

Assessment of Clinical Documentation Quality and Completeness Among Hospitalized Patients in an Emergency Ward: A Cross-Sectional Study

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Abstract:

➤ Background:

Clinical documentation is an essential component of quality healthcare delivery. Accurate, complete and timely documentation improves patient safety, enhances communication among healthcare providers and facilitates clinical decision-making. Poor documentation, however, remains a persistent challenge in many healthcare institutions, particularly in low- and middle-income countries.

➤ Objective:

To assess the completeness and quality of clinical documentation and determine factors associated with documentation practices among hospitalized patients.

➤ Methods:

A cross-sectional study was conducted using 156 patient records. Data were extracted using a structured checklist assessing patient demographics, documentation completeness, examination findings, frequency of patient review, and discharge summaries. Documentation quality was categorized as poor, fair, or good. Statistical analysis included descriptive statistics, chi-square test, Fisher's exact test, ANOVA, and logistic regression.

➤ Results:

Most patient identifiers were documented, including patient name (100%), age (98.7%), and sex (96.8%). However, folder numbers were documented in only 21.8% of records. Vital sign documentation varied, with pulse rate documented in 96.2% and blood pressure in 30.1%. Documentation completeness was significantly associated with cadre of doctor ($\chi^2=24.355$, $p<0.001$). However, documentation quality showed no significant association with cadre ($p=0.172$). Frequency of patient review was significantly associated with discharge summary documentation ($\chi^2=18.145$, $p<0.001$).

➤ Conclusion:

Clinical documentation practices were suboptimal, particularly regarding completeness and vital sign recording. Targeted interventions including training, supervision, and institutional policies are recommended to improve documentation quality.

Keywords: Clinical Documentation, Medical Records, Bayelsa, Documentation Completeness, Hospital Audit, Nigeria.

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I. INTRODUCTION

Clinical documentation is an essential component of quality healthcare delivery and serves as the foundation for effective patient management, continuity of care, and communication among healthcare professionals. Accurate, complete, and timely documentation ensures that relevant clinical information is available to guide decision-making and monitor patient progress¹. In addition, medical records provide important evidence for medico-legal purposes, healthcare planning, research, clinical audit, and quality improvement initiatives^{2,3}. High-quality clinical documentation has been associated with improved patient outcomes, reduced medical errors, and enhanced interdisciplinary collaboration⁴.

Despite its recognized importance, poor clinical documentation remains a major challenge globally, particularly in low- and middle-income countries where healthcare systems are often affected by inadequate staffing, heavy workload, and limited infrastructural resources⁵. Studies conducted in Nigeria, Ethiopia, Kenya, and South Africa have consistently reported deficiencies in documentation of patient identifiers, examination findings, treatment plans, and discharge summaries⁶⁻⁹. Incomplete documentation may result in communication gaps among healthcare providers, delayed diagnosis, inappropriate treatment decisions, duplication of investigations, and poor continuity of care¹⁰. Furthermore, poor record keeping weakens institutional accountability and limits the ability to conduct effective clinical audits and healthcare evaluations¹¹.

Vital sign documentation is especially important in hospitalized patients because it provides objective information regarding physiological stability and clinical progression. Parameters such as temperature, pulse rate, respiratory rate, blood pressure, height, and weight are essential for early recognition of patient deterioration and monitoring response to treatment¹². Failure to adequately document these parameters may delay intervention and increase the risk of adverse patient outcomes¹³. Previous studies have shown inconsistent documentation of vital signs in many healthcare institutions, particularly in resource-constrained settings where patient load is high and documentation systems are largely paper based^{14,15}.

Several factors influence the quality and completeness of clinical documentation. These include the cadre and level of training of healthcare workers, workload, institutional policies, availability of standardized documentation tools, supervision, and organizational culture¹⁶. Junior doctors often perform initial patient clerking and may lack adequate training in proper documentation standards, while senior clinicians may provide more comprehensive and structured documentation¹⁷. Studies have also demonstrated that

supportive supervision, regular audit, and continuing professional education significantly improve documentation practices among healthcare workers^{18,19}.

