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Medical record documentation quality in the hospital accreditation

Saiedeh Sharifi[1], Mansour Zahiri[1], Hosein Dargahi[2], Farzad Faraji-Khiavi[1,3]

Abstract:

BACKGROUND: Medical records constitute a legal and professional document regarding the activities of medical staff in hospitals. This study was conducted with the aim of identifying the factors that affect the quality of medical records by implementing the accreditation models in hospitals.

MATERIALS AND METHODS: This was a qualitative study. The data were collected via 28 semi-structured interviews. The research population included administrators and supervisors of nursing, medical records and accreditation in educational hospitals in Ahvaz, southwest Iran. Content analysis method was used to analyze the data. Descriptive statistics were used to present demographic characteristics of interviewees.

RESULTS: Facilitators and barriers to improve the quality of documentation were categorized into three levels: organizational, environmental, and personal, all achieved after the implementation of accreditation model in hospitals. Six facilitating factors were identified including organizational structure, organizational culture, management support, individual characteristics, and perceived benefits science and technology. The barriers included five factors including program structure, organizational structure, beliefs, justice, and individual characteristics.

CONCLUSIONS: The identification of factors affects the quality of medical record documentation and it seems that health managers and policymakers should take measures to improve the quality of medical recording documentation through strengthening the facilitators and overcoming the barriers in the program since the purpose of accreditation is to improve the quality in hospitals.

Keywords:

Accreditation, documentation, hospitals, medical records, quality

[1]Department of Health Services Management, School of Health, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran, [2]Department of Management Sciences and Health Economics, School of Public Health, Health Information Management Research Center, Tehran University of Medical Sciences, Tehran, Iran, [3]Social Determinants of Health Research Center, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran

Address for correspondence:
Dr. Farzad Faraji-Khiavi, Department of Health Services Management, School of Health, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran.
E-mail: faraji-f@ajums.ac.ir

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Introduction

Centers for providing health-care services play a major role in improving the health status of a country and providing health services. They should collect different pieces of information properly, manage them correctly, and give them to all decision-makers and hospital managers after monitoring, classifying, and making inferences at right times.[1] Health service accreditation programs constitute an important mechanism for controlling and directing the quality improvement programs in Iran's Ministry of Health. As an effective tool, accreditation has been implemented in all hospitals of Iran since 2011 to result in continuous quality improvement programs or to create new leadership for improving continuous quality plans.[2] Hospital medical records are among the most important components of this documentation program. It evaluates the quality of documenting patient records, history form, and record summary as well as reviewing the medical records, storing and reviewing the data, coding and classifying the diseases, and the treatment proceedings.[3]

Medical information registration is, in fact, the documentation of the activities performed by the medical team in hospital records and reflects the activities of doctors, nurses, and other medical staff teams.[4] These

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documents render the clinical, para-clinical care, and financial information about the patient.[5] Furthermore, medical documentation can be used for more than pricing provided services by focusing on quality and patient safety. Some reports are emphasizing that poor documentation can end to adverse events based on evidence.[6]

Medical record quality was not equal in all Iran before Accreditation. For instance, hospital medical record units in North Khorasan Province showed acceptable performances,[7] and the same results were reported for medical records in Hamadan province.[8] However, medical record units' performance was estimated as average in Ahvaz ,[9] and in another research, perceived quality for medical records was assessed significantly lower than what was expected in a major city in Iran, Isfahan.[10] However, computerized medical records enhanced retrieval and access to medical records in some major cities,[11] and it seems that some improvements could be made through running accreditation program.

In fact, despite the importance of medical record documentation, according to a previous research in Iran, the quality of the medical record documentation by doctors, nurses, and the reception staff has not been satisfactory before implementing the accreditation program.[12] In other words, one way to improve the quality and safety in health-care organizations is through accreditation which emphasizes the continuous improvement of quality and improving patient and staff safety.[4]

Furthermore, quality management and documentation of medical records have been focused on evaluating the quality of care and hospital accreditation.[6] Changes have been exerted in accreditation program regarding documentation standards in medical records and other units, and it is expected to improve the quality of medical records during the years of implementation.[12] There were some studies which estimated hospital medical record performance; however, no research has been conducted to identify facilitators and barriers to improve the quality of medical record documentations. It is expected that such a study can ultimately help hospitals to achieve the main objective of accreditation, that is, continuous quality improvement and patient safety as well as providing strategies to eliminate the defects. In addition, it can provide a new perspective for other researchers in order to quality development in medical records. Hence, this research aimed to phenomenological study on the quality of medical record documentation based on the accreditation model in the educational hospitals of Ahvaz, southwest Iran. The present study was conducted to identify facilitators and barriers in improving the quality of medical record documentation in the accreditation model by obtaining a thorough understanding of changes in the quality of medical documentation in recent years.

