Completeness Of Nursing Evaluation Documentation In Integrated Patient Development Records In Diabetes Mellitus Patients In A Palembang Hospital

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ABSTRACT

Background: Diabetes mellitus is a chronic disease that has increased to 76.77% globally. Patients with diabetes mellitus need continuous Care in the nursing process. Documentation of integrated diabetes mellitus nursing evaluation in progress notes is a communication tool in integrated Care carried out by professional caregivers in providing health services to diabetes patients. Incomplete documentation will form an unfavorable framework that will exacerbate the PPA framework because documentation is essential for the professional practice of doctors, nurses, pharmacists and nutritionists to avoid unexpected events (KTD), medication errors Hospital intervention errors. Objectives: This study looks at the factors that most influence PPA in documenting integrated patient development records in the Inpatient Room of A Hospital Palembang. Research Methods: The research design is a non-experimental or analytic survey with a cross-sectional approach. The research was conducted from April 27, 2023, to May 17, 2023. The population in this study were caregivers consisting of doctors, nurses, pharmacists and nutritionists. The sampling technique for this study was proportional random sampling with a total sample of 72. The data analysis used was Chi-Square. Results: The description of the results of this study shows that the research conducted at Hospital A found Integrated Patient Progress Notes completeness by four professional care providers but incomplete integrated patient progress notes filling was found at 76.4% Conclusion: Obtained incomplete documentation of integrated patient progress notes at Hospital A Palembang.

Keywords: Nursing Documentation, Nursing Evaluation, Integrated Progress Notes, Diabetes Mellitus.
INTRODUCTION

The paradigm of health services has begun to change by focusing health services on patients. It no longer places one profession as the center of service, but requires integration of Care from various service-giving professions (Healy, J. and Dugdale, P. 2009). Patient-focused services require integrated documentation that requires each profession to record on the same document. This method is expected to increase effective communication between professions, record keeping can be done more optimally because all professions write on the same document, minimize miscommunication, reduce the number of unexpected events and in the end it all aims to improve patient safety and have an impact on improving service quality. (Frelita, G, Situmorang, T.J & Silitonga, D.S. 2011).

One sign of the lack of communication between the various health care professions is the continued use of separate medical records from treatment records and other health professional records to record patient conditions. The notes made do not describe information about the patient's response and the things the patient feels, in fact many observations are not recorded in the medical record. To improve the quality of medical records is to integrate health professional records into one integrated patient record, namely integrated patient progress notes. Improving service quality by providing services efficiently and effectively, namely by adjusting professional standards, service standards according to patient needs, utilizing appropriate technology and research results to develop health or nursing services so that optimal degrees are achieved (Nursalam, 2012).

Internationally, the effectiveness of the quality management system to improve service quality and patient safety in Hospitals is not convincing enough. Quality management systems have a different focus than clinical service quality and patient safety (Healy, J. and Dugdale, P. (eds) 2009). In Indonesia patient safety has become a serious concern. The first research was conducted by Sutoto, et al. (2017) Hospitalized in 17 Hospitals with 4500 medical records, the results showed that the incidence of adverse events varied widely, namely: 8.0% to 98.2% for diagnostic error Hospitals and 4.1% to 91.6% for medication errors, 8.2% to 98.4% for intervention errors.

In Indonesia, the quality of health and patient safety services has a strong legal basis. Law (UU) on health no 36/2009 mandates that safe, quality and affordable health services are the government's responsibility and everyone's right (articles 5 and 19) (Ministry of Health Republic of Indonesia. 2011). The number of reports about errors of health workers in providing services means that the government no longer places one profession as a service center, but requires integration of Care from various service provider professions by documenting integrated patient development records (Hospital Accreditation Commission. 2017).

Integrated patient progress notes are documentation records carried out by health workers to coordinate or collaborate between health workers in documenting health services to patients. The integrated patient development record (integrated patient progress notes) is a tool for communicating between health teams, where communication is the delivery of information in a face-to-face interaction containing ideas, feelings, concerns, meanings, and thoughts given to the recipient of the message with the hope that the recipient of the message will use the
information to change attitudes and behavior.

