



Physicians' clinical documentation and patient's healthcare management: The need for pragmatic approach

Benson Macaulay Oweghoro^{1*}

¹Department of Library and Information Studies, University of Ibadan, Ibadan, Nigeria

Corresponding author*: E-mail: bmoweghoro@gmail.com

ABSTRACT

Background/Objective Clinical documentation is an important legal and professional requirement for health professionals and goes a long way to determine the value of care a patient receives. **Methods/Design:** This study reviewed and discussed issues relating to physicians' clinical documentation and reported on opinion assessment of physicians with regards to clinical documentation. **Result:** It was found that clinical documentation serves as a basis for organizing the patients care plan and for continuity of care. Physicians, as well as other healthcare providers acknowledge the importance of effective clinical documentation. However, inadequacies persist in existing clinical documentation practice especially in paper-based systems. **Conclusion:** The study recommends that hospitals need to develop written policies and guidelines on clinical documentation for physicians. In addition, there should be regular clinical documentation training programme for physicians and other care givers in order to reduce errors during documentation.

Keywords: Clinical Documentation; Physicians; Patient Care Management; Attitude; Health Records; Nigeria

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INTRODUCTION/DISCUSSION

Clinical documentation involves the capturing and recording of care details provided to patients. In patient care management, physicians are required to record pertinent facts, findings, and observations about the patient's past and present health history, examinations, tests, treatments, and outcomes¹. This practice documents the total care rendered to the patient and becomes the record of the patient's care forming an important element contributing to high quality care. This facilitates communication of a patient's information to all members of the healthcare team and it is vital to ensure holistic patient care management². Clinical document is anything that might be found in a patient's health records or anywhere else that document clinical observations and the care given to that patient. It includes any and all forms of documentations by a physician

recorded in a professional capacity and in relation to the provision of patient care³. It has been shown that accurately documented health record can reduce many of the medical errors and hassles associated with healthcare². A well-documented patient's health record may serve as a legal document to verify the care provided. According to Putul and Mukesh⁴, nothing is more devastating to an innocent physician's defense against the allegations of medical malpractice than an inaccurate, illegible or skimpy record because the health record is the basic legal document in medical malpractice litigation. A well-organized, well-documented patient record is the best defense for a physician.

The existence of clinical documentation over the years has made a significant progress on health record management². The purpose of complete and accurate clinical documentation is

to foster quality and continuity of care by serving as a medium of communication among physicians and between physicians and other healthcare providers. This information facilitates the ability of the physician and other health professionals to evaluate and plan for the patient's immediate and future treatments, monitor patient's healthcare over time and evaluate the quality of care provided. Clinical documentation is a fundamental part of clinical practice and it demonstrates the physician's accountability and records their professional practice. Documenting patient care facilitates diagnosis and treatment, communicates pertinent information to other care providers to ensure patient safety, reduces medical errors, and serves an important medico-legal function in risk management^{5,6}. The relevance of clinical documentation most time is based on the fact that it is trusted on authorities that produces them and considered as one of the most important areas which should be prioritized by health providers⁷.

Physicians, other care professionals and healthcare institutions are required by policy, regulation and law to document care provided because the accuracy of this documentation apart from serving as a communication tool in patient care, it is essential for medical and legal purposes⁸. As a result, care providers, hospitals, and patients all have an interest in ensuring that physicians practice high-quality clinical documentation of patient care. Quality clinical documentation of patients' care by physicians is key to quality patients' care management. It is obvious that what is written is what is known about a patient and will go a long way to determine the medical plans and actions to be taken and the output of the care a patient received. Experience has shown that human errors due to negligence in clinical documentation had contributed to medical

failures, patients' deaths and legal issues in many hospitals. Lack of enough information on a patient, misplacement of information or error in prescriptions resulting from incomplete or poor clinical documentation due to lack of policy guideline on clinical documentation has been an issue of concern to hospital management.

