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Original Article

ATTITUDE OF HEALTH WORKERS TOWARDS THE DOCUMENTATION OF MEDICAL RECORDS AT PADER HEALTH CENTER III. A CROSS-SECTIONAL STUDY.

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ABSTRACT

Background

Health care practices require complete, accurate, and timely documentation to effectively ensure continuity of care, communication among health care providers, health facility planning, risk management in terms of reducing medical errors, provision of proof in medico-legal issues, and the facilitation of evidence-based decision making at all centers of health care facility. Thus, the purpose of this study was to assess the attitude of health workers towards medical records documentation at Pader Health Center III, Pader district.

Methodology

A descriptive cross-sectional survey was used which involved both qualitative and quantitative methods of data collection and it involved 30 health workers (respondents) while using self-administered questionnaires. Data collected was thematically presented and analyzed using descriptive frequencies and percentages using Microsoft Excel.

Results

The majority of the respondents were aged between 31 – and 40 years, and 25(83%) had attained University/ Tertiary education. Health workers had a poor attitude towards documentation of medical records since most of the respondents 12 (41%) disagreed with the fact that health workers should have the basic principles of documentation, 15(50%) disagreed that medical documentation helps health workers to gain sufficient knowledge, documentation is part of professional obligation. That documentation ensures continuity of patient care.

Conclusion

Generally, health workers had poor attitudes towards documenting medical records.

Recommendation

Let there be strengthening of rules and regulations that would enable the health workers to document the medical records to avoid incompleteness, inaccuracy, and untimeliness of medical records.

Keywords: *Attitude, Documentation, Medical records, Health workers*
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BACKGROUND

(S. Verma, 2020) defines documentation as a clear concise and accurate history of the patient's life and illness written from the medical point of view. He went further to say that before the records can be completed, they must contain sufficient data written in a sequence of events to justify the diagnosis and warrant the treatment and the result. Health care practices require complete, accurate, and timely documentation to effectively ensure continuity of care, communication among health care providers, health facility planning, risk management in terms of reducing medical errors, provision of proof in medico-legal issues, and the facilitation of evidence-based decision making at all centers of health care facility. According to the International Classification of Diseases (ICD) guidelines, it was announced that diagnostic information should be organized systematically while utilizing standard record tools and methods. (WHO, 2024). One of the key requirements of high-quality medical care is the documentation of the patient's health status, the time of entry of all the information about patient hospitalization, lab test and imaging modalities needed, the patient's clinical notes and the availability of family support (Ala A, 2014).

Health workers` attitude about documentation has an impact on the health care of patients, the medical profession, the medico-legal suits, and the health care providers themselves. (Hana, 2017). Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based health practice. Healthcare attitudes and documentation impact the quality of how and what they document (Ehrenberg, 2010). Poor medical attitude about principles of medical documentation usually results in unfinished and low-quality records (Salameh, 2019). Furthermore, the most important reason for incomplete records is that the doctor and the surgeons believed that the medical and surgical care required for

patients is vital. Still, documentation of the data concerning care is not considered a part of the treatment process by them. In contrast, the time spent to register and complete the patient's medical records must be considered as part of the care process. (Tovakoli, 2016)

Poor attitude of health workers leads to documentation errors in the patient's records, which these errors can cause misdiagnoses, wrong dosages of medications, administration of drugs that have dangerous interactions or cause severe allergic reactions, and other problems. This can directly let the patient sue the health facility in the courts of law. Although keeping a patient record is part of the professional obligation, many studies identified deficiencies in the attitude towards documentation among health workers across the globe. (Lindo, 2016). Studies in various settings found that while nurses consider documentation as important for the nursing profession, they consider it a burdensome secondary task that takes nurses away from direct patient care. (Smith, 2012).

Health workers need to be encouraged to improve their attitude towards nursing care documentation as it renders the quality of services to the patients. (Andualem et al, 2019). Thus, the purpose of this study was to assess the attitude of health workers towards medical records documentation at Pader Health Center III, Pader district.

METHODOLOGY

Study Design

A descriptive Cross-sectional design was used, with both qualitative and quantitative methods. The quantitative method presented variables in numerical figures for easy representation on tables and charts while Qualitative methods described and explained the meaning of data presented on tables and charts by words.

