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Attitude and practices of health workers towards the documentation of medical records at Mulago National Referral Hospital. A cross-sectional study.

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Abstract

Background

Documentation is essential for ensuring safe, high-quality, and continuous patient care and research work. The study aimed to identify the attitudes and practices of health workers towards the documentation of medical records at Mulago National Referral Hospital.

Methodology

A cross-sectional study design. A sample size of 35 health workers was used, and a purposive sampling technique was used in the study.

Results

The majority 20(57.14%) of respondents were above 40 years, and least 15(42.86%) were between 25-40 years of age. 33(94.29%) communication was more essential during the documentation of medical records, followed by continuous patient care, 30(85.71%). 10(28.57%) considered accuracy as one of the principles followed when documenting medical records, 8(22.86%) timeliness, and the least 4(11.43%) completeness. 30(85.71%) considered documentation a burden. 31(88.57) used paper-based/manual systems for documentation, while the least 4(11.43%) used electronic systems. 25(71.43%) are not trained about the required documentation knowledge, while the least 10(28.57%) are trained. 34(97.14%) documents manually and 1(2.86%) document electronically. 25(71.14%) are familiar with the required documentation knowledge while the least 10(28.57%) are not. The majority, 27(77.14%), document anytime a case is rendered while the least 8(22.86%) don't.

Conclusion

Health workers had a poor attitude towards the documentation of medical records, and poor practices during the documentation of medical records.

Recommendation

The hospital administrators to design appropriate penalties for all health workers who carry out poor documentation practices of patient medical records. These may include: a deduction of payment for the given time.

Keywords: *Attitudes, Practices, Data source, Mulago National Referral Hospital.*
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Background of the study.

Documentation is essential for ensuring safe, high-quality, and continuous patient care and research work (Petkovsek & Skela, 2015). By means of documentation, health workers communicate with each other. They perceive documentation as an important part of their work. They believe that documentation enhances transparency, quality, continuity of care, and patient safety. In South West Ethiopia, proper documentation of clinical data leads to better continuity of patient care, avoids medical errors, and provides accurate and complete healthcare data and information to support legal proceedings however, though few studies were done in this area, the extent to which health workers practice documentation of medical records and their level of knowledge and attitude regarding it, results showed that due to incompleteness of the data, it was not analyzed (Abiru, Gugsa, et-al, (2019).

In East Africa, results showed that proper documentation was practiced by 70%, and the majority of respondents (96.7%) properly document anytime a case is rendered, 3.3% document 3-4 times in a shift, 84.8% by sitting at the station and reading what they have written to make corrections respectively and 7.4% check the previous information and formulate theirs (Rahimi et al, 2015). Namayanja and Berna (2016), assess the level of knowledge, attitude, and practices among Health workers towards documentation at Uganda Heart Institute, results showed that despite health workers being aware that documentation

was vital in practices as it helps to record information on diagnosis and treatment of patients, majority of health workers had good attitude since they believed that different patients had different information and they did not know what they suffered from thus the need to document. They, however, had poor practices; where the majority did not record regularly, and never consulted their fellows, which led to partial recording and recording wrong information. The study aimed to identify the attitudes and practices of health workers towards the documentation of medical records at Mulago National Referral Hospital.

Methodology

Study Design

This study used a cross-sectional study design to assess the attitude and practices of health workers toward the documentation of medical records in Mulago National Referral Hospital. This was because the researcher was able to measure proper documentation and the exposure of the participants at the same time.

Study Area

The study was carried out in Mulago National Referral Hospital, Kampala District. Located in the central region of Uganda, Kawempe Division. Mulago National Referral Hospital is located on Mulago Hill in the northern part of the city of Kampala, and it is 4km from Kampala to Mulago. Its coordinates are 000 20 16" N and 320 34' 32" E.

Study Population

The population comprised nurses, physicians\ doctors, and medical records personnel.

Sample Size Determination

The sample size of 35 health workers was used, which was distributed as follows.

Table 1. Category of participants.

NUMBER	HEALTH WORKERS
15	Nurse
5	Physicians/ Doctors
15	Medical records personnel

Sampling Technique

A purposive sampling technique was used in the study. This was because the study was selective only to health workers who were very involved in the documentation of medical records and were working in the inpatient and outpatient departments both day and night; therefore, it involved those willing to participate in the study positively.

