Vol. 4(1), pp. 1- 8, September 2023
https://doi.org/10.14662/arjhim2023010

ISSN: 2734-2190
https://www.academicresearchjournals.org/ARJHIM/Index.htm

Academic Research Journal on Health Information Management

Research paper

Attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital

Sylvanus A. Wosa, Dr. Gaius Ada, Pauline Chindinma Okocha, Dr. Hanson Levi Usende & Ikpoko-ore-ebirien Dike Isaruk

[1-5]School of Health Information Management Rivers State College of Health Science and Management Technology, Port Harcourt. Email: [1]wosasylvanus@gmail.com [5]dykeman1974@gmail.com
[2] Rivers State Ministry of Health Port Harcourt, Nigeria. Email: adagaius5@gmail.com
[3]Rivers State Primary Health Care Department Obio/Akpor Local Government Area, Rivers State, Nigeria. Email: chipal83@yahoo.com
[4] Rivers State Primary Health Care Management Board, Port Harcourt, Nigeria. Email: belejit97@gmail.com

Accepted 23 September 2023

The aim of this study the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital. The research study design of this study is a comparative design method. The population comprised of 482 healthcare providers at University of Port Harcourt Teaching Hospital. The data collected or gathered from the administration of the instrument were analysed using the IBM Statistical Package for Social Science (SPSS) version 25. The data collected were using descriptive and inferential statistics. The results from the study revealed the respondents did not differ on the attitude of healthcare providers towards documentation of medical records. The t(1) = 1.284, p =.200; the p-value is greater than the chosen alpha value of 0.05 (p> 0.05). Therefore, the null hypothesis is not rejected, meaning that there is no significant difference on the attitude of healthcare providers towards documentation of medical records between University Port Harcourt Teaching Hospital. Therefore, the study concluded that, there is no difference between the study variable in University of Port Harcourt Teaching Hospital on the documentation of medical records.

Keywords: Attitude, Healthcare, Medical records, Documentation, Healthcare providers

Cite this article as: Wosa, S.A., Ada, G., Okocha, P.C., Usende, H.L., Isaruk, I-O-E. D. (2023). Attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital. Acad. Res. J. Health. Inform. Manage. 4(1):1-8

INTRODUCTION

In healthcare settings, the documentation of medical records is a critical aspect of providing quality patient care. It involves recording detailed information about a patient's medical history, diagnosis, treatment plans, medications, and other relevant data. The accuracy and completeness of these records are paramount for ensuring continuity of care, enabling effective communication among healthcare professionals, and serving as legal documentation.

The attitudes of healthcare providers towards this process play a crucial role in maintaining the integrity and reliability

of medical records. These attitudes encompass a range of perspectives, beliefs, and behaviors that influence how healthcare professionals approach documentation. For instance, some providers may view meticulous record-keeping as a fundamental duty, recognizing its significance in delivering safe and effective care. They may see it as a means to track patient progress, identify trends, and make informed clinical decisions.

On the other hand, there may be instances where healthcare providers perceive documentation as a time-consuming administrative task that detracts from direct patient care. This perception can impact the thoroughness and accuracy of the recorded information. Factors such as workload, time constraints, and competing responsibilities can influence these attitudes. Moreover, attitudes towards documentation can also be influenced by factors like training, organizational culture, and the availability of technological tools for electronic health records (EHRs). Healthcare professionals who receive comprehensive training on documentation best practices and are provided with user-friendly EHR systems may be more likely to approach this task with a positive and diligent mind-set.

Understanding the attitudes of healthcare providers towards medical record documentation is crucial for identifying potential areas of improvement. It can lead to the development of targeted training programs, workflow enhancements, and technological interventions to support providers in maintaining high-quality, accurate, and up-to-date medical records. Ultimately, a positive attitude towards documentation contributes to better patient outcomes, improved communication, and a higher standard of care delivery.

Paradiye (2020) study on the attitude and perception of health care providers towards medical documentation among pre-intern doctors in Sri Lanka, the result shows that the attitude and perception towards medical records documentation among the participants, the majority (52.266) of participants perceived that they have a satisfactory level of competency in writing a diagnosis card majority of them perceived that they have received adequate training on diagnosis card until so far the findings on attitude and level of competency in writing diagnosis card are in line with several other studies among health care workers (Ayele, Gobena, Birham, et al., 2021; Kalengo, 2015), and Nakate, Dahl, Drake, et al., (2015) on attitude toward documentation and its associated factors among nurses working in the public hospital of Hawassa City Administration, Southern Ethiopia.

