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Importance of Effective Clinical Documentation by Medical Doctors to Patient Care Management in Federal Teaching Hospital, `Ido Ekiti, Ekiti State, Nigeria

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Abstract:- This study scrutinized clinical documentation by medical doctors as a factor affecting patient care management and goes a long way to determine the quality of care given to patients in Federal Teaching Hospital, Ido - Ekiti Nigeria. The study adopted descriptive survey research design by administering questionnaire to respondents. The result disclosed that larger percentage of respondents agreed that the objectives of clinical documentation in patient care management are to acquiesce with legal regulatory and institutional requirements that will assure compliance with clinical documentation Moreover, the result shows that, greater number of the doctors consented that adherence to policy procedure with maen=1.80 and SD=0.45 is the level of blunders that are the most practised in clinical documention guideline/standard in the health institution ,while those that are less practised in the health institutions are medical history, medical follow up, drug administration and proper diagnosis with (×=1.40, SD=0.55). It was also discovered from the result that the use of clinical documentation aids in continuity of evaluation of patient 95.5%, the use of accurate clinical documentation can help reduce errors 95.4%. Majority of respondents agreed that, the use of clinical documentation provides a basis for follow-up.In addition, the result signifies that the most areas of blunders in clinical documentation in the health institutions are of disparaging remarks with mean of 2.80 and SD=0.45.Lastly, the result points out that the perception of clinical documentation has a temperate significant relationship with patient care management N=450, r=.363, p <.05. This implies that the level of doctor's perceptions of clinical documentation have the propensity to increase the level of patient care management in the health institution.**

Keywords:- *Clinical Documentation; Health Care; Medical Records; Physicians; Patient Care; Management; Nigeria.*

I. INTRODUCTION

Clinical documentation (DC) is the invention of digital or analogue record detailing a medical treatment, medical trail or clinical test. Clinical documentation is a vital legal and professional requirement for all health practitioners. Suitable documentation enhances patients' interpersonal relation through a well fostered information to all members of the health care system and this is equally pertinent to ensure holistic patient care management. When clinical documentation improvement (CDI) was first introduced in the United States (US), the policy climate of the Bush administration, with a major focus on increasing the effectiveness of hospital care and reducing the cost of the healthcare system. The Deficit Reduction Act 2005 was a combination of withholding reimbursement (for hospital acquired conditions), giving some mandatory indicators ("Present on Admission" flags) and incentivizing best practice (through "value-based purchasing") [1]

Clinical documentation involves the capturing and recording that is effective and credible to produce trusted record of care that is capable of providing complete and important details about the patient. The existence of clinical documentation over the years has made a significant progress on health record in the sector [2]. The need for clinical documentation has brought about active clinical note taking support to practitioners, the accurate recording of all events within a consultation including diagnosis, procedures and management of patient information.

It is expedient for Healthcare providers and provider organization by local policy, regulation and law to retain documentation of care that has been provided for specific time periods, however, this appear a deficient as it did not has significant effects on many health organizations considering the level of record that is involved. However, the communication and continuity of care among physicians has an implication on the patient other than health care professionals involved in terms of their accuracy and

timelines. The review of quality clinical documentation in most of the hospitals have been evaluated to ensure that ,collection of data that may be useful for research and education are made real. Also the accuracy of this documentation on patient's records serves as a communication tool for all health personnel involved in the care of a patient and is essential for medical and legal purposes [3].

In view of the this, health care systems, hospitals, residency training programmes, medical schools, and patients all have an interest in ensuring physicians are practicing high-quality clinical documentation for patient care management. [3].

Wood, 2010 [4] opined that the importance of quality documentation on patient care management cannot be overemphasised as it provides information for optima health records of a patient in acute care hospital. Equally, effective documentation enhances professional capacity care, right judgement, and critical assessment as related to the provision of patient care.

This serves as fundamental part of clinical practice and it demonstrates the clinicians' accountability and records their professional practice. Documentation in medical records facilitates diagnosis and treatment, pertinent information to other caregivers to ensure patient safety and reduce medical errors and serves an important medico-legal function in risk management.

Tower, 2013 [5] maintained that clinical documentation is critical for patient's care management because it presents the process and actions involved towards achieving efficient and quality patient care.

