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Analysis of Factors Influencing Compliance with Electronic Medical Record Documentation by Nurses and Midwives in the Inpatient Department of Siloam Hospital Bangka

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Abstrak

Pendokumentasian dengan menggunakan rekam medis elektronik (RME) berdampak kepada meningkatnya kualitas pengisian rekam medis pasien secara signifikan. Rumah Sakit Siloam Bangka telah menerapkan RME dan terdapat beberapa kendala dalam penerapannya di departemen rawat inap. Penelitian ini bertujuan untuk menganalisis faktor-faktor yang memengaruhi kepatuhan dokumentasi RME oleh perawat dan bidan di Departemen Rawat Inap dengan memperhatikan aspek pengetahuan, motivasi, supervisi, dan ketersediaan infrastruktur. Penelitian ini menggunakan pendekatan kuantitatif dengan desain *cross-sectional*. Sampel penelitian ini menggunakan teknik *total sampling* berjumlah 33 perawat dan bidan di Departemen Rawat Inap. Data dikumpulkan melalui kuesioner dan checklist observasi audit RME pasien rawat inap pada periode 15 hingga 22 Januari 2025. Data dianalisis menggunakan *fisher exact* dan regresi logistik berganda untuk menentukan variabel dominan yang memengaruhi kepatuhan dokumentasi. Hasil penelitian menunjukkan bahwa ada hubungan signifikan antara pengetahuan (*p-value* 0,000;OR=184,000) dan supervisi (*p-value* 0,000;OR=46,000) terhadap kepatuhan dokumentasi perawat dan bidan. Tidak ada hubungan signifikan antara motivasi dan ketersediaan infrastruktur terhadap kepatuhan dokumentasi perawat dan bidan. Variabel yang paling dominan memengaruhi kepatuhan dokumentasi adalah pengetahuan dengan nilai OR 169,068. Penelitian ini menyimpulkan bahwa kepatuhan dokumentasi dipengaruhi oleh pengetahuan dan supervisi dengan pengetahuan sebagai faktor paling dominan. Oleh karena kepatuhan dokumentasi pada rekam medis elektronik mendukung kualitas pelayanan kesehatan di RS Siloam Bangka, maka Rumah Sakit disarankan untuk mengadakan program pelatihan rutin mengenai penggunaan rekam medis elektronik.

Kata Kunci : RME, kepatuhan, dokumentasi, pengetahuan, supervisi

Abstract

Documentation using Electronic Medical Records (EMR) significantly improves the quality of patient medical record completion. Siloam Hospital Bangka has implemented EMR; however, several challenges have arisen in its application within the inpatient department. This study aims to analyze the factors influencing compliance with EMR documentation among nurses and midwives in the inpatient department, focusing on aspects of knowledge, motivation, supervision, and infrastructure availability. This study employs a quantitative approach with a cross-sectional design. The sample consists of 33 nurses and midwives in the inpatient department, selected using a total sampling technique. Data were collected through questionnaires and an audit observation checklist of inpatient medical records during the period from January 15 to January 22, 2025. Fisher's exact test and multiple logistic regression were used to determine the dominant variables influencing documentation compliance. The research results indicate a significant relationship between knowledge (p-value = 0.000; OR = 184.000) and supervision (p-value = 0.000; OR = 46.000) with nurses and midwifes compliance in documentation. However, no significant relationship was found between motivation or infrastructure availability and documentation compliance. This study concludes that documentation compliance is influenced by knowledge and supervision, with knowledge being the most dominant factor. Since documentation compliance in electronic medical records supports the quality of

healthcare services at Siloam Hospital Bangka, the hospital is recommended to implement regular training programs on the use of electronic medical records.

Keywords : EMR, compliance, documentation, knowledge, supervision

INTRODUCTION

All healthcare facilities are required to implement Electronic Medical Records (EMR) in accordance with the provisions stipulated in the Regulation of the Minister of Health of the Republic of Indonesia No. 24 of 2022, no later than December 31, 2023 (Ministry of Health of the Republic of Indonesia, 2022).

Documentation using electronic medical records has a significant impact on improving the quality of patient medical record completion. Nursing documentation is a crucial component of clinical services, in which relevant patient information must be conveyed accurately and precisely to ensure continuity of care and patient safety (Agarta & Febriani, 2019).