In Nigeria, documentation practices remain inconsistent across healthcare institutions, with persistent deficiencies reported in discharge summaries, examination findings, and continuity-of-care records^{20,21}. However, there is limited local evidence assessing the relationship between clinician cadre, frequency of patient review, and documentation quality among hospitalized patients.

This study therefore aimed to assess the completeness and quality of clinical documentation among hospitalized patients in a tertiary healthcare facility and determine factors associated with documentation practices.

II. METHODOLOGY

➤ Study Design

A cross-sectional descriptive study was conducted to assess the quality and completeness of clinical documentation.

➤ Study Setting

The study was conducted in a tertiary healthcare facility. Patient case notes were retrieved over a 1-year period, spanning January 2025 to January 2026 and reviewed to evaluate documentation practices.

➤ Study Population

A total of 156 patient records were retrieved and reviewed. Records included patients admitted during the study period.

➤ Inclusion Criteria

- All admitted patients during the study period
- Complete case files available for review

➤ Exclusion Criteria

- Missing case files
- Incomplete admission documentation
- Patients who died before completion of documentation

➤ Data Collection

Data recorded or communicated on admission, handover and discharge was recorded using a standardised proforma adapted from the Royal College of Physicians Health Informatics Unit. Variables collected included: Patient identifiers, Admission details, Examination findings, Vital signs documentation, Frequency of patient review, Discharge summary documentation and Cadre of documenting doctor.

➤ Data Analysis

Data were analyzed using statistical software. Descriptive statistics were presented as frequencies and percentages. Chi-square test was used to assess associations between categorical variables. Fisher's exact test was used where expected cell counts were less than five. ANOVA was used to compare mean documentation scores among doctor cadres. Logistic regression analysis was performed to identify predictors of documentation completeness. Statistical significance was set at $p < 0.05$.

➤ Ethical Considerations

Ethical approval was obtained from the Ethics committee of the hospital. Confidentiality of patient

information was maintained. No patient identifiers were included in the data collection tool.

III. RESULTS

➤ Documentation of Patient Identifiers

Most patient identifiers were well documented. Patient name was recorded in all cases (100%), while patient age and sex were documented in 98.7% and 96.8% respectively. However, folder number documentation was low (21.8%). Discharge summary documentation was present in 59% of records while legible handwriting was observed in 75% of records (Table 1). These findings indicate adequate documentation of basic patient identifiers but highlight deficiencies in continuity-related documentation.

Table 1 Documentation of Patient Identifiers

Variable	1 (%)	0 (%)
Patients Name	156 (100)	0 (0)
Patients Age	154 (98.7)	1 (0.6)
Patients Sex	151 (96.8)	1 (0.6)
Date clerked in	150 (96.2)	5 (3.2)
Time clerked in	111 (71.2)	43 (27.6)
Patients name written on first page	150 (96.2)	5 (3.2)
Patients name written on subsequent pages	94 (60.3)	61 (39.1)
Folder no. on each page	34 (21.8)	121 (77.6)
Name and Signature of doctor at each documentation	140 (89.7)	13 (8.3)
Location of admission	136 (87.2)	14 (9)
Legible handwriting	117 (75.0)	35 (22.4)
Discharge Summary	92 (59)	55 (35.3)
Countersignatures on additions and correction in a document	143 (91.7)	2 (1.3)

0= Not Documented, 1= Documented

➤ Documentation of Vital Signs

Vital sign documentation varied widely. Pulse rate (96.2%) and respiratory rate (93.6%) were well documented, while blood pressure (30.1%) and height (20.5%) were poorly

documented. Temperature was documented in 78.2% of cases. These findings indicate inconsistent recording of essential clinical parameters (Fig. 1)