Study Area

The study was conducted at Pader Health Center III, located in Pader town council, Pader district, in northern Uganda. Pader district is bordered by Kitgum district in the north, Lira district in the south, Gulu district in the west, and Kotido district in the East. It's a government health facility offering various services like maternal services, outpatient services, antenatal services, ART services, Laboratory services, and dental services. Its coordinates are 2°52'37.9"N, 33°05'26.2"E (Latitude: 2.8772000°; Longitude: 33.0906000°). The facility is 430 km from Kampala, the capital city of Uganda, and it is 98 km from Gulu Regional Referral Hospital, the biggest health facility in the Northern region of Uganda.

Study Population

The study involved facility health workers responsible for the documentation of medical records that is to say Medical Records Assistants, Clinicians, Nurses, Midwives, and Laboratory personnel.

Sample Size Determination

The sample size of Health workers who participated in the study was determined by using a statistical formula suggested by Kish and Leslie (1965) which states that;

$$n = \frac{Z2P(1-P)}{d2}$$

Where; n = Sample size

Z = Standard deviation at 96% confidential level (i.e. 1.96)

P = estimated proportion of health workers

d = acceptance degree of error

For P = 2%, then, $n = \frac{(1.96)2*0.02(1-0.02)}{(0.05)2}$ therefore; n = 30.

Therefore, the sample size was **30** respondents.

Sampling Technique

Non-probability Convenience sampling technique was used to select respondents for the study since it's easy and inexpensive for the researcher. Also, since it's a busy health facility, the technique was expected to yield a greater outcome (positive response) since they were only required to participate at their free/convenient time.

Sampling Procedure

In their different departments, health workers (respondents) were explained by the researcher about the study, and those who turned positive (willing) were given tools (questionnaires) for capturing data and they used/ filled them at their convenience/ free time.

Data Collection Methods

Data was collected using both interview and questionnaire methods. It's because the study involved gathering information from medical professionals who were literate and could understand the study questions.

Data Collection Tools

Both interview guides and self-administered questionnaires were used to collect data from the respondents. Interview guides were used by the researcher to collect data from respondents who were not willing to read and write while questionnaires were issued to those willing to write and read and they were expected to be filled at the respondents' convenience time.

Data Collection Procedures

After approval of the research proposal; an introductory letter from the Kampala School of Health Sciences (KSHS) research committee to the study area was obtained. After getting permission, respondents were explained the purpose of the study, then the researcher administered the questionnaires to the respondents and translated interview guides were used. Verbal or written consenting was

allowed, then data collection, and then they were thanked for taking part in the study.

Study Variables

These included dependent and independent variables.

Independent Variable

Demographic factors.

Dependent Variable

Documentation of medical records among health workers

Quality Control

The researcher ensured the quality of the study by pretesting the questionnaire, training the research assistants, giving ample time for data collection, having clear inclusion and exclusion criteria, and adhering to standard operating procedures.

Pre-Testing

A pilot questionnaire was administered before the main study to a group of 10 respondents with similar dynamics as the final respondents selected on convenience, to correct the questionnaire and eliminate potential problems. Respondents used in the pilot study were not included in the final study. Once the researcher is satisfied with the results, the tool is ready for use in the final study.

Inclusion Criteria

The study included those who were available at the time of study from different departments that is to say; medical records, Nursing, midwives, clinical, and Laboratory.

Data Analysis and Presentation

Data was analyzed manually using tally sheets and entered into a computer using Microsoft Excel computer program to generate tables, pie charts, and bar graphs for easy presentation of findings.

Ethical Considerations

Before commencing the study, a letter of introduction was obtained from the Kampala School of Health Sciences, which introduced the researcher to seek permission from the health in charge of Pader Health Center III to carry out the study. An informed consent was obtained and participants were assured of maximum confidentiality and security. The study would only continue after the objectives of the study were explained to the participants.

