PHYSIOTHERAPY SERVICE WITHOUT DOCUMENTATION AT A COMMUNITY BASED REHABILITATION FOR CHILDREN WITH DISABILITIES IN MAKASSAR CITY: A CASE STUDY OF PHYSIOTHERAPIST’S PERSPECTIVE

Triana Karnadipa1, Ari Nurfitri2
1Physiotherapy Department, Vocational Education Program of Universitas Indonesia
2Hospital Administration, Vocational Education Program of Universitas Indonesia
Corresponding Email: trianakarnadipa@gmail.com

ABSTRACT
This study aims to analyse the consequences of a lack of documentation in a community-based rehabilitation (CBR) unit for children with disabilities. 278 hours of observation and two structured interviews were conducted. Observation notes were depicted in a fishbone chart and interview findings were coded manually in a series of open, axial, and selective coding. The findings, field notes, and self-reflective notes were triangulated and link thematically. The findings revealed that the unit does not yet have a standardised documentation guidelines and forms. Failures to address children’s needs and progress, inability to modify the intervention and audit the quality of care based on evidence and lack of confidence in the therapists’ professionalism are the common problems experienced by the therapists due to lack of record-keeping. These are evaluated as contributing factors to risks of patients safety and poor quality of care. While the needs of CBR units are greatly increased for people with disabilities, CBR organisations and the Indonesia physiotherapy association need to cooperate in order to develop a clear clinical pathway and standardised documentation for a CBR context.

Keywords: Patient safety, risk analysis, community-based rehabilitation, children, disability

INTRODUCTION
Patient safety has been accounted for as a worldwide issue due to the recognition that patients can be harmed by their healthcare (Bates, Larizgoitia, Prasopa-Plaizier, & Jha, 2009; Haxby, 2010). This concern has led national and international healthcare organisations to take initiatives to improve patient safety and the quality of care. Nevertheless, a report from the National Patient Safety Agency (NPSA) for children and young people suggests that there have been more than 60,000 incidents in the community health service (NPSA, 2009). This fact revealed that, in a developed country such as the UK, the improvement of patient safety is challenging for staff working with children with disabilities. However, it can be argued that it would be more challenging in developing countries with limited resources and different cultures, values, and beliefs (Raghavendra, 2013).

In developing countries, people with disabilities live in poverty, stigmatisation, and limited access to health care (Achu et al., 2010). Therefore, in 1978, the World Health
Organization (WHO) (2010) established and implemented the community-based rehabilitation (CBR) approach as a strategy to improve access to health and rehabilitation services for people with disabilities in developing countries, including Indonesia. The CBR framework of a non-government organisation (NGO) in a contract of public-private partnerships with the government has a multisectoral yet complex management structure. Under the contract, the CBR managers are responsible for designing, establishing, and maintaining the infrastructure as well as providing service while receiving financial support from the government (EPEC, 2012).

While documentation has been identified as an aspect that needs to be improved in the implementation of CBR, Kuipers, Wirz, & Hartley (2008) suggested that clear guidelines, procedures, and strategies for documentation, data collection and analysis should be established to ensure that the measurement of the users’ needs and outcomes are accurate. In addition, Francis (2013) suggested that the policies, guidance, and strategies should abide by fundamental standards to protect the quality of service provided.

Harrison, Wai, & Cohen (2015), however, revealed that there is a lack of evidence of safety incidents among paediatric patients in Southeast Asia. Nevertheless, the NPSA report showed that in the UK, the problems with documentation have been identified as the sixth most common incidents (8%) involving children and young people. Even though there is no specific patient safety surveillance agency for children and young adults available in Indonesia, it could be argued that these incidents might more frequently happen in Indonesia. Furthermore, these errors are most likely to occur when an organisation does not have any standardised templates of documentation leading to an ineffective plan of care (Pearson, 2008).

This present paper examines the care delivery of a community-based rehabilitation unit for children with disabilities in Makassar city. This case study of the rehabilitation unit aims to (1) analyse factors contributing to errors in the care delivery; (2) evaluate possible consequences that might happen due to one of the errors. This paper also aims to inform the health units without documentation the possible problems that may arise from lack of record keeping.