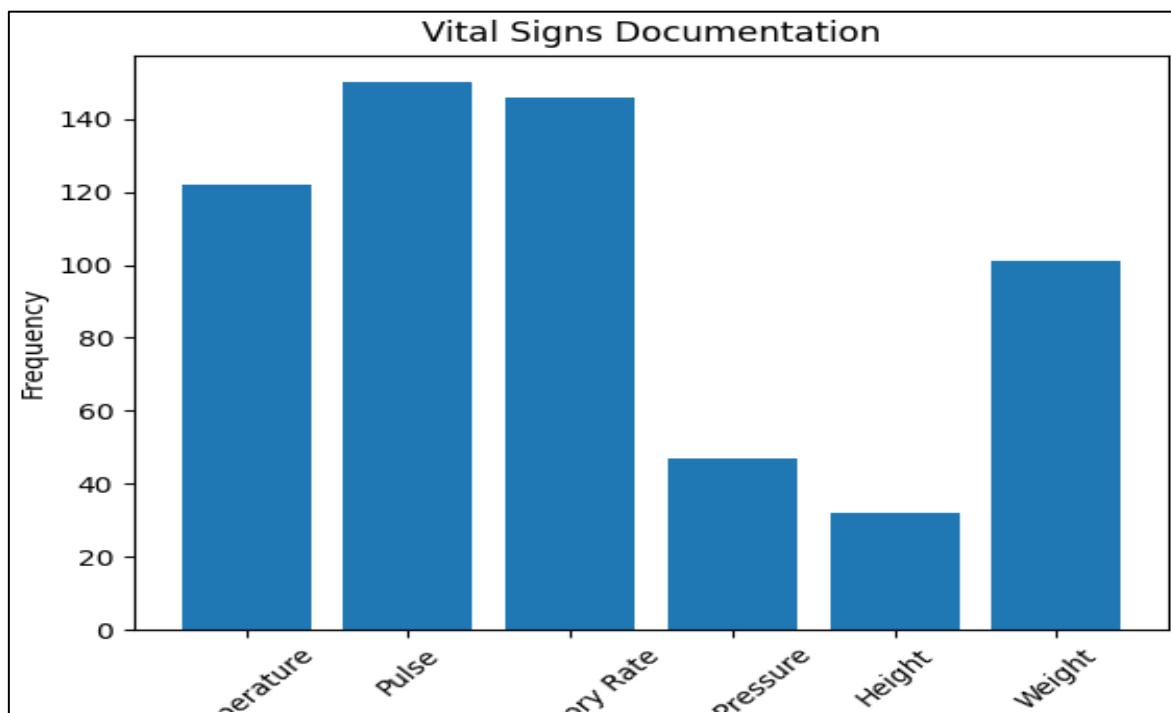


Fig 1 Bar Chart Depicting Vital Signs Documentation
(Source; Authors' Data)

➤ *Frequency of Patient Review*

Most patients were reviewed twice daily (62.8%). Only 10.3% were reviewed once daily. These findings suggest adequate patient monitoring in most cases (Fig.2)

