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DOCUMENTATION PRACTICES WITHIN A QUALITY ASSURANCE FRAMEWORK: MIDWIVES' EXPERIENCES IN THE GREATER ACCRA REGION

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Midwives' Experiences with Documentation Practices

DECLARATION

I, Augustina Yirenkyi Danquah declare that this thesis is the result of my own original work done under supervision. I also declare that with the exception of published materials which were used in this research and was duly acknowledged, this work has not been submitted in any form for any other degree in this university or elsewhere or any tertiary institution.

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ABSTRACT

Midwifery Documentation (MD) is the means by which all care and services rendered to women of the reproductive age, especially during antenatal and postnatal periods are made known to others through either handwritten or electronic means. MD is a major way through which midwifery knowledge is built for the advancement of the profession. This mandatory practice, however, has not received the attention it deserves all over the world due to so many reasons. The theory of Quality Assurance by Avedis Donabedian was used to guide this study to explore midwives' experiences with Midwifery Documentation Practice (MDP) in the Greater Accra Region (GAR) of Ghana. The study employed a qualitative exploratory descriptive design. Thirteen (13) practicing midwives were purposively sampled from the GAR, precisely a district hospital in the Tema metropolitan area. Data was obtained through one-one interview by means of a semi-structured interview guide. The interviews were audio-recorded, transcribed and analyzed using thematic content analysis. Five (5) major themes emerged from the data which included; the structures for Midwifery Documentation Practices (MDP), steps involved in MDP, outcome as a result of MDP, challenges with Midwifery Documentation (MD) and attitude towards electronic documentation. The last two themes emerged in addition to the ones in the Donabedian quality assurance theory. The findings of this study established that midwives experience many challenges with MD. This finding again disclosed that the negative effects of MDP could be avoided and MDP improved if the identified challenges are worked on by the authorities involved in maternal health issues. These findings have implications for midwifery practice and future research in midwifery.

DEDICATION

This work is dedicated to the Almighty God who in His grace has made the impossible possible. I also dedicate this work to my family, especially my husband Mr. Alex Yirenkyi Danquah and daughter Miss Akua ObenewaaYirenkyi Danquah and the entire adopted sons and daughters in the MPhil Nursing group 2019 for their support and assistance which made this a success.

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LIST OF ABBREVIATIONS

DP: Documentation Practices

EHR: Electronic Health Record

GHS: Ghana Health Service

HITECH: Health Information Technology for Economics and Clinical Health

ICM: International Confederation of Midwives

ICN: International Council of Nurses

MD: Midwifery Documentation

MDP: Midwifery Documentation Practice

MHR: Maternal Health Records

MOH: Ministry of Health

NICE: National Institute of Clinical Excellence

NICU: Neonatal Intensive Care Unit

NMC: Nursing and Midwifery Council

NMC-UK: Nursing and Midwifery Council United, Kingdom

PIH: Pregnancy Induced Hypertension

PMTCT: Prevention of Mother to Child Transmission

PPH: Post-Partum Haemorrhage

PS: Patient Satisfaction

QAF: Quality Assurance Framework

SPO: Structure- Process-Outcome

TGH: Tema General Hospital

TMHD: Tema Metropolitan Health Directorate

CHAPTER ONE

INTRODUCTION

This chapter elaborates on the meaning, significance of documentation and the attitude of midwives concerning documentation of midwifery services. The chapter further discusses the impact of documentation on improving and ensuring the quality of services rendered to pregnant women and their unborn babies.

Background to the Study

Comprehensive documentation of midwifery services is of equal importance as the care rendered to clients and can be used as the foundation of building midwifery knowledge, setting the standards of midwifery education and clinical practice. It can also serve as a communication link among health professionals for continuity of care, providing the data for future health planning and risk management (Dike, Olayinka, & Njoku, 2015). Further, accurate documentation of services rendered by a midwife serves as a benchmark for the learning experiences for students as well as for the protection of the clients' rights. Considering that midwives care for two or more persons at a time, the effects of her actions and/or inactions have multiple repercussions on communities and generations yet unborn. Regardless of the obvious benefits of accurate documentation in midwifery, documentation of midwifery services are often incomplete, inconsistent, irregular and inappropriate with the care rendered (Kebede, Endris, & Zegeye, 2017; Nakate, Dahl, Drake, & Petrucka, 2015).

