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Overview of Compliance in Filling-in Initial Nursing Assessment by Nurses in Hospital

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Abstract:
The initial nursing assessment is a holistic record of the patient's condition and needs, which is used as a reference to determine effective and appropriate nursing interventions for the patient. Incomplete filling can affect the quality of health services provided to patients. This research aims to determine the description of compliance in filling out the initial nursing assessment by nurses at the hospital. This research was conducted from 21-26 October 2024 with a sample size of 68 medical record files. The design of this research is descriptive research. The results of this study show that of the eight components examined in this study, it was found that the highest level of completeness in filling out the initial nursing assessment form was in the physical assessment component of the patient, namely 35 medical records (51.4%), as well as the general assessment and assessment of the patient's medical history, namely as many as 33 medical records (48.5%). The component with the lowest completeness is the Gordon pattern assessment component, namely, zero medical records. The percentage of compliance for nurses is 89.7%, with the number of initial nursing assessment files being 61 files. This shows that the nurses are still not compliant in documenting the initial nursing assessment.

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INTRODUCTION

Medical records comprehensively document a patient's identity, medical history, treatments, and healthcare interactions (Falcetta et al., 2023). These records are vital for guiding clinical decisions, ensuring continuity of care, and maintaining accurate health information for future reference (Ding & Peng, 2022). Beyond clinical use, they are legal documents providing evidence in medico-legal disputes and ethical reviews (Oliva et al., 2022). By capturing a patient's holistic health status, medical records enable healthcare providers to deliver safe, effective, and personalized care (Tapuria et al., 2021).

A critical component of medical records is the initial nursing assessment, which provides a detailed evaluation of a patient's physical, psychological, and social needs upon admission (Rossi et al., 2022). This assessment forms the foundation for tailored nursing interventions and care planning (Ajibade, 2021). By identifying immediate and long-term patient requirements, nurses can prioritize actions, anticipate complications, and collaborate with other healthcare professionals (Curley et al., 2024). The accuracy and completeness of this assessment directly influence the quality of subsequent care, making it indispensable in clinical practice (Cao et al., 2025).

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Despite their importance, medical records often face issues of incomplete documentation (Poulos et al., 2021). Gaps in recording patient data can lead to flawed analyses, misdiagnosis, or inappropriate interventions, jeopardizing patient safety (Msiska et al., 2023). Incomplete initial nursing assessments, for instance, may result in overlooked symptoms or unmet needs, undermining care continuity (Chaboyer et al., 2021). Such deficiencies compromise individual patient outcomes and reflect poorly on institutional credibility and legal accountability, highlighting the need for rigorous documentation standards (Michl et al., 2023).

Several human-related factors contribute to incomplete medical records (Shin et al., 2021). Nurses' knowledge gaps about documentation protocols and age and experience levels may affect their ability to capture comprehensive data (Moy et al., 2021). Older or less experienced nurses might struggle with evolving record-keeping technologies or complex assessment frameworks (Hossain et al., 2025). Additionally, a lack of motivation due to insufficient rewards or accountability measures can discourage thorough documentation, perpetuating complacency in compliance (Hosseini et al., 2021).

Institutional factors, such as ineffective monitoring and evaluation systems, exacerbate documentation challenges (Nijor et al., 2022). Without regular audits or feedback mechanisms, errors or omissions may go unnoticed, reinforcing poor practices. The absence of a structured reward and punishment system further diminishes accountability, as there are no incentives for diligence or consequences for negligence (Corfmat et al., 2025). These systemic gaps highlight the need for robust quality assurance frameworks to uphold documentation standards (Reegu et al., 2022).

Inadequate facilities and infrastructure hinder complete documentation (Pai et al., 2021). Overburdened nurses may lack access to user-friendly electronic health record systems, sufficient training, or time to complete assessments amid high workloads (Baporikar, 2024). Outdated tools or poorly designed workflows can delay data entry, increasing the likelihood of incomplete records (Al Bahrani & Medhi, 2023). Addressing these resource constraints is essential to creating an environment that supports thorough and efficient documentation.

