IJNRD.ORG ISSN : 2456-4184
INTERNATIONAL JOURNAL OF NOVEL RESEARCH AND DEVELOPMENT (IJNRD) | IJNRD.ORG
An International Open Access, Peer-reviewed, Refereed Journal

Accurate Documentation for Effective and Efficient Healthcare Delivery in Niger Delta University Teaching Hospital, Okolobiri.

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ABSTRACT

The project work was based on accurate documentation for effective and efficient healthcare delivery in Niger Delta University Teaching Hospital, Okolobiri. The objectives of the work are to determine the importance of accurate documentation in health care delivery; to determine the efficiency and effectiveness of accurate documentation in health care delivery. A descriptive survey research design was employed for the study. Data were collected with the aid of a structured questionnaire and analyzed using SPSS Version 20. Result: from the analysis, it was observed that accurate documentation is the reflection of the degree of care rendered to patients insignificant as the mean value of 3.74 which exceed the decision rule of 3.5 which implies that documentation is an indicator of patient care; it was also noted on the statement there is poor documentation system patient information in the hospital. This is significant (3.60±1.382) which means that the documentation is poor in the area of the study. Conclusion: It was concluded that clear documentation is very important in medical records keeping as well the as quality of patient care. Also, appropriate documentation can enhance healthcare delivery. Therefore, health care providers should endeavour to make their writing legible to ensure that records kept in the hospital are accessible to other healthcare professionals. There is a need to enhance the documentation of medical records in the study area. The patient should ensure that they are able to ensure that their records are taken properly.

Keywords: Accurate documentation; Effective; Efficient; Healthcare delivery;

Introduction

Accurate clinical documentation is a requirement for good communication. It is how comorbidities will be captured and evidence-based logic explained. To prevent duplication or omission of services, documentation must be proactive in monitoring services rendered. In addition, hospitals that coordinate clinical documentation requirements, quality initiatives, and collaborative training will be better positioned for the transition to ICD-10 [(1)]. Medical documentation is believed pertinent facts of a medical care plan. It is a warehouse for patients' information and interaction with their caregivers in particular. However, there is a lack of completeness, consistency, proper recoding and other constraints regarding the current medical record practice [(2)].

Documentation is a record of the care, the clinical assessment, professional judgment and critical thinking used by a health professional in relation to the provision of patient care. This documentation may include written and electronic health records, observation charts, actions, outcomes, checklists, communication books, shift/management reports, and clinical anecdotal notes or personal reflections (held by the clinicians personally or any other form of documentation pertaining to the care provided. The medical documentation (medical record or paper-based record) therefore, is one of the health (clinical) records in which we need to assess its practice level or status. Of course, the practice or the documentation may be recorded or done by doctors, nurses, midwives, and other care providers (health professionals) in general [(3)].

Documenting accurate information about a patient is critical in order to provide optimal care. When poor record-keeping occurs, it often leads to both internal and external reports being incorrect. More importantly, patient care suffers [4].

Despite widespread interest in standardizing of health records in many parts of the world [5], narrative text record (manually written documentation) for patient information is a usual trend everywhere. The data in documentation can be organized in a variety of ways including time-oriented, problem-oriented, and source-oriented approaches. Based on a recent review, an emphasis on data attributes (accuracy, completeness, and timeliness) is needed for documentation to quality measurement [6].

Statement of the problem is that accurate documentation for effective and efficient health care delivery cannot be overemphasized the quality of patient health records depends on the quality of documentation and management. Accurate documentation enables health care benefactors to capture relevant data & information concerning care rendered to every patient. Accurate documentation is the reflections of the degree of care rendered to a patient and facilitate communication between members of the health care team. But this has been deliberately neglected by the health care givers. Therefore, imposing avoidable challenges such as illegibility, lack of patience on the part of the staffs and patients particularly in the aspect of giving the right information to the healthcare professionals by patient as well as staff in hurry to finish documentation, lacking clarity in the documentation, lack of qualitative and quantitative analysis of records, lack of trained staffs, specificity, difficult to retrieve, not concise and not readily available. Hence, making end users such as health care planners, researchers even the health care givers themselves to face the consequences. The above actually stirred up the researcher to examine the accurate documentation for efficient and effective health care delivery

Accurate healthcare documentation records all details of patient monitoring and treatment. If done properly and in a timely manner, the patient will benefit. Plus, effective documentation will protect the provider from unnecessary legal problems. Most importantly, it ensures professionalism and is proof the provider believes accurate record-keeping is important [4].