Also, clinical documentation ensures certainty in patient's care management because whatever that is recorded will be guiding physician in furthering patients' care.

Also, any entry in clinical documentation should not be reduced in a careless manner and using any such materials such as correction ink, eraser, liquid paper, and the like. Any overdue entry or supplemental entry should be indicated separately together with the date and corresponding notes and signature. 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. In nutshell, a clinical documentation has every detail about the patient from the moment of admission up to the release. There are specific rules that should be followed in keeping clinical documentation. The most common is the correct recording of the patient's chief complaint, The diagnosis and any procedures carried upon indicating when, how, where, who performed it, date and time together with the authorized signature and also the official role of the professional involved. The record should also be followed by the name, age, date of birth, address and contact information of the affected person [6]

Boone, 2011 [7] stated that there are two key functions to Clinical document; they communicate relevant clinical information between health care providers separated by time or distance and support compliance with local policy, regulation and law. Peculiar characteristics supporting these functions are credibility and completeness,). A clinical Document must be credible to be effective. This implies that often times trusted authority produced it and is itself a trusted record of care that was provided. Clinical documents should also be complete records of care that do not leave out important details. The judgment of what is relevant or important within a clinical document at the time it was written is left to the trusted authorities that produce them.

Clinical documentation is a process of recording and communicating a written rationale of intervention, and as such becomes an integral part of the patient medical record. It involves a comprehensive assessment, identified problems, expected outcomes, Tahoe plan of care and care delivered (or not delivered); advice sought in decision making, and the patient's response to treatment, discharge and plans for on-going care.

In all, it is worthy to say that Clinical documentation is a process of recording and communicating a written rationale of intervention, and as such becomes an integral part of the patient medical record. It involves a comprehensive assessment, identified problems, expected outcomes, Tahoe plan of care and care delivered (or not delivered); advice sought in decision' making, and the patient's response to treatment, discharge and plans for ongoing care.

Baird (2009) [8] opined that, clinical Documentation or source document/documentation referred to by the coder should describe the patient's condition using terminology that includes specific diagnosis, as well as symptoms, problems, or reasons for the service. Clinical document tells a story about care being provided to a patient. Like any other story, the clinical Document has a particular setting in space and time and a cast of character that the reader should understand in order to make sense of what had been recorded. Okaisu et.al (2014) [9] observed that, it involves patients receiving diagnostic services only during an encounter/visit, coders are reviewing the documentation for the diagnosis, condition, problem, or other reason for encounter visit shown in the medical record to be chiefly responsible for the outpatient services during the encounter visit.

In other word, for patients receiving therapeutic services only during an encounter/visit, the coder is expected to review the medical record for the diagnosis, condition, problem, or other reason for his/her visit documented in the medical record. Meaning that, he should be chiefly responsible for the patient provided during the encounter/visit. Also, with

outpatient diagnostic service, there should be specific guidelines and tips for the coders to follow to be in compliance with your policy [10]. In fact, it is observed that, many single physician practices are sole proprietorship. The legal distinction between the healthcare provider as a person and the organization that they operate is virtually non-existent.

According to Cradock , (2012) [11] documentation may include written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, shift/management reports, incident reports and clinical anecdotal notes or personal reflection (held by the clinicians personally or any other type or form of documentation pertaining to the care provided. Good patient care and health outcomes are dependent on accurate, clear, complete and timely documentation of a patient's diagnosis functional status, interventions, problems, treatment and progress. Global studies have shown that quality information contained within a patient's health record improves patient care and outcomes.

Other forms of documentation which are relevant to evidence of clinical practice and of interest to the employer, a regulatory authority, the ministry of health, courts, funding bodies and the General public. These documentations are equally important in policies, procedures and protocols, critical incident/occupational health and safety reports, personnel file, performance appraisal, clinical assessments and published reports/papers. Documentation is the primary form for which payers traditionally reimburse. Systematic documentation should be used to demonstrate how pharmacist interventions improved patient care and should not just be used for reimbursement. Documentation should be complete, complementary, compelling with supportive evidence, standardized and systematic to complement oral communication among providers [8].

Brunero, & Stein-Parbury, (2011) [12] is of the opinion that documentation should reflect patient agreement with the care plan among multiple providers in terms of medication reconciliation, data collection, continuity of care, and the transitioning of care. Practitioners should maintain treating the patient in line with documentation and rather than interpreting laboratory result. Diverse documentation methods must be adopted to record pharmacist interventions, comprising unstructured notes, semi structured notes, and systematic records.