This study analyzes nurses' compliance with initial nursing assessment documentation at Kaliwates Hospital. By evaluating the extent of completeness in these records, the research seeks to identify underlying barriers—such as knowledge gaps, systemic inefficiencies, or resource limitations—and propose targeted interventions. The findings will inform strategies to enhance documentation practices, ultimately improving patient care quality and institutional accountability (Bhati et al., 2023).

METHOD

This study employs a quantitative descriptive design to evaluate the completeness of initial nursing assessment documentation at Kaliwates Hospital. The target population consists of all medical records from patients admitted to the hospital's RPD unit between October 21 and 26, 2024. Sixty-eight medical records were identified during this period, and total sampling was applied to ensure comprehensive coverage. This approach was chosen to analyze real-world documentation practices without introducing selection bias, providing a clear snapshot of compliance levels among nurses in the RPD unit.

Medical records were included if they pertained to patients still undergoing inpatient treatment at Kaliwates Hospital's RPD unit during the specified dates. Records from other departments or those dated outside the study period were excluded to maintain focus on the target population and

setting. These criteria ensured data relevance and minimized confounding variables, allowing the study to isolate factors influencing documentation completeness within the RPD unit.

The study utilized a structured checklist adapted from the hospital's standard operating procedures (SOPs) for nursing documentation. The researcher modified the checklist to align with the specific components of the initial nursing assessment, ensuring validity and applicability to the RPD context. Data collection involved collaboration with the RPD unit supervisor to gather eligible records, followed by systematic coding and assessment of completeness. Each record was reviewed for adherence to documentation standards, with gaps recorded and categorized for analysis.

Ethical approval for the study was obtained from Kaliwates Hospital's institutional review board to ensure compliance with research ethics standards. Data were analyzed using descriptive statistics to quantify the proportion of complete and incomplete documentation across the 68 records. Results were tabulated to identify patterns of non-compliance, informing recommendations for improving documentation practices. This approach emphasizes objectivity and transparency, aligning with the study's goal of enhancing patient care quality through accurate record-keeping.

RESULT

Initial Nursing Assessment Components

Table 1. Distribution Analysis of Completeness of Completion of Initial Nursing Assessment Components at RPD Kaliwates Hospital (n=68)

No	Initial Nursing Assessment Components	Complete		Incomplete	
		n	%	n	%
1	Conduct a general assessment of the patient	33	48.5	35	51.5
2	Review the patient's medical history	33	48.5	35	51.5
3	Review the patient's physical examination	35	51.4	33	48.5
4	Assess the patient's Gordon pattern	0	0	68	100
5	Filling in the evaluation (S-O-A-P)	32	47.1	36	52.9
6	Filling in the follow-up	24	35.3	44	64.7
7	Filling education health patients on the way home	21	30.9	47	69.1
8	Signatures and nurse's full name	23	33.8	45	66.2

Based on table 1, it can be seen that from a total of 68 medical records studied, there are several components of the initial nursing assessment , including the majority of general patient assessments were filled in completely, namely 33 medical records (48.5%), the majority of patient medical history components were filled in completely, namely 33 medical records (48.5%), the majority of patient physical examination components were filled in completely, namely 35 medical records (51.4%), the Gordon pattern components of the patients were not filled in completely, the majority of evaluation components (SOAP) were filled in completely, namely 32 medical records (47.1%), the majority of follow-up components were filled in completely, namely 24 medical records (35.3%), the majority of patient health education components upon discharge were filled in completely, namely 21 medical records (30.9%), the majority of nurse signature and complete name components were filled in completely, namely 23 medical records (33.8%).

Based on Table 1, it can be seen that the complete completion of the initial nursing assessment form is in the patient's physical assessment component, which is 35 medical records (51.4%), as well as general assessment and patient medical history assessment, which is 33 medical records (79.5%). Meanwhile, the component with the lowest completion is the Gordon pattern assessment component, which is zero medical records.

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Compliance in Completing the Initial Nursing Assessment

Table 2. Distribution of Percentage Analysis of Compliance Figures for Completing the Initial Nursing Assessment at the RPD RSU Kaliwates (n=68)

No	Percentage of Compliance in Completing the Initial Nursing Assessment at the RPD of Kaliwates Hospital	n	%
1	Less compliant	61	89.7
2	Not compliant	7	10.3

Table 2 shows that RPD nurses' compliance percentage at Kaliwates Hospital is 89.7%, with 61 initial nursing assessment files.