Sampling Procedure

The researcher targeted health workers with more than 1 year of working experience at Mulago National Referral Hospital, asked for their positive participation in the study, interviewed them, and finally included them in the study to constitute the sample size.

Data Collection Method

Questionnaire method

This method was used to obtain demographic data.

Interview method

This method was used to find out the knowledge of health workers regarding the documentation of medical records.

Observational method

This method was used to identify the attitude of health workers and their practices toward the documentation of medical records.

Data Collection Tools

Self-administered questionnaire

This was developed in the English language to collect demographic data.

Key informant interview guide

This was developed to assess the knowledge of health workers regarding the documentation of medical records.

Checklist

This was developed to assess the attitude of health workers and their practices towards the documentation of medical records.

Data Collection Procedure

The purpose of the study was clearly explained to the participants, and their consent was obtained before data collection. Data was acquired from health workers working in the hospital departments by using the designed tools prepared in the English language.

Study Variables

The study variables included both the dependent and the independent variables. The independent variable was the documentation of medical records, and the dependent variable was the knowledge, attitudes, and practices of health workers.

Quality Control
Data collection tools were checked for completeness and accuracy by the researcher and then pretested by the supervisor.

Data Analysis and Presentation
The collected data was checked for completeness, sorted, edited, and processed manually by the researcher. This was done with the help of the computer, and the analyzed data was presented in the form of percentages, frequency tables, pie charts, and graphs.

Ethical Considerations
An introductory letter was obtained from the research ethical committee of the School of Medical Records and Health Informatics to the Administrators of MNRH. Signed consent was obtained from all respondents who participated in the study, and time was given to explain to respondents the intent of the study. Greater confidentiality and anonymity were highly ensured.

Results
Respondents Biodata.

Table 2: Shows results of respondents' Biodata, n=35

VARIABLE	CATEGORY	FREQUENCY	PERCENTAGE (%)
AGE	**25-40 years**	**15**	**42.86**
	Above 40 years	**20**	**57.14**
SEX	**Female**	**21**	**60.00**
	Male	**14**	**40.00**
LEVEL OF EDUCATION	**Diploma**	**24**	**68.57**
	Bachelor degree	**7**	**20.00**
	Certificate	**4**	**11.43**
MEDICAL CADRES	**Nurse**	**15**	**42.86**
	Physician\ doctor	**5**	**14.29**
	Medical records personnel	**15**	**42.86**
WORK EXPERIENCE	**1-5 years**	**9**	**25.71**
	5-10 years	**20**	**57.14**
	10 and above	**6**	**17.14**

Source: Primary Data (2022)

Table 2, Most respondents 20(57.14%) were above 40 years of age while the least 15(42.86%) were between 25-40 years of age, 21(60%) being female and the rest 14(40%) male. Many respondents, 24(68.57%), had attained a diploma, followed by 7(20%) with a bachelor's degree, while the least 4(11.43%) had a certificate. Among them, 15(42.86%) represented both nurses and medical records personnel, while the least 5(14.29%) were doctors. Many respondents 20(57.14) had 5-10 work experience followed by 9(25.71%) who had 1-5 while the least 6(17.14%) had 10 and above.

Attitude of health workers towards documentation of medical records.

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Table 1Showing the respondents' responses on health workers' attitude towards documentation of medical records, n=35

S/N	VARIABLE	CATEGORY	YES	(%)	NO	%
4.3.1	Whether documentation is essential for;	**Communication purposes**	**33**	**94.29**	**2**	**5.71**
		Continuous patient care	**30**	**85.71**	**5**	**14.29**
4.3.2	What principles do health workers follow when documenting?	**Completeness**	**4**	**11.43**	**31**	**88.57**
		Accuracy	**10**	**28.57**	**25**	**71.43**
		timeliness	**8**	**22.86**	**27**	**77.14**
4.3.3	Do health workers consider documentation a burden?		**30**	**85.71**	**5**	**14.29**
4.3.4	Systems used when documenting	**Paper-based / manual systems**	**31**	**88.57**	**4**	**11.43**
		Electronic system	**4**	**11.43**	**31**	**88.57**

Source: Primary data (2022)

In Table 3, the majority of the respondents, communication was more 33(94.29%) essential during documentation of medical records, followed by continuous patient care, 30(85.71%). Most respondents 10, 28.57%) considered accuracy as one of the principles followed when documenting medical records, followed by 8(22.86%) timeliness, while the least was 4(11.43%) completeness. The majority of the respondents, 30(85.71%), considered documentation a burden, and at least 5(14.29%) did not**.** The majority of the respondents, 31(88.57), used paper paper-based/manual system for documentation, while the least 4(11.43%) used an electronic system.

