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FACTORS ASSOCIATED WITH NURSES' COMPLIANCE IN DOCUMENTING NURSING CARE IN ELECTRONIC MEDICAL RECORDS AT RSUD PAMEUNGPEUK GARUT

FAKTOR–FAKTOR YANG BERHUBUNGAN DENGAN KEPATUHAN PERAWAT DALAM PENDOKUMENTASIAN ASUHAN KEPERAWATAN PADA ELEKTRONIK REKAM MEDIS DI RSUD PAMEUNGPEUK GARUT

Iman Nurjaman [1*], Daryana [2], Ina Saparlina [3]
[1] Faculty of Nursing, Bhakti Kencana University, Garut, Indonesia, Email: iman.nurjaman@bku.ac.id
[2] Faculty of Health Science and Technology, Jenderal Achmad Yani University, Cimahi, Indonesia Email: daryanaghazy@gmail.com
[3] College of Teacher Training and Education, Garut, Indonesia, Email: inasaparlina@gmail.com

*email Koresponden: iman.nurjaman@bku.ac.id

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Abstract

This study aims to analyze the relationship between nurse characteristics and factors associated with nurses' compliance in documenting nursing care in EMRs at RSUD Pameungpeuk Garut. This research employed an analytic survey with a cross-sectional approach and involved 94 respondents. Primary data were collected using questionnaires on nurses' characteristics, knowledge, attitude, motivation, and head nurse supervision. Data analysis was conducted using the Chi-Square test. The results showed a significant relationship between head nurse supervision (p = 0.027) and nurses' compliance in documenting nursing care in EMRs. The study concludes that there is a relationship between head nurse supervision and nurses' compliance in nursing care documentation within EMRs. Nurses who receive regular supervision tend to have higher compliance in documentation compared to those who are not supervised by the head nurse.

Keywords: Nursing Care Documentation; Electronic Medical Records; Nurse Compliance; EMR; Nurse Supervision.

Abstrak

Penelitian ini bertujuan untuk menganalisis hubungan karakteristik perawat dan faktor–faktor yang berhubungan dengan kepatuhan perawat dalam melakukan pendokumentasian asuhan

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keperawatan dalam RME di RSUD Pameungpeuk Garut. Penelitian ini menggunakan rancangan survei analitik pendekatan cross sectional, dengan sampel 94 orang. Menggunakan data primer (kuisioner karakteristik perawat, pengetahuan, sikap, motivasi dan supervisi kepala ruangan). Analisis data menggunakan Chi-Square. Hasil penelitian menunjukan adanya hubungan antara supervisi kepala ruangan (p=0,027) dalam kepatuhan pendokumentasian asuhan keperawatan pada RME. Simpulan penelitian terdapat hubungan antara supervisi kepala ruangan dalam kepatuhan pendokumentasian asuhan keperawatan pada RME, bahwa perawat yang sering dilakukan supervisi akan mengalami peningkatan kepatuhan dokumentasi, dibandingkan perawat yang tidak dilakukan supervisi oleh kepala ruangan.

Kata Kunci : Dokumentasi Asuhan Keperawatan; Elektronik Rekam Medis; Kepatuhan Perawat; RME; Supervisi Perawat.

1. INTRODUCTION

Nursing documentation is a critical component of professional healthcare practice, serving as a written record that provides legal protection and evidence of care delivery. Nurses are required to document nursing care in a manner that is complete, clear, and comprehensible to others. Proper documentation is essential not only for ensuring continuity and quality of care but also as a legal safeguard in the event of disputes or claims against healthcare providers.

Following the Indonesian Ministry of Health Regulation No. 24 of 2022 regarding medical records, all healthcare services are mandated to implement Electronic Medical Records (EMRs). EMRs are an integral part of the Health Facility Information System, connected with other subsystems to support efficient healthcare delivery. Consequently, all healthcare providers, including nurses, are obligated to record every aspect of patient care within the EMR system. Each nursing encounter must be recorded, including a concise summary of the patient's care needs and the interventions performed (Sulastri & Sari, 2018).