Some key factors of effective healthcare documentation include [4]:

- ✓ Provide factual, consistent, and accurate input
- ✓ Update the information after any recordable event
- ✓ Make sure all information is current
- ✓ Confirm that all entries are legible and signed
- ✓ Avoid meaningless jargon, phrases or abbreviations that aren't commonly understood

According to [4], there are many reasons why accurately documenting a patient's healthcare records is important. First and foremost, it allows for a continuum of information to flow smoothly from one provider or specialty to another.

Medical transcriptions contain data and critical information regarding the patient's past and present condition, as well as treatment protocols. In short, accurate healthcare documentation should provide an accurate description of the patient's medical story.

Healthcare documentation improvement is also important because it allows for accurate and timely reimbursement. Any healthcare institution or clinic will cite the importance of being paid on time. A profession known as clinical documentation integrity (CDI) is charged with ensuring healthcare records are documented accurately and thoroughly [(4)].

Medical Record Officers should ensure they have documentation policy, procedure and quality assurance mechanisms in place which clarify [(3)].

- The legislative requirements for documentation
- The minimum requirements for documentation
- Format and type of documentation (including acceptable documentation tools and forms)
- The roles and responsibilities of the clinical staff in relation to documentation
- Accepted abbreviations in the organization (including their agreed meaning)
- Any requirements for witnessing or counter signing documentation (and the meaning and responsibility assigned to these practices)
- Requirements for access, storing, archiving and retaining documentation
- Requirements for documentation of verbal orders and provision of telephone advice/information
- Requirements for confidentiality and privacy.

Clinical Competence in Relation to Documentation: Appropriate documentation promotes; A high standard of clinical care; Continuity of care; Improved communication and dissemination of information between and across service providers; An accurate account of treatment, intervention and care planning; Improved goal setting and evaluation of care outcomes; Improved early detection of problems and changes in health status; Evidence of patient care.

A clinician's documentation should be able to demonstrate the following:

- A full account of the clinician's assessment of the patient and the care planned and provided
- Relevant information in relation to the patient's condition at any given time and the interventions and actions taken to achieve identified health outcomes and/or respond to actual or potential adverse events
- Evidence that the clinician met their duty of care and taken all reasonable decisions and actions to provide the highest standard of care
- Evidence that the clinician met their duty of care and that any actions or omissions did not compromise the patients safety or identified health outcomes
- A record of all communications with other relevant others in relation to the patient

Guiding principles for documentation

Guiding Principle 1: Comprehensive and complete record

Clinical staff has a professional obligation to maintain documentation that is clear, concise, and comprehensive, as an accurate and true record of care [(3)].

Professional documentation by clinical staff is an integral part of practice to ensure safe and effective care. Documentation is a record of the care provided, and the judgment and critical thinking used by a health professional in the provision of that care.

Documentation acts as evidence of the unique and important contribution of each staff member to health care. It forms the basis for evidence of the area that can be used for research, legal analysis and determination, allocation of resources, and as a primary communication between health professionals [3].

Comprehensive and complete documentation and record-keeping

- A clear, concise, complete record of clinical care (including, assessment, plan of action outcome, and evaluation of care)
- Factual, accurate, true and honest record
- Avoids duplication of information
- Legible and non-erasable, permanent, retrievable, confidential, patient-focussed, and non-judgmental
- Representative and reflective of professional observations and assessment
- Timely and completed as close as possible after an episode of care or event
- A complete record including completed forms, charts, methods, and systems
- A chronological record of care (late entries recorded as soon as possible as to rectify the absence)
- Prefaced with date and time of care or event (including recording of late entries, changes or additions)
- Identifying details of person who provided/documented care
- Identifying of source of information (including information provided by another health care professional or provider)
- Inclusive of signatures (or initials) and professional designation of the person recording information
- Contains meaningful and relevant information (avoids meaningless phrases such as ‘slept well or ‘usual day’)
- Minimise transcription of data
- Easily interpreted over time and after significant time has elapsed
- Avoid the use of abbreviations (other than those approved and documented in organisational policy by the Medical Record Department)
- Detailed documentation in relation to critical incidents such as patient falls, harm to patients, or medication errors [3].

Guiding Principle 2: Patient-centered and Collaborative

Documentation is patient-centred, patient-focused, collaborative, and appropriate to the setting in which the care is provided and the purpose for which the information is recorded. Documentation must be patient-focused.