Nursing documentation is the process of recording and reporting that serves as an important task for nurses, as nursing care provided to patients requires documentation that functions as a form of accountability for various patient problems (Anila, Kusumawijaya, & Maryana, 2023). An electronic medical record is not merely a digitized paper record; rather, it is a digital application that enables active interaction between users and patients, provides various data and analyses, and supports communication in clinical interventions, quality improvement, and patient safety. A meta-analysis study on electronic medical records in healthcare services showed a 22.4% reduction in documentation time, higher compliance with clinical guidelines, and lower medication errors (Janett & Yeracaris, 2020).

A study conducted in a hospital in Kuala Lumpur involving 189 inpatient department nurses found that 50.8% of respondents had low knowledge of electronic documentation, while 89.4% had a positive attitude toward electronic documentation. No significant relationship was found between sociodemographic factors such as age, education level, work experience, or attitude and electronic documentation (Hussein et al., 2021).

Research conducted at RSUD Pameungpeuk Garut in 2024 with 94 implementing nurse respondents found that the majority were male (76.5%) with a Ners education level (85.0%). Most had ≤ 5 years of work experience (82.8%), were in middle adulthood (80%), had good knowledge (75.9%), a positive attitude (75.6%), high motivation (80.6%), and received good supervision from the head nurse (94.6%), which contributed to compliance in completing nursing documentation in electronic medical records. The study also found that supervision from the head nurse had a significant relationship (p-value = 0.039) with the documentation of nursing care in electronic medical records at RSUD Pameungpeuk Garut (Daryana et al., 2024).

Nurses perform various responsibilities, including providing direct patient care, preparing medications, and recording information in electronic medical records, which takes approximately 13%–25% of their total working hours. Overall, nurses are required to record and document patient data during each work shift (Kodama et al., 2023).

Siloam Hospital Bangka has implemented electronic medical records, provided by the SPIRO system. The first department to use EMR was the outpatient department, and starting in July 2023, EMR began to be used in the inpatient department as part of the transition from manual (paper-based) medical records to electronic ones. Based on a review of medical records at Siloam Hospital Bangka for the period April–June 2024, out of 1,466 total inpatients, 129 samples were reviewed. The results showed 92.56% timeliness and 86.80%

completeness in medical record documentation.

Nurses and midwives play a very important role in providing healthcare services to patients. With the EMR system, nurses and midwives interact directly with this technology in their daily work. In the inpatient department, EMR usage tends to be higher than in other units such as outpatient care, because nurses and midwives must document every nursing care activity and medical information routinely during each shift. Therefore, it is important to evaluate how this system affects their work, which in turn can influence compliance, efficiency, and effectiveness of healthcare services.
Given this background, the researcher is interested in conducting a study on the "analysis of factors influencing compliance with electronic medical record documentation by nurses and midwives in the inpatient department of Siloam Hospital Bangka".

Methods

This study employed a quantitative approach with a cross-sectional design. The sample was selected using a total sampling technique, comprising 33 nurses and midwives in the Inpatient Department of Siloam Hospital Bangka who met the inclusion and exclusion criteria. Data were collected through questionnaires and an observational checklist for auditing inpatient EMR documentation during the period from January 15 to January 22, 2025.

The questionnaire used in this study had undergone validity and reliability testing and was declared valid, with validity test results ranging from *r* count 0.358 to 0.907 (*r* count > *r* table 0.2455), and a Cronbach's Alpha value of 0.988.

Observation was conducted by auditing electronic medical records of inpatients, which included: initial nursing/midwifery assessment, integrated patient progress notes, multidisciplinary education notes, routine observation, and fluid balance. Documentation was considered compliant and complete if filled out by nurses and midwives within 24 hours after the patient was admitted to the inpatient ward, during the period from January 15 to January 22, 2025.

Data analysis consisted of univariate analysis, bivariate analysis using Fisher's Exact Test, and multivariate analysis using multiple logistic regression to determine the dominant variable influencing documentation compliance.

Research Results

Table 1 shows that, out of a total of 33 nurses and midwives, the majority were female (93.9%), with the largest age group being respondents aged 21–30 years (90.9%). The majority of respondents were nurses (81.8%), while midwives accounted for 18.2%. Most respondents held a Ners degree (72.7%), and the majority had a length of service of three years or less (63.6%).