DISCUSSION

General Patient Assessment

Based on the results of this study in Table 1, it is known that most of the general patient assessment components were filled in entirely by nurses, namely 33 medical records (48.5%). A complete and systematic assessment of existing facts and conditions is crucial in nursing care (Putri et al., 2021). In the initial nursing assessment form at Kaliwates Hospital, in the general assessment component, several data need to be filled in, such as patient identity (name, date of birth, medical record number), date and time of admission, information obtained (which is how nurses get information to fill in the initial assessment such as auto anamnesis or hetero anamnesis), how the patient entered (walking without assistance, wheelchair, walking with assistance, or push bed), name of the accompanying nurse, identity bracelet, diagnosis at admission, history of allergies, main complaints, pain scale, and risk of falling (Morse/Humpty).

Patient History Assessment

Based on the results of this study in Table 1, it is known that most patient medical history component files were filled in completely, namely 33 medical records (48.5%). In the initial nursing assessment form at Kaliwates Hospital, in the patient's medical history component, several data must be filled in, including current and past medical history. Filling in the patient's medical history component is important because incomplete medical history information can hinder the patient's treatment process (Alexiuk et al., 2023).

Patient Physical Examination Assessment

This study's results indicate that most patient physical examination components were filled in completely, namely 35 medical records (51.4%). The physical examination component in this study was the component with the highest completeness. Physical examination is a helpful initial step to identify whether the patient's body condition shows abnormalities (Patrizio et al., 2021). In the initial nursing assessment form available at Kaliwates Hospital, in the patient's physical examination assessment component, several data need to be filled in, including assessment of the respiratory, cardiovascular and circulatory, digestive, urinary, nervous, integumentary, and musculoskeletal/ mobilization systems.

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Gordon Pattern Assessment

Based on this study, Table 1 shows that all components of the patient's Gordon pattern are incomplete. The Gordon model or pattern is an assessment framework that identifies 11 human functional patterns, including health perception and management patterns, nutritional patterns, elimination patterns, activity-exercise patterns, sleep-rest patterns, cognitive-perceptual patterns, role-relationship patterns, sexual-reproductive patterns, coping patterns, value-belief patterns, and self-concept patterns (Butcher et al., 2024). However, in the initial nursing assessment form at Kaliwates Hospital, there are differences in the Gordon pattern assessment; the data reviewed include reproductive patterns, rest and sleep patterns, socio-economic patterns, psychological patterns, family/closest person coping patterns, and attaching supporting examination results: laboratory, radiology, and others. The Gordon pattern can help nurses group patient data based on functional patterns, making it easier to analyze data and identify patient problems (Davarpanah et al., 2023). In addition, the Gordon pattern focuses on assessing patient needs to identify any unmet patient needs and enable nurses to provide more comprehensive, holistic, effective, and focused nursing care (Dikmen & Bayraktar, 2023).

Evaluation (S-O-A-P)

The results of this study indicate that the evaluation components (S-O-A-P) were mainly filled in completely, namely 32 medical records (47.1%). Nursing evaluation is the final stage in the nursing care process. Evaluation can compare the results of nursing implementation with the objectives and outcome criteria set in nursing interventions to determine whether nursing interventions have been achieved or require other approaches (Parreira et al., 2020). Thus, incomplete nursing evaluations can impact assessing the patient's condition, affecting future follow-up actions planned for the patient. In the initial nursing assessment form at Kaliwates Hospital, several data must be filled in in the patient evaluation component, including subjective, objective, analysis, and planning data (S-O-A-P).

Follow-up

Based on the results of this study, it is known that most follow-up components were filled in completely, namely 24 medical records (35.3%). A follow-up plan is a plan for developing actions that will be given to patients to improve the patient's health condition (Karam et al., 2021). The initial nursing assessment form at Kaliwates Hospital has several options in the follow-up plan component, such as outpatient, inpatient, discharged at request, referred, or died.

Patient Health Education Upon Discharge

The results of this study show that the patient health education component upon discharge is filled in completely, namely 21 medical records (30.9%). Health education is an independent action of nurses as one of the nursing care to improve the health status of patients to optimal (Pueyo-Garrigues et al., 2021; Antoro et al., 2025). In the initial nursing assessment form at Kaliwates Hospital, the health education components include regular eating/drinking of medication, diet, control, and care.

