assessment documents, which are a fundamental tool for accessing patient information for care, were absent. However, some documents were reported to be available, such as the fluid balance sheet, medication administration sheet and progress note sheet. In contrast, the checklist used to assess hospital units in showed that medication administration sheets, incident report sheets, nursing care plans, discharge planning forms, and vital signs forms were all available and used in every unit. Informed consent forms were used in four out of six units, while only the Intensive Care Unit used additional documents like a transfer form, flow chart, and patient assessment form, which was adapted. This shows a clear difference between what nurses report and what is actually present and used in hospital units.

The comparison between questionnaire responses and the checklist assessment presented significant discrepancies regarding the availability and use of nursing documents for heart disease patients at Regional Hospitals Bamenda, which serves as a teaching hospital attached to the University of Bamenda. The survey also identified that there was no continuity of care since there were no nursing documents for documentation of nursing care on patients. Every time a patient returned to the hospital, a new document was used therefore caused a rupture in the continuity of care. This creates a serious gap in nursing care as most patients will likely report similar cases repeatedly without proper verification of progress, hence increasing the cost of hospitalization of patients and giving a steadily increasing number of heart disease cases as recorded by the hospital from 2022 to 2025. These inconsistencies suggest a lack of awareness, training, or engagement among nursing staff regarding available documentation, which again indicates the lack of nursing documents separate from some other medical files. The use of the checklist was thus essential for accurately verifying document present, adaptation, and actual use, highlighting gaps in nursing documentation practice and continuity of care. The irregularity also underscores the systemic disconnection between policy, practice, and staff communication.

Analyzing these findings through Neuman's Systems Model illustrates a breakdown in the holistic application of nursing theory. The model emphasizes client-centered care, environmental influences, and multiple defense lines Lawson [9], but the current documentation practices fail to reflect this systems-based approach. Neuman's concept of continuity of care through integrated systems and records is absent nurses lack access to essential tools like patient assessment sheets, leading to fragmented care. Hsu [10] emphasized the need for patient-centered, readable documents for heart disease care. while Nishimura [11] advocated standardized documentation for valvular heart disease management. Similarly, Hernandez-Madrid [12] called for precise and consistent documentation in managing heart diseases. In contrast, the current setting lacks consistency and adaptation of

documents to unit-specific needs, ignoring resilience-building and defense mechanisms as proposed in Neuman's framework. These discrepancies point to a critical need for standardized, and effectively implemented documentation practices to support holistic, continuous nursing care.

- **Frequency of Use of Documents on Patients with Heart Diseases at the RHB**

The study found that most nurses had a positive attitude toward using the available nursing documents. Most of the nurses (81.6%) reported that documents were regularly used for managing heart diseases. When compared to the checklist assessment, which showed that key documents like medication sheets, care plans, and vital signs forms were available and used in all hospital units, it suggests a gap between what is available and how often nurses actually use them. While the units appear well-equipped with some necessary documents, individual usage by nurses may still vary, showing that availability does not always translate to regular use. This could be as a result of work overload, shortage of staff and poor remuneration. This inconsistency shows that nurses are not fully applying the Nursing Process Theory, which encourages a step-by-step approach to patient care starting with assessment, followed by planning, action, and evaluation [13]. It also shows that the Information Processing Theory (IPT), which views documentation as a way for nurses to think through and remember patient information, is not being used effectively [14]. When these models are not applied, documentation becomes scattered, and there is less focus on following up and checking patient outcomes. Schmieding, underscores the importance of aligning nursing practice with theoretical models to ensure holistic and coordinated care delivery. Her framework emphasizes that theoretical integration is essential for fostering comprehensive documentation and clinical reasoning, which supports the critique in the discussion that without effective application of such models, nursing documentation risks becoming fragmented and less useful for patient outcome monitoring [15].

- **Reasons for Effective Use of Documents on Patients with Heart Diseases at the RHB**

According to the nurses in this study, they use nursing documents mainly for patient assessment and to ensure continuity of care. This shows that nurses mostly view documentation as a practical tool for completing specific tasks rather than as part of a bigger system of care. More so, the disparity between the survey and checklist will contradict this report, as it earlier reported a lack of founder mental documents, such as patient assessment, indicating a breakdown in continuity of care. More so, when compared with the checklist results, which showed that key documents like care plans, discharge forms, and progress notes were available and in use across most hospital units, it suggests that the system supports more comprehensive and continuous care. The difference shows that while the documents are available and meant to support the full nursing process, many nurses are still focused on using them mainly for immediate tasks, rather than for long-term care planning and follow-up.