Documentation in midwifery "refers to any and all forms of records done by a midwife in a professional capacity in relation to the provision of midwifery care" (Dike et al., 2015). Documentation is a vital component in nursing and midwifery care, especially for a woman in

labour. It offers evidence of care rendered to women and contains significant information that improves the quality and continuity of care (Broderick & Coffey, 2013). Kerkin, Lennox, and Patterson (2017) described midwifery documentation as a profound piece of work which demonstrates the midwife's responsibility and contribution to research. Good documentation from nurses and midwives is needed as stipulated by the Nurses' and Midwives' regulatory bodies in their guidelines to facilitate the flow of information about clients among all the professionals in the health teams (Instefjord, Aasekjær, Espehaug, & Graverholt, 2014; NMC-UK, 2012).

Documentation serves as a communication link between nurses, midwives and other professionals in the health care settings. Furthermore, documentation serves as proof of care given in cases of lawsuit against the midwife or institution. Midwifery Documentation (MD) as evidence exposes every documentation to the maximum level of analysis. Hence, Dike et al. (2015) were of the opinion that demonstrating knowledge and skills in documentation should be mandatory for midwifery professionals as a standard. Therefore their presentation should be attributable, comprehensible and truthful (NMC-UK, 2017). According to Information Governance Manager, records are the information of any kind completed by, handed over to, established and maintained as a result of the contract and kept as evidence (IGM, 2016). The degree of use of exact practices in the ways of documenting services rendered varies generally across facilities. These differences result from practice style together with both intrinsic and extrinsic factors rather than differences in the needs of women and newborn (Sakala, Yang, & Corry, 2013).

The process to advance quality care and promotion of professional standards accordingly is through documentation as a tool of professional practice (Duclos-Miller, 2016). Documentation must, therefore, give an exact account of what occurred and at what time it occurred. Midwives' practice is unique among other practitioners registered with the Nursing and Midwifery Council

in that they must comply with the statutory rules relating to their practice, including their record keeping which must follow the general principles and guidelines (NMC-UK, 2012). Maternity record keeping standards should be at a high standard because of the statutory provisions in the rules and the requirement for supervision (Rao et al., 2016). Unfortunately, the adverse comments by judges in lawsuits, for example, Wyisniewski versus Central Manchester Health Authority, 1998 where midwifery records were used as evidence suggested that the information presented by the midwives had considerable room for improvement.

Altaf, Oppenheimer, Shaw, Waugh, and Dixon-Woods (2006), in the UK, reported that the National Institute for Clinical Excellence (NICE) guidelines on foetal heart monitoring had deviations with the majority 80% of these occurring in relation to documentation. Documentation on Restructured Guidelines on intrapartum care, advice low-risk women to deliver at Midwifery Units (NICE, 2014). However, a study by Gardner, Bunton, Edge, & Wittkowski, (2014) about intrapartum mothers reported loneliness immediately after delivery in midwifery care. Contrary to this, 78% of women were reported to have received one client to one midwife in 90% of all women who access midwifery services (NICE, 2014).

Globally, regardless of the abundance of supervisory bodies both in nursing and midwifery and other health organizations, there is poor documentation practices which has become a worldwide problem leading to violations of data consistency. In Ghana, midwifery documentation is regulated by the indigenous bodies such as the Nursing and Midwifery Council of Ghana and associations such as the International Council of Nursing's Code of Ethics section, International Configuration of Midwifery (WHO, 2014). These bodies are to make sure that documentation by nurses and midwives give accounts of care provided to ensure care steadiness. However, documentation inadequacies still prevail as researchers continue to investigate its challenges and

obstacles (Okaisu, Kalikwani, Wanyana, & Coetzee, 2014). Although, a study by Jamieson, Ailon, Chien, and Mourad (2017) observed an improvement of quality as well as quantity in documentation in clinical electronic documentation, nevertheless, it did not clarify the increase in the quality.

Creating countrywide recording and checking tools was thought would quickly increase understanding of best practices for safe health information technology implementation and use (Bowman, 2013) but then providers of these tools must do their part by re-engineering prevailing manners of care to take full advantage of the efficiencies offered by health informatics section. This can be made possible by documenting