A study to assess the healthcare worker attitude towards documentation in Hawassa city administration public hospital Southern Ethiopia revealed that 58.8% of them have favorable attitudes towards documentation (Ayele, Gobena, Birham&Yaduta, 2021). Findings showed that knowledge of significant factors with attitude towards documenting was consistent with the findings of the current study. Again, attitude and practice towards the method of Medical Records Documentation have been demonstrated among Iranian medical students. The study has concluded that more than half of the study participants are not having a good attitude toward medical records documentation, it was also shown that 77.86 of the medical students had low knowledge of Medical Documentation of records not considering the completion of records in the evaluation of the students can attract their practice.

A study done to assess the current medical documentation practice of Health Professionals and attitude toward it at the University of Gondar Hospital, Gondar, North West Ethiopia (2016) concludes that health professionals have somewhat poor documentation practice and unfavorable attitude to medical documentation the study saw that the inconsistency might be due to the knowledge differences among study participants and other organizational differences.

Ayele, et al., (2021) in the study of attitude toward documentation and its associated factors among nurses working in public Hospitals of Hawassa city Administration shows that according to the result that 24.3 (58.8%) of nurses have favorable attitudes towards documentation the same is in line with the result of the studies conducted in Zambia 54% (Kalengo 2015), Uganda 54% (Nakate 2015), Addis Ababa 55%, Hana 2017 and Amhara region 50% (Andualem, 2018). On the other hand, these findings are higher than the findings from European Hospitals like Slovenia 44% (Petkovek & Skela-Savic 2015) and Norway 46% (Bjerka& Olsen 2017) though the discrepancy could be a result of differences in the size of the study sample and the number of hospitals included in the studies. Moreover, the findings that the study conducted in Indonesia 83% (Mote 2016), Iran 55% (Aghdan et al (2012), India 95.86 (Juliet & Sudha, 2013) South Africa 71.7% (Oliver, 2010) and Gondar 60.7% (Kebede, 2017). Though it could be afraid that the discrepancy might be due to nurses' lack of attention to nursing documentation as professional duties and responsibilities or high workload or even lack of in-service training and induction on documentation on component-wise attitude, 205 (49.6%) of respondents said documentation ensures counting of care which was lower than the findings of a study done in Nigeria (98.5%) (Taiye, 2015). This difference might be due to the knowledge difference of respondents about documentation having a positive impact on patient safety which is in line with the study done in a European hospital in Slovenia (Petkovsek & Skela, 2015). In this study 49.6% of the respondents like documentation because it ensures continuity of care. This finding was also inconsistent with the findings of a study conducted in Nigeria 100% (Taiye, 2015). The inconsistency might be due to the knowledge difference among study participants about documentation and other organizational differences.

All over the world, the delivery of quality healthcare lies in the way medical records are been managed by healthcare providers in the healthcare facilities which also involves documentation of all services rendered. Documentation is any communicable material that is used to describe, explain or instruct regarding some attributes of an object, system or

procedure, such as its parts, assembly, installation, maintenance and use (Ada, 2019. Examples are user guides, white papers, online help, and quick-reference guides. Medical records are a chronological written account of the examination of the patient, medical history and complaint, caregivers' findings, and the result of the tests, procedures, and medications therapeutic services. (UK Data Archive, 2009).

Good documentation is crucial to a data collection's long-term vitality; without it, the resource will not be suitable for future use. Proper documentation contributes substantially to a data collection's scholarly value. At a minimum, documentation should provide information about a data collection's contents, and structure, and the terms and conditions that apply to its use. It needs to be sufficiently detailed to allow the data creator to use the resource in the future, when the data creation process has started to fade from memory. It also needs to be comprehensive enough to enable others to explore the resource fully, and detailed enough to allow someone who has not been involved in the data creation process to understand the data collection and the process by which it was created.

Similarly, Huffman (2021) stated that medical records are linked to the term who, what, why, where, when, and how of the patient care during an episode of care rendered. She further opined that the idea behind the terms is to provide care to the beneficiaries through careful documentation of every detail of healthcare activities that have with the patient/client.

