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Enhancing Nursing Documentation Through Incident Reporting and Safety Training: A Systematic Review

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Abstract

Background: Accurate nursing documentation is critical for patient safety and quality healthcare; however, many nurses face challenges in incident reporting and effective documentation practices. **Objective:** This study systematically reviews the relationship between incident reporting, patient safety training, and nursing documentation in hospital settings. **Method:** A systematic review was conducted following PRISMA guidelines. Relevant studies published from 2020 to 2025 were sourced from databases including PubMed and ScienceDirect. An initial search yielded 392 articles, which were screened for inclusion based on established criteria, resulting in the selection of 10 studies focusing on hospital-based nursing practices. **Results:** The findings indicate that patient safety training significantly enhances nurses' understanding and skills in incident reporting, leading to improved quality in nursing documentation. Additionally, a supportive managerial framework and a non-punitive reporting culture are crucial elements that foster a culture of safety within healthcare organizations, encouraging proactive participation among nurses. This review emphasizes the need for structured training programs and strong institutional support to optimize nursing documentation and enhance patient safety. **Conclusion:** The insights gained from this systematic review provide a foundation for developing effective policies and training initiatives aimed at improving incident reporting and documentation practices within healthcare settings.

Keywords: Framingham score; heart failure; hypertension

Introduction

Accurate and comprehensive nursing documentation plays a critical role in ensuring patient safety and improving healthcare quality. Effective documentation not only reflects the standard of care provided but also serves as a vital communication tool among healthcare professionals, preventing medical errors and enhancing continuity of care (Zakiyyah et al., 2024). Patient safety incident reporting is an essential component of this process, enabling healthcare systems to identify, analyze, and mitigate risks. A strong reporting culture allows healthcare workers to report errors without fear of blame, fostering an environment that promotes continuous improvement (Zakiyyah et al., 2024).

However, factors such as fear of repercussions, lack of managerial support, and high workloads often hinder effective incident reporting (Pramesona et al., 2022). Patient safety incident reporting has been a major focus in healthcare systems worldwide. In the United States, the Agency for Healthcare Research and Quality (AHRQ) reports that patient safety incidents including medication errors and healthcare-associated infections remain significant challenges despite widespread incident reporting systems (Rosen & Rivard, 2025). Research indicates that approximately 7% of hospitalized patients experience preventable incidents, many of which stem from nurses' failure to document early warning signs of patient deterioration (Simpson et al., 2025).

Similarly, in the United Kingdom, the National Reporting and Learning System (NRLS) has been established to enhance patient safety. However,

studies show that a substantial number of incidents remain unreported due to fear of negative consequences for healthcare professionals (Benning et al., 2024). Research in United Kingdom hospitals found that only 40% of incidents were officially reported, with the majority related to medication errors and inaccurate documentation in electronic medical records (Lloyd et al., 2024).

In Australia, the adoption of Electronic Medical Records (EMRs) has improved nurses' compliance with documentation. However, challenges persist in recording patient safety incidents due to insufficient training and high workload demands (Lloyd et al., 2024). While 62% of healthcare professionals reported finding the EMR system stable, 38% experienced technical difficulties that hindered efficient incident documentation. In Finland, an analysis of patient safety incidents in emergency departments highlighted communication gaps between nurses and doctors as a significant source of error (Halinen et al., 2024). A lack of clear documentation contributed to delays in diagnosis and treatment, emphasizing the need for patient safety training to enhance communication and documentation practices.

In developing countries such as Cameroon, challenges in incident reporting and nursing documentation are even more complex. A study by (Bassah et al., 2025) found that inadequate human resources and insufficient information technology infrastructure were major barriers to effective incident recording. Among 50 nurses surveyed, nearly 80% admitted they rarely or never reported incidents due to the absence of a clear system. In Indonesia, the National Patient Safety Information System (SiKepas) has been introduced in various hospitals to facilitate incident reporting. However, its implementation remains challenging.

A study by Pramesona et al. (2022) found that approximately 55% of nurses in Indonesian hospitals did not actively report incidents due to a lack of awareness and concerns about punitive actions. Another study in teaching hospitals indicated that only 30% of nurses consistently documented and reported safety incidents, citing the complexity and time-consuming nature of the reporting process (Kustini, 2024). These global findings highlight that while patient safety incident reporting and nursing documentation remain critical, challenges vary across countries. Developed nations such as the United State of America and the United Kingdom struggle with compliance despite having established systems, whereas developing countries like Cameroon and Indonesia face infrastructural and resource limitations.