Many physicians have been hampered with the care of their patients by poor clinical documentation. Physicians, especially those in teaching hospitals caring for quite a number of patients on a daily basis need adequate information from clinical documentation as a guide to provide needed medical care. The realization of the importance of clinical documentation in patient care management requires that a policy on clinical documentation be put in place and sustained.

This study sought to examine essentials of clinical documentation by physicians as it affects patient healthcare management with a look at physicians' opinions from South-West Nigeria.

Clinical documentation in patient care management

Clinical documentations are meaningful information that physicians can later rely on to refresh their memory of crucial events in treatment, predicted outcome and patient's response to treatment. It provides a basis for a physician's reflection and self-assessment on the patient's evaluation, diagnoses, treatment plans and services⁹. The professional obligation to prepare appropriate clinical documentation serves an important role of helping to assure quality patient care management as it makes physicians think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their practice and weigh alternative approaches to the care¹⁰. Clinical

documentation highlights the fundamental record of clinical practice that demonstrates the clinician's accountability and records their professional practice¹¹. Clinical documentation communicates the treatment, care and the outcome of care provided. It has the clinical assessment, professional judgment and critical thinking used by a health professional or physicians in the provision of patient care¹².

A physician's competence in the art of clinical documentation will influence high standard patient care and continuity through improved communication and dissemination of information among providers. Such competence will ensure the provision of accurate account of treatment, intervention and care plan, improved goal settings and evaluation of care outcomes, improved early detection of problems and changes in health status, evidence of patient care¹³. It therefore follows that clinical documentation is critical to patient care management in the hospital setting.

Purpose of clinical documentation by physicians

The objective of a complete, accurate and comprehensive clinical documentation is to foster quality and continuity of care through access to patient information by those responsible for patient care management. Baird¹⁴ opined that, clinical documentation should describe the patient's condition using terminology that includes specific diagnoses, as well as symptoms, problems, or reasons for service provided. Clinical document tells a story about care provided to the patient. Like any other story, a clinical document has a particular setting in space and time and a cast of characters that the reader should understand in order to make sense of what has been recorded¹⁴. Documentations by clinical staff are integral parts of a physician's practice to ensure safe and

effective patient's care¹⁴. Documentation records the care provided, the judgment and critical thinking used by physicians in the provision of that care. It informs of the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record¹⁵.

Clear, complete, accurate and factual documentation provides a reliable, permanent record of patient care. In addition to care management, data accessed from clinical documentation and coded are used as an appropriate tool for identifying the type of care that patients require, the services provided and the efficiency and effectiveness of care provided¹⁵. Any of these factors may impact on funding and resource allocation. Accurate and comprehensive documentation of interventions provides a valuable source of evidence and rationale for funding and resource management¹⁵. Boone¹⁶ noted that clinical documents have primarily two functions; they communicate relevant clinical information among physicians; and between physicians and other care providers separated by time or distance. Key features supporting these functions are credibility and completeness.

Elements of a good clinical documentation for patient care management

Good and complete documentation in a patient's health record has been linked to both quality of care and health care costs¹⁷. There are basic rules to clinical documentation for patient care management, which includes each record must contain the name, age, date of birth, address and contact information of the patient¹⁸. Physicians must ensure that all documented information are authenticated by author's signature, the designation, date and time entry was made. According to Bates¹⁸, strict privacy must be observed and there should be a limit to using

abbreviations and acronym, as wrong usage of these may lead to misunderstanding the material later which could lead to confusion. A rule of clinical documentation in correcting errors is to cross-out such errors using a single line, countersign and dated. Under no circumstances should entry be corrected using such materials as correcting fluids, eraser or liquid paper. Any overdue entry or supplemental entry should be indicated separately together with the date and corresponding notes and signatures. It is very important for any clinical documentation to be comprehensive in every respect and should follow all the standard rules and guidelines to avoid risks brought by noncompliance. Good clinical documentation requires that the patients' health records should at all times be legible, easy to read and understood using standard formats and documentation materials¹⁹.