Clinical documentation may record diverse information within and across services and settings. Given the diversity of care provided, clinicians must consider the purpose of documentation and how by whom and for what purpose that information is to be used. Effective documentation systems require regular review and revision. Patient-centred documentation a record-keeping

- Documentation systems and practices appropriate to the specific needs of the patient/patient population and context of the care
- Appropriate documentation systems to support shared documentation processes
- A record of independent and collaborative actions with other health professionals or care providers (e.g. those ordered by another appropriate health professional)
- Contemporary, secure, resource efficient documentation systems
- Documentation systems relevant to the setting in which the care occurs (including patient held records, electronic records and mobile record systems)
- Identification of objective and subjective data in documenting assessment of the patient needs/health status
- Individualized, comprehensive and current plan of care
- Based on professional observation and assessment that does not have any basis in unfounded conclusions of personal judgments
- Identifies problems that have arisen and actions taken to rectify/address
- Frequency of documentation consistent with professional judgment in relation to complexity/stability of patient, organizational policy, standards and legislation
- Documented valid consent of any clinician proposed intervention or operation
- Accessible relevant previous/other documentation (including patient history, long and short term intervention, diagnostic investigations most recent previous documentation by other clinical staff
- Appropriate supporting documentation systems and forms
- Documentation of intervention via telephone (including information obtained and advice given) [(3)].

Guiding Principle 3: Ensure and maintain confidentiality

Documentation systems (including electronic systems) will ensure and maintain patient confidentiality, in all care settings. Clinicians have legislative, professional and ethical obligations to protect patient confidentiality. It is essential that the confidentiality of that information be safeguarded and shared only as necessary to protect the interests of the person and to ensure the best outcomes of care. This includes maintaining confidential documentation and patient records. Electronic information, mail and communication systems are increasingly used as effective means of maintaining and transferring documentation and information in the health care environment. Precautions must be taken to ensure that clinical staff are fully informed of appropriate, safe and secure use of electronic information systems. It should be assumed that any and all clinical documentation will be scrutinized at some point. Confidential documentation and record keeping

- Ensure and maintain the confidentiality of the patient
- Develop and implement practices that protect confidentiality of information and data when documenting in a record (including charts)
- Records stored and archived confidentially
- Confidentiality of electronic documentation and information

- Systems and practices are in place that maximize the confidentiality of documentation and records in diverse settings
- Systems for sharing information with others ensures only relevant information with relevant others (also required to maintain confidentiality)
- Ensuring copies are used, managed stored and/or destroyed appropriately
- Ensure copies are readable (including photocopies/faxes)
- Patient records are secure from unauthorized access, loss or theft during transfer, transmission (i.e. electronic transfer), or transportation
- Disposing of documentation (where appropriate to destroy) in a manner that maintains confidentiality (e.g. confidential bins /shredding)
- Those accessing (or seeking to access) documentation have the authority to access it.
- Meets requirements for storage and disposal scheduling [3].

METHODS

Study Setting

The study was carried out at the Niger Delta University Teaching Hospital (NDUTH), Okolobiri, formerly known as the General Hospital, Okolobiri established by the then military Governor of the old Rivers State, Alfred Papapreye Diete-Spiff under Gen Yakubu Gowon Military Rule in 1973. Okolobiri General Hospital existed for about 18 years before the creation of Bayelsa state by General Sani Abacha in 1996. In 2007, during the administration of Timipre Silva as the Governor of Bayelsa State, the then General Hospital, Okolobiri was upgraded to a 158-bed and latter to 200 beds complement tertiary healthcare centre in order to meet the healthcare demands of the state and also change its nomenclature to Niger Delta University Teaching Hospital (NDUTH) so as to be attached to the Niger Delta University Amassoma to operate as a tertiary healthcare level [7].

Study design

A descriptive survey research design was employed for the study.

Study Population

The target population of this study comprised the total number of health professionals in Niger Delta University Teaching Hospital, Okolobiri.

Inclusion and Exclusion Criteria

1. All health professional in Niger Delta University Teaching Hospital, Okolobiri that deals with patient directly.

While the exclusion criteria include

1. All other non-health professionals working in the hospital that has no direct contact with patient.

Sample size

A sample size of 248 was determined using Taro Yamane's formula below.

$n = \frac{N}{\quad}$

$1 + N (e)^2$

Where:

n signifies the sample size

N signifies the population under study (650)

e signifies the margin error (it could be 0.10, 0.05 or 0.01) (0.05).

Sampling techniques

Simple random sampling techniques were employed for the study.