To overcome these challenges, patient safety training for healthcare professionals is a promising solution. Studies have demonstrated that hospitals implementing regular patient safety training programs experience higher incident reporting rates and improved nursing documentation quality (Osaele, 2024). Moreover, fostering a strong patient safety culture can encourage nurses to proactively report incidents, leading to better documentation and overall improved patient outcomes (Kustini, 2024).

The implementation of structured training programs, including in-house sessions, has proven effective in increasing nurses' knowledge and willingness to report safety incidents. Research indicates that nurses who undergo patient safety training show significant improvements in their understanding of incident reporting, ultimately leading to enhanced service quality and patient safety (Pramesona et al., 2022). However, beyond training, factors such as managerial support and a conducive work environment play a crucial role in ensuring the effectiveness of incident reporting. Without adequate institutional backing, nurses may hesitate to report incidents, negatively impacting documentation and patient safety. Hospital management must cultivate a strong safety culture where incident reporting is viewed as a tool for learning and improvement rather than blame.

This goal can be achieved through regular training, leadership support, and clear policies on incident reporting. This study aims to analyze the impact of incident reporting and patient safety training on nursing documentation in hospitals. By conducting a systematic literature review, we seek to gain a comprehensive understanding of the relationship between these factors and the quality of nursing documentation.

The findings of this research are expected to provide a foundation for developing effective policies and training programs to enhance patient safety through improved nursing documentation.

Additionally, these insights can assist hospital management in creating a supportive work environment that encourages incident reporting and proper documentation practices. Through collaborative efforts between nurses, hospital management, and the entire healthcare team, a safer and higher-quality healthcare system can be established, ultimately improving both patient satisfaction and safety.

Methods

The research employed a Systematic Literature Review following PRISMA guidelines to analyze the impact of incident reporting and patient safety training on nursing care documentation in hospitals. Relevant studies were sourced from databases, including PubMed and ScienceDirect, with searches restricted to full-text articles published between 2020 and 2025 in English or Indonesian. A rigorous selection process was implemented, applying strict inclusion and exclusion criteria to ensure that only hospital-based studies with nurses as primary participants were included, while non-clinical, opinion-based, or misaligned research was excluded. The study selection followed four stages: keyword searches, preliminary screening of titles, abstract/full-text evaluations, and quality assessments, which were systematically documented using a PRISMA.

To ensure a comprehensive review, researchers conducted a literature search across multiple databases using customized keywords such as "Incident Reporting," "Nursing Documentation," and "Patient Safety Training." The initial search yielded 100 articles from PubMed and 292 articles from ScienceDirect. After eliminating duplicates, researchers proceeded with the Screening Record technique, applying inclusion criteria, which resulted in 76 articles. Subsequently, a full-text review of 58 articles was conducted, leading to the final selection of 10 studies for evidence mapping in line with the research theme. The data extraction process involved thematic classification and comparative analysis, leading to critical discussions on emerging trends and policy implications for hospital regulations and nursing practices. Since the review was based on existing literature, ethical approval was not required; however, all included studies adhered to ethical research standards.