Materials and Methods

This study was a qualitative research. Its population consisted of 28 administrators and supervisors of nursing, medical records and accreditation in educational hospitals. The study setting included five educational hospitals affiliated with Ahvaz Jundishapur University of Medical Sciences (AJUMS). The method of collecting data was the interview. Interviews with experienced and involved people in the field of documentation continued until the data were saturated and failure was felt in obtaining new data and codes. Inclusion criteria for participation were at least 1-year experience in the area of documentation and medical records and their willingness to participate in the study.

This research was approved by the Research Ethics Committee of AJUMS. The data were collected through semi-structured interviews. After collecting demographic information, the interview questions were taken into account with regard to the specific goals of the study in order to collect the data. The researcher had already done the necessary co-ordinations with the respondents by visiting them in person or by phone to determine the time of the interview. An information sheet containing the goals and the methods for implementation of the study as well as the moral principles was given to the participants before doing the interviews. The participants were also asked to sign a consent form and declare their willingness to participate in this study. Then, the researcher visited and conducted the interview at a specified time. Each interview took time 30–50 min. The interviewees answered questions "how accreditation affected documentation in hospitals?" "What are the barriers to improve documentation quality in medical records?" and "What may facilitate documentation improvement in medical records?" The interviews were recorded and transcribed with the permission from the interviewee, which led to transferring the data on paper with high accuracy and authenticity. Data analysis started simultaneously with collecting the data. Colaizzi's seven-step method was followed to analyze data obtained from interviews.[13] Researchers did it through:

(1) Being familiar with the data, by reading through all the manuscripts of interviews several times, (2) identifying significant statements that were directly related to medical record documentation quality facilitators and barriers, (3) formulating meanings relevant to phenomenon from significant statements, (4) clustering identified meanings into categories and themes that

are common across all interviews, (5) developing an exhaustive description of phenomenon, (6) producing the fundamental structure of the studied phenomenon, and (7) seeking verification of the fundamental structure by asking participants about final categorizations.

Lincoln and Guba's four criteria were used for evaluating the trustworthiness of the data which included credibility, dependability, confirmability, and transferability. To increase trustworthiness of findings, we used analyst triangulation (each researcher formulated and clustered meanings; separately, then they unified results) as well as triangulation of resources (interview with all the parties involved in medical record documentation).[14]

Results

The participants in the study were 28 managers, chief nursing officers, supervisors, accreditation administrators, and medical record managers of educational hospitals in AJUMS. The participants' demographic features are shown in Table 1.

Facilitating factors in improving the quality of medical recording documentation were classified into three themes: organizational, environmental, and individual. Six categories including three organizational, one environmental, and two individual factors were extracted from 14 codes.

The facilitating categories and codes for improving the quality of medical record documentation and the codes expressed by participants besides the frequency and percentage of interviewees who expressed each code are represented in Table 2.

More than 60% of interviewees mentioned that understanding the importance of documentation in legal cases is one of the items can help improving the quality of medical records. "We already were kipping our medical records based on regulations, just in case for legal claims, medical research, education and etc." one manager mentions (Participant 3), while a medical record unit manager claims "Hospitals were stuck in inactivity and daily routine jobs and accreditation made them move especially in documentation" (Participant 5). Furthermore, accreditation motivated managers to follow role models "We have modeled hospitals with high scores, especially how they tried to make their documentation perfect" (Participant 8).

Table 1: Demographic characteristics of interviewees

Variable	groups	Frequency (%)
Gender	Woman	4 (14.28)
	Man	24 (85.72)
Age (year)	20- 30	2 (7.14)
	31- 35	4 (14.28)
	36- 40	10 (35.71)
	41- 45	4 (14.28)
	Up to 46	8 (28.75)
License's degree	PhD	3 (10.71)
	Master	5 (17.85)
	bachelor	20 (71.44)
Record of service (year)	5<	2 (7.14)
	5- 10	5 (17.85)
	11- 20	13 (46.42)
	20>	8 (28.75)

Barriers to improving the quality of medical record documentation were also divided into 3 themes as same as facilitators. Five categories including one organizational, two environmental, and one individual were derived from 13 codes. Five categories included accreditation program structure, organizational structure, beliefs, justice, and individual characteristics. These barriers as well frequency and percentage of interviewees who expressed the code are shown in Table 3.