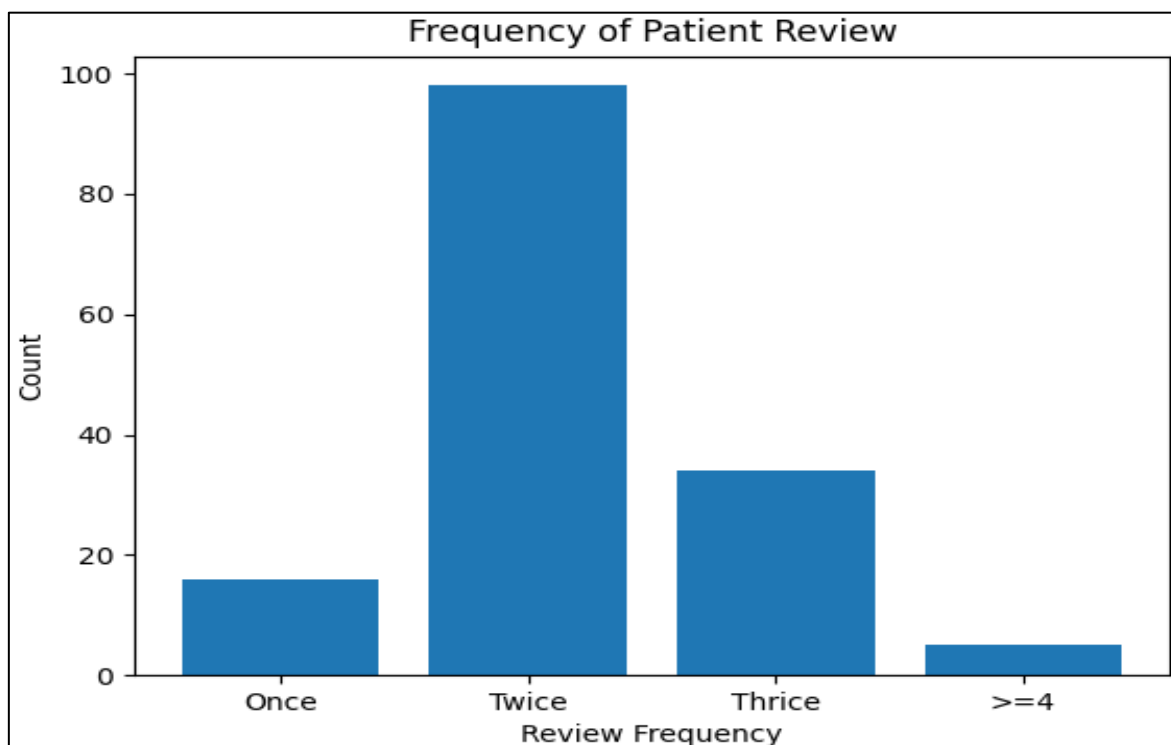


Fig 2 Bar Chart Showing Frequency of Patient Review
(Source; Authors' Data)

➤ *Source of Referral*

Table 2 shows that most patients were self-referred (83.3%), while referrals from primary health facilities

accounted for 7.1%. This indicates that majority of patients presented directly to the tertiary facility.

Table 2 Source of Referral

Variable	Frequency (%)
Self	130 (83.3)
Primary Health Facility	11 (7.1)
Private Facility	2 (1.3)
Secondary Health Facility	2 (1.3)

➤ *Association between Cadre of Doctors and Documentation Completeness*

Documentation completeness was significantly associated with cadre of doctor ($\chi^2=24.355$, $p<0.001$).

Consultants had higher rates of complete documentation compared to junior staff (Table 3).

Table 3 Association Between Cadre of Doctors vs. Completeness of Document

	Completeness of Document		Total (%)	Inferential Test
	0 (%)	1 (%)		
House Officer	36 (31.3)	2 (1.7)	38 (33.0)	$\chi^2=24.355$ $p = 0.000021$
Junior Resident	54 (47.0)	0 (0.0)	54 (47.0)	
Senior Resident	15 (13.0)	0 (0.0)	15 (13.0)	
Consultant	5 (4.3)	3 (2.6)	8 (7.0)	
Total	110 (95.7)	5 (4.3)	115 (100.0)	

0= Incomplete Documentation, 1= Complete Documentation, χ^2 = Chi Square Test

➤ *Quality of Documentation*

Table 4 shows that most documentation was classified as good (55.7%), followed by fair (43.4%). Only 0.9% were

poor. No significant association was observed between cadre of doctors and documentation quality.

Table 4 Quality of Documentation

	Quality of Document			Total	Inferential Test
	1 (%)	2 (%)	3 (%)		
House Officer	0 (0.0)	15 (13.0)	23 (20.0)	38 (33.0)	$\chi^2=9.030$ $p = 0.172$ Fisher's Exact Test: $p = 0.296$
Junior Resident	0 (0.0)	27 (23.5)	27 (23.5)	54 (47.0)	
Senior Resident	1 (0.9)	6 (5.2)	8 (7.0)	15 (13.0)	
Consultant	0 (0.0)	2 (1.7)	6 (5.2)	8 (7.0)	
Total	1 (0.9)	50 (43.4)	64 (55.7)	115 (100.0)	

1= Poor Documentation, 2= Fair Documentation, 3= Good Documentation, χ^2 = Chi Square Test

➤ *Association Between Source of Referral and Vital Sign Completeness*

No statistically significant association was observed between source of referral and vital sign completeness as shown in table 5.