Makassar city is the capital city of South Sulawesi province of Indonesia. According to a report by Kemenkes RI (2018), there are 8,771,970 people living in Makassar city and 8.87% of them live in poverty. The latest report on the prevalence of people older than 15 years old living in South Sulawesi revealed that 23.8% of them have a disability (Kemenkes 2014). This prevalence is the highest compared to other provinces in Indonesia. The report also pointed out that the current health programmes for children with disabilities are to reinforce health clinics in exclusive schools and health guidance for families of the children (Kemenkes 2014). However, a physical rehabilitation programme has not yet developed by the Indonesian government. Therefore, the families, especially those who live in poverty, have to seek help from a community-based rehabilitation for children with disabilities managed by an NGO body.

The Community Based Rehabilitation for Children with Disabilities in Makassar City, the physiotherapy professional authority body in Indonesia and the NGO have not yet established any quality assurance standards, standards and guidance of record-keeping, and standards of proficiency to support decision-making and care planning. Consequently, the physiotherapy staff lack of adherence to record-keeping duty without knowing that they do not achieve their standards of proficiencies. In particular, Pearson (2008) identified this consequence as a breach of duty in which the staffs showed insufficient adherence to history-taking and examination without following the standardised guidance. This way, the staff tend to have inadequate observations and fail to detect and anticipate complications.

**METHOD**

The case study was conducted between January to June 2019. In the first three months, we conducted 278 hours of observation. We observed the service delivery of the rehabilitation unit for in-depth exploration and analysed contributing risk factors to patient safety (Yin, 2014). Observation notes and recorded observations in minutes were taken. The observation notes were analysed and categorised. The identified factors were analysed in a structured approach using a fishbone chart to ensure the risks are rightly defined (Cleland, Habli, & Medhurst, 2012). Two semi-structured interviews were conducted between April to May 2019, involving two physiotherapists of the rehabilitation unit. Interviewee
participation was voluntary, informed consent taken, and their identity was anonymised for confidentiality. Field notes were taken immediately after the interview. Interview transcripts and observation notes were coded manually and were through the open, axial, and selective coding process (Streubert & Carpenter, 2011). We also used self-reflective notes to check our assumptions and biases. Data generated from all sources were triangulated and linked thematically to identify key findings.

RESULTS

The rehabilitation unit encompasses the geographical area of South Sulawesi Province, Indonesia. The unit provides four hours (9:00 to 12:00) of rehabilitation care in weekdays, in a medium-size (16x24 m) room without proper resources. There were 3 physiotherapists and 43 internship students from two physiotherapy schools who took shifts after 1 to 3 months. The expertise ranged from their first year in the profession to more than 10 years of expertise in paediatric rehabilitation. The students were in the first year of their internships. The unit implements a flexible and unscheduled appointment system and does not have any standardised documentation forms. This unit also keeps receiving the on-going self-referral requests from other provinces to treat children and young people with developmental delays or disabilities.

The fishbone (Figure 1) illustrating four key findings that could contribute to adverse events was made. The consequences of the Measurement/Documentation domain were explored and analysed in this article.

Failure to address the children’s needs and progress

Inability to address the children’s needs and evaluate their progress were prominent problems among the physiotherapists due to lack of documentation. Based on their subjective experiences, most of them had no exact knowledge about the children’s condition and progress. It is because their diagnosis, physiotherapy assessment, and prescribed intervention were not kept in any medical record. Based on our observation, the children were only assessed on the first meeting for their current gross motor function. However, the assessment only based on their developmental age, not on objective and standardised assessment tools. The assessment results were not kept, and the children were not assessed further afterwards. There also no assessment or evaluation conducted following the first assessment.

A physiotherapist said, “Sometimes, it feels confusing... For instance, there is no medical record of the patients that contains their diagnosis, intervention or exercise to what progress they have achieved. As for the assessment…. I think it should be measured objectively.” – D1

This problem also affected the physiotherapy process. Confusion in the selection of therapy techniques was addressed as a prominent barrier in the physiotherapy session. Due to this confusion, they had to ask the family whenever they experienced this confusion. The children’s current condition and what kind of therapies had been given before were mostly asked. One of the therapists also adds that this conduct showed their lack of professionalism.

A physiotherapist said, “One patient was not treated by the same physiotherapist all the time, so there should be a documentation of the patient’s conditions in the form of a medical record. But in this case… because there is medical record such as the patient’s progress and…… the given intervention, we sometimes need to re-anamnesis the patient and their family when they came for a therapy session.” – D8

A physiotherapist said, “When I do that... I feel that I am not professional. This is kind of an irony….” – D5
Altogether, this failure to address the children's needs and progress due to lack of documentation prevented the physiotherapists to design and give a suitable intervention for the children’s current ability and progress. This drawback also affected the therapy process and the therapists’ confidence in their professionalism.