Hospitals must routinely evaluate and improve nursing documentation practices, particularly in the context of post-accreditation quality assessments. In March 2023, RSUD Pameungpeuk began implementing the EMR system using SIMRS Khanza, a hospital information management system supported by the West Java Provincial Government. According to Fadilah (2020), various factors such as personal characteristics, knowledge, motivation, time constraints, and attitudes significantly influence nurses' compliance in nursing documentation. Furthermore, Sulastri and Sari (2018) emphasized that IT-based documentation systems are essential in the modern era, offering data accuracy, improved care planning, and enhanced performance in delivering quality nursing care.

A preliminary study conducted at RSUD Pameungpeuk in August 2023 revealed mixed responses to EMR usage among nurses. Of the ten nurses interviewed, only one consistently documented nursing care electronically, five used the system occasionally, and four never used it at all. The primary barriers cited included limited computer availability in wards and prioritization of clinical interventions over EMR documentation. Although all nurses had received in-house training on EMRs and were guided by the hospital's IT team, computer use in inpatient rooms was still shared with administrative staff.

The Indonesian National Nurses Association (PPNI) has integrated the SIMRS Khanza system with national standards such as SDKI (Standard Nursing Diagnosis), SLKI (Standard Nursing Outcome), and SIKI (Standard Nursing Intervention). Despite these efforts, nurse compliance in documenting the full scope of nursing care—from assessment and diagnosis to

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planning, implementation, and evaluation—remains at only 65%. A noteworthy finding during this transitional phase from manual to electronic documentation is the variability in compliance levels. This transition, particularly in a remote hospital setting like RSUD Pameungpeuk, presents unique challenges, including unstable internet connections and technological limitations.

This study aims to explore the factors influencing nurses' compliance in documenting nursing care in EMRs at RSUD Pameungpeuk. As the healthcare industry moves toward digital transformation, nurses need to adapt and align with evolving documentation practices to ensure quality, accountability, and continuity of patient care.

2. RESEARCH METHOD

This study employed a descriptive-correlational analytic survey design using a cross-sectional approach. The research was conducted at RSUD Pameungpeuk Garut. The population consisted of 122 staff nurses working in various units, including Flamboyan, Cendana, Meranti, Aster, Perinatology, ICU/NICU, Emergency Department, Outpatient Department, and Operating Room. A total of 94 respondents were selected as the study sample.

The sampling technique used was based on the Slovin formula while also applying purposive sampling to ensure that participants met the pre-defined inclusion and exclusion criteria.

Validity testing was conducted to ensure that the questionnaire accurately measured each variable. The test used item-total correlation with 30 nurses at RSUD Singaparna Medika Citrautama, a hospital similar in type and setting to the main study site. For the knowledge questionnaire (X2), 17 out of 20 items were valid. For the attitude questionnaire (X3), 19 out of 20 items were valid. For the motivation questionnaire (X4), 64 out of 73 items were valid. The invalid items were revised for clarity but were not re-tested due to time limitations. The supervision variable (X5) was not tested for validity because the instrument was already standardized.

Reliability testing was performed using Cronbach’s Alpha with the same group of 30 respondents. The knowledge questionnaire (X2) showed a reliability score of 0.736, the attitude questionnaire (X3) scored 0.934, and the motivation questionnaire (X4) scored 0.975. All values were above the minimum acceptable level, indicating that the instruments were reliable. The analysis was carried out using statistical software.

The research instrument consisted of structured questionnaires designed to assess nurse compliance, nurse characteristics, knowledge, attitudes, motivation, and head nurse supervision related to nursing care documentation in electronic medical records at RSUD Pameungpeuk Garut. The scoring for nurse characteristics was based on categorical data. Gender was coded as 1 for male and 2 for female. Educational level was coded as 1 for professional nurse (Ners) and 2 for diploma in nursing (D3). Work duration was coded as 1 for more than five years and 2 for five years or less. Age was categorized as 1 for late adulthood, 2 for middle adulthood, and 3 for early adulthood.

Nurses’ knowledge was measured through multiple-choice questions, with each correct answer receiving one point. The total score was converted into a percentage and classified into three levels: good (>75%, score 1), fair (60–75%, score 2), and poor (<60%, score 3). This approach allowed for a clear and objective assessment of the respondents’ understanding of nursing care documentation.