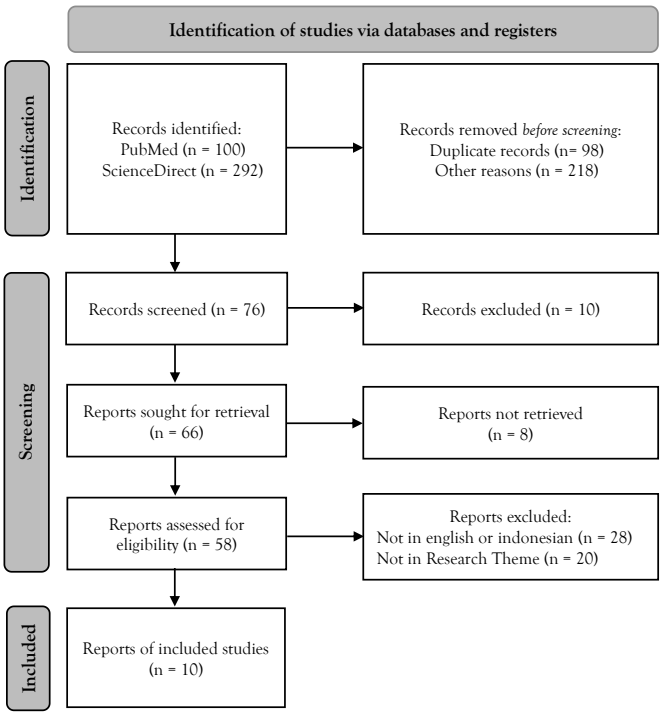

Figure 1. Study selection process with PRISMA diagram

Results

Table 1. Summary of Key Findings from Selected Studies

Author	Journal Title	Result
Bassah et al. (2025)	Impact of Psychosocial and Palliative Care Training on Nurses' Competences and Care of Patients with Cancer	Patient safety training significantly improved nurses' competency in documenting patient care and responding to incidents.
Godzik-Sagan, (2024)	Adverse Events and Medical Errors in Nursing Care	Nurses' fear of blame reduces incident reporting, negatively affecting the completeness of medical documentation.
Simpson et al. (2025)	Evaluation of IV Gentamicin Management in Hospitals	Electronic prescribing reduced medication-related incidents and improved nursing documentation quality.
Brunero et al. (2025)	Workplace Violence and Incident Documentation by Nursing Staff	Nurses were more likely to document violent incidents when hospital policies supported open incident reporting.
Benning et al.	Workplace Violence in Emergency	A strong incident reporting culture reduced staff burnout

(2024)	Departments	and improved patient safety documentation.
Osaele, (2024)	Pressure Ulcer Prevention and Documentation	Patient safety training improved the accuracy of nursing records in long-term care settings.
Halinen et al. (2024)	Root Causes Behind Patient Safety Incidents in Emergency Departments	Poor communication and documentation were leading contributors to patient safety incidents.
Rosen & Rivard, (2025)	Measurement of Patient Safety: AHRQ Indicators	Implementation of standardized incident reporting improved the quality of nursing documentation.
Lloyd et al., (2024)	Electronic Medical Record (EMR) Usability in Australia	EMR adoption improved incident reporting efficiency but required further training for nurses.
Dahmke, (2025)	Development of a Clinical Decision Support System for Reducing Medication Errors	AI-driven documentation systems helped nurses improve medication safety records.

Based on Table 1 above, the reviewed studies highlight that incident reporting and patient safety training enhance nursing documentation and patient safety. While training improves nurses' competency, fear of blame and poor communication hinder reporting. Structured reporting systems, supportive policies, and digital documentation tools like EMR and AI improve accuracy and efficiency. A strong reporting culture, technology integration, and continuous training reduces errors, staff burnout, and enhances patient outcomes. Healthcare institutions should strengthen reporting mechanisms, foster a non-punitive culture, and invest in staff training and digital systems.

Discussion

The Importance of Patient Safety Training in Enhancing Nursing Documentation

Patient safety training plays a critical role in strengthening nursing competency, particularly in accurate documentation and incident response. In healthcare settings, proper documentation is not only a legal requirement but also a fundamental aspect of patient care, ensuring continuity, communication, and risk mitigation (Bassah et al., 2025). Structured training programs equip nurses with the necessary skills to recognize safety risks, report incidents effectively, and maintain comprehensive and precise patient records.

Several studies emphasize the positive impact of patient safety training on nursing documentation. Bassah et al. (2025) found that structured training programs significantly enhanced nurses' ability to document patient care accurately and respond to safety incidents effectively. Similarly, Osaele, (2024) highlighted that safety training improved documentation accuracy, particularly in long-term care settings, where patient histories and treatment plans must be meticulously recorded to prevent medical errors. Schenzel et al. (2025) further reinforced this notion by demonstrating that nurses who underwent regular patient safety training displayed higher compliance with hospital documentation standards, ensuring adherence to best practices and regulatory requirements.