Cranor, et.al (2013) [13] equally noted that documentation should be clear concise, legible, non-judgmental, patient focused, and standardized, and it should ensure patient confidentiality. Also, in most cases, clinician record seems to be in professional capacity in relation to the provision of patient care. Systematic documentation provides completeness, consistency, and organization. Documentation without a systematic structure may be time consuming and confusing, especially if pharmacist varies the placement of information from different sources. One example involves the placement of a patient's height, weight, and allergies. A clinician may document this information in the subjective field, while another one may place it in the objective field.

II. OBJECTIVES OF THE STUDY

The research aims to achieve the following objectives:

a. To assess the level of effectiveness of clinical documentation among medical doctors in Federal Teaching Hospital, Ido-Ekiti
b. To identify the importance of clinical documentation to patient management in Health Institution
c. To determine the perceptions of medical doctors on clinical documentation in the hospital

III. METHODOLOGY

The Research work was conducted at Federal Teaching Hospital, Ido-Ekiti, a hospital of 300-bed capacity and the only Federal Teaching Hospital in Ekiti State, Nigeria.

Descriptive survey research design was adopted for the study. Data was generated from the respondents on importance of effective clinical documentation to patient care management.

The research design is concerned with the totality of the plan used in executing a research study. It lays out the plan for investigation the research questions and details of the study which flows from the specific questions asked. [14]

All medical doctors were solicited to partake in the study. Thus, three hundred and twenty (320) questionnaire were administerd in which three hundred (300) questionnaires were returned, yielding 93.75% response rate. According to Sekaran (2000), [15] a response rate of thirty percent (30%) is regarded as acceptable for most research purposes. This good response rate can be attributed an informed decision through personal interview of the respondents in which the purpose and objectives of the research was well explained to the respondents .

The sample (n=320) comprised of males and females, permanent doctors/physicians and contract employees spanning across the following professional classes: Consultants/PhD, Senior Registrar, Registrar, House officers and other medical doctors who are not specialized

- *Methods of Data Collection*

Data collected was analysed using descriptive statistics. The descriptive statistics was used to present details of the demographics using frequencies, percentages, means and standard deviations.

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➢ *Ethical Consideration.*

After the participants were duly informed of the purpose and users of the study, their right to either stay or withdraw from the study and after assurances of utmost confidentiality of data to be obtained, informed consent was received from them.

IV. RESULTS AND DISCUSION

➢ *Demographic Information*

Age group	Frequency	percentage
20-29 years	56	18.7
30-39 years	58	19.3
40-49 years	146	48.7
50yrs and above	40	13.3
Total	300	100.0

Table 1:- Distribution of respondents by Age

In the table 1 above, the result reveals that respondents age 40-49 years has the percentage of 48.7% while those at age level 30-39 years are 19.3% and those that are below 30 years are 18.7% while those at above 50years constitute 13.3%. This shows that the majority of the respondents were within 40-49 years age bracket.

Gender	Frequency	Percentage
Male	180	60.0
Female	120	40.0
Total	300	100.0

Table 2:- Distribution of respondents by gender

Table 2 shows that 220 (73.3%) of the respondents were male while 120 (40.0%) were female. It can be inferred from the analysis that male constituted the greater majority of respondents.

Years of practice	Frequency	percentage
1-5 years	26	8.7
6-10 years	37	12.3
11-15 years	64	21.3
16-20 years	115	38.3
More than 20 years	58	19.3
Total	300	100.0

Table 3:- Distribution of respondents by Year of practice

The distribution of the respondents by years of practice shows that 115 (38.3%) are within 16-20-years of practice; 64 (21.3%) were within 11-15yrs of practice, 58 (19.3%) were within more than 20yrs, while 37 (12.7%) were within 6-10years while 1-5years constitute the least with 35 (8.7%). This result implies that highest percentage of the respondents are within 16-20yrs in practice.