Every bit of information is essential in identifying a solution to a patient's disease condition. Hence reasons why a physician needs to perform certain tests must be clear on records and test results, billing, claims, and reimbursements should be kept detailed and complete to avoid legal risks. Records of patients' care are expected to contain not only the present medical details but also their past medical and health history²⁰. Disregarding the documentation of patients' clinical details would amount to endangering patient's lives.

Clinical documentation and errors in patient care management

Medical errors in patient care management occurs when physicians fail to document properly which may result to wrong diagnosis and procedures, choosing an inappropriate method of care or improperly executing appropriate method of care. Medical errors are often described as human errors in healthcare, in treatment and drugs

administration to patient²¹. Errors in patient care management compromise physicians' and patients' confidence in the healthcare delivery and increase in health-care costs. The problems and sources of errors in patient care management are multidisciplinary and multifactorial. Errors may occur from lack of knowledge, substandard performance and mental lapses, defects or failures in systems and importantly poor communication^{22,23}. Studies^{22,24,25} observed that errors in patient care management may come in various form; medication errors such as prescribing errors, omission error, wrong time error, unauthorized drug error, improper dose error, wrong drug-preparation error, wrong dosage-form error, wrong administration-technique error, deteriorated drug error, monitoring error, compliance error, dispensing errors, medication administration errors, and patient compliance errors. Errors in patient care management can have serious negative influence in medical practice. Researches^{26,27} have shown that common causes of errors in patient care management result from improper transcription and poor documentation.

Clinical documentation guidelines and standards in patient care management

Researchers^{26,5} are of the opinion that a guiding principles essential for documenting patient care include that clinical documentation be comprehensive and complete, patient centered and collaborative and confidential. In order for patient's record to be comprehensive and complete documentation must be clear, concise, legible, timely, patient-focused and accurate. This is essential because patient record acts as evidence of the unique and important contribution of each physician to care management. It forms the basis for evidence of care that can be used for research, legal analysis

and determination, allocation of resources and as a primary communication medium for Physicians.

Patients' health records and information are confidential because physicians have legislative, professional and ethical obligations to protect patient privacy. It is essential that the confidentiality of the information documented be safeguarded and shared only as necessary to protect the interests of the patient and to ensure the best outcomes of patient care. According to WHO²⁸, Royal College of Physicians²⁹, Lowe³⁰, and Huffman¹, the quality of the entries documented in a patient medical record is judged by their availability, accuracy, adequacy legibility, and accountability. These attributes provide part of the essential guidelines that should be considered if standards are to be upheld in clinical documentation.

Opinions of Nigerian physicians on clinical documentation

In an unpublished study, Oweghoro³¹ found that Nigerian physicians have positive perceptions toward clinical documentations as the majority of them admitted that clinical documentations provide basis for follow-ups, demonstrate knowledge and skills of the physician, minimise healthcare facility's vulnerability during litigation and external audits, and that patient injuries occur because of errors, omissions, illegible entries that results from poor clinical documentations of patient care.

The physicians observed that there are no written policy guidelines on clinical documentation in Nigeria but, though they adhere to documentation procedures as learnt from medical schools and improved upon through practices³¹. The design, structure and standardisation of forms facilitate effective clinical documentation³¹. Physicians also admitted that clinical documentation has a

moderate significant relationship with patient care management³¹.

Conclusion

Despite reported inadequacies and inconsistencies in clinical documentation especially from Nigeria³²⁻³⁵, physicians appreciate the importance of effective clinical documentation as a basis for quality patient care management. That clinical documentation directly drives what is reported in the patient health records. Illegible writing, inaccurate, inadequate and poor quality clinical documentation can lead to error in decision making which may lead to poor patient care management with accompanying negative consequences.

It is therefore important that hospitals develop clinical documentation policy guidelines and physicians should be encouraged to strictly adhere to the requirements for proper clinical documentation in order to reduce level of errors to the barest minimum. Clinical Documentation-Improvement Training Programme (CDTP) should be organized for physicians and other care givers with a view to improving their clinical documentation practices.

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Authors Contribution:

OBM conceived of the study, initiated its design, participated in literature search, article selection and review, data analysis and coordination and drafted the manuscript.