Table 1. Research Respondent Characteristic

No.	Variable		f	P(%)
1	Sex	Male	2	6.1
		Female	31	93.9
		Total	33	100
2	Age	21 – 30 yo	30	90.9
		31 – 40 yo	1	3
		41 – 50 yo	2	6.1
		Total	33	100
3	Profession	Ners	27	81.8
		Midwive	6	18.2
		Total	33	100
4	Education lebel	D3	5	15.2
		D4	2	6.1
		Bachelor	2	6.1
		Ners	24	72.7
		Jumlah	33	100
5	Length of work	≤ 3 ys	21	63.6
		4 - 7 ys	11	33.3
		≥ 8 ys	1	3
		Total	33	100

Table 2. Frequency distribution of factors influencing documentation compliance

No.	Variable		f	P (%)
1	Knowledge	Good	24	72.7
		Not good	9	27.3
		Total	33	100
2	Motivation	Strong	28	84.8
		Weak	5	15.2
		Total	33	100
3	Supervision	Good	26	78.8
		Not good	7	21.2
		Total	33	100
4	Infrastructure availability	Good	29	87.9
		Not good	4	12.1
		Total	33	100

Table 2 shows that the compliance of nurses and midwives in documenting within the electronic medical record is influenced by several factors. A total of 72.7% of respondents had good knowledge, 84.8% had strong motivation, 78.8% rated supervision in their work environment as good, and 87.9% assessed the availability of infrastructure as good.

Table 3. Frequency of documentation compliance

No.	Variable		f	P (%)
1	Nurse Compliance	obedient	24	72.7
		Not obey	9	27.3
		Total	33	100

Table 3 shows that more than half (72.7%) of nurses and midwives in the Inpatient Department of Siloam
Hospital Bangka were compliant in entering data into the electronic medical record.

Table 4 The relationship of factors to compliance with documentation in electronic medical records by nurses and midwives at Siloam Hospital Bangka

No.	Variable		Documentation Compliance				
			Not obey n (%)	Obedient n (%)	Total	*p-value*	OR (95% CI)
1	Knowledge	Good Deficient	1 (4.2) 8 (88.9)	23(95.8) 1 (11.1)	24 (100) 9 (100)	0.000*	184.000 (CI: 10.265 – 3298.194)
2	Motivation	Strong Weak	6 (21.4) 3 (60)	22 (78.6) 2 (40)	28 (100) 5 (100)	0.111	5.500 (CI: 0.741-40.803)
3	Supervision	Good Deficient	3 (11.5) 6 (85.7)	23 (88.5) 1 (14.3)	26 (100) 7 100)	0.000*	46.000 (CI: 4.030-525.126)
4	Infrastructure availability	Good Deficient	6 (20.7) 3 (75)	23 (79.3) 1 (25)	29 (100) 4 (100)	0.052	11.500 (CI: 1.007-131.281)

Bivariate Analysis

Table 4 presents the results of the bivariate analysis using Fisher's Exact Test, which showed a significant relationship between the independent variables—knowledge and supervision—and the dependent variable, documentation compliance. This was evidenced by p-values smaller than 0.05, indicating statistically significant associations.

Among the 24 respondents with good knowledge, 95.8% were compliant with documentation. Statistical analysis showed a significant relationship between nurses' and midwives' knowledge and documentation compliance in electronic medical records, with a p-value of 0.000 ($p < 0.05$). The odds ratio (OR) for the knowledge variable was 184.000, with a 95% confidence interval of 10.265–3,298.194. This means that individuals with good

knowledge were 184 times more likely to comply with documentation compared to those with poor knowledge.

Among the 28 respondents with strong motivation, 78.6% were compliant with documentation. Statistical analysis showed no significant relationship between motivation and documentation compliance in electronic medical records in the inpatient department of Siloam Hospital Bangka, with a p-value of 0.111 (p > 0.05).

Among the 26 respondents who received good supervision, 88.5% were compliant with documentation. Statistical analysis showed a significant relationship between supervision and documentation compliance in electronic medical records in the inpatient department of Siloam Hospital Bangka, with a p-value of 0.000 (p < 0.05). The OR for the supervision variable was 46.000, with a 95% confidence interval of 4.030–525.126. This means that individuals who received better supervision were 46 times more likely to comply with documentation compared to those who received poor supervision.