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Attitudes toward electronic medical record use were assessed using Likert-scale statements addressing cognitive, affective, and behavioral domains. Total scores were compared with the mean value of 67.5. Scores above the mean indicated a favorable attitude (score 1), while scores equal to or below the mean indicated an unfavorable attitude (score 2).

Motivation was also measured using a Likert-type scale. The overall score was compared to a cutoff mean value of 246. Respondents with scores above this threshold were categorized as having high motivation (score 1), while those scoring equal to or below 246 were categorized as having low motivation (score 2).

Head nurse supervision was measured through a series of statements using a Likert scale, and total scores were compared with a mean value of 82.5. A score above the mean reflected good supervision (score 1), while scores at or below the mean indicated poor supervision (score 2). This measurement captured the level of managerial support perceived by nurses.

Nurse compliance in documentation was assessed using a direct observation checklist. Observers recorded whether each aspect of the documentation process was completed. A compliance level of ≥85% was considered compliant (score 1), while <85% was categorized as non-compliant (score 2). This method ensured objective evaluation of actual documentation practices.This study was approved by the Health Research Ethics Committee of the Faculty of Health Science and Technology, Universitas Jenderal Achmad Yani, Cimahi, Indonesia, with the ethical clearance number 017/KEPK/FITKes-UNJANI/II/2024

3. RESULTS AND DISCUSSION

The data in this study were obtained through an analytic survey using instruments that included multiple-choice questionnaires, Likert-scale items, and observation forms. A total of 148 items were used, comprising 5 items for nurse compliance observation, 4 items for nurse characteristics, 20 items for knowledge, 20 items for attitude, 73 items for motivation, and 26 items for head nurse supervision. Each response was scored according to predetermined criteria, with correct or appropriate answers receiving corresponding points. Data analysis was conducted using SPSS version 25, employing descriptive statistics (frequency test) and inferential analysis using the Chi-Square test to identify significant relationships among the studied variables. The results of the analysis are presented as follows:

Univariate Analysis

a. Nurse Compliance

Table 1. Frequency Distribution of Nurse Compliance at RSUD Pameungpeuk Garut

No	Variable		f	P (%)
1	Nurse Compliance	Compliant	69	73,4
		Non-Compliant	25	26,6
		Total	94	100,0

The results of the analysis showed that more than half of the nurses (73.4%) at Pameungpeuk Garut Hospital complied with documenting nursing care in the electronic medical record system.

b. Individual Nurse Characteristics Affecting Compliance

Table 2. Frequency Distribution of Nurse Characteristics (Gender, Education, Work Experience, Age) at RSUD Pameungpeuk Garut

No	Variable		f	P (%)
1	Gender	Male	51	54,3

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		Female	43	45,7
		Total	94	100,0
2	Education	Diploma in Nursing	74	78,7
		Registered Nurse	20	21,3
		Total	94	100,0
3	Work Experience	> 5 Years	64	68,1
		≤ 5 Years	30	31,9
		Total	94	100,0
4	Age	Young Adult	84	89,4
		Middle Adult	10	10,6
		Total	94	100,0

The analysis results show that the individual characteristics of nurses working at RSUD Pameungpeuk Garut are as follows: in terms of gender, more than half are male (54.3%); in terms of education, the majority (78.7%) hold a diploma in nursing (D3); regarding work experience, more than half (68.1%) have been working for more than 5 years; and in terms of age, the vast majority (89.4%) are young adults aged between 20 and 40 years.

c. Factors Influencing Nurse Compliance

Table 3. Frequency Distribution of Factors: Nurse Knowledge, Attitude, Motivation, and Head Nurse Supervision at RSUD Pameungpeuk Garut

No	Variable		f	P (%)
1	Nurse Knowledge	Good	29	30,9
		Fair	47	50,0
		Poor	18	19,1
		Total	94	100,0
2	Nurse Attitude	*Favorable*	41	43,6
		Unfavorable	53	56,4
		Total	94	100,0
3	Nurse Motivation	High Motivation	31	33,0
		Low Motivation	63	67,0
		Total	94	100,0
4	Head Nurse Supervision	Adequate	19	20.2
		Inadequate	75	79.8
		Total	94	100,0

The analysis results indicate that several factors influence nurses' compliance in documenting nursing care in electronic medical records at RSUD Pameungpeuk Garut. In terms of knowledge, half of the respondents (50.0%) demonstrated a moderate level of knowledge. Regarding attitude, more than half of the nurses (56.4%) exhibited an unfavorable or poor attitude. In terms of motivation, 67.0% of the nurses were found to have low motivation. Finally, concerning head nurse supervision, the majority (79.8%) reported that supervision was inadequate.