Medical records which are also called hospital records according to McGibony (1952) in Aqyeman, et al (2018) are a chronicle of both medical and scientific processes found in the hospital. Medical records have been adjudged as an important primary tool in the practices of medicine, and literature has also revealed medical records as a storehouse of knowledge concerning patients' care and medical history. Sahile, et al., (2020) averred medical records as a collection of data on patients including but not limited to history, statement of the current problem, diagnosis, and treatment procedures. Furthermore, medical records contain details of patients' medical care and demographic data like name, address, gender, and date of birth among others (Natrayan, 2010).

Medical records compiled timely in a manner should also contain sufficient data to identify the patient, support the diagnosis or reason for health care episode to justify treatment, and accurately document the results to have visible evidence, of hospital clinical activities and accomplishments. Globally, proper management of medical records in health facilities has been a challenge ranging from loss of patients' case notes, improper filing, lack of records retention and disposal policy, and engagement of non-professionals in medical records management practices (Danso, 2015; Ondieki, 2017).

Oftentimes, medical records are either in the format of paper-based or electronic-based. But, the management of individual health facilities adopts and implements the format that it feels best suits its activities. According to Adeleke (2014), a paper-based medical record is seen as a systematic collection of patients' personal information which includes health history that is documented or written on a paper form. In contrast, Berg (2001) observed electronic medical records format as a computerized medium that accommodates clinical information recorded based on healthcare providers' interaction with patients/clients in the course of healthcare service delivery. However, Torray (2011) opined that electronic medical records (EMR) as an e-version of patients' health information that has been created, used, and stored in a paper chart for future usage by authorized persons.

Medical records can be viewed through the following indicators, accessibility, filling, retrieval, dissemination, and usage. Accessibility of medical records can be beneficial to both, the patients, clients, the caregivers as it enhances prompt communication between the two-party as well as helps the patients to better understand their health condition, and this is usually achieved through proper documentation. Filing of medical records involves a systematic way of arranging patients' case notes in the hospital using a defined criterion. Furthermore, the management of medical records in the hospital which involves proper filing, enhances prompt retrieval, dissemination, usage, and proper continuation of care not to be aligned with appropriate documentation.

Documentation according to Isaruk (2021), is the act of capturing/creating or entering data elements or information on treatments rendered to patients or organizational business transactions within or outside its environment using approved formats and methods. He further maintained that documentation of health or medical records must comply with a stipulated standard like clear and accurate capturing or recording of things or activities in a legible manner with the use of signs, symbols, and abbreviations that were appropriate for readability, sharing, and reproducibility when future demands occur.

Wang, Yu, and Halley (2013) opined that the documentation process, format, and structure, focus mainly on the completeness and accuracy of detained medical records. According to Hasanain and Cooper (2014), documentation of medical records is an integral part of good health professional practices in the delivery of quality care, whether it is in paper-based or electronic base records management. This helps in communication amongst professionals, eases continuity of care, and also helps to guarantee good quality healthcare to patrons. To ascertain effective and efficient health service delivery to people, medical records documentation is required to record, facts, results, and investigations as well as an observation about an individual's health history, as well as past and present illnesses, and plan of alternatives for future care management. Therefore, the study evaluated the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital.

Statement of the Problem

Medical records are scientific data that support and serve as evidence of services provided by healthcare practitioners in hospitals to patients/clients irrespective of their diverse health situations. However, studies have shown that medical records in the majority of hospitals in developing nations are often not well carried out in tandem in meeting up its primary (patient care) and secondary (administrative) purposes thereby leading to poor quality of healthcare services delivery (Danso, 2015; Luthuli & Kalusope, 2017). In Nigerian hospitals, Ajayi (2010) posited that the continuous long waiting time for patients to get their medical records before being seen, treated, or referred by healthcare providers in public hospitals has been a challenge over time. Similarly, Omang, et al., (2020) averred that the issue of the long waiting times of patients at public healthcare facilities is becoming a major challenge to Nigerians across the different regions of the country. In addition, long waiting time also presents challenges for healthcare providers and managers because it denies them the opportunity of connecting with the patients due to a loss of confidence in the healthcare service delivery system (Omang et al., 2020). Therefore, the study investigated the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital.

Objectives of the Study

The objective of this study is to investigate the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital. The specific objective of this study is to:

a. Examine the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital.

Research Questions

The following research questions are formulated to guide the study:

1. What is the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital?

Hypotheses

Three null hypotheses are formulated by the researcher to guide this study.