RESULTS

Demographic data

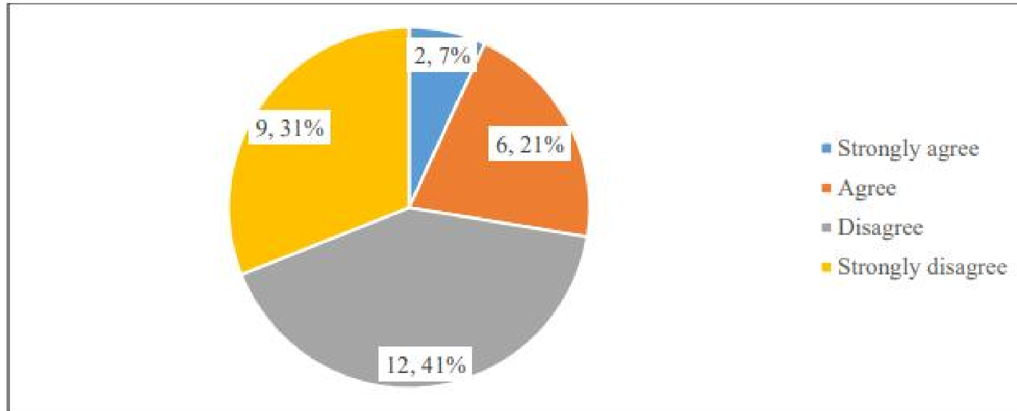
Table 1; shows the respondents' demographic data

RESPONSE	FREQUENCY (N=30)	PERCENTAGE (%)
AGE		
Below 30 years	9	30
31 – 40 years	15	50
41 – 50 years	4	13
51 & above	2	7
SEX		
Male	10	33
Female	20	67
Marital status		
Single	14	47
Married	16	53
Religion		
Catholics	13	43
Anglican	8	27
Moslems	3	10
Others	6	20
Education level		
Secondary	5	17
University/ Tertiary	25	83

From Table 1, the majority of the respondents were aged between 31 – 40 years while the minority were aged 51 years and above. Regarding respondents' sex, the majority of the respondents 20 (67%) were female while 10 (33%) were male, majority of the respondents 16(53%) were married while the minority 14(47%) were single. Regarding respondents' religion, 13(43%) were Catholic, 8(27%) were Anglican, 3(10%) were Muslims and the rest 6(20%) belonged to other religious affiliations, majority of the respondents 25(83%) had attained University/ Tertiary education while the minority 5(17%) had attained only secondary level of education.

Having the basic principles of documentation

Figure 1: Shows the distribution of respondents according to whether all health workers should have the basic principles of medical documentation. (N= 30)



From Figure 1, most of the respondents 12(41%) of the respondents disagreed that all health workers should have basic principles of medical documentation, while the least 2(7%) strongly agreed.

Medical documentation is a key to gaining sufficient information about a patient.

Table 2: Showing responses to whether medical documentation helps health workers gain sufficient knowledge about a patient. (N= 30)

Response	Frequency (f)	Percentage (%)
Strongly agree	4	13
Agree	9	30
Disagree	15	50
Strongly disagree	2	7
Total	**30**	**100**

From Table 2, half of the respondents 15(50%) disagreed that medical documentation helps health workers to gain sufficient knowledge about a patient whereas the least 2(7%) strongly disagreed.

Continuity of patient care

Table 3: Shows the distribution of respondents according to whether documentation of medical activities ensures the continuity of patient care. (N= 30)

Response	Frequency (f)	Percentage (%)
Strongly agree	15	50
Agree	9	30
Disagree	4	13
Strongly disagree	2	7
Total	**30**	**100**

From Table 3, the majority of the respondents 15(50%) strongly agreed that documentation of medical activities ensures the continuity of patient care, whereas the minority 2(7%) strongly disagreed.

Documentation as part of professional obligation

Table 4: Shows the distribution of respondents according to whether medical documentation is part of the professional obligation, not just a waste of time. (N= 30)

Response	Frequency (f)	Percentage (%)
Strongly agree	15	50
Agree	9	30
Disagree	4	13
Strongly disagree	2	7
Total	**30**	**100**

From Table 4, most of the respondents 15(50%) strongly agreed that medical documentation is part of the professional obligation, not a waste of time whereas the least 2(7%) strongly disagreed.