Table 5 Association Between Source of Referral and Vital Sign Completeness

Variables	Vital Sign Completeness		Total	Inferential Test
	Incomplete	Complete		
Self	7 (5.8)	1 (0.8)	8 (6.6)	$\chi^2=0.994$ $\rho = 0.803$ Fisher's Exact Test: $\rho = 0.296$
	91 (75.2)	12 (9.9)	103 (85.1)	
Primary health facility	7 (5.8)	2 (1.7)	9 (7.4)	
	1 (0.8)	0 (0.0)	1 (0.8)	
Private facility	106 (87.6)	15 (12.4)	121 (100.0)	
Total				

0= Incomplete, 1= Complete, χ^2 = Chi Square Test➤ *Cadre of Doctors that Clerked in Patients*

House officers formed the majority of respondents, with 53 participants (34.0%). Consultants accounted for 5.8% of

the respondents. Fewer senior-level doctors were represented (Fig.3).

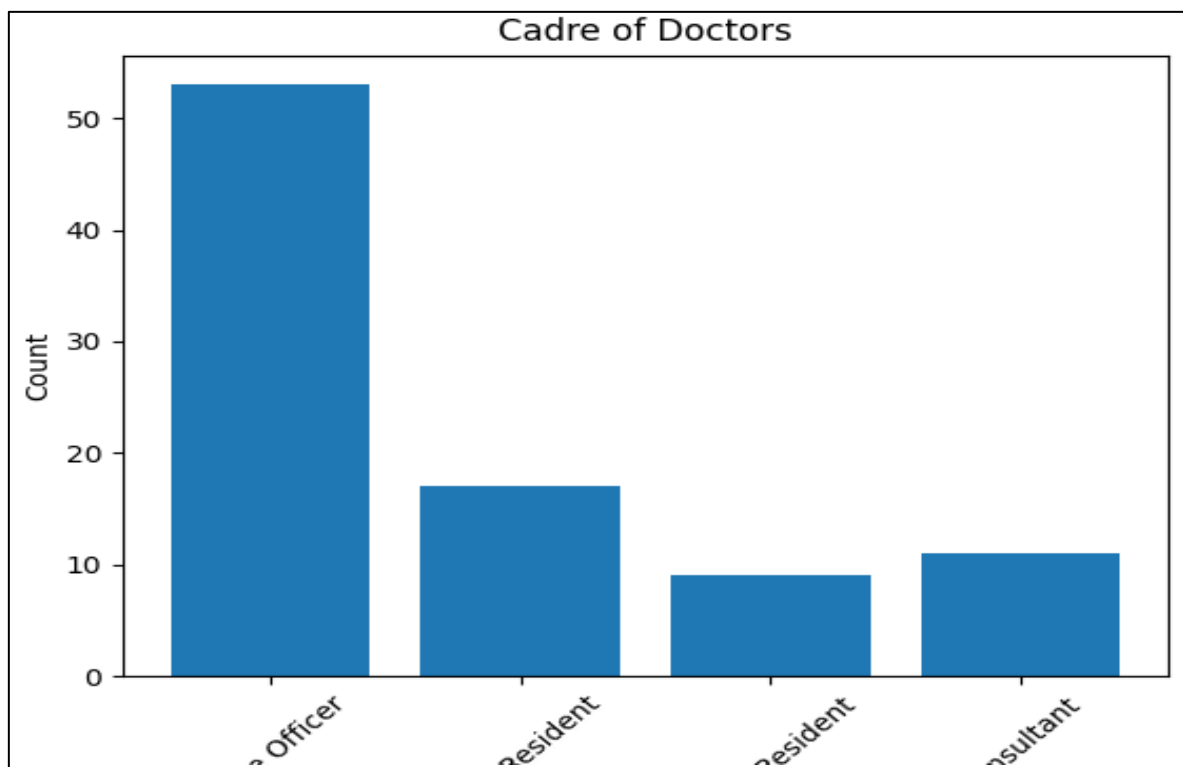


Fig 3 Bar Chart Showing Cadre of Doctors that Clerked in Patients
(Source: Authors' Data)

➤ *Association Between Cadre of Doctor and Documentation Quality*

A chi-square test showed no statistically significant association between cadres of doctor and documentation

quality ($\chi^2=9.030$, $\rho = 0.172$) (Table 6). Fisher's Exact Test was also performed (some expected cell counts were less than 5) and similarly showed no significant association ($\rho= 0.296$).