H_{01}: There is no significant difference on the attitude of healthcare providers towards documentation of medical records between University Port Harcourt Teaching Hospital.

METHODOLOGY

The research study design used in this study is a survey design. The population was 482 healthcare providers at University of Port Harcourt Teaching Hospital. Total enumeration was adopted for the study. The nature/sources of data for this study is the primary source, it is a questionnaire. Data for this study were collected through the primary sources of data. The data collected or gathered from the administration of the instrument were analysed using the IBM Statistical Package for Social Science (SPSS) version 25.

RESULTS AND DISCUSSION OF FINDINGS

This section presented the results from the analysis of data administered to the representative sample and discussion. The results section includes answers to research questions.

Research Question One: What is the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital?

Items	Hospital					
	UPTH = 199		RSUTH = 147			
	Yes(%)	No(%)	Yes(%)	No(%)	□	p-value
I see documentation of medical records as one of their primary functions to do every day.	159(80)	40(20)	114(78)	33(22)	1.555	.212
I see documentation as not vital task to do	43(22)	156(78)	44(30)	103(70)	5.033	.143
I always shows partial interest in documentation of medical records in this hospital	150(75)	49(25)	102(69)	45(31)	1.301	.254
Documentation is seen as not necessary since everybody can document medical records without professional training	168(84)	31(16)	115(78)	32(22)	.176	.675
I view documentation as a criterion for quality healthcare delivery	154(77)	45(23)	116(79)	31(21)	8.338	.104
I believe that documentation is a waste of time	55(28)	143(72)	35(24)	112(76)	4.109	.143
Documentation is a yardstick for evaluation and medical audit	137(69)	62(31)	99(63)	48(33)	4.545	.133

In Table 1above, majority of the respondents from health facilities accept most the items “I see documentation of medical records as one of their primary functions to do every day” UPTH = 159(80%); “I see documentation as a not vital task to do” UPTH = 156(78%); “I always shows partial interest in documentation of medical records in this hospital” UPTH = 150(75%); “Documentation is seen as not necessary since everybody can document medical records without professional training” UPTH = 168(84%); “I view documentation as a criterion for quality healthcare delivery” UPTH =154(77%). However, they both disagree on this item “I believe that documentation is a waste of time” UPTH = 143(72%); and accept the item “Documentation is a yardstick for evaluation and medical audit” UPTH = 137(69%). From the analysis of the respondents’ responses, it shows they have positive attitude towards documentation of medical records.

Test of Hypotheses

Hypothesis One: There is no significant difference on the attitude of healthcare providers towards documentation of medical records between University Port Harcourt Teaching Hospital.

Health Facilities	N	Mean	Std. Dev.	df	t-value	p-value	Decision
UPTH	199	5.377	1.387				
				344	1.284	.200	Not Significant
RSUTH	147	5.177	1.465				

In Table 2 above, UPTH (*M* = 5.38, *SD* = 1.39 did not differ on the attitude of healthcare providers towards documentation of medical records. The $t(1) = 1.284$, $p = .200$; the *p*-value is greater than the chosen alpha value of 0.05 ($p > 0.05$). Therefore, the null hypothesis is not rejected, meaning that there is no significant difference on the attitude of healthcare providers towards documentation of medical records between University Port Harcourt Teaching Hospital.

Discussion of Findings

The results from the study revealed the respondents have positive attitude towards documentation of medical records, there is no difference on the attitude of healthcare providers towards documentation of medical records from both facilities and also it revealed that there is no significant difference on the attitude of healthcare providers towards documentation of medical records between University Port Harcourt Teaching Hospital. This finding is similar to the findings of Paradiye (2020) and Ayele et al. (2021).

Paradiye (2020) studied the attitude and perception of health care providers towards medical documentation among pre-intern doctors in Sri Lanka. The result shows that the attitude and perception towards medical records documentation among the participants, the majority of participants perceived that they have a satisfactory level of competency in writing a diagnosis card majority of them perceived that they have received adequate training on diagnosis card until so far the findings on attitude and level of competency in writing diagnosis card are in line with several other studies among health care workers. Ayele et al. (2021) investigated the attitude toward documentation and its associated factors among nurses working in public Hospitals of Hawassa city. Their result revealed that most of the nurses have favorable attitudes towards documentation.