Practices of health workers towards the documentation of medical records.

Table 2Showing responses on health workers' practices towards documentation of medical records, n=35

S/N	VARIABLE	AGREE	%	DISAGREE	%
4.4.1	Whether medical records documentation is an important part of the medical process, as it is an essential way of communication within the health care system	33	94.29	2	5.71
4.4.2	Whether health workers are trained on how to document patients' medical records	10	28.57	25	71.43
4.4.3	Whether documentation of medical records is practiced manually more than electronically	34	97.14	1	2.86
4.4.4	Whether health workers are familiar with the required documentation knowledge	25	71.43	10	28.57

Source: Primary data (2022)

Table 4, the majority of the respondents, 33(94.29%), see medical records documentation as an important part of the medical process as it is an essential way of communication within the health care system, while the least 2(5.71%) don't. 25(71.43%) are not trained about the required documentation knowledge, while the least 10(28.57%) are trained. Majority 34(97.14%) document manually while the least 1(2.86%) document electronically. 25(71.14%) are familiar with the required documentation knowledge while the least 10(28.57%) are not.

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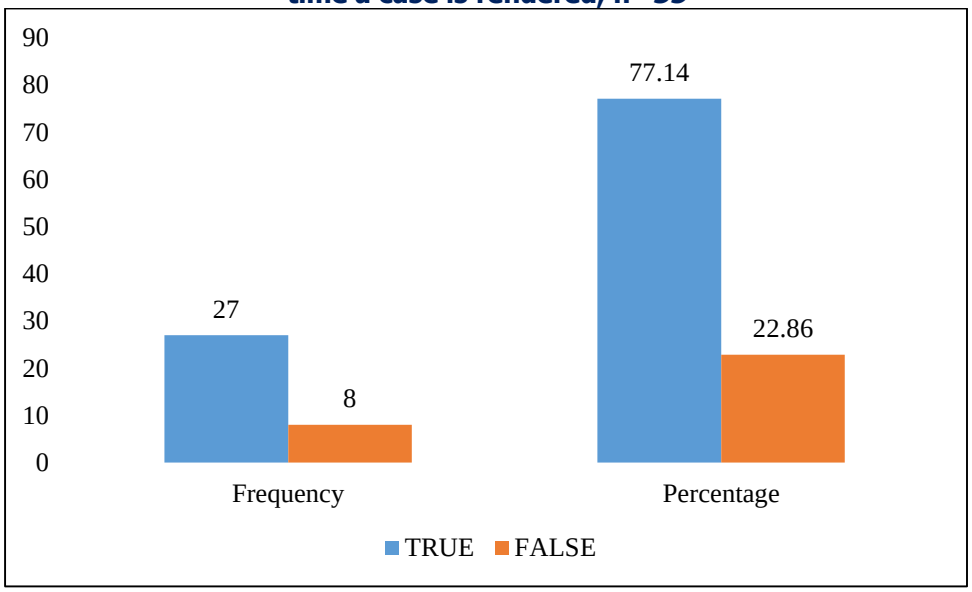
The majority of health workers document any time a case is rendered

Figure 1: Showing responses to whether the majority of health workers document at the time a case is rendered, n =35



Sources: Primary data (2022)

Figure 1, the majority of 27(77.14%) document any time a case is rendered, while the least 8(22.86%) don't.

Discussion

The attitude of health workers towards documentation of medical records.

The findings indicated that in most respondents (94.29%), communication and (85.71%) continuity of patient care were more essential during the documentation of medical records, but continuity was less compared to communication. This is because there is no way a health worker can get information from a patient when there is no communication. These findings are by Petkovsek and Skela (2015) who stated that documentation is essential for ensuring safe, high-quality quality, and continuous patient care and research work. By means of documentation, health workers communicate with each other. They perceive documentation as an important part of their work. They believe that documentation enhances transparency, quality, and continuity of care and patient safety. Many respondents' medical records were incomplete (88.57%) and inaccurate (71.43%), considering the principles followed when documenting medical records. This is probably because of the poor attitudes of health workers towards the documentation of medical records. These findings are in line with the study done by Mohammed (2017), who indicated that most of the health workers' actions are either not documented or inappropriately documented. It lacks accuracy due to the poor attitude of health workers, which creates a problem when it comes to the evaluation of the client's care. Alkouri et al. (2016) indicated that health workers' poor attitudes about principles of documentation usually result in unfinished and low-quality records. This implies that incompleteness and inaccuracy are high during the documentation of medical records.