Bivariate Analysis

Table 4. Relationship Between Characteristics and Factors With Compliance in Nursing Care Documentation in Electronic Medical Records at RSUD Pameungpeuk Garut

No	Variable	Nurse Compliance in EMR (Electronic Medical Record)	χ^2	*P-value*

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			Compliant n (%)	Non-Compliant n (%)	Total n (%)		
1	Gender	Male	39 (76,5)	12 (23,5)	51 (100)	0,248	(0,618)
		Female	30 (69,8)	13 (30,2)	43 (100)		
2	Education	Registered Nurse	17 (85,0)	3 (15,0)	20 (100)	1,077	(0,299)
		Diploma in Nursing	52 (70,3)	22 (29,7)	74 (100)		
3	Work Experience	> 5 Years	45 (69,2)	20 (30,8)	65 (100)	1,251	(0,263)
		≤ 5 Years	24 (82,8)	5 (17,2)	29 (100)		
4	Age	Middle Adult	8 (80,0)	2 (20,0)	10 (100)	0,249	(1,000)
		Young Adult	61 (72,6)	23 (27,4)	84 (100)		
5	Nurse Knowledge	Good	22 (75,9)	7 (24,1)	29 (100)	0,130	(0,937)
		Sufficient	34 (72,3)	13 (27,7)	47 (100)		
		Poor	13 (72,2)	5 (27,8)	18 (100)		
6	Nurse Attitude	*Favorable*	31 (75,6)	10 (24,4)	41 (100)	0,036	(0,849)
		Unfavorable	38 (71,7)	15 (28,3)	53 (100)		
7	Nurse Motivation	High	25 (80,6)	6 (19,4)	31 (100)	0,750	(0,386)
		Low	44 (69,8)	19 (30,2)	63 (100)		
8	Head Nurse Supervision	Good	18 (94,7)	1 (5,3)	19 (100)	4,266	(0,039)
		Poor	51 (68,0)	24 (32,0)	75 (100)		
		Total	69 (73,4)	25 (26,5)	94 (100)		

The analysis results show the relationship between individual characteristics of nurses and their compliance with nursing documentation. Based on gender, more than half of male nurses (76.5%) complied with filling out the EMR, while only 30.2% of female nurses complied. Regarding education, the majority of nurses with a D3 diploma (70.3%) complied with filling out the EMR, while only 15% of nurses with a Ners degree complied. Regarding work experience, nurses with more than 5 years of service showed higher compliance (69.2%), while only 17.2% of nurses with ≤ 5 years of service complied. In terms of age, the majority of young adult nurses (72.6%) complied with filling out the EMR, while only 20% of middle-aged nurses complied.

Nurses' knowledge of nursing documentation also affects compliance. The majority of nurses with sufficient knowledge (72.3%) complied with filling out the EMR, while only a small percentage (24.1%) of nurses with good knowledge complied. Nurses' attitudes also play a role, with more than half of nurses with unfavorable attitudes (71.7%) complying with filling out the EMR, while 24.4% of nurses with favorable attitudes complied. Nurses' motivation, which is mostly low (69.8%), is also associated with compliance in filling out the EMR, while only a small percentage of nurses with high motivation (19.4%) complied.

Based on the p-values greater than $\alpha = 0.05$, namely (gender = 0.618), (education = 0.299), (work experience = 0.263), (age = 1.000), (knowledge = 0.937), (attitude = 0.849), and (motivation = 0.386), it can be concluded that there is no significant relationship between individual characteristics, knowledge, attitude, and motivation of nurses in the compliance of nursing documentation on the electronic medical record at RSUD Pameungpeuk Garut.

However, in terms of supervision by head nurses, more than half of the nurses (68.0%) with inadequate supervision still complied with filling out the EMR, while only a small percentage (5.3%) of nurses with adequate supervision did not comply. Based on the p-value

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of 0.039, which is smaller than α = 0.05, it can be concluded that there is a significant relationship between supervision by head nurses and compliance with nursing documentation on the electronic medical record at RSUD Pameungpeuk Garut.