One of the participants implied "the items needed for medical records must be more practical and frequently repeated and less important items must be eliminated; so remained items will be efficient" (Participant 11). One medical record manager expressed, "if I had enough personnel, they could do their job perfectly. However, required documents and bureaucratic processes are too much for descent accurate completion of information by very limited personnel" (Participant 5). One interviewee reminds that "hospital losses a lot of scores because physicians are not cooperating. They do not care about accreditation requirements. We asking them through formal canals, workshops and individually to fill records completely but they answer I'll complete records not more than I do. As a result nurses have to complete physician records in addition their own jobs" (Participant 4). A doctor says "if we spend too much time to complete records, we won't have enough time for the most critical job, treatment of patients, while others can complete these forms for us" (Participant 20). It seems lack of cooperation from physicians, and excessive pressure on nurses was repeated the most in interviews.

The overall findings of the study are shown in Figure 1.

Discussion

In codifying the accreditation standards, the documentation of activities has been emphasized.[15] Correct and valid documentation of medical records for the patients is an essential goal for the management and the administration of a hospital.[16] Although accreditation does not play a major role in improving documentation quality in view of the managers, the matron, the supervisors, and the accreditation

Table 2: Facilitators in improving the quality of medical record documentation

Themes	Categories	Codes	Frequency (%)	Participants' remarks
Organizational	Organizational structure	Regulatory functions from the hospital in completing records	2 (7.14)	Hospital's monitoring program on documentation has increased, with certain criteria, of course
		Determining the organizational roles and limitations of responsibilities in the registration of documents	10 (35.71)	Everyone knows which forms are related to his or her duty and is responsible for its completion
		Documentarians are accountable towards shortcomings in recording	5 (17.85)	I pay attention to the content of the forms while filling out because I will be questioned.
	Organizational culture	Integrating goals of the hospital and the staff	6 (21.42)	All the hospital's goals are recorded in written forms
				One unit (accreditation) coordinates all the hospital
		Empowering the staff	11 (39.28)	The hospital came out from stagnation
				Led to the thought of changing our working process
				Then our relationships increased with other staff and even other hospitals
				We modeled those who had more points
	Management support	Presence in the Committee of Medical Records	6 (21.42)	The hospital manager is involved in all meetings
				Nothing goes well without management support
		Emphasizing the importance of documentation	3 (10.71)	Personnel are motivated and work better when the manager is aware of the work process
				He will understand us better if he is aware of details
Environmental	Science and technology	The use of technology	4 (14.28)	The competition in getting better rankings among hospitals has led to using the updated equipment and facilities in hospitals
		The use of expert groups	6 (21.42)	The use of technology needed experts
		The use of updated standards	9 (32.14)	Accreditation was a model imported from the West and was localized to be implemented
				It is good to know we are close to international standards
Individual	Individual characteristic	Knowledge and awareness	15 (53.57)	We were forced to seek knowledge and new technologies
				We needed a level of science beyond the previous knowledge - We looked for updated science in medical records
		Self-efficacy	7 (25.00)	The importance of documentation in accreditation might have attracted us to our documentations
				Though treatment is our main task, but we looked deeper to documentations
				The importance of the medical records in accreditation program is bold and this makes our views deeper to our activities and more committed in registering the documents
	Benefits perception	Understanding the importance of documentation in legal cases	17 (60.71)	When a complaint or medical error occurs for any reason, we go for records and the importance of those records will be understood
		Understanding the importance of documentations in facilitating the work of documentarians and other personnel	16 (57.14)	Integrating forms and removing duplicates in some forms
				Removing duplicates in some forms

administrators of educational hospitals in AJUMS, there are other factors that should be examined. These activities were regarded only as adding further measures. It is worth noting that the important facilitating factors and the barriers in the quality of medical record documentation are described with respect to the participants' talks in this study.