The majority of the respondents (85.71%) considered documentation to be a burden. This is probably because they have to document everything, yet they have a lot of patients to work on. These findings are in line with the study done by Smith (2012), who stated that various settings found that while health workers reflect documentation as important for the professional, they consider it burdensome and a task that takes health workers away from direct patient care. The majority of the respondents (88.57%) used a paper-based system for documentation. This is probably because of financial factors. These findings agree with the study done in Ethiopia by Kebede (2017), who indicated that nearly all the documentation was conducted through paper-based records. This implies that an electronic system of documentation has to be implemented.

Practices of health workers towards the documentation of medical records.

The study revealed that the majority of the respondents (94.29%) see medical records documentation as an important part of the medical process, as it is an essential way of communication within the health care system. This is probably because health workers are aware of the importance of medical records documentation. These

findings are from the study done by Mulugeta, Miftah, et al. (2022), who reported that medical records documentation is an important part of the medical process as it is an essential way of communication within the health care system. However, medical documentation in the private sector was not practiced since more than half of the medical services provided were not registered; therefore, it is important to put extra effort into improving documentation practice by providing planned training on standards of documentation to all health workers. This implies that though many health workers see medical records documentation as an essential part of the medical process, their practice towards it is still poor.

Many respondents (71.43%) are not trained in the required documentation knowledge. This is probably because of a lack of time due to overcrowding of the hospital clinics. These findings are in line with the study done by Takla and Biftu (2020), who stated that documentation is practiced poorly, and therefore, it is better to put further efforts towards improving documentation practice by providing training on the standards of documentation. This implies that although documentation of medical records is done by skilled health professionals, there is still a need to train them about the essential data elements. The majority of the respondents (97.14%) document manually more than electronically. This is probably because the manual system is so reliable and easy to use, these findings are in line with the study done by Cebul et al., (2011) who indicated that even though patient documentation is practiced more through a written than electronic method, a study reported that an electronic system has better health care outcome as compared to the paper-based system.

Many respondents (71.43%) were familiar with the required documentation knowledge. This is probably because documentation is done by skilled health professionals. These findings are from the study done by Blake et al. (2013) in Jamaica, which showed high levels of accurate documentation by health workers at a referral hospital in western Jamaica, and health workers appeared to be familiar with the required documentation guidelines, with policy manuals available on each ward. Many respondents (77.14%) document any time a case is rendered. This is probably because health workers work on one patient at a time, and on the other hand, it is because of worker overload, so they end up forgetting to document. These findings are in line with the study done by Taiye (2015), who stated that several studies from sub-Saharan Africa have reported different levels of patient care documentation practice. A study conducted in Nigeria showed that good client documentation was practiced, and the majority of respondents document any time a case is rendered. Another finding in Nigeria disagreed that the majority of the respondents did not document immediately following a procedure, and only documented when it was convenient.

Conclusion

Health workers had a poor attitude towards the documentation of medical records, and poor practices during the documentation of medical records.

Study Limitations

The absenteeism of health workers at work interfered with the regular collection of data, and the research was time-consuming.

Recommendation

The hospital administrators to design appropriate penalties for all health workers who carry out poor documentation practices of patient medical records. These may include: a deduction of payment for the given time.

The Ministry of Health, Health Planners, and policymakers to identify the potential areas that still require policy improvements, as well as the development of a national policy on effective documentation of medical records.

Researchers are carrying out similar studies to use as a reference for future research.

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List of Abbreviations

MNRH: Mulago National Referral Hospital

Source of funding

The study was not funded.

Conflict of interest

No conflict of interest was declared.

Author Biography

Robinah Nalugya Angella is a student Diploma program at the School of Medical Records and Health Informatics, Uganda Institute of Allied Health and Management Sciences- Mulago.

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