**Inability to modify the intervention and audit the quality of care**

The difficulty to modify the intervention was experienced by the physiotherapists. Because there was no documentation of the evaluation of the therapy, the therapists relied on their memory to design their therapy plan. Furthermore, they found it difficult to know if their current therapy plan was effective or not because of a lack of evidence.

A physiotherapist said, “Sometimes... I find it difficult to modify the exercise, and...... difficult to analyse the appropriate further needs of the exercise.”— D2

A physiotherapist said, “It is.... very difficult to evaluate the prescribed intervention, so we have difficulty in modifying the intervention...” – D9

The therapists also explained that they did not do any audit in their delivery service because there is no record of the patients’ visits.

A physiotherapist said, “Well.... there is no data or documentation. Therefore, it is difficult to know how many patients come in one day.”— D3

Overall, the therapist found it difficult to evaluate their therapy plan and the delivery system without any records of the therapy. Due to this lack of data, the therapist could not improve and reflect on their practice based on evidence. This lack of documentation would lead to a failure to detect ineffectiveness in the therapy and an error in the service.

**Lack of confidence in their professionalism**

As documentation is one of the physiotherapist's standards of proficiency, not doing so means that the therapist does not meet the standards to be acknowledged as a professional. This was recognised by the therapists of the rehabilitation unit. As a consequence, they questioned their delivery of service and their professionalism.

A physiotherapist said, “I try to give my best as a responsibility.... even though I do not do the documentation. Actually... I feel that I am not professional.” – D4

A physiotherapist said, “It is difficult to work without documentation of the patient’s condition... How were their progress.... What kind of intervention that have been prescribed? To be honest.... I don’t know if what I did was right or wrong.” – D6

To conclude, this lack of record-keeping also affected the therapists’ confidence in their
proficiency. A sense of guilt also described by the therapists. It is because they deemed their practice was not appropriate as a professional therapist.

**DISCUSSION**

This study found three consequences arose from a CBR unit without documentation. One of the consequences is lack of confidence in their professionalism. According to the Nursing and Midwifery Council (2018), “Record-keeping is an integral part of Nursing, Midwifery, and Allied Health Professionals’ practice and is essential to the provision of safe and effective care.” In accordance with this, the Chartered Society of Physiotherapy (CSP) regulation (Row, Wc, Tel, & November, 2017) and the NHS Professionals (2010) also state that record-keeping is a vital and legal obligation of physiotherapists. Furthermore, according to the physiotherapist standards of proficiency, the physiotherapists are accountable to keep the records accurate, comprehensive, and comprehensible. They also have to acknowledge the need for managing records and other information in accordance with applicable legislation, protocols, and guidelines (HCPC 2013). Whether using paper-based or electronic records, a documentation template should contain the HSCIC (2013) standardised lists of record heading, and the information should be documented under each heading across the health professions (Health Professions Council, 2013). Effective record keeping has to meet the guidelines (NHS Professionals, 2010) for evaluation and management corresponding with the standard of good practice (Health Professions Council, 2013) being abided by a specific health professional authority (Donn, 2005). Burton & Ormrod (2011) emphasize that the act of not performing documentation or not adhering to record-keeping will be interpreted as a breach of duty or accountability, an act of clinical negligence.

While such standards, resources, guidelines, and templates are not yet established by the Indonesia Physiotherapist Association for the CBR unit, the deficiencies in documentation and the lack of compliance with record keeping are highly likely to happen in their health care services. Even though this problem is only supported by the evidence in clinical practice, Mcgeehan (2007) argue that, while a wide range of literature is available to support and highlight good practice, issues regarding poor documentation continue to be a significant problem in health care. Harris (2003) had reported that, in 2003, 90% of 300 reviewed medical records of patients who had orthopaedic surgeries in the UK were found to provide deficient information for the purpose of medicolegal reports. Surprisingly, in the same year, Mann & Williams (2003) found the incomplete structures, and contents of the medical notes across five hospitals in England and Wales might have a correlation with this deficiency. Dimond (2005) argues that human and system errors might contribute to the deficiencies of medical records. Inaccurate or missing information, errors in spelling and decimals, negligence in history taking, and a disorganised and insecure system of record-keeping have been identified as major factors in the manifestation of adverse events and endanger the safety of the patients (Dimond, 2005). The consequences could cause minor to major injuries or, in the worst case, the death of the patient.