Among the 29 respondents with good infrastructure availability, 79.3% were compliant with documentation. Statistical analysis showed no significant relationship between infrastructure availability and documentation compliance in electronic medical records by nurses and midwives in the inpatient department of Siloam Hospital Bangka, with a p-value of 0.052 (p > 0.05).

Table 5. Multivariate Analysis of Multiple Logistic Regression

Stage	Variable	B	Sig.	Exp(B)	95% C.I.for EXP(B)	
					Lower	Upper
One	Knowledge	5.707	0.017	300.855	2.799	32341.956
	Motivation	2.103	0.340	8.191	0.109	615.451
	Supervision	3.683	0.105	39.776	0.461	3432.380
	Infrastructure avaibility	2.205	0.331	9.072	0.106	776.769
	Constant	-21.734	0.017	0.000		
Two	Knowledge	5.570	0.020	262.421	2.435	28280.306
	Supervision	3.784	0.084	43.980	0.603	3209.163
	Infrastructure avaibility	2.563	0.251	12.973	0.164	1026.710
	Constant	-18.810	0.022	0.000		
Three (final)	Knowledge	5.130	0.011	169.068	3.245	8807.716
	Supervision	4.234	0.048	69.001	1.046	4551.165
	Constant	-14.462	0.016	0.000		

Multivariate Analysis

In the first stage, all independent variables were entered into the model—Knowledge, Motivation, Supervision, and Infrastructure Availability. The results showed that only Knowledge had a significant relationship with documentation compliance, with B = 5.707, p = 0.017, and Exp(B) = 300.855. Other variables such as Motivation, Supervision, and Infrastructure Availability did not show significant associations (p > 0.05).

In the second stage, non-significant variables were eliminated to obtain a simpler and more accurate model. The variable Motivation was removed (p-value = 0.340). The results indicated that Knowledge remained a significant factor with B = 5.570, p = 0.020, and Exp(B) = 262.421. Variables Supervision and

Infrastructure Availability still did not show significant associations (p > 0.05).

In the final stage, only significant variables were included in the model—Knowledge and Supervision. The analysis showed that Knowledge remained significant (B = 5.130, p = 0.011, Exp(B) = 169.068), meaning that individuals with good knowledge had 169 times greater odds of complying with documentation compared to those with poor knowledge. Supervision became significant in the final model (B = 4.234, p = 0.048, Exp(B) = 69.001), indicating that individuals who received better supervision were 69 times more likely to comply with documentation than those who did not receive adequate supervision.

Discussion

The Relationship between Knowledge and Documentation Compliance in Electronic Medical Records

The frequency distribution showed that 72.7% (24 nurses and midwives) had good knowledge of electronic medical records, while 27.3% (9 nurses and midwives) had poor knowledge.

Bivariate analysis revealed a significant relationship between knowledge and documentation compliance among nurses and midwives in the Inpatient Department of Siloam Hospital Bangka, with a p-value of 0.000 (p < 0.05). The OR for the Knowledge variable was 184.000 with a 95% confidence interval of 10.265–3,298.194. This means that individuals with good knowledge were 184 times more likely to comply with documentation compared to those with poor knowledge.

These findings are consistent with research by Orangbio, Wagey, and Vanda Doda (2023), which found a significant effect of knowledge on the completeness of medical record files, with p = 0.000. Similarly, a study by Anila, Kusumawijaya, and Marjaya (2023) reported a p-value of 0.023 (< 0.05), indicating a significant relationship between knowledge level and nursing care documentation in the inpatient ward of UPTD RSUD Dr. (H.C) Ir. Soekarno in 2022. Further analysis showed a POR of 3.606 (95% CI = 1.305–9.962), indicating that respondents with good knowledge were 3.606 times more likely to complete nursing care documentation than those with poor knowledge.

However, not all studies have found a significant relationship between knowledge and documentation compliance. Daryana et al. (2024), in their study, reported no significant association between nurses' knowledge and compliance in nursing care documentation in electronic medical records at RSUD Pameungpeuk Garut (p-value > α = 0.05, p-value = 0.937).

Thus, it can be concluded that good knowledge of electronic medical records is positively associated with compliance in documentation. Therefore, enhancing the knowledge of nurses and midwives through training and education can be an effective strategy to improve compliance in electronic medical record documentation.