Discussion

a. Nurse Compliance in Nursing Documentation on Electronic Medical Records (EMR)

This finding demonstrates that the majority of nurses consistently apply proper documentation practices, reflecting their awareness of the importance of accurate, complete, and timely entries in supporting patient safety and care quality. The successful implementation of EMR is also aligned with the hospital's achievement of a "paripurna" accreditation rating, indicating institutional readiness for digital transformation in healthcare.

However, the presence of 26.6% non-compliant nurses reflects persistent barriers within the clinical environment. Non-compliance is attributed to organizational factors such as limited time, lack of monitoring, inadequate communication, and weak supervision at the ward level. These findings highlight the urgent need for stronger nursing leadership, structured supervision systems, and improved coordination to ensure full compliance with EMR documentation standards across all nursing staff.

b. Individual Characteristics Related to Nurse Compliance in Documenting Nursing Care on Electronic Medical Records

The findings suggest that compliance tends to be higher among younger nurses, those with more education, and those with longer work experience. These factors appear to contribute to better understanding, adherence to documentation standards, and professional accountability.

The pattern observed indicates that work experience enhances familiarity with documentation protocols, while education strengthens cognitive and technical skills related to EMR use. Additionally, younger age groups may demonstrate greater adaptability to digital systems. Together, these characteristics form a foundation for improved nursing care quality through consistent and accurate documentation. These results underscore the need to consider nurse profiles when designing interventions to improve compliance with electronic medical records.

c. Factors Related to Nurses' Compliance in Nursing Care Documentation on Electronic Medical Records

The findings emphasize that nurses' compliance in electronic nursing documentation is significantly shaped by a combination of cognitive, affective, and organizational factors. Moderate knowledge alone appears insufficient to drive optimal documentation behavior when not supported by positive attitudes, strong motivation, and structured supervision. The high prevalence of low motivation and inadequate supervisory support reflects deeper systemic challenges that may affect nurses' performance, autonomy, and accountability in digital record-keeping.

Improving documentation compliance requires a strategic focus on enhancing internal factors such as cultivating favorable attitudes and professional motivation while strengthening external supports like head nurse supervision. These findings highlight the critical role of leadership engagement and continuous professional development in ensuring accurate, consistent, and quality nursing documentation, which ultimately contributes to improved patient outcomes and institutional credibility.

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d. The Relationship Between Factors and Nurses' Compliance in Nursing Care Documentation on Electronic Medical Records

The findings of this study highlight the pivotal role of head nurse supervision in improving nurse compliance with electronic medical record (EMR) documentation. While various individual characteristics such as gender, educational background, work experience, age, knowledge, attitude, and motivation showed no statistically significant association with compliance, supervision emerged as the only factor with a meaningful relationship ($p = 0.039$). This underscores that regardless of personal or professional background, nurses are more likely to adhere to documentation standards when they receive consistent guidance, feedback, and monitoring from their immediate supervisors.

These results point to the critical function of leadership and managerial support in clinical practice. Strengthening supervisory structures especially through targeted, department-wide oversight can enhance documentation quality, reduce variability in compliance, and ultimately support better patient care outcomes. In settings where technical systems like EMR are still evolving, leadership engagement becomes a key enabler of successful implementation and behavioral change among nursing staff. Therefore, hospital management should prioritize ongoing training and empowerment of head nurses to serve not only as clinical leaders but also as effective mentors and quality controllers in documentation practices.

4. CONCLUSION

The findings of this study indicate that more than half of the nurses at RSUD Pameungpeuk Garut demonstrated good compliance in documenting nursing care in the Electronic Medical Records (EMR). Most respondents were male, held a D3 nursing degree, had more than five years of work experience, and were in the young adult age group (20–40 years). While half of the nurses had adequate knowledge, more than half showed unfavorable attitudes, low motivation, and reported inadequate supervision from head nurses. Interestingly, despite these challenges, many nurses still complied with EMR documentation, and among all observed factors, only head nurse supervision showed a statistically significant relationship ($p < 0.05$) with nurse compliance in EMR documentation. This highlights the crucial role of effective supervision in enhancing documentation practices and maintaining the quality of nursing care.

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