Some forms of implementation of integrated Care are documentation carried out by doctors, nurses, pharmacists and nutritionists. Documentation carried out in integrated notes is in the form of progress notes written based on subjective data (S), objective data (O), Data Analysis (A) and Planning/planning (P). Integrated documentation can be used as written evidence of the activities carried out by multidisciplinary health workers in the inpatient room. Documentation is said to be complete if the records carried out by doctors, nurses, pharmacists and nutritionists comply with the Hospital's standards to protect health workers Hospital against legal problems that occur (Hariyati, Tutik Sri. 2014).

Documentation is a proof of health services that contains recording activities, authentic reporting and storage of all activities related to client management that can be used to reveal an actual and accountable fact. Documentation in the medical record is a means of communication between health professionals in providing services to patients. The communication in question is interprofessional communication that aims to prevent misinformation, interdisciplinary coordination, preventing repeated information, assisting nurses in time management (Khler, J, Hafner, Spelz, L.M, Steen, S & Weaver, K. 2019).

Incomplete documentation in the treatment room according to Laitinen, Kaunonen and Astedt-Kurki (2010) in Hariyati (2014), one of the reasons is that multidisciplinary health workers do not document the patient’s previous medical history and quality of life. According to a study conducted by Bergh (2017), inadequate documentation is caused by the incompatibility of the stages of the documentation process.

Incomplete documentation will form an unfavorable framework that will exacerbate the framework of the health team, because documentation is important in relation to professional practice of doctors, nurses, pharmacists and nutritionists so that the services provided to patients are inaccurate, inefficient and will have a negative impact on the performance of health workers Hospital and other professions, such as increasing demands from the community so that people’s knowledge of the rights of the community as recipients of health services (Dinarti & Ratna Aryani. (2019).

Research conducted by Rebbi (2016) found that as many as 23.4% of 536 visits in July 2015 to the Non-Surgical room were returned from the medical records department to the room due to incomplete status filling. In several statuses, names and signatures for filling out progress notes were not found, so they cannot be held accountable. In the 5 (five) statuses that the researchers took randomly, there was no filling out of the planning (P) that had to be done by the doctor, 3 (three) other statuses, there was no match between progress notes made by nurses and nutritionists with progress notes made by doctors, 3 (three) status integrated patient progress notes were not filled out by pharmacists. By default, this integrated care filling must be filled in at least once every 24 hours or when conditions change patients, but in the status that the researchers observed, integrated Care was only filled after 2 (two) days of patient care.

Hospital A is a type C Hospital with an Islamic nuance in Palembang. The vision of this Hospital is to become the best choice Hospital in South Sumatra with Islamic services. From the medical record data, the completeness of the medical
records for 3 (three) months was 92% complete, 8.0% incomplete for November 2022 and December 94% complete, 6.0% incomplete, while January 2022 was 95% complete and 5.0% incomplete (Medical Records of Siti Khadijah Islamic Hospital, 2023).

Based on a preliminary study conducted by researchers on April 20, 2023 in the Medical Records section of Paembang A Hospital, from medical record data on Diabetes Mellitus patients, it was found that in 2021 there were 501 patients, in 2022 there were 682 patients and in 2023 from January to May there were 287 patients. This is the basis for researchers to choose cases of Diabetes Mellitus, which is the ten most common disease every month, in A Palembang Hospital and is a metabolic disease that needs effective interdisciplinary communication.

METHODOLOGY

The type of research used is quantitative research with a cross-sectional design approach, where data is collected at the same time and once data is collected (Sugiono, 2012). The population in the study amounted to 72 people, the sample was obtained by random sampling. The questionnaire that was distributed previously was tested for validity and also carried out an ethical test at the research ethics committee of the medical faculty of Andalas University with number 239/KEP/FK/2018. This research was conducted from April 27 2023 to May 17 2023 by giving questionnaires to respondents who fit the criteria, namely willing to become respondents, PPA is not currently on leave, training and education, INTEGRATED PATIENT PROGRESS NOTES sheets for inpatients who have been treated ≥ 1 day/24 hours.