Professional status	frequency	percentage
House officers	70	23.3
Registrar	110	36.7
Senior registrar	50	16.7
Consultants	40	13.3
Professor	30	10.0
Total	300	100.0

Table 4:- Distribution of respondent by professional status

Table 4 presents A professional status of respondents. The result shows that, Registrar has the highest frequency of 110 (36.7%), followed by the house officers with 79 (23.3%), senior registrars have 50 (16.7%), Consultants have 40 (13.3%) while professor constitutes the least with 30 (10.0%). This therefore implies that majority of the respondents are registrar.

Year of cadre	Frequency	Percentage
1-5years	37	12.3
6-10years	145	48.3
11-15years	60	20.0
16-20years	41	13.7
21 above	17	5.7
Total	300	100.0

Table 5:- How long have you been in the cadre?

The above result shows that 145 (48.3%) are within 6-10years in cadre, 60 (20.0%) were within 11-15years in cadre, 41 (13.7%) were within 16 -20 years in cadre, 37 (12.3%) were within 1-5yrs while 21years above constitute the least with 17 (5.7%). This result implies that majority of the respondents are within 6-10years in cadre.

	Yes	No
Manual health record	203 (67.7%)	97 (32.3%)
Electronic health record	214 (71.3%)	86 (28.7%)
Hybrid health record	218 (72.7%)	82 (27.3%)
Computerized medical record	208 (69.3%)	92 (30.7%)

Table 6: Do you use these types of health records in your healthcare institution?

Type of health records being used in health care were revealed in table 6. It was made evident that a larger percentage, 218 (72.7%) of the sampled population claimed hybrid health record, 214 (71.3%) claimed electronic health record, 208 (69.3%) claimed computerized medical record, 203 (67.7%) claimed manual health record.

	Frequency	percentage
Manual health record	50	16.7
Electronic health record	154	51.3
Hybrid health record	96	32.0
Total	300	100.0

Table 7:- Which of these types of health records do you think is best to achieve quality clinical documentation?

From the above table, 154 (51.3%) claimed that electronic heath record is the best to achieve quality clinical documentation, 96 (32.0%) claimed hybrid health record while 50 (16.7%) claimed manual health record. The result implies that electronic health record would be the best to achieve clinical documentation in health sector.

- *Research Question:*

What is the importance of clinical documentation by medical doctors on patient care management?

Item	strongly Agree	Agree	Disagree	Strongly Disagree	Mean
To document professional work/records of the patient.	108 (36.0%)	97 (32.3%)	58 (19.3%)	37 (12.3%)	2.08
To serve as the basis for organization and continuity of care of the patient by the practitioner.	116 (38.7%)	91 (30.3%)	63 (21.0%)	30 (10.0%)	2.02
To serve as the basis for subsequent continuity of care of the patient	120 (40.0%)	100 (33.3%)	50 (16.7%)	30 (10.0%)	1.97
To serve as recording for use by other practitioners who may serve the patient in future.	115 (38.3%)	90 (30.0%)	61 (20.3%)	34 (11.3%)	2.05
It serves as a meaningful data regarding the patient care management.	109 (36.3%)	96 (32.0%)	62 (20.7%)	33 (11.0%)	2.06
For risk management purposes	127 (42.3%)	75 (25.0%)	58 (19.3%)	40 (13.3%)	2.04
To protect against malpractice lawsuits and professional discipline	130 (43.3%)	82 (27.3%)	52 (17.3%)	36 (12.0%)	1.98
To aid in defending effectively against any such lawsuits or complaints.	117 (39.0%)	90 (30.0%)	71 (23.7%)	22 (7.3%)	1.99
To comply with legal regulatory and institutional requirements that will assure compliance with clinical documentation	128 (42.75)	84 (28.0%)	63 (21.0%)	25(8.3%)	1.95
For recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations and rules.	116 (38.7%)	86 (28.7%)	65 (21.7%)	33 (11.0%)	2.05
To facilitate quality assurance and utilization review.	132 (44.0%)	82 (27.3%)	62 (20.7%)	24 (8.0%)	1.94
To record professional activities, process and substance of assessment.	132 (44.0%)	82 (27.3%)	62 (20.7%)	24 (8.0%)	1.93
Differential diagnosis, treatment and service planning, clinical decision.	104 (34.7%)	105 (35.0%)	62 (20.7%)	29 (9.7%)	2.05
Making and the results of treatments and other services provided.	119 (39.7%)	80 (26.7%)	69 (23.0%)	32 (10.7%)	2.05
To facilitate coordination of professional efforts by fostering communication and collaboration between members of the treatment team.	124 (41.3%)	85 (28.3%)	55 (18.3%)	36 (12.0%)	2.01

Table 8:- showing frequency distribution, mean and standard deviation of the purpose of clinical documentation by medical doctors on patient care management?