Nurse's Signature and Full Name

This study's results indicate that most nurses' signature and complete name components were filled in, namely 23 medical records (33.8%). Signatures and full names are authentic evidence in medical records. This component is important in medical records because it is a form of accountability for actions taken by health workers. Incomplete filling of signatures and full names

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can hurt the quality of hospital services and make medical records unable to be used as valid legal evidence (Suti et al., 2021).

Analysis of Compliance in Completing Initial Nursing Assessments

The analysis of compliance in completing initial nursing assessments at Kaliwates Hospital reveals that RPD nurses are still struggling with complete adherence to documenting these assessments. Despite a relatively high compliance rate of 89.7%, as evidenced by the review of 61 initial nursing assessment files in Table 2, there remains room for improvement in ensuring all required components are consistently and thoroughly documented. This indicates that while most of the assessments meet the necessary standards, there are still instances where critical elements are either incomplete or overlooked, highlighting the need for targeted interventions or additional training to enhance documentation practices and achieve complete compliance (Bunting, 2022).

CONCLUSION

This study examined the completeness of documentation in eight components of the initial nursing assessment form. It was found that the physical assessment component, along with the general assessment and medical history evaluation, demonstrated the highest level of completion. Conversely, the Gordon pattern assessment component showed no recorded completion at all. While a significant percentage of nurses demonstrated compliance in documenting initial assessments, there is still room for improvement, particularly in ensuring thoroughness across all components. This highlights the need for further training and emphasis on comprehensive documentation practices to enhance the quality of nursing care.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest related to the creation of this manuscript from start to finish.

REFERENCES

Ajibade, B. (2021). Assessing the patient's needs and planning effective care. *British Journal of Nursing*, *30*(20), 1166-1171. https://doi.org/10.12968/bjon.2021.30.20.1166

Al Bahrani, B., & Medhi, I. (2023). Copy-Pasting in Patients' Electronic Medical Records (EMRs): Use Judiciously and With Caution. *Cureus*, *15*(6), e40486. https://doi.org/10.7759/cureus.40486

Alexiuk, M., Elgubtan, H., & Tangri, N. (2023). Clinical Decision Support Tools in the Electronic Medical Record. *Kidney International Reports*, *9*(1), 29-38. https://doi.org/10.1016/j.ekir.2023.10.019

Antoro, Ro'isah, & Marfuah. (2025). The Effect of Health Education Using the Emo-Demo Method on Parental Behavior in Meeting Children's Nutritional Needs. *Health and Technology Journal (HTechJ)*, *3*(1), 83–90. https://doi.org/10.53713/htechj.v3i1.312

Baporikar, N. (2024). Role of Information Technology in Enhancing Healthcare Services. In *Digital Technologies for a Resource Efficient Economy* (pp. 63-87). IGI Global. http://dx.doi.org/10.4018/979-8-3693-2750-0.ch004

Bhati, D., Deogade, M. S., & Kanyal, D. (2023). Improving Patient Outcomes Through Effective Hospital Administration: A Comprehensive Review. *Cureus*, *15*(10), e47731. https://doi.org/10.7759/cureus.47731

Bunting, J. (2022). Strategies to Improve Compliance with Clinical Nursing Documentation Guidelines in the Acute Hospital Setting: A Systematic Review and Analysis. *SAGE Open Nursing*. https://doi.org/10.1177/23779608221075165

Butcher, R. D. C. G. E. S., Guandalini, L. S., de Barros, A. L. B. L., Damiani, B. B., & Jones, D. A. (2024). Psychometric evaluation of the Functional Health Pattern Assessment Screening Tool–Modified Brazilian Version. *Revista Latino-Americana de Enfermagem*, *32*, e4119. https://doi.org/10.1590/1518-8345.6755.4119

Cao, Y., Gao, Y., Chappell, K., & Zhou, W. (2025). Factors affecting nurses' genetic nursing competency: A systematic review. *Nurse Education in Practice*, *84*, 104304. https://doi.org/10.1016/j.nepr.2025.104304