Facilitators in documentation

The participants pointed out three more detailed issues about facilitating factors in organizational structure in the discussion including: first, hospital control on completing the records; second, clarifying the roles and limitation of responsibilities in registering the documents; and third, the documentarians' accountability for flaws in the

Table 3: Barriers to improving the quality of medical record documentation

Themes	Categories	Code	Frequency (%)	Participants' remarks
Organizational	Organizational structure	Shortage of nurses with regard to patients	14 (50)	Perhaps the biggest problem is the lack of sufficient manpower
				Severe shortage of manpower sacrifices documentation for treatment or vice versa
		Lack of cooperation from physicians and excessive pressure on nurses	16 (57.14)	One of the downsides is the lack of adequate attention to issues of accreditation by physicians
				Hospitals lose many grades due to lack of cooperation from physicians
				Some doctors say I write no more; just a few physicians did the right job considering whatever it was asked in meetings and educational classes
		Prolonging the patients' waiting time in receiving services	13 (46.42)	When we pay more attention to registering the records than treatment
				When we spend more time recording anything we do, then waiting queues will certainly be formed
		Necessity to using trained personnel in the field of documentation	3 (10.71)	Nursing is a delicate job, some of the newly arrived personnel or students who do nursing neglect registering the documents and this leads to incomplete records
		Lack of separation between clinical and documentarian staff	9 (32.14)	A nurse cannot both be at the bedside and do flawless documentation
Environmental	Accreditation program structure	Large number of measures	15 (53.57)	The requested items in records should get more practical
				Their number should be smaller, and the unimportant ones and duplicates should be deleted
				They want items that really affect the quality of work
		Time-consumingness of measures	11 (39.28)	Documentations are helpful only if they are registered correctly
				If my poor personnel were enough in number, they would at least have time to do the right job
	Justice	Method of evaluation	6 (21.42)	Evaluators act arbitrarily
				Anyone expects something from you and they have different opinions
				They do not consider the type of hospital and specialization
		The need for doing a lot of documentation by nursing forces	8 (28.57)	Many of the accreditation measures are the among the duties of nurses
				The major part of the score a hospital gets in accreditation is dependent on the nurses
				The pressure is on the nurses
Individual	Beliefs	Lack of attention to understanding the importance of correct and timely documentation for treatment outcomes	7 (25.00)	We write many things such as the unimportant things at the end if we remember to write them
		Lack of attention to understanding the importance of documentation in reducing hospital costs	7 (25.00)	If the medical records are registered correctly, there is no need to rework and the proper medical diagnosis is increased
	Individual characteristic	Evaluation of Apprehending the evaluation	2 (7.14)	A small ignorance sometimes leads to very low scores
				They value documentation rather than our main function
		Little knowledge and awareness in the field of correct documentation	9 (32.14)	Some of the accreditation measures were slurred and difficult to understand
				We learned lots of things from the trial and error method
				We do not know what some documentations are for

records. In a study regarding nursing reports, Esmaeelian *et al*. have stated that more monitoring and control over how to complete reports and having comprehensive programs are good ways to improve the quality of documentation in clinical records.[17] Besides, working discipline and proper planning can reduce workforce per capita (nursing and support) per bed.[18] In fact, the organizational structure should be efficient, making it