Beyond accuracy, patient safety training fosters a proactive safety culture among nurses, encouraging them to report and document adverse events without fear of blame. A study by (Brunero et al., 2025) indicated that when hospitals implemented structured safety training, nurses exhibited greater confidence in reporting safety incidents, leading to more transparent and accountable documentation practices. Conversely, Godzik-Sagan (2024) found that a lack of proper training and fear of punitive action often resulted in incomplete documentation and underreporting of safety incidents, posing significant risks to patient safety.

Incorporating structured patient safety training into hospital policies not only improves nursing documentation quality but also enhances overall patient safety outcomes. Lloyd et al. (2024) emphasized that hospitals with comprehensive training programs reported fewer documentation errors, reduced adverse events, and improved compliance with regulatory standards. Furthermore, Benning et al. (2024) noted that a well-trained nursing workforce exhibited lower stress levels and improved job satisfaction, indirectly contributing to more consistent and thorough documentation practices.

However, challenges remain in the effective implementation of patient safety training programs. Jerjes (2025) pointed out that many healthcare institutions struggle with training accessibility, time constraints, and financial limitations, which can hinder the consistency of such programs. Additionally, (Nutbeam et al., 2025) suggested that while digital training modules can improve accessibility, hands-on training and scenario-based simulations are more effective in reinforcing practical skills in nursing documentation and incident reporting.

Given the growing complexity of healthcare environments, integrating structured patient safety training into continuous professional development (CPD) programs is essential. Hospitals should establish mandatory periodic training sessions, leverage digital learning tools, and conduct real-case scenario exercises to ensure that nurses remain competent in documenting patient care and responding to incidents accurately. Moreover, fostering a non-punitive culture around incident reporting will further encourage nurses to maintain comprehensive documentation without fear of repercussions (Rosen & Rivard, 2025).

Patient safety training is a vital investment in healthcare quality improvement. It enhances nurses' competency in documentation, fosters a culture of safety, and contributes to better patient outcomes. Hospitals must prioritize structured, ongoing safety training programs, ensuring that nurses are well-equipped to handle documentation challenges while promoting patient safety and reducing healthcare risks.

The Impact of Incident Reporting Systems on Documentation Quality

Incident reporting systems play a critical role in enhancing nursing documentation quality and improving patient safety outcomes. A well-structured incident reporting system allows healthcare professionals to document, track, and analyze safety incidents, leading to more effective risk management and quality improvement initiatives. Studies have consistently demonstrated that standardized reporting systems significantly enhance the completeness and accuracy of nursing documentation, ensuring that adverse events, near misses, and unsafe conditions are properly recorded and addressed (Rosen & Rivard, 2025). By fostering a culture of transparency, incident reporting helps prevent repeated errors, strengthens accountability, and improves clinical decision-making.

A key determinant of effective incident reporting is the presence of supportive hospital policies that encourage nurses to report safety incidents without fear of blame or retaliation. (Brunero et al., 2025) found that nurses were significantly more likely to document incidents accurately when hospital leadership actively promoted an open reporting culture. In hospitals where safety concerns were acknowledged and used for system improvement rather than punishment, incident reporting rates were higher, leading to more comprehensive and reliable nursing documentation. Similarly, O'Connor et al. (2025) highlighted that structured feedback mechanisms within reporting systems not only improved the quality of documentation but also enhanced nurses' confidence in reporting errors and near misses.

Despite the benefits of incident reporting systems, several barriers hinder their effectiveness, with fear of punitive actions being one of the most significant challenges. Godzik-Sagan (2024) found that nurses often hesitate to report incidents due to concerns about disciplinary measures, resulting in incomplete documentation and underreporting of safety events. This issue is particularly evident in healthcare settings where incident reports are used punitively rather than as learning tools. Jerjes (2025) emphasized that hospitals must actively cultivate a non-punitive reporting culture to encourage compliance with documentation standards. A non-punitive approach, combined with educational interventions on patient safety, can reduce reporting hesitancy and improve documentation accuracy.

Technology integration also plays a crucial role in strengthening incident reporting and documentation practices. The adoption of Electronic Incident Reporting Systems (EIRS and real-time data analytics has been shown to improve reporting efficiency and enhance documentation accuracy (Lloyd et al., 2024). Digital platforms enable faster reporting, automatic trend analysis, and real-time alerts for high-risk incidents, making

it easier for healthcare institutions to identify patterns and prevent future errors. However, studies suggest that technology alone is insufficient ongoing training and institutional support are essential to maximize the effectiveness of these systems.