Table 6 Association Between Cadre of Doctor and Documentation Quality

Variable	N	Mean DOC_SCORE	SD
House Officer	38	9.84	1.103
Junior Resident	54	9.48	.947
Senior Resident	15	9.27	1.831
Consultant	8	10.50	1.309
Total	115	9.64	1.193

SD= Standard Deviation

➤ *Association Between Frequency of Patients' Review and Discharge Summary Documentation*

Frequency of patient review was significantly associated with discharge summary documentation ($\chi^2=18.145$, $p<0.001$).

Table 7 Association Between Frequency of Patients' Review and Discharge Summary Documentation

Variable	Discharge Summary		Total	Inferential Test
	0 (%)	1 (%)		
Once a day	12	3	15	$\chi^2 = 18.145$ $p = 0.000$ Fisher's Exact Test: $p = 0.000$
	(8.2)	(2.0)	(10.2)	
Twice a day	26	71	97	
	(17.7)	(48.3)	(66.0)	
Thrice a day	15	16	31	
	(10.2)	(10.9)	(21.1)	
4 or more times a day	2	2	4	
	(1.4)	(1.4)	(2.7)	
Total	55	92	147	
	(37.4)	(62.6)	(100.0)	

0= Not Documented, 1= Documented, χ^2 = Chi Square Test

➤ *ANOVA Analysis*

Table 8 shows that mean documentation scores varied across cadres, with consultants having the highest mean score (10.50). However, ANOVA showed borderline significance ($p=0.051$).

Table 8 ANOVA Analysis

DOC_SCORE					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	10.915	3	3.638	2.666	0.051
Within Groups	151.467	111	1.365		
Total	162.383	114			

➤ *Logistic Regression*

Logistic regression analysis showed no statistically significant predictors of documentation completeness.

Table 9 Logistic Regression

Variable	p-value	Exp(B)	95% C.I.	Hosmer-Lemeshow Test
House Officer	0.644			$\chi^2=4.200$ $p=0.521$
Junior Resident	0.339	0.652	0.271-1.568	
Senior Resident	0.994	1.005	0.269-3.763	
Consultant	0.637	1.528	0.262-8.911	
Sources of referral	0.190	.428	0.120-1.522	
Frequency of patients review	0.189	1.503	0.818-2.763	
Constant	0.598	1.674		

IV. DISCUSSION

This study assessed the quality and completeness of clinical documentation among hospitalized patients in a tertiary healthcare facility. The findings revealed that although some components of documentation such as patient name, age, sex, and date of clerking were adequately recorded, major deficiencies existed in documentation completeness, particularly with folder numbers, discharge summaries, and vital sign recordings. Documentation completeness was significantly associated with the cadre of doctors, while frequency of patient review significantly influenced discharge summary documentation. Overall, these findings underscore persistent gaps in clinical documentation practices in resource-limited healthcare settings.

Accurate clinical documentation is an essential pillar of quality healthcare delivery because it facilitates communication among healthcare providers, supports continuity of care, enhances patient safety, and provides medico-legal evidence of care rendered. Similar observations have been reported by Odonkor and Frimpong¹, who emphasized that incomplete documentation contributes significantly to adverse clinical outcomes and medical errors in low-resource settings. Adeyemi and Akinyemi² also reported that poor clinical documentation compromises healthcare quality and weakens institutional accountability systems.

The present study demonstrated excellent documentation of patient names (100%), age (98.7%), and sex (96.8%). These findings are comparable to studies conducted in Nigeria and other African countries where basic

demographic details were generally well documented³⁻⁵. Bello and Ijaiya³ reported over 95% documentation of patient identity information in a clinical audit conducted in South western Nigeria. Similarly, Naidoo and Sibiya¹⁰ in South Africa observed high compliance with documentation of demographic identifiers among hospitalized patients. Proper identification of patients is critical for preventing medical errors such as wrong-patient medication administration or incorrect procedures.⁶

Despite the adequate documentation of core demographic information, the present study revealed poor documentation of folder numbers on each page (21.8%). This finding suggests deficiencies in continuity and traceability of patient records. Similar gaps have been documented in studies from Ethiopia and Ghana where poor pagination and incomplete identification details negatively affected retrieval and continuity of medical records.^{8,20} Inadequate folder numbering may predispose healthcare institutions to misplacement of records and fragmentation of patient information, especially in paper-based record systems commonly used in developing countries.⁷

The study further found that legible handwriting was observed in 75% of records. Although this proportion appears relatively satisfactory, illegible handwriting in approximately one-quarter of records remains concerning. Poor handwriting has long been recognized as a major contributor to medical errors and communication failures among healthcare professionals.