Chaboyer, W., Harbeck, E., Lee, O., & Grealish, L. (2021). Missed nursing care: An overview of reviews. *The Kaohsiung Journal of Medical Sciences*, *37*(2), 82-91. https://doi.org/10.1002/kjm2.12308

Corfmat, M., Martineau, J. T., & Régis, C. (2025). High-reward, high-risk technologies? An ethical and legal account of AI development in healthcare. *BMC Medical Ethics*, *26*(1), 4. https://doi.org/10.1186/s12910-024-01158-1

Curley, M. A., Zalon, M. L., Seckel, M. A., Alexandrov, A. W., Sorce, L. R., Kalvas, L. B., Hooper, V. D., Balas, M. C., Vollman, K. M., Carr, D. S., Good, V. S., Latham, C. L., Carrington, J. M., Hardin, S. R., & Odom-Forren, J. (2024). Call to action: Blueprint for change in acute and critical care nursing. *Nursing Outlook*, *72*(6), 102271. https://doi.org/10.1016/j.outlook.2024.102271

Davarpanah, I., Adine, M., Elahi, N., Haghighizadeh, M. H., & Javaherforooshzadeh, F. (2023). The Effect of Implementing Nursing Care Based on Gordon's Model on the Clinical Outcomes of Patients Undergoing Coronary Artery Bypass Surgery: A Quasi-experimental Study. *Jundishapur Journal of Chronic Disease Care*, *13*(2). https://doi.org/10.5812/jjcdc-139899

Dikmen, B. T., & Bayraktar, N. (2023). Postoperative nursing process of a pregnant patient with meningioma: a case report. *Nursing in the 21st Century*, *22*(4 (85)), 288-296. https://doi.org/10.2478/pielxxiw-2023-0035

Ding, X., & Peng, X. (2022). The impact of electronic medical records on the process of care: Alignment with complexity and clinical focus. *Decision Sciences*, *53*(2), 348-389. https://doi.org/10.1111/deci.12485

Falcetta, F. S., De Almeida, F. K., Lemos, J. C. S., Goldim, J. R., & Da Costa, C. A. (2023). Automatic documentation of professional health interactions: A systematic review. *Artificial Intelligence in Medicine*, *137*, 102487. https://doi.org/10.1016/j.artmed.2023.102487

Hossain, M. K., Sutanto, J., Handayani, P. W., Haryanto, A. A., Bhowmik, J., & Frings-Hessami, V. (2025). An exploratory study of electronic medical record implementation and record-keeping culture: the case of hospitals in Indonesia. *BMC Health Services Research*, *25*(1), 1-20. https://doi.org/10.1186/s12913-025-12399-0

Hosseini, N., Kimiafar, K., Mostafavi, S. M., Kiani, B., Zendehdel, K., Zareiyan, A., & Eslami, S. (2021). Factors affecting the quality of diagnosis coding data with a triangulation view: A qualitative study. *The International Journal of Health Planning and Management*, *36*(5), 1666-1684. https://doi.org/10.1002/hpm.3254

Karam, M., Chouinard, C., Poitras, E., Couturier, Y., Vedel, I., Grgurevic, N., & Hudon, C. (2021). Nursing Care Coordination for Patients with Complex Needs in Primary Healthcare: A Scoping Review. *International Journal of Integrated Care*, *21*(1), 16. https://doi.org/10.5334/ijic.5518

Volume 03 Number 02
April 2025
p-ISSN: 2986-5662
e-ISSN: 2985-959X

Michl, G., Paterson, C., & Bail, K. (2023). 'It's all about ticks': A secondary qualitative analysis of nurse perspectives about documentation audit. *Journal of Advanced Nursing*, *79*(9), 3440-3455. https://doi.org/10.1111/jan.15685

Moy, A. J., Schwartz, J. M., Chen, R., Sadri, S., Lucas, E., Cato, K. D., & Rossetti, S. C. (2021). Measurement of clinical documentation burden among physicians and nurses using electronic health records: A scoping review. *Journal of the American Medical Informatics Association*, *28*(5), 998-1008. https://doi.org/10.1093/jamia/ocaa325