Secondly, Failure to address the children’s needs and progress was significantly addressed by the therapist. It is because that medical records assist the health practitioners in the scientific evaluation and the review of patient management outcomes. Meanwhile, it is also the only way for the practitioners to prove that they have carried out the treatment properly (Thomas, 2009). When the intervention or the examination is not recorded, it is almost likely to assume that it had not been done (Dimond, 2005). Society has entered a litigious era where patients are willfully or, in many cases, are encouraged to complain about health care services that they have received (Mcgeehan, 2007). The legal system relies mostly on the medical records as evidence to aid the defence lawyer. Therefore, it serves as a ‘silent witness’ which could be the best defence for health professionals and be the plaintiff’s best witness (Donn, 2005). When an accusation of negligence is alleged by the patient or his/her relatives, incomplete medical records could be defined as poor protection against the alleged negligence, and no records could indicate that there is no evidence to defend him/her (Thomas, 2009). In many cases, the litigation would proceed due to the lack of documentation, not because of the wrongdoings of a physiotherapist. Thus, the patient’s recollection would be the basis of a claim against the physiotherapist (Hill, 2005). If the records did
not properly document the process of care and did not contain the explanation behind the decision-making, the practitioner’s diagnosis and treatment would be proved to fall below the minimal standards of care. As a consequence, the practitioner could be held liable (Soisson, VandeCreek, & Knapp, 1987). In this case, professional regulatory bodies are permitted to give intervention ranging from simple advice to the withdrawal of the health practitioner’s practise privileges (Haxby, 2010).

Thirdly, inability to modify the intervention and audit the quality of care was also revealed in this study. Improving quality and safety have been a greater priority in the Prudent Healthcare approach and have been identified as of paramount importance in healthcare policies all over the world (Bevan Commission, 2015). Quality improvement (QI) is safeguarded through effective clinical governance while harnessing the clinical audit as the centre of the QI process (Haxby, 2010; Scally & Donaldson, 1998). The clinical audit relies on information and the exchange of data about the quality of provided care from medical records and notes (1000 Lives Improvement, 2014). Olsen et al. (2007) emphasize that real-time medical records contained the widest range of events and information and its review could identify more adverse events and potential adverse events than incident reports, NPSA (2008), however, argues that valuable information about risks and system weaknesses might not be apparent at the local level. Thus, a national learning system is useful to identify the patterns of the event and the key risks. Information from local and national learning system could be used in the clinical audit to guide the team to improve patient safety and the quality of care (Olsen et al., 2007). Specific actions or recommendations for improvement tend to be taken as the results of the audit (CSP 2012). However, missing clinical data has caused substantial failings in clinical governance (Scally & Donaldson, 1998). This inadequate information affects the judgment-making about clinical quality and safety.

CONCLUSION
This study identified four domains contributing to errors in care delivery of a CBR unit for children with disabilities and discussed possible consequences that might happen due to lack of documentation. The needs of CBR units is greatly increased in Indonesia due to limited facilities provided by the government. However, based on our findings, the CBR unit in Makassar City did not conduct documentation on a daily basis and did not have a standardised documentation form. Due to this drawback, the therapists failed to address the children’s needs and progress. Thus, they could not provide evidence-based practice in their unit. Lack of confidence about their proficiency was also addressed by the therapists. This revealed that lack of documentation affected not only the physiotherapy process but also the therapists, personally. The CBR in Indonesia needs to work hand in hand with the Indonesian physiotherapy association to develop a clear clinical pathway and a standardised documentation form. Along with training and long-term application of the pathway, the frequent documentation would be formed as a habit. This way, better quality physiotherapy service through the series of audit and modification would be achieved.

ACKNOWLEDGEMENT
The author would like to thank the children and their guardian, the physiotherapists, the CBR manager and staff who have participated in this study.

REFERENCES
and Behaviours, p. 38.
Cleland, G., Habli, I., & Medhurst, J. (2012). Using safety cases in industry and healthcare. London: Health Foundation Evidence:


EPEC. (2012). The guide to guidance: how to prepare, procure and deliver PPP projects. https://doi.org/10.2867/29497


Olsen, S., Neale, G., Schwab, K., Psaila, B., Patel, T., Chapman, E. J., & Vincent, C. (2007). Hospital staff should use more than one method to detect adverse events and potential adverse events: incident reporting, pharmacist surveillance and local real-time record review may all have a place. Quality and Safety in Health Care, 16, p. 40. https://doi.org/10.1136/qshc.2005.017616