RESULTS

The variable of integrated patient development record documentation (integrated patient progress notes) by health workers is in a categorical form so that it is analyzed by proportion and presented in a frequency distribution table. In detail can be seen in the table below:

<table>
<thead>
<tr>
<th>Hospital Documentation of integrated patient progress notes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>17</td>
</tr>
<tr>
<td>Uncomplete</td>
<td>55</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
</tr>
</tbody>
</table>

DISCUSSION

The completeness of the integrated patient development record documentation in the table above can be concluded that at A Hospital in Palembang City, almost all of the INTEGRATED PATIENT PROGRESS NOTES were not filled in entirely by caregiving professionals. The results of a study conducted at A Hospital Palembang found that there were 55 (76.4%) integrated patient development records incomplete and 17 (23.6%) completely filled out.

This is due to the absence of supervision in filling out management's integrated patient progress notes. According to Etidawati's research (2012), there is a relationship between supervision carried out by the head of the room on the completeness of nursing care documentation in INTEGRATED PATIENT PROGRESS NOTES. The same thing was conveyed by Agung's research (2019), regarding the supervision of the head of the room for the implementation of nursing care documentation, showing a relationship between supervision of the
implementation of nursing care documentation.

The results of this study are in line with research conducted by Rebbi (2016) at M.Djamil Hospital Padang, which found that only 16.7% of health workers filled out the form completely, meaning that most or approximately 83.3% were incomplete in documenting the integrated patient progress notes. From the results of this study it can be concluded that more than half of the health workers were incomplete in carrying out integrated patient progress notes documentation.

Integrated Care is a team activity consisting of doctors, nurses, nutritionists and pharmacists in carrying out integrated Care in one medical record location, which is carried out in collaboration from each profession. Integrated services are oriented towards the interests of the patient and are not dominated by one particular profession, as before doctors were the sole care provider. Why should that be the case, because the current profession has developed so rapidly that it is no longer possible for doctors to fully master their knowledge. Of course this will have a very positive impact on the quality of health services (Sutoto, et al. 2017).

Integrated patient progress notes are records carried out by health workers to coordinate or collaborate between health workers in documenting health services to patients. The form of implementation of integrated Care is documentation carried out by doctors, nurses, pharmacists and nutritionists. Documentation carried out in integrated notes is in the form of progress notes written based on subjective data (S), objective data (O), Data Analysis (A) and Planning/planning (P). Integrated documentation can be used as written evidence of the activities carried out by multidisciplinary health workers in the inpatient room. Documentation is said to be complete if the records carried out by doctors, nurses, pharmacists and nutritionists comply with the Hospital's standards to protect health workers from legal problems (Hariyati, Tutik Sri. 2014).

The completeness of the integrated patient development record for health workers who did not complete the integrated patient progress notes documentation at most were pharmacists and nutritionists at a hospital, as much as 70.2%. Integrated patient progress notes documentation is very important, considering that the documentation carried out by health workers will be used as material for evaluating the performance of health workers and for accountability and accountability. Patient-focused services require integrated documentation that requires each profession to record on the same document in order to improve service quality by providing services efficiently and effectively.

Based on the researcher’s analysis that from several health workers at a hospital in the city of palembang related to integrated patient progress notes Diabetes Mellitus, which is complete in filling out, can be seen from several factors including a lack of understanding of the benefits of filling in integrated patient progress notes, besides that health worker also lack support from superiors in completing and the lack of Hospitals facilitating filling it.

CONCLUSION
The conclusions from the results of the research on the completeness of integrated patient development record documentation (integrated patient progress notes) are as follows: Documentation of integrated patient development records (integrated patient progress notes) Diabetes Mellitus in a hospital in Palembang was 76.4%
incomplete.

SUGGESTION
Suggestions for professional care givers:

a. Professional care providers need to increase their knowledge of integrated patient care and the impact of implementing it.

b. Care giving professionals need to increase their internal motivation to document the integrated patient progress notes ultimately to improve patient-focused care quality.

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