Msiska, G., Chilemba, E., Kamanga, M., Mulenga, C., Namathanga, A., Mapulanga, P., & Kazembe, A. (2023). Patient safety challenges and practical ethical legal issues in low-and middle-income countries. In *Research Handbook on Patient Safety and the Law* (pp. 257-277). Edward Elgar Publishing. https://doi.org/10.4337/9781802207064.000022

Nijor, S., Rallis, G., Lad, N., & Gokcen, E. (2022). Patient safety issues from information overload in electronic medical records. *Journal of Patient Safety*, *18*(6), e999-e1003. https://doi.org/10.1097/pts.0000000000001002

Oliva, A., Grassi, S., Vetrugno, G., Rossi, R., Della Morte, G., Pinchi, V., & Caputo, M. (2022). Management of Medico-Legal Risks in Digital Health Era: A Scoping Review. *Frontiers in Medicine*, *8*, 821756. https://doi.org/10.3389/fmed.2021.821756

Pai, M. M., Ganiga, R., Pai, R. M., & Sinha, R. K. (2021). Standard electronic health record (EHR) framework for Indian healthcare system. *Health Services and Outcomes Research Methodology*, *21*(3), 339-362. https://doi.org/10.1007/s10742-020-00238-0

Parreira, P., Neri, M., Marques, A., & Queirós, P. (2020). Work Methods for Nursing Care Delivery. *International Journal of Environmental Research and Public Health*, *18*(4), 2088. https://doi.org/10.3390/ijerph18042088

Patrizio, E., Calvani, R., Marzetti, E., & Cesari, M. (2021). Physical Functional Assessment in Older Adults. *The Journal of Frailty & Aging*, *10*(2), 141-149. https://doi.org/10.14283/jfa.2020.61

Poulos, J., Zhu, L., & Shah, A. D. (2021). Data gaps in electronic health record (EHR) systems: An audit of problem list completeness during the COVID-19 pandemic. *International Journal of Medical Informatics*, *150*, 104452. https://doi.org/10.1016/j.ijmedinf.2021.104452

Pueyo-Garrigues, M., Pardavila-Belio, M., Canga-Armayor, A., Esandi, N., Alfaro-Díaz, C., & Canga-Armayor, N. (2021). NURSES' knowledge, skills and personal attributes for providing competent health education practice, and its influencing factors: A cross-sectional study. *Nurse Education in Practice*, *58*, 103277. https://doi.org/10.1016/j.nepr.2021.103277

Putri, P., Tri Afandi, A., & Wahyu Fajaryanti, D. (2021). Relationship of Leadership Style to Completeness of Filling in The Early Nursing Assessment in Hospital. *Nursing and Health Sciences Journal (NHSJ)*, *1*(1), 64-66. https://doi.org/10.53713/nhs.v1i1.19

Reegu, F. A., Abas, H., Gulzar, Y., Xin, Q., Alwan, A. A., Jabbari, A., Sonkamble, R. G., & Dziyauddin, R. A. (2022). Blockchain-Based Framework for Interoperable Electronic Health Records for an Improved Healthcare System. *Sustainability*, *15*(8), 6337. https://doi.org/10.3390/su15086337

Rossi, L., Butler, S., Coakley, A., & Flanagan, J. (2022). Nursing knowledge captured in electronic health records. *International Journal of Nursing Knowledge*, *34*(1), 72-84. https://doi.org/10.1111/2047-3095.12365

Shin, G. W., Bahn, S., Lee, Y., & Lee, H. (2021). The effects of environmental, operational, and organizational factors on the usage of and satisfaction with electronic medical records. *Human Factors and Ergonomics in Manufacturing & Service Industries*, *31*(5), 516-531. https://doi.org/10.1002/hfm.20900

Suti Ismawati, N. D., Supriyanto, S., Haksama, S., & Hadi, C. (2021). The Influence of Knowledge and Perceptions of Doctors on the Quality of Medical Records. *Journal of Public Health Research*. https://doi.org/10.4081/jphr.2021.2228

Volume 03 Number 02
April 2025
p-ISSN: 2986-5662
e-ISSN: 2985-959X

Tapuria, A., Porat, T., Kalra, D., Dsouza, G., Xiaohui, S., & Curcin, V. (2021). Impact of patient access to their electronic health record: systematic review. *Informatics for Health and Social Care*, *46*(2), 194–206. https://doi.org/10.1080/17538157.2021.1879810