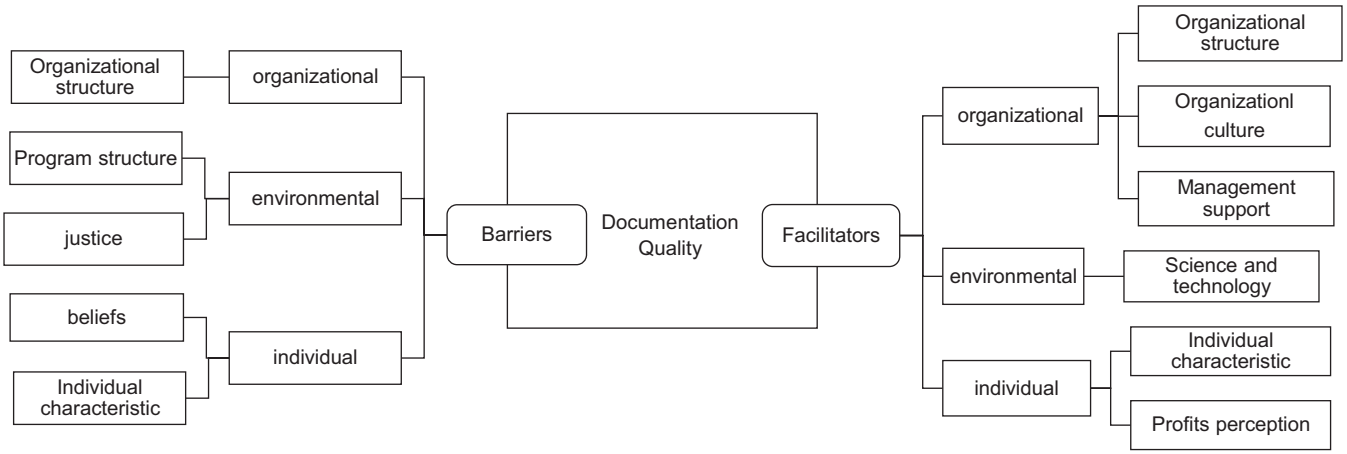

Figure 1: Barriers and facilitators in medical record documentation quality

possible for people to play their role and achieve their goals in an effective way in an environment which is full of changes. To do this, all members of the organization should have an understanding of the structure and the organization in which they are.

The next topic raised by the participants was the organizational culture. It included the two subjects of the integration of personnel and hospital goals and empowering the staff. Establishing appropriate organizational culture in order to increase the quality of services was one of the important steps in the implementation of the accreditation program.[18] The integration of personnel goals with the hospital facilitates personnel's attempts to achieve their goals and leads to better performance in the record documentation. Empowering the staff increases their ability in performing their expected duties. Some studies have shown that conducting workshops on ways of documentation for the staff has empowered the staff and has resulted in the integration of goals. In their study, Rangraz-Jeddi *et al*. estimated a high rate of data documentation in emergency records, referring to the related workshops.[19] These workshops may increase the personnel self-efficacy which improves the quality of medical records by changing attitudes, abilities, and individual skills.

Management support and his presence in the Committee of Medical Records were found significant in improving documentation from the perspective of participants. A study conducted before the implementation of the accreditation program by Neisi and Azizi in Ahvaz showed that the partial combination of committee meetings and absence of the manager in the committee leads to weak results.[20] The presence of the manager in the Committee on Medical Records can cause more support and monitoring of the staff. The management's awareness and emphasis on the importance of documentation affect the staff's performance. The knowledge and awareness of people who do documentation are also effective in decisions and actions. More than half of the interviewees in this study mentioned the impact of knowledge and awareness as a facilitator. One of the participants has declared: "Perhaps the importance of documentation and accreditation attracted our attention to our documentations and though our main duty is treatment, we found documentation very important. The importance of medical records is bold in the accreditation program, and this makes us take a deeper look into our activities and feel more commitment in registering documents" (Interviewee 8).

Another issue that the participants in this study stated as an affecting factor in improving the quality of medical records was the impact of environmental factors. Information management systems in the area of treatment have a great importance in responding to environmental factors and the balance between the hospital's environment, the internal structures, and the processes.[21] Science and technology is one of the environmental factors that have been affecting the quality of documentation by the implementation of accreditation. Its impact includes using various soft wares, employing specialized groups, and using updated standards in medical record documentation. Another factor that improved the quality of medical records was promoting the use of technology in hospitals as well as the use of international and cutting-edge standards in the accreditation program.

The importance of workforce in successful management of information systems should be taken into account. Creating a positive attitude toward documentation among nurses can have a positive impact in improving patient care and documentation of medical records. A significant correlation between the positive attitude of nurses, completeness of the information, and the quality

of patient care is shown in the study of Rouzbahani *et al*.[21] One factor that can create a positive attitude among the staff is their understanding of the benefits. The perceived benefits by the staff constitute another factor which improves the quality of medical records. A large number of interviewees in our study expressed the impact of perceived benefits as a facilitator. This has been done by understanding the importance of documentation in legal matters and understanding the importance of documentation in facilitating the work of employees gained by implementing the accreditation program. Esmaeelian *et al*. in their study stated that documentation quality is a quality indicator of health-care services to patients and that accreditation evaluator's comment from the documentations.[17] Medical record documentation is often used to protect the legal rights of the patients and the staff, providing information for medical research, training the health-care staff, and qualitative reviews.[22] Understanding the importance of documentations, especially in legal cases, can make the staff more serious in recording the necessary items in written form. Understanding the importance of documentations in the personnel's duties will certainly encourage them to do a better job.