The Relationship between Motivation and Documentation Compliance in Electronic Medical Records

The frequency distribution showed that 84.8% (28 nurses and midwives) had strong motivation, while 15.2% (5 nurses and midwives) had weak motivation. Bivariate analysis indicated no significant relationship between nurses' and midwives' motivation and documentation compliance in electronic medical records in the Inpatient Department of Siloam Hospital Bangka, with a p-value of 0.111 (p > 0.05).

This finding is consistent with research by Daryana et al. (2024), which reported no significant relationship between motivation and compliance with nursing care documentation in electronic medical records at RSUD Pameungpeuk Garut (p > α = 0.05, p-value = 0.386).

However, different results were found in the study by Anila, Kusumajaya, and Maryana

(2023), which showed that the majority of respondents who completed nursing care documentation were from the high work motivation group, amounting to 19 respondents (67.9%). The chi-square statistical test produced a p-value = 0.000 ≤ 0.05, indicating a significant relationship between work motivation and completeness of nursing care documentation in the Inpatient Ward of UPTD RSUD Dr. (H.C) Ir. Soekarno in 2022.

Another study by Darmawan (2019) also found a significant relationship between motivation and completeness of electronic documentation in the Inpatient Installation of RS Paru Jember (p-value = 0.000).

Based on the above explanation, motivation was not found to have a significant effect on documentation compliance (p > 0.05) in this study. This suggests that other factors, rather than motivation, play a more prominent role in determining the compliance level of nurses and midwives in documenting electronic medical records. Nevertheless, nurses need to have strong internal drive and willingness. If nurses' motivation is low or suboptimal, documentation may not be carried out properly, which could ultimately affect the quality of healthcare services. Strong motivation tends to encourage healthcare workers to be more disciplined in performing their duties, comply with hospital policies, and improve the quality of patient care.

The Relationship between Supervision and Documentation Compliance in Electronic Medical Records

The frequency distribution showed that 78.8% of respondents (26 nurses and midwives) assessed supervision in their work environment as good, while 21.2% (7 nurses and midwives) considered it poor. Bivariate analysis revealed a significant relationship between supervision and documentation compliance in electronic medical records in the Inpatient Department of Siloam Hospital Bangka, with a p-value of 0.000 (p < 0.05).

Several supporting studies provide evidence consistent with these findings. Research by Orangbio, Wagey, and Vanda Doda (2023) showed that 20 respondents (60.60%) reported good supervision, which correlated with completeness in filling out medical records. Meanwhile, 6 respondents (18.18%) perceived inadequate supervision, resulting in incomplete medical records. Statistical analysis using the chi-square test indicated a significant effect of supervision on medical record completeness, with p = 0.000 and an odds ratio of 20, meaning that good supervision was 20 times more likely to result in complete documentation.

Research by Loblobly (2021) showed that supervision by head nurses in five wards at Harapan Hospital Magelang could be classified into poor (9.0%), adequate (33.0%), and good (58.0%) categories. The results revealed a significant relationship between nursing care documentation compliance and supervision by the head nurse, with a p-value of 0.027 (< 0.05).

Similarly, research by Anila, Kusumawijaya, and Marjaya (2023) reported a p-value of 0.019 (< 0.05), indicating a significant relationship between head nurse supervision and compliance with nursing care documentation in the Inpatient Ward of UPTD RSUD Dr. (H.C) Ir. Soekarno in 2022.

Furthermore, findings from Daryana et al. (2024) also indicated a significant relationship between head nurse supervision and nursing care documentation through electronic medical records at RSUD Pameungpeuk Garut. Although more than half of the nurses (68.0%) complied with EMR documentation, only a small number (5.3%) complied despite receiving good supervision. Statistical testing yielded p = 0.039 (< 0.05), confirming a significant relationship between head nurse supervision and documentation compliance.

Based on the above explanation, the researcher believes that the more frequent the supervision conducted by the head nurse, the more complete the electronic medical record documentation will be. Supervision should ideally be carried out directly while nurses are documenting in the EMR, with the head nurse accompanying them. Additionally, indirect

supervision can be performed through written or verbal reports. Consistent and continuous supervision can have a positive impact on documentation completeness.

The Relationship Between Infrastructure Availability and Documentation Compliance in Electronic Medical Records

The frequency distribution showed that 87.9% (29 nurses and midwives) assessed infrastructure availability as good, while 12.1% (4 nurses and midwives) considered it poor. Bivariate analysis indicated no significant relationship between infrastructure availability and documentation compliance in electronic medical records by nurses and midwives in the Inpatient Department of Siloam Hospital Bangka, with a p-value of 0.052 ($p > 0.05$).