Adeyemi and Ijadunola highlighted that illegible documentation contributes to medication errors, delayed interventions, and avoidable patient harm.¹⁶ Similar findings were reported by Ojo et al.,²⁴ who documented substantial challenges with readability of clinicians' notes in tertiary hospitals in Nigeria. The persistence of handwritten records in many low-resource settings likely contributes to this problem and reinforces the need for progressive adoption of electronic health records.

Discharge summary documentation was present in only 59% of records reviewed in this study. This finding indicates suboptimal transition-of-care documentation and may negatively affect continuity of care after discharge. Discharge summaries are essential for communicating diagnoses, treatment provided, medications, follow-up instructions, and ongoing care needs to subsequent healthcare providers. Ojo and Akinyemi similarly reported poor discharge summary completion rates in Nigerian tertiary hospitals, with documentation gaps contributing to fragmented patient care and increased risk of readmissions.¹² Comparable findings have also been documented in Ethiopia and Kenya.^{9,11} Incomplete discharge summaries may particularly affect patients with chronic illnesses requiring long-term follow-up and multidisciplinary management.

Vital sign documentation in the present study showed marked variability. Pulse rate and respiratory rate were documented in over 90% of cases, whereas blood pressure and height were poorly documented. Blood pressure was

recorded in only 30.1% of patient records, while height was documented in merely 20.5%. These findings reflect inconsistent adherence to standard patient assessment protocols. Vital signs are critical indicators of physiological stability and are essential for early recognition of patient deterioration. Failure to adequately document these parameters may delay clinical decision-making and worsen patient outcomes.¹⁷

The poor documentation of blood pressure observed in this study aligns with reports from other African studies. Mwangi and Wanjiru⁹ in Kenya found that blood pressure recording was inconsistently documented among admitted patients despite its importance in monitoring cardiovascular status. Similarly, Tesfaye and Abera¹¹ in Ethiopia reported substantial deficiencies in recording complete physical examination findings, including vital signs. In contrast, some studies from developed healthcare systems reported much higher compliance rates in vital sign documentation due to stricter institutional protocols and electronic monitoring systems.¹⁸ These differences highlight disparities in healthcare infrastructure, staffing, and institutional quality assurance mechanisms between high-income and low-income settings.

Weight documentation in the present study was relatively higher (64.7%) compared to height documentation. Weight measurement is particularly important in medication dosing, nutritional assessment, and fluid management. However, the inadequate documentation of height may limit proper calculation of body mass index and nutritional evaluation. Similar findings were documented by Okechukwu et al.²¹ in paediatric settings where anthropometric measurements were incompletely recorded despite their clinical relevance. Poor anthropometric documentation may significantly affect paediatric and adolescent healthcare where growth monitoring is crucial.

This study also examined frequency of patient review and found that most patients were reviewed twice daily. Frequent patient review is generally associated with improved monitoring and timely identification of clinical deterioration. The study demonstrated a statistically significant association between frequency of patient review and discharge summary documentation. Patients reviewed more frequently were more likely to have discharge summaries documented. This may reflect improved overall clinical engagement and greater attention to documentation practices among clinicians conducting regular reviews. Similar observations were made by Chukwu and Nwafor,¹⁴ who reported that increased clinical supervision and ward rounds positively influenced documentation quality.

Most patients in this study were self-referred to the tertiary healthcare facility. This finding is consistent with previous Nigerian studies demonstrating weak referral systems and the tendency of patients to bypass primary and secondary healthcare facilities.^{19,25} Direct presentations to tertiary hospitals contributes to overcrowding, increased clinician workload, and reduced time available for detailed documentation. Abubakar and Mohammed¹⁹ reported that

excessive workload remains a major barrier to comprehensive clinical documentation in Nigerian hospitals. High patient volume may therefore partly explain the deficiencies observed in this study.