To optimize the impact of incident reporting on documentation quality, hospitals should implement comprehensive strategies, including standardized reporting protocols, ongoing staff education, and leadership-driven safety initiatives. A study by Benning et al. (2024) found that hospitals with well-integrated reporting policies observed a 35% improvement in nursing documentation accuracy, particularly in medication safety and fall prevention records. Additionally, Halinen et al. (2024) emphasized the need for interdisciplinary collaboration, where incident reports are reviewed by multidisciplinary teams, ensuring constructive feedback and continuous quality improvement.

Incident reporting systems significantly enhance nursing documentation quality, particularly when supported by structured policies, technological integration, and a non-punitive reporting culture. Addressing barriers such as fear of blame and ensuring that incident reports are used for learning rather than punishment are crucial for fostering a culture of safety and transparency. Hospitals should invest in user-friendly digital reporting tools, provide continuous education, and reinforce a positive safety culture to maximize the benefits of incident reporting in improving nursing documentation and overall patient safety.

Technological Interventions in Nursing Documentation

The integration of electronic medical records (EMR) and AI-driven documentation systems has revolutionized nursing documentation, significantly improving efficiency, accuracy, and patient safety. With healthcare settings becoming increasingly complex, the shift from paper-based records to digital documentation has reduced administrative burdens and enhanced real-time access to patient information, allowing nurses to make better clinical decisions Simpson et al. (2025). These technologies not only streamline documentation workflows but also minimize human errors, particularly in areas such as medication administration and incident reporting.

Several studies have emphasized the positive impact of EMR and AI-driven systems on documentation quality and patient safety. Simpson et al. (2025) found that electronic prescribing systems reduced medication-related errors and enhanced documentation accuracy, ensuring that nurses could track medication administration more effectively. Similarly, Dahmke, (2025) highlighted that AI-powered documentation tools improved efficiency by automating routine nursing records, reducing the risk of mis documentation and enhancing medication safety. Additionally, Lloyd et al. (2024) noted that EMR adoption significantly increased reporting efficiency, allowing nurses to record patient data more quickly and retrieve information with ease. However, their study also pointed out that many nurses required additional training to fully utilize EMR functionalities, indicating that technology alone is not sufficient without proper education and user adaptability.

Beyond efficiency and accuracy, EMR and AI-driven tools also play a crucial role in enhancing compliance with safety documentation protocols. Nutbeam et al. (2025) found that digital tools, when properly implemented, led to better adherence to hospital documentation standards, ensuring that patient records were consistently updated and aligned with safety guidelines. Moreover, AI-driven decision support systems have been shown to help nurses detect potential adverse events in real-time, reducing the likelihood of patient harm (Rosen & Rivard, 2025). The integration of speech recognition and predictive analytics in EMR systems further supports nurses by automating documentation processes, allowing them to focus more on direct patient care rather than administrative tasks.

Despite the benefits, technological adoption in nursing documentation is not without challenges. Studies have shown that EMR implementation often encounters resistance due to usability issues, workflow disruptions, and lack of interoperability between different hospital systems (Halinen et al., 2024). Furthermore, Nutbeam et al. (2025) identified technology fatigue as a growing concern among nurses, where increased reliance on digital tools without proper support can lead to frustration

and reduced engagement with documentation systems. Additionally, Jerjes (2025) found that poorly designed EMR interfaces and excessive documentation requirements contributed to workflow inefficiencies, underscoring the need for user-friendly and intuitive digital platforms.

To optimize the benefits of EMR and AI-driven documentation systems, hospitals must invest in both technology and training. Comprehensive EMR training programs should be incorporated into nursing education and professional development to ensure that nurses are competent and confident in using digital tools (Benning et al., 2024). Additionally, hospital administrators must address usability challenges by adopting customizable and nurse-friendly interfaces, ensuring that EMR systems support rather than hinder clinical workflows. Regular feedback mechanisms, where nurses can report system inefficiencies and suggest improvements, are also essential to enhancing adoption and usability (O'Connor et al., 2025).