Table 8 reveals the purpose of clinical documentation by medical doctors on patient care management. The mean point cut-off of 2.00 above was used to the purpose of clinical documentation. The mean result shows that the greater proportion of the respondents claimed that the purpose is to document professional work/records of the patient. (mean =2.08,SD=1.02), followed by 'It serves as a meaningful data regarding the patient care management. With (mean=2.06, SD=1.01) third in the rank, 'It serves as recording for use by other practitioners who may serve the patient in future. This is in line with [16] that good documentation among doctors and nurses commonly resulted in effective treatment of patient's and indication for less medical error. 'For recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations and rules' 'differential diagnosis, treatment and service planning clinical decision ' and 'making the result of treatments and other services provided' has equal mean value of 2.05, with standard deviation of 1.02, 1.02, 0.97,1.03 respectively. Also, 'for risk management purposes ' has (mean=2.04,SD=1.07) while the least level among the rank that is below the mean cut-off point is 'to record professional activities, process and substance of assessment'(mean=1.93, SD=0.98). This result reveals that major importance of clinical documentation on patient care management is to document professional/records of patient since it has the highest mean value of 2.08.

What are the perceptions of medical doctors on clinical documentation in the hospital?

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Item	Strongly agree	Agree	Disagree	Strongly disagree	Mean	SD
I am capable of documenting patient information based on the federal guidelines	101 (33.7%)	90 (30.0%)	71 (23.7%)	38 (12.7%)	2.15	1.0-
Use of clinical documentation provide a basis for follow-up	109 (36.3%)	99 (33.0%)	63 (21.0%)	29 (9.7%)	2.04	0.9-
Clinical document contain real and factual fact	128 (42.7%)	80 (26.7%)	52 (17.3%)	40 (13.3%)	2.01	1.0-
Have the ability to hand write large amounts of information about the patient during the consultation.	127 (42.3%)	82 (27.3%)	60 (20.0%)	31 (10.3%)	1.98	1.0-
Demonstrate the knowledgeand skills necessary to document patient care as dictated by a physician in a legible and clear manner.	113 (37.7%)	88 (29.3%)	68 (22.7%)	31 (10.3%)	2.06	1.0-
Use of clinical documentation helps in continuity of evaluation of patient	111 (37.0%)	97 (32.3%)	66 (22.0%)	26 (8.7%)	2.02	0.9-
Adequate knowledge of computer usage	128 (42.7%)	82 (27.3%)	62 (20.7%)	28 (9.3%)	1.97	1.0-
Ability to operate viewing on computer monitors for extended periods of time	130 (43.3%)	89 (29.7%)	57 (19.0%)	24 (8.0%)	1.92	0.9--
Demonstrate an ability to maintain confidentiality and privacy in accordance with regulations of the organization.	130 (43.3%)	77 (25.7%)	61 (20.3%)	32 (10.7%)	1.98	1.03
With use of accurate clinical documentation, we can reduce errors	122 (40.7%)	86 (28.7%)	55 (18.3%)	37 (12.3%)	2.02	1.0
Document the correct time of patient care related activities.	122 (40.7%)	85 (28.3%)	59 (19.7%)	34 (11.3%)	2.02	1.03
Document the physician dictated patient history, including history of present illness	158 (52.7%)	71 (23.7%)	41 (13.7%)	30 (10.0%)	1.81	1.02
Complete and present the medical record in collaboration with the supervising physician	159 (53.0%)	72 (24.0%)	40 (13.3%)	29 (9.7%)	1.80	1.0
Maintain and demonstrate an understanding of the team approach to patient care and documentation	155 (51.7%)	75 (25.0%)	42 (14.0%)	28 (9.3%)	1.81	1.0
When the physician concludes the patient's encounter, the physician will review all documentation	152 (50.7%)	79 (26.3%)	45 (15.0%)	24 (8.0%)	1.80	0.9
Physical examination, patient diagnosis and procedures as performed by the physician	152 (50.7%)	85 (28.3%)	34 (11.3%)	29 (9.7%)	1.80	0.9