A significant association was observed between cadre of doctors and documentation completeness. Consultants demonstrated higher rates of complete documentation compared with junior doctors. This finding supports the assumption that greater clinical experience and professional maturity positively influence documentation practices. Junior staff members, especially house officers and junior residents, are often responsible for initial clerking and may lack adequate training in comprehensive documentation standards. Similar findings have been reported in several African studies.^{15,26} Olagunju and Adeoye noted that targeted documentation training significantly improved the quality of clinical records among junior doctors in Nigeria.¹⁵

Although documentation completeness differed significantly across cadres, documentation quality itself did not show a statistically significant association with cadre of doctors. This suggests that while senior clinicians may complete more documentation elements, the overall qualitative standard of documentation may not substantially differ across professional groups.

Comparable findings were reported by Danladi et al., who observed that institutional culture and supervision may exert stronger influences on documentation quality than professional rank alone.³⁴ This indicates that improving documentation quality requires system-wide interventions rather than focusing solely on individual clinicians.

The ANOVA analysis showed that consultants had the highest mean documentation scores, although the association was only borderline significant. This finding may reflect the relatively small number of consultants included in the study. Nonetheless, the trend supports existing evidence that senior clinicians often demonstrate better adherence to documentation standards due to greater clinical experience and accountability.^{13,30} Structured mentorship and supervision by senior clinicians may therefore help improve documentation practices among junior healthcare providers.

The logistic regression analysis did not identify statistically significant predictors of documentation completeness. This suggests that documentation practices are likely influenced by multiple interacting factors rather than isolated variables. Previous studies have identified workload, inadequate staffing, poor supervision, lack of standardized forms, time constraints, and insufficient training as important determinants of documentation quality.^{1,31,35} Institutional factors such as availability of documentation tools and enforcement of documentation policies may also play critical roles.²⁷

The findings of this study have important implications for healthcare quality improvement. Poor documentation compromises patient safety, continuity of care, clinical audits, and healthcare planning. Inadequate documentation may also

expose healthcare providers and institutions to medico-legal risks. Several interventions have been proposed to improve clinical documentation practices, including regular training programs, implementation of standardized documentation templates, routine clinical audits, supportive supervision, and transition to electronic health record systems.^{28,32} Studies have shown that electronic documentation systems significantly improve completeness, legibility, and accessibility of patient records.³³ However, implementation of electronic systems in many low-resource settings remains limited by financial and infrastructural constraints.

Regular clinical audit and feedback mechanisms may further strengthen compliance with documentation standards. Lawal et al.²⁹ demonstrated that periodic audit and performance feedback significantly improved documentation completeness among healthcare workers in Nigeria. Similarly, Adebayo et al.³⁰ recommended continuous professional education and supportive supervision as effective strategies for sustaining documentation quality improvement initiatives. Institutional leadership and policy support are therefore essential for achieving long-term improvements in clinical documentation practices.

In conclusion, this study demonstrated that although basic patient identifiers were generally well documented, substantial deficiencies existed in completeness of clinical documentation, particularly regarding folder numbering, discharge summaries, and vital sign recording. Documentation completeness was significantly associated with cadre of doctors, while frequency of patient review influenced discharge summary documentation. Strengthening documentation practices through regular training, supportive supervision, standardized protocols, and institutional quality improvement strategies is necessary to improve patient safety and healthcare quality in resource-limited settings.

V. LIMITATIONS

- The study utilized a cross-sectional design based on retrospective review of patient case notes. This may have resulted in underestimation of actual clinical activities.
- Incomplete or missing case files may have introduced selection bias, as records with severe deficiencies might not have been available for review.
- The study focused mainly on written documentation and did not assess other important aspects of healthcare quality such as clinical outcomes, patient satisfaction, or healthcare workers' perspectives regarding barriers to proper documentation.
- The use of paper-based records may have contributed to inconsistencies in documentation quality, legibility, and completeness.

RECOMMENDATIONS

- Regular Training and Continuing Medical Education
- Implementation of Standardized Documentation Templates
- Strengthening Clinical Supervision and Audit

- Improvement in Vital Sign Documentation
- Promotion of Electronic Health Record Systems
- Development and Enforcement of Institutional Policies

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