Reasons for poor attitude towards documentation

Text 1: Showing responses about the reasons contributing to poor attitude towards documentation, (n=30)

Most of the respondents said that documentation is time-consuming plus being tiresome due to their heavy workload, and it requires some technical skills to organize a medical record.
Some said that medical terms are difficult to write.
Some said that documentation work is for only medical records staff, not all hospital staff.

DISCUSSION

Attitudes towards documentation of medical records among health workers

The study showed that most of the respondents 12(41%) of the respondents disagreed that all health workers should have basic principles of medical documentation, while the least 2(7%) strongly agreed. Since respondents were from different departments, some even didn't know that there are principles of documentation. Some respondents had a sense that following documentation principles is time-consuming hence having poor attitude. This is in line with Salmeh, (2019) who said that poor medical attitude about principles of medical documentation usually results in unfinished and low-quality records. (Salmeh,2019).
Furthermore, the study results showed that 15(50%) of the respondents disagreed that medical documentation helps them to gain sufficient knowledge about a patient. This is likely to be a result of having a good number of Outpatients, of which they are treated and their medical records are not stored, this promotes a sense of not documenting since there is no follow-up at all. This eventually makes some health workers think that documentation is of no value in terms of knowing a patient. Poor attitude of health workers leads to documentation errors in the patient's records, which these errors can cause misdiagnoses, wrong dosages of medications, administration of drugs that have dangerous interactions or cause allergic reactions, and other problems, (AHIMA 2015).
Findings revealed that the majority of the respondents 15(50%) strongly agreed that documentation of medical activities ensures the continuity of patient care, whereas the minority 2(7%) strongly disagreed. Since respondents were all health professionals, well-educated and mentored, they knew that for a patient to continue with medical treatment in any health facility there must be a clear documented medical record for that particular patient. And they knew that medical documentation is part of the professional obligation as 50% agreed. This is in line with a study done by Lindo, (2016) who said that although keeping a patient record is part of the professional obligation, many studies identified deficiencies in the attitude towards documentation among health workers across the globe.
Concerning reasons for poor attitude, respondents reported that documentation is time-consuming and a burdensome secondary activity that takes health workers away from direct patient care. Studies in various settings found that while nurses consider documentation as important for the nursing profession, they consider it a burdensome secondary task that takes nurses away from direct patient care. (Smith, 2012). Other studies indicated that most of the nurses' actions are either not documented or inappropriately documented. Also, it lacks accuracy due to the poor attitude of nurses, which creates a problem when it comes to the evaluation of client care. (Mohammed, 2017)

Conclusions

Based on the results of the study, the researcher concludes that effective documentation enhances action communication, interdisciplinary team coordination, and timely care outcomes. Notwithstanding the challenges they face in effectively recording patient care, omissions, fragmentation, and inconsistent documentation were found. Patient safety is put at risk by a lack of documentation of care. The integration of care requires the documentation of patient care and integration results in better care outcomes.
Generally, health workers had poor attitudes towards the documentation of medical records, to the point that most of the respondents disagreed that all health workers should have basic principles of medical documentation and disagreed that medical documentation helps health workers gain sufficient knowledge about a patient.

Study Limitations

Some respondents were not willing to participate in the study due to their busy working schedules.

Since the researcher is a student, the study was inadequately funded which hindered the quality.

Recommendations

To combat poor attitudes among health workers towards documentation, it is recommended that there be strengthening of rules and regulations that would enable the health workers to document the medical records to avoid incompleteness, inaccuracy, and untimeliness of medical records. In addition to that, there was a need for the education of health workers about the impact of incompleteness, inaccuracy, and untimeliness of medical records on the continuity of patients' care.

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Abbreviations and Acronyms

KSHS**:** Kampala school of Health Sciences
WHO**:** World Health Organization
AHIMA: American Health Information Management Association
ART: Antiretroviral therapy
H/C: Health Center
ICDs: International Classification of Diseases.

Conflict of interest

No conflict of interest declared

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The study was not funded.

Author Biography

Charity Alimocan is a student of the Diploma in Medical Records and Health Informatics at Kampala School of Health Sciences.

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