CONCLUSIONS

The study assesses the attitude of healthcare providers towards documentation of medical records at the University Port Harcourt Teaching Hospital. From the investigation, it was revealed that there is no difference on the attitude of healthcare providers towards documentation of medical records. The study also revealed that there is no significant difference on the attitude of healthcare providers towards documentation of medical records in University of Port Harcourt Teaching Hospital. Therefore, the study concluded that, there is no difference between attitude of healthcare providers on documentation of medical records at the University Port Harcourt Teaching Hospital.

RECOMMENDATIONS

Based on the significant of the findings, the study made the following recommendation that:

1. The hospital management should encourage the healthcare providers more on the positive attitude of documentation of medical records in other to maintain quality health delivery services.

REFERENCES

Ada, G., (2018). Lecture note on measurement and evaluation in health information management practice. Rivers State College of Health Science & Management Technology, Port Harcourt, Nigeria.

Adiyia, M. & Ashton, W., (2017). *Comparative research.* Rural Development Institute, Brandon University, Manitoba, Canada.

Agyeman, C. M., Binfoh, K. A. & Lakhawat, P. S., (2018). Assessing the dimensions of hospital records (medical records) in delivering quality of service to patients. *Pharma Tutor, 6*(8), 1-8. Doi: https://doi.org/10.29161/PT.v6.i8.2018.1

Ahmed, H. A. A., El-Salami, R. M., Ayad, K.M. & El-Deeb, A. E-A. F., (2019). Assessment of medical records documentation in secondary health care facilities in Kafr El-Sheikh and El-Mahalla El-Kubra Cities. *Medical Journal of Cairo University, 87*(1), 183-194.www.medicaljournalofcairouniversity.net

Aina, O. M., Musa, A. K. & Opeyemi, O. P. (2020). Importance of effective clinical documentation by medical doctors to patient care management in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria. *International Journal of Innovative Science and Research Technology, 5*(7), 462-470. www.ijisrt.com.

American College of Obstetricians and Gynecologists (2018). The importance of vital records and statistics for the obstetrician–gynecologist. ACOG Committee Opinion No. 748.*Obstetrics & Gynecology, 132*(2), e78–81.

Asika, N., (2012). *Research methodology in the behavior sciences.* Learn Africa Plc, Ikeji, Lagos State, Nigeria.

Beltran-Aroca, C. M., Girela-Lopez, E., Collazo-Chao, E., Montero-Pérez-Barquero, M. & Muñoz-Villanueva, M. C. (2016). Confidentiality breaches in clinical practice: What happens in hospitals? *BMC Medical Ethics, 17*(52), 1-12. DOI 10.1186/s12910-016-0136-y

Binfoh, K. A., Agyeman, C. M. & Lakhawat, P. S. (2018).Assessing the dimensions of hospital records (medical records) in delivering quality of service to patients.*PharmaTutor, 6(8), 1-8.*http://dx.doi.org/10.29161/PT.v6.i8.2018.1.

Borbolla, D., Becerra-Posada, F. & Novillo-Ortiz, D. (2019). Legal framework for electronic medical records in the Region of the Americas: definition of domains to legislate and situation analysis. *Rev Panam Salud Publica,* 43(e25), 1-7. https://doi.org/10.26633/RPSP.2019.25.

Danso, J., (2015). A study of records management practice at health facilities in Upper Denkyira West District of Ghana. *Advances in Life Science and Technology, 31,* 64-72. www.iiste.org

Dev, S & O'Farrel, P. (2014) The impacts of hospital accreditation clinical documentation compliance: *A Life Cycle*

Explanation Using Interrupted Time Series Analysis, Bmj 2a (online) 4(8) eoo5240-e5240

Durodolu, O. O., Mamudu, P. A. & Tsabedze, V. O. (2020). Management of Electronic Records for Service Delivery at the University College Hospital, Ibadan, Nigeria. *IGI Global.*119-294.DOI: 10.4018/978-1-7998-2527-2.ch011.

Elikwu, I. M., Igbokwe, A. C. & Emokhare, G. (2020). Effect of electronic health information system on medical records management in public healthcare institutions. *Unizik Journal of Business, 3*(1), 43-56. 10.36108/unizikjb/0202.30.0140.

Elkum, N., Fahim, M., Shoukri, M. & Al-Madouj, A., (2009). Which patients wait longer to be seen and when? A waiting time study in emergency department. *East Mediterr. Health Journal, 15*(2), 416-424.