Method of Data Collection

Based on the design of the study, a self-designed instrument was structured for the collection of data. The instrument was divided mainly into two (2) sections, A & B. Section A captured their required biographic data from respondents while Section B consist of both natively and positively phrased liket-type/scale format of the questionnaire under different sub-headings precisely. The response levels were as follows: Strongly agreed (SA), Agreed (A), Undecided (U), Disagreed (D), strongly disagreed (D).

Method of Data Analysis

The data was presented using tables and percentages and were analyzed with the aid of SPSS (Statistical Package for the social sciences version 21. Means and standard deviations were used for the data analysis.

Ethical Consideration

Prior to the research study, consent was sorted from the respondents in Niger Delta University Teaching Hospital (NDUTH), Okolobiri, and they were assured that their responses would be treated with confidentiality and would be strictly used for the purpose of the study and was granted consent to carry out the study in the Hospitals.

Results

The value of respondents by gender indicates that there are more female respondents (64.1%) than male respondents (35.9%). this is a true reflection of the demographic mix in the health institutions with more females in the health labour force than the male counterparts

Respondents are distributed across different ages as those between 26 and 30 years are 25% of the respondents. Those between 31 and 35 years are 19.4%. Respondents between 36 and 40 years are 26.6% of the sample just as those between 41 and 45 years are 14.1% of the entire sample. Those who are above 46 years complete the sample (14.9%).

Respondents are largely married (33.5%) as that category accounts for 83 out of 248 respondents. Single respondents are 21.8% of the sample. Those who indicated divorced are 16.1% of the sample. Widows/widowers make up 12.1 % of the sample a as those cohabiting account for 41 respondents

The distribution of respondents indicates that 13.7% are health information management workers, nurses make up 28.2%. Doctors are 37.9% of the sample while pharmacists are 20.2% of the sample.

The distribution of respondents indicates that all respondents have tertiary level qualification. Those with a national diploma make up 33.5% of the sample. Those with Higher national diploma or a first degree are 51.2% of the sampled respondents. Respondents with a master's degree make up 15.3%

Research question 1: Is accurate documentation important in health care delivery system?

Table 1: Responses on the importance of accurate documentation in health care delivery system

Variables	Mean	Std. Deviation	Maximum
Accurate documentation is the reflection of the degree of care rendered to patient	3.74	1.340	Accepted
Health care professionals do not see accurate documentation as important.	3.39	1.413	Rejected
Health care professionals documents all findings of the patient	2.09	1.312	Rejected
Accurate documentation enhances effective and efficient health care delivery	3.81	1.196	Accepted
Accurate documentation enhances effective and efficient health care delivery	3.81	1.196	Accepted

Source: Dogiye et al. 2022 Field survey

Responses to the statement "Accurate documentation is the reflection of the degree of care rendered to patient" is significant as the mean value 3.74 exceed the decision rule of 3.5 which implies that documentation is an indicator of patient care. Responses to the statement "Health care professionals do not see accurate documentation as important" is not significant as the mean is below the decision rule 3.39. This implies that healthcare professionals see documentation as important. The value for the response to the statement "Accurate documentation enhances effective and efficient health care delivery" is significant (3.81± 1.196).

Research question 2: What is the level of efficiency and effectiveness of accurate documentation in health care delivery?

Table 2: Responses on the level of efficiency and effectiveness of accurate documentation

Variables	Mean	Std. Deviation	Maximum
There is poor documentation system of patient information in this hospital.	3.60	1.382	Accepted
The lack of completeness, consistency leads to inefficient patient documentation.	2.73	1.356	Rejected

Source: Dogiye et al. 2022 Field survey

The value of responses to the statement "There is poor documentation system of patient information in this hospital" is significant (3.60± 1.382) which means that the documentation is poor in the area of study.

Research question 3: Does accurate documentation improve proper patient care in health care delivery?

Table 3: Responses on the level of efficiency and effectiveness of accurate documentation

Variables	Mean	Std. Deviation	Decision
The lack of completeness, consistency leads to inefficient patient documentation.	2.73	1.356	Rejected
Efficient documentation enhances quality of care in the health care system	3.70	1.298	Accepted
Inaccurate documentation may lead to loss of life	3.72	1.432	Accepted
Inaccurate documentation can lead to wrong medication and diagnosis	3.53	1.316	Accepted

Source: Dogiye et al. 2022 Field survey

The response value to the statement "The lack of completeness, consistency leads to inefficient patient documentation" is not significant (2.73± 1.356) implying that efficiency does not affect patient documentation. Respondents agree on the average that accurate documentation actually improves the quality of patient care (3.85± 1.331) just as respondents agree that efficient documentation enhances the quality of care in the health care system (3.70±1.298) on average respondents agree that inaccurate documentation may lead to loss of life (3.72± 1.432). Lastly, respondents agree on the average that inaccurate documentation can lead to wrong medication and diagnosis (3.53± 1.316).