Barriers in documentation

Determining the structure of the program for the accreditation model can be noted as the first barrier to the quality of medical records in hospitals under study. Almost more than half of the interviewees expressed the impact of the program structure as a barrier. They stated that a large number of requested documents were among the factors that prevented the correct registration of information; in addition, some required items are time-consuming, and they can be provided only via formal recording of some of the medical information. Pomey *et al*. in their study have expressed accreditation as a time-consuming factor, causing administrative bureaucracy, and increased workload and stress in the staff.[23] It is necessary only to ask for the essential items to spare enough time for completing information. This will result in more precise work considering the shortage of nurses. The next relevant topic is the hospital's organizational structure that many interviewees considered it as a barrier to improve. The shortage of nurses in ratio to patients resulted in lack of sufficient attention to correct documentations. Salehian *et al*. believe that skilled workforce is needed for implementing successful accreditation in a national level, which is subject to extensive planning in this area and required financing from relevant institutions.[18]

One of the main barriers is the physicians' lack of adequate attention to issues of accreditation. In a study, they expressed that this program was not related to them.[24] Lack of cooperation from physicians leads to excessive pressure on the nursing staff, and this is another factor that prevents having records of good quality. They must undertake to complete medical records related to them by accepting their role in the accreditation program. Moreover, the priority given to documentation rather than the clinical practice of the nurses leads to long waiting queues for the patients in receiving nursing services as well as the haste and carelessness in writing and recording the patient's medical records. It is necessary that research be done with regard to the timing of documentation and the services protocol be provided with regard to appropriate time for recording the information.

Sometimes, the doctors and nurses do not do recordings at the right time due to lack of time or being busy and postpone service registration to another time. Consequently, the records do not have the required quality because forgetting details. It is demonstrated by evidence that educational interventions can significantly improve documentation quality among doctors.[25] Some interviewees claim performing clinical work and documentation by nurses has reduced the effectiveness of documentation. The need for trained employees in the field of documentation and its impact, on the other hand, should be taken into account. Underestimating the importance of proper documentation by the staff leads to lack of correctness in recordings. Improvements in the nursing process and registration of patients' information by nurses have been expanded as a framework of activity and an essential tool for providing and evaluating treatment-nursing care, so that the slightest negligence in this process can lead to professional problems for them. Therefore, registration by the nurse must be complete, accurate, on time, and true, and this is not possible without frequent evaluation.[26] Underestimating the importance of proper documentation in reducing hospital costs, better management, and time-saving is another destructive factor that threatens the quality of record writing. This lack of attention brings about negligence in correct recording of the contents in medical records. Therefore, more effective training is deemed necessary for the employees' better performance.

The method of evaluation is another item which is affecting the performance of people who are doing the documentation. Nurses are documenting most of medical records. Evaluating nurses only based on these documents makes them anxious about the accuracy of documentation and consequences. Having anxiety with regard to the hospital's evaluation will also eliminate the incentive in the personnel to work properly. However, it should be noted that standards are only limited tools to compare the quality of care in hospitals.[27] Before the implementation of the accreditation program, Sarani *et al*. showed that the performance of nurses in

registering information is not desirable. They mentioned several factors causing this undesirable situation which included lack of awareness regarding what data must be registered by the nurses, neglecting the importance of documentation, and the lack of nursing management and medical records.[26] Documentarians' and medical record personnel's little knowledge leads to the lack of sufficient attention in registering and maintaining medical records. As to training the staff, it should be noted that the training should result in consequential actions by doctors, nurses, and all the people who are associated in one way or another with completing the medical records: a sense of commitment is a dire need in completing the records.

Limitations of the study

Limited time of some managers was a limitation of the current study, but they were kind enough to make an appointment for interview and participating in research. Furthermore, this study was conducted in Ahvaz; and as a primary limitation of qualitative research, it may not be generalized to other cities in Iran. However, provided information about medical facilitators and barriers may be used by interested parties.

Conclusions

Various factors affect the quality of medical record documentation in three levels: organizational, groups, and individuals. Hospital administrators can improve the quality of documenting in hospitals by creating an appropriate organizational structure and compliance with the environmental factors as well as the employees' individual characteristics. Moreover, the implementation of accreditation has had impacts on improving the quality of medical record documentation with positive side effects. Therefore, it is recommended that hospital managers take measures to improve the quality of medical records by removing the barriers identified in the study and implementing accreditation models properly.

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Conflicts of interest

There are no conflicts of interest.

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