A study conducted by Furroidah, Maulidia, and Maria (2023) revealed that nurse characteristics, including the availability of facilities, did not have a significant correlation with compliance in nursing care documentation.

Similarly, research by Laila et al. (2024) stated that the main challenges in implementing electronic medical records were more related to legal and regulatory aspects, as well as the availability of human resources, rather than infrastructure factors.

Although good infrastructure is an essential element in supporting the operational use of electronic medical records, the findings of this study suggest that other factors—such as healthcare workers' knowledge level, motivation, and attitudes—have a greater influence on documentation compliance. Therefore, efforts to improve compliance should not only focus on providing infrastructure but also on enhancing healthcare workers' competencies and motivation through optimal training and supervision.

The Most Dominant Factor Influencing Documentation Compliance in Electronic Medical Records by Nurses and Midwives

The results of the multivariate analysis, based on multiple logistic regression, indicate that the individual's level of knowledge is the primary factor influencing documentation compliance. The knowledge variable consistently demonstrated a significant positive effect on the outcome, with a high odds ratio at every stage ($p < 0.05$). In the final stage of multiple logistic regression, knowledge remained significant ($B = 5.130$, $p = 0.011$, $Exp(B) = 169.068$), meaning that individuals with good knowledge were 169 times more likely to comply with documentation compared to those with poor knowledge.

These findings are supported by research conducted by Orangbio, Wagey, and Vanda Doda (2023), in which knowledge was found to be the most influential variable among the significant factors, playing a greater role in determining the completeness of medical record files. This was supported by a significance value of 0.000 (< 0.05) and an odds ratio of 60.707.

Supervision also became significant in the final model of this study ($B = 4.234$, $p = 0.048$, $Exp(B) = 69.001$), indicating that individuals who received better supervision were 69 times more likely to comply with documentation compared to those who did not receive adequate supervision.

This is in line with research conducted by Daryana et al. (2024), which identified head nurse supervision as the most dominant factor, with a regression coefficient ($b = 0.252$), indicating that nurses who received more frequent supervision from the head nurse experienced a 25.2% increase—ranging from 0.030 to 0.474—in compliance with nursing care documentation in electronic medical records at RSUD Pameungpeuk Garut, compared to nurses who did not receive such supervision.

CONCLUSION

A total of 33 nurses and midwives from the inpatient department participated in this study. The majority were female, with the largest age group being 21–30 years old. Most

respondents were nurses with a Ners education level, and the majority had work experience of three years or less.

The factors influencing documentation compliance in electronic medical records encompassed several aspects. Most respondents had good knowledge, strong motivation, good workplace supervision, and good infrastructure availability.

More than half of the nurses and midwives in the Inpatient Department of Siloam Hospital Bangka were compliant in entering data into the electronic medical record. There was a significant relationship between knowledge and supervision of nurses and midwives and documentation compliance in electronic medical records in the inpatient department.

No significant relationship was found between motivation or infrastructure availability and documentation compliance in electronic medical records in the inpatient department.

The knowledge variable was the most influential factor affecting documentation compliance in electronic medical records.

RECOMMENDATIONS

1. Develop a help feature within the electronic medical record (EMR) system in the form of FAQs (Frequently Asked Questions) and video tutorials on how to handle common technical issues that occur in EMR usage.
2. Conduct more interactive socialization activities, such as case studies or live simulations, to help nurses and midwives understand how EMR can simplify their work and improve service efficiency.
3. Withdraw hardcopy forms that are already available in the EMR, so that healthcare workers are motivated and required to use EMR for documentation and work processes.
4. Highlight healthcare workers who have successfully implemented EMR as motivational role models. Having a role model or mentor who is already proficient in using EMR can encourage other nurses and midwives to follow their example and feel more confident in its use.
5. Develop a reminder feature in the EMR system for head nurses to conduct regular verification and review of documentation, accompanied by feedback for nurses and midwives.
6. Optimize the role of head nurses or supervisors in providing guidance and mentorship more proactively.
7. Enhance the use of EMR during shift handovers between nurses and midwives to ensure continuity of care.
8. Make the EMR system more user-friendly and tailored to user needs.

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