Table 9: showing frequency distribution, mean and standard deviation of the perceptions of medical doctors on clinical documentation in the hospital

Enquiring about perceptions of medical doctors on clinical document with a mean cut-off point of 1.94 shows that 63.7% of the sample population were of the strong opinion that 'they are capable of documenting patient information based on the federal guidelines' while 36.3% disagreed on the opinion (mean=2.15, SD=1.03). Only 67.0% of the study sample believed strongly that 'demonstrate the knowledge and skill necessary to document patient care as dictated by a physician in a legible and clear manner' while the remaining 33.0% disagreed strongly (mean=2.06, -SD=1.01). Also 69.3% of the total respondents agreed that 'use of clinical documentation provide a basis for follow-up' but the remaining 30.7% disagreed (mean=2.04, SD=0.98). 'Use of clinical documentation helps in continuity of evaluation of patient' 'with use of accurate clinical documentation, we can reduce errors ' and 'Document the correct time of patient care related activities' has equal mean value (mean=2.02, with different SD=0.94, 1.04 & 1.03). Also, 69.4% of the respodents claimed that Clinical document contain real and factual fact while 30.6% did not (mean=2.01, SD=1.07). This agrees with [18] 'Have the ability to handwrite large amount of information about the patient during the consultation' and 'Demonstrate an ability to maintain confidentiality and privacy in accordance with regulations of the organization' has equal mean value of 1.98 with SD=1.02 &1.03 and the least in the rank that is lower than the cut-off is 'when the physician concludes the patient's encounter, the physician will review all communication' with (mean=1.80, SD=0.97).

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Item	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	SD
Facilitate provision of health care to the patient	107 (35.7%)	102 (34.0%)	61 (20.3%)	30 (10.0%)	2.05	0.98
It improves data for medical audit	116 (38.7%)	89 (29.7%)	51 (17.0%)	44 (14.7%)	2.08	1.07
It improves accuracy and quality of patients clinical data entry	118 (39.3%)	85 (28.3%)	67 (22.3%)	30 (10.0%)	2.03	1.01
Reduces error of medication	113 (37.7%)	95 (31.7%)	56 (18.7%)	36 (12.0%)	2.05	1.02
Assesses quality of care through a descriptive examination	119 (39.7%)	88 (29.3%)	59 (19.7%)	34 (11.3%)	2.03	1.02
promotes medical examination	126 (42.0%)	89 (29.7%)	53 (17.7%)	32 (10.7%)	1.97	1.01
Develops plans that minimises the risk and maximises potential benefits to patients.	145 (48.3%)	79 (26.3%)	57 (19.0%)	19 (6.3%)	1.83	0.95
It is a bases for patient's continuity of care and encourages charting performed at the patient's bedside instead of consultation room	118 (39.3%)	95 (31.7%)	56 (18.7%)	31 (10.3%)	2.00	1.00
It enhances effective and reliable patient's information	103 (34.3%)	93 (31.0%)	71 (23.7%)	33 (11.0%)	2.13	1.02
It is usually perfect because clinicians are trained on documentation	113 (37.7%)	95 (31.7%)	61 (20.3%)	31 (10.3%)	2.03	1.00
Promotes concern, reduces mistake and increase confidence in the data	116 (38.7%)	100 (33.3%)	57 (19.0%)	27 (9.0%)	1.98	0.97
Clinicians do not see the need for legible handwriting as this could promote the documentation process	1191 (39.7%)	84 (28.0%)	70 (23.3%)	27 (9.0%)	2.02	1.00
No formal policy on patient clinical documentation.	125 (41.7%)	82 (27.3%)	65 (21.7%)	28 (9.3%)	1.99	1.01
There is a language problem during documentation	126 (42.0%)	95 (31.7%)	48 (16.0%)	31 (10.3%)	1.95	1.00
Time is needed enough for a comprehensive documentation	118 (39.3%)	99 (33.0%)	64 (21.3%)	19 (6.3%)	1.95	0.93
It forms the basis of clinical coding	112 (37.3%)	107 (35.7%)	55 (18.3%)	26 (8.7%)	1.98	0.95
Quality and comprehensive care is assured	119 (39.7%)	95(31.7%)	58 (19.3%)	28 (9.3%)	1.98	0.98
Promotes consultation and patient waiting time	126 (42.0%)	83 (27.7%)	62 (20.7%)	29 (9.7%)	1.98	1.01
Generates error in clinical coding due to bad handwriting	127 (42.3%)	82 (27.3%)	56 (18.7%)	35 (11.7%)	2.00	1.04
Providers use consistence language and specific diagnostic terms to provide complete information	124 (41.3%)	102 (34.0%)	53 (17.7%)	21 (7.0%)	1.90	0.93
It supports high quality patient care that leads to accurate, relevant, confidential, reliable, valid and complete services	103 (34.3%)	93 (31.0%)	67 (22.3%)	37 (12.3%)	2.13	1.02
It is clinically important, patient -centred, and represents an individual's lifetime health and healthcare	141 (47.0%)	81 (27.0%)	55 (18.3%)	23 (7.7%)	1.87	0.97
problem-oriented presentation of patient data favours higher-quality interactions at the bedside, during ward rounds, and between nurses and physicians.	114 (38.0%)	85 (28.3%)	72 (24.0%)	29 (9.7%)	2.05	1.00