This pattern is similar to what Pancha [16] pointed out. The need for clear and

organized documentation to record important heart disease-related information, especially in places with limited resources like Ngaoundéré. Yet, in this study, only 10.9% of nurses mentioned using documentation for patient follow-up, showing a gap in keeping track of patients over time. In the same way, Meno [17] found major gaps in how care goals were documented for patients with adult heart disease at the end of life. This highlights a common issue of incomplete or scattered records, which can weaken long-term care planning and make it harder for healthcare providers to make informed decisions.

- **Reasons for Neglect of Documents on Patients with Heart Diseases at the RHB**

In this study, most nurses (83.0%) said they often skipped nursing documentation because of heavy workloads. A smaller number also mentioned reasons like not knowing how to document properly, not having the documents available, or the lack of systems to check if documentation was being done. However, when looking at the checklist results, it was clear that many of the key documents, such as medication sheets, care plans, and vital signs forms, were actually available and in use across most hospital units. This shows a mismatch between what nurses say and what was found: documents were mostly available, but due to pressure from workload and limited support or training, nurses still struggled to use them consistently.

These findings point to problems at the system level, where heavy workloads and staff shortages are bigger issues than gaps in procedures. This matches what Alkouri [18] found that high workloads and a lack of proper training are major reasons nurses struggle with documentation in clinical settings. Rahman [19] also showed that when nurses are under pressure, especially in busy or emergency areas, they often put documentation last, which leads to incomplete records and weaker care. In this study, the lack of focus on staff training and system accountability shows an ongoing issue in low-resource health systems, where documentation is often overlooked, even though it is known to be important for good patient care.

According to the nurses, poor documentation was mainly due to documents not being available, while others mentioned low motivation and the lack of systems to check if documentation was being done. This matches what was found earlier, where nurses reported that many important forms, like assessment sheets and consent forms, were often missing or not used regularly. However, the checklist results showed that many of these key documents were actually present and being used in most hospital units. This difference suggests that while documents may be physically available, nurses may not always be aware of them, may not have easy access, or may not feel supported or motivated to use them properly, leading to inconsistent documentation. These findings are similar to what Pancha [16] found, showing that problems with infrastructure and lack of supplies are major barriers to proper documentation of heart health in Cameroon. Meno [17] also pointed out that poor documentation in end-of-life care often results from both system failures and a lack of involvement from healthcare workers. Similarly,

a study by Rahman [19] emphasized that nurses under high work pressure deprioritize documentation, especially in emergency and high-acuity care settings, leading to fragmented care. The limited emphasis on staff education and system accountability in this study reflects a persistent pattern in under-resourced health systems where documentation is deprioritized despite its recognized clinical value. The pattern in this study suggests that there is no strong culture of documentation, with ongoing problems like limited resources, weak supervision, and little motivation for staff. Without clear guidelines and regular checks, nurses are left to decide on their own whether to document or not, which leads to gaps in patient records and reduces the quality and continuity of care.

4. Conclusion

This study looked at the nursing documents used for heart disease patients at the Regional Hospital Bamenda and found that, while some important documents do exist, they are not always available or used consistently across hospital units. Important nursing documents like patient assessments and discharge plan documents were often missing or not used, even though they are key to providing good and continuous care. Nurses reported using documents more often in cases of heart disease and in the ICU, but the checklist showed that these documents were not always on hand. Nurses mostly used documentation for assessing patients and checking on their care, but the fundamental documents marking the beginning of assessment were absent that and other problems got in the way, such as too much work, lack of supervision, low motivation, and poor knowledge of documentation steps. These issues have a big impact, making it harder for staff to make good decisions, follow up on care properly, and keep patients safe.

5. Recommendations

This study recommends as following:

- There should be implementation of standardized documentation protocols, especially for critically ill, heart disease patients across all departments, to ensure consistent use of essential forms as depicted in the standardized documents, which ensure continuity and quality of care for patients with heart diseases.
- Institutions should conduct regular in-service training of nursing staff on documents and documentation methods in clinical practices.
- We recommend the promotion of uniform documentation practices by mandating the use of standardized forms for all patients, not only the critically ill, to ensure ethical and nurses' responsibility in care delivery.
- We recommend that institutions clearly distinguish between nursing and medical documents. This will ensure effective nursing documentation and enhance interprofessional communication among care providers.
- We recommend appropriate motivation of nursing staff to encourage job satisfaction and compliance.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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