Fomundam, H. N., Tesfay, A. R., Mushipe, S. A., Nyambi, H. T., & Wutoh, A. K., (2021). Medical records documentation of HIV/AIDS clinical services at Primary Health Care (PHC) facilities and its implications on continuum of care and operational research in South Africa. *World Journal of AIDS, 11*, 60-70.https://www.scirp.org/journal/wja.

Funmilayo, O. M., (2020). The factors militating against effective medical record documentation. A case study of Ekiti State University Teaching Hospital Ado Ekiti. *International Journal of Innovative Science and Research Technology, 5*(6), 247-252.www.ijisrt.com.

Garba, K. D., (2016). Significance and challenges of medical records: A systematic literature review. Retrieved 24/08/2022 from https://www.researchgate.net/publication/309034245.

Garba, K. D., &. Harande, Y. I., (2018). Significance and challenges of medical records: A systematic literature review. *Journal of Advances in Librarianship, 9(1), 26-31.* https://www.researchgate.net/publication/330039863.

Gisemba, R. N., Ngeno, E. &Bosire, E., (2022). Medical records management to support evidence-based medical practice at Kisii Teaching and Referral Hospital, Kenya. *Library Philosophy and Practice, 6993*.https://digitalcommons.unl.edu/libphilprac/

Hasanaian, R. A., & Croper, H. (2014). Solution to overcome technical and social barriers to electronic records implementation in Saudi public and private hospitals of information in developing countries, 8(1),

Huffman, E. K. (1978). Medical records management (6th Ed). Physicians' Record Company, Berwyn, Illinois.

Isaruk, I. D. (2016). Lecture notes on records documentation system (unpub). School health information management rivers state college of health science & management technology, Port Harcourt, Nigeria.

Isaruk, I. D. (2021). Health records management practices, referral systems and quality health care service delivery in public health facilities in Rivers State, Nigeria. A Dissertation submitted to the Department of Information Resources Management for the award of Master of Science Degree in Health Information Management, Babcock University Ilishan-Remo, Ogun State, Nigeria.

Isaruk, I. D., Ikonne, C. N. & Alegbeleye, G. O. (2021). Health records management practices, referral systems and quality healthcare service delivery in public health facilities in Rivers State, Nigeria. Academic Research Journal on Health Information Management, 2(1), 1-8. Doi:https;//doi.org/10.14662/arjhim20211030.

Kosciejew MRS (2015) Disciplinary Documentation in Apartheid South Africa "A

conceptual from work of documents associated practice and their effects; *Journal of Documentation. 71No1,PG96-115 https://doi.org/10.1108/JD-10-2003-013*0

Ksmil, H, Rachmah, R, Wordani (2018), What is the problem with nursing documentation? perspective of Indonesia Nurses International*. Journal African of Nursing Sciences, 9 pp111-114.*

Mathioudakis, A., Rousalova, I., Grant A. A., Saad, N. & Hardaralla, (2016).H ow to keep good clinical record breaths.12(4), 369-73.

Matlala, M. E. & Maphoto, A. R. (2020). Application of the records life-cycle and records continuous mmodels in organizations in the 21st century. *Journal of the Eastern and Southern Africa Regional Branch of the International Council on Archives, 39*, 81-98. https://dx.doi.org/10.4314/esarjo.v39i1.6.

Mokhtar, U. A. &Yusof, Z. M. (2016). Records management practice: The issues and models for classification. *International Journal of Information Management, 36,* 1265–1273 http://dx.doi.org/10.1016/j.ijinfomgt.2016.09.001.

Motloba, P., Ncube, O., Makwakwa, L. & Machete, M. (2018). Patient waiting time satisfaction at a Tertiary Dental School. SAD Jouenal, 73(6), 400-405.

Murray, L., Gopinath, D., Agrawal, M., Horng, S., Sontag, D. & Karger, D. R. (2021). MedKnowts: Unified documentation and information retrieval for electronic health records. In UIST 2021: ACM Symposium on User Interface Software and Technology, October 10–13, 2021, Virtual. ACM, New York, NY, USA.https://doi.org/10.1145/nnnnnnn.nnnnnnn.