Table 10:- Showing of frequency distribution, mean and standard deviation of the aspect at which patient care relate to clinical documentation

The above table showed the aspect of patient care that clinical documentation related to. The result shows that 64.3% agreed that 'It enhances effective and reliable patient's information ' and it supports high quality patient care that leads to accurate, relevant, confidential, reliable, valid and complete services' while 35.7% disagreed. 68.4% of the respondents agreed that 'It improves data for medical ' while 31.6% disagreed on the opinion. Also, 69.7% strongly agreed that it 'facilitates provision of health care to the patient ' and 'reduces error of medication' while the remaining 30.6% disagreed. More so, 69.4% of the response strongly agreed that 'It is usually perfect because clinicians are trained on documentation' while 30.6% disagreed. This agrees with Devkaran and O'Farrell (2014) [18] who pointed out that implementation and proof of compliance to Standards and efficient hospital care are dependent on quality clinical documentation.

Furthermore, the aspect of patient care on clinician documentation can be determined by an average mean score of 2.00. The mean cut-off point of 2.00 was used to consider the aspect of patient care. Details of the analysis revealed that 10 items had above 2.00, item 9 and 21 was an evidenced by highest mean score of 2.13 (SD=1.02) followed by item 2 with mean=2.08 (SD=1.07). This result implies that the clinical document enhances effective and reliable patient's information and supports high quality patient care that leads to accurate, relevant, confidential, reliable, valid and complete services.

V. CONCLUSION

The strategies to maintain quality documentation practice has to do with the systems and policies that are being operated in the hospital and how strictly the policies are being adhered to. Specifically, it includes; Effective system to support accurate and concise documentation of practice in medical records, appropriate policies and procedures in relation to effective documentation systems, practices and management of patient health information, risk management strategies that support effective documentation of practice (including incident reporting) and the provision of adequate time allocation to document appropriately and review previous documentation as part of patient care.

This study has shown that Medical doctor's clinical documentation form the basis of clinical coding for adequate patient care management. Several guidelines /standard in coding calls for disease and intervention codes based on physician information. However, these diagnoses must be further supported by physician documentation to be classified as significant co-morbidities. Therefore, physician documentation directly drives what is reported in the clinical data. Inadequate clinical documentation can lead to inaccurate code assigned to patient which may lead to inaccurate representation of patient care. Studies have also noted that, lack of accuracy in the documentation, for example, where the final diagnosis following discharge was not correctly recorded in the discharge may lead to errors. The relationship that exists between clinical documentation and physician's perception is a determinant to what happen to the patient care management.

RECOMMENDATIONS

The following recommendations are made based on the findings of the study:

- Physicians should be encouraged to comply with legal regulatory and institutional requirements for proper clinical documentation.
- Physician should strictly adhere to the policy and standard in clinical documentation to minimize level of errors if not totally eradicated.
- There should be medical follow up by the physicians and drug administration should be done based on proper diagnosis of patient.
- Where necessary, an electronic based clinical documentation should be encouraged at every health institution to also limit errors and enhance accuracy and speed in documentation.

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