Research question 4: What are the factors militating against accurate documentation in Niger Delta University Teaching Hospital, Okolobiri?

Table 4: Responses on factors militating against accurate documentation

Variables	Mean	Std. Deviation	Decision rule
Lack of patience on the part of the health professionals in documentation is a factor that militates against accurate documentation	3.42	1.533	Rejected
Lack of patience on the part of the patient in giving detail and accurate information about themselves is a factor that militates against accurate documentation.	3.98	1.357	Accepted

Illegible writing of the health professionals is a factor that militate against effective and efficient documentation	3.81	1.359	Accepted

Source: Dogiye et al. 2022 Field survey

The value for the responses to the statement "Lack of patience on the part of the health professionals in documentation is a factor that militates against accurate documentation" is not significant (3.42± 1.533) this implies that respondents do not attribute patience as a factor. They agree that "Lack of patience on the part of the patient in giving detail and accurate information about themselves is a factor that militates against accurate documentation as the mean score is significant (3.98±1.357) lastly, Respondents agree that illegible writing of the health professionals is a factor that militates against effective and efficient documentation as the mean score (3.81± 1.359) is significant.

The value for the statement "Health care professionals documents all findings of the patient" is not significant (2.09 ±1.312) this implies that health care professionals are deficient in the documentation.

Discussion

The study pierced accurate documentation for effective and efficient healthcare service delivery. This study made use of 248 respondents, of which (64.1%) were female respondents while (35.9%) were male respondents, indicating that majority of the respondents were females. The study observed that majority of the respondents fall within the age bracket 26-30. Also, most of the respondents were married persons. For educational level, it was revealed that all respondents have tertiary level qualifications with more of Higher National Diploma or a First Degree. This study further identified that various health professionals responded with Medical doctors having the highest response to be (37.9%) while Health Information Management professionals had the least response to be (13.7%).

The findings of the Responses to the statement "Accurate documentation is the reflection of the degree of care rendered to the patient" are significant as the mean value of 3.74 exceeds the decision rule of 3.5 which implies that documentation is an indicator of patient care. Responses to the statement "Health care professionals do not see accurate documentation as important" is not significant as the mean is below the decision rule 3.39. This implies that healthcare professionals see documentation as important. The value for the response to the statement "Accurate documentation enhances effective and efficient health care delivery" is significant (3.81± 1.196).

Further findings on this study depicted that the response value to the statement ''There is poor documentation system of patient information in this hospital" is significant (3.60± 1.382) which means that the documentation is poor in the area of study.

Also, the response value to the statement "The lack of completeness, consistency leads to inefficient patient documentation" is not significant (2.73± 1.356) implying that efficiency does not affect patient documentation. As well, respondents agree on the average that accurate documentation actually improves the quality of patient care (3.85± 1.331). Respondents likewise agree that efficient documentation enhances the quality of care in the

health care system (3.70±1.298). Additionally, the average respondents agree that inaccurate documentation may lead to loss of life (3.72± 1.432). Lastly, respondents agree on the average that inaccurate documentation can lead to wrong medication and diagnosis (3.53± 1.316).

The present study disclosed that the value for the responses to the statement "Lack of patience on the part of the health professionals in documentation is a factor that militates against accurate documentation" is not significant (3.42± 1.533), this implies that respondents do not attribute patience as a factor. They agree that "Lack of patience on the part of the patient in giving detail and accurate information about themselves is a factor that militates against accurate documentation as the mean score is significant (3.98±1.357). Moreover, respondents agree that illegible writing of the health professionals is a factor that militates against effective and efficient documentation as the mean score (3.81± 1.359) is significant. Finally, the value for the statement "Health care professionals documents all findings of the patient" is not significant (2.09 ±1.312) this implies that health care professionals are deficient in the documentation.

Conclusion

It is clear that documentation is important in medical record keeping. This importance has led to a consensus among respondents on the importance of medical documentation. It is the case that appropriate documentation can enhance health care delivery, and allow for effective and efficient health care in the area of study as well as in all medical establishments.

Acknowledgment

We wish to appreciate all that contributed to the success of this work.

Conflict of interest

No conflict of interest was declared

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