Ngo, E., Patel, N., Chandrasekaran, K., Tajik, A. J. & Paterick, T. E. (2016). The Importance of the medical record: A critical professional responsibility. *Practice Management*, 305-308. www.greenbranch.com

Ogbonna, M., Ayodele, K.M &Ojo, P.O (2020) *Importance of effective clinical documentation by medical doctor to patients care* management in

federal teaching hospital, Ido Ekiti, Ekiti State, Nigeria : *International Journal Innovative of Science and Research Technology vol. 5, issue 7*

Omoit, D. F. O. (2021).Compliance with the medical records documentation standard operating procedure among health

workers in Bungoma Hospital County, Kenya. A Thesis for the award of the Degree of Master of Science in Health Information Management in the School of Public Health and Applied Human Sciences of Kenyatta University.

Omang, J. A., Ndep, A. O., Offiong, D. A., Out, F. T. & Onyejose, K. N. (2020). Patient waiting time: A public health perspective. *International Journal of Innovative Science Research and Technology, 5*(1), 866-868.

Ondieki, F. (2017). Effects of health records management on service delivery: A case study of Kisil teaching and referral hospital. *Journal of Hospital and Medical Management, 3*(1), 2-5.

Osundina, K. S., Kolawole, J. A. & Ogunrewo, J. O. (2015).The role of records management in secondary health care delivery system in selected state hospitals in Osun State, Nigeria. *Information and Knowledge Management, 5*(12), 105-115. www.iiste.org

Prideaux, A. (2011). Issues in nursing documentation and record-keeping practice.*British Journal of Nursing, 20*(22), 1450-1454.Downloaded from magonlinelibrary.com by 130.113.111.210.

Sahile, A. T., Teka, M. W., Teshome, M. A. & Jata, T. D. (2020).Medical record documentation system in Ethiopia.*American Journal of Biomedical Science and Research, 10*(4), 375-376.

Saravi, B. M., Asgari, Z., Siamian, H., Farahabadi, E. B., Gorji, A. H., Motamed, N., Mohammad Fallahkharyeki, M, &Mohammadi, R. (2016). Documentation of medical records in hospitals of Mazandaran University of Medical Sciences in 2014: A quantitative study. *ACTA Inform Med, 24*(3), 202-206. doi: 10.5455/aim.2016.24.202-206.

Seyf-Rabiei, M., Sedighi, I., Mazdeh, M., Dabras, F, Shokouhi-Solgi M., &Maradi A. (2009). A study of hospital records registration in teaching hospitals Hamadan University of medical sciences, *Sci j Hamdanuniv Med Sci. 16*(2):45- 9.

Singh, P. &John, S. (2017). Analysis of health record documentation process as per the national standards of accreditation with special emphasis on tertiary care hospital.*Journal of Health Sciences & Research, 7*(6) 286-292.www.ijhsr.org

Stedman's Medical Dictionary 28th edition (2006).Linppincott Williams & Wilkins, Baltimore, Maryland, USA.

Supriadi, &Dewi, N. (2019).Factors causing incomplete filling of medical records of inpatients in private hospitals X Tangerang City.AIPHC 2019, October 09-11, Padang, Indonesia.DOI 10.4108/eai.9-10-2019.2297246.

Tasew, H, Mariye, T., &Teklay, G., (2019) Nursing documentation practice and associated factors amongst nurses in public hospital Tigray, Ethopia. *B.M.C Research Notes https://doi.org/10.1186/513104-019-466.x*

Tiechman P.G. (2000). Documentation for reducing malpractice risk. *American Academy of Family Physicians*

Torrey A. (2011). Electronic health records and electronic medical records ethics, and EMR(s) patients' empowerment at Algont.com.teachingpatients.to take care of their medical and health records.

Tsalits, M. H., Muhammad, M. & Ekowati, S. K. P. (2018). The incompleteness of medical record documents: Causative factor and solution studied on private hospital in Malang City. *International Journal of Science and Research, 7*(7), 576-580. DOI: 10.21275/ART20181875.

Varela, H. L., Wiebe, N., Niven, D. J., Ronksley, P. E., Iragorri, N., Robertson, H. L. & Quan, H. (2019). Evaluation of interventions to improve electronic health record documentation within the inpatient setting: A protocol for a systematic review. *Systematic Reviews, 8*(54), 1-6. https://doi.org/10.1186/s13643-019-0971-2.

Victery B. C., (2018). Concept of documentation. *Journal of documentation 34:* pp27a-287.