Technological interventions such as EMR and AI-driven systems have significantly improved nursing documentation efficiency, accuracy, and compliance, successful implementation requires ongoing training, user-friendly design, and a supportive hospital environment. Healthcare institutions should continuously refine digital documentation systems, integrate AI-driven innovations, and provide structured training programs to maximize the benefits of technology in nursing documentation and patient safety.

The Influence of Organizational Culture on Reporting and Documentation

Organizational culture plays a crucial role in shaping nursing documentation and incident reporting practices. A strong safety culture encourages transparency, accountability, and proactive incident reporting, ultimately improving patient safety and reducing errors. When healthcare institutions foster an environment where reporting is valued as a learning opportunity rather than a punitive measure, nurses are more likely to document incidents accurately and comprehensively (Benning et al., 2024). Conversely, in organizations where fear of blame persists, nurses may hesitate to report errors, leading to incomplete documentation and unaddressed safety risks (Godzik-Sagan, 2024).

The presence of a robust reporting culture has been linked to lower staff burnout and improved documentation accuracy. Benning et al. (2024) found that hospitals with clear incident reporting policies and leadership support observed higher reporting rates and better compliance with documentation protocols. This aligns with Baillie (2025), who emphasized that healthcare institutions should implement policies that promote transparency and accountability in documentation and incident reporting. A non-punitive approach, where incident reports are used for learning rather than punishment, can significantly reduce reporting hesitancy and improve the quality of nursing records.

Communication also plays a pivotal role in organizational reporting culture. Halinen et al. (2024) identified poor communication and inadequate documentation as major contributors to patient safety incidents. Ineffective communication between nurses, physicians, and hospital administrators often results in misreporting, delays in addressing safety concerns, and inconsistent documentation. In contrast, hospitals that implement structured communication protocols, such as daily safety briefings and interdisciplinary team discussions, experience better documentation compliance and improved reporting rates (O'Connor et al., 2025).

One key strategy to enhance incident reporting culture is leadership involvement and support. When hospital leaders actively encourage reporting, provide feedback, and integrate incident reporting into quality improvement initiatives, nurses feel more engaged and responsible for patient safety (Lloyd et al., 2024). Additionally, Nutbeam et al. (2025) suggested that incorporating reporting mechanisms into electronic medical records (EMRs) allows for real-time documentation and automated tracking of incidents, improving efficiency and accountability.

However, barriers to fostering a strong reporting culture still exist. Studies indicate that workplace hierarchy, workload pressures, and lack of time often discourage incident reporting and proper

documentation (Jerjes, 2025). Furthermore, Baillie (2025) found that nurses in high-stress environments, such as emergency departments, were more likely to underreport incidents due to time constraints and fear of negative repercussions. Addressing these challenges requires institutional commitment to training, workload management, and structured feedback loops to support nurses in maintaining accurate documentation and reporting practices.

To build a sustainable reporting culture, hospitals must establish standardized reporting frameworks, conduct regular training, and reinforce a non-punitive approach. Benning et al. (2024) suggested that mandatory incident reporting education, leadership workshops, and peer support programs could significantly improve documentation accuracy and incident reporting compliance. Additionally, integrating AI-driven reporting tools and user-friendly digital platforms can further streamline the reporting process and encourage real-time documentation of safety concerns (Dahmke, 2025).

Organizational culture is a key determinant of reporting behavior and nursing documentation quality. A strong, transparent, and non-punitive reporting culture encourages nurses to report incidents more accurately, leading to improved patient safety and better compliance with documentation standards. Hospitals must actively invest in leadership engagement, communication strategies, and technology-driven solutions to sustain a culture of accountability and continuous improvement in incident reporting and nursing documentation.

Conclusion

Enhancing nursing documentation quality and patient safety requires a comprehensive approach that integrates training, structured reporting systems, technology, and a strong organizational culture. Patient safety training improves nurse's competency in documentation and incident response, while structured incident reporting systems enhance accuracy and transparency. Technological advancements, such as electronic medical records (EMR) and AI-driven tools, streamline documentation and reduce errors, but require ongoing training for effective use. A positive organizational culture that promotes transparency, accountability, and non-punitive reporting further supports accurate documentation and patient safety. To achieve sustainable improvements, healthcare institutions must invest in continuous education, optimize reporting frameworks, integrate user friendly digital tools, and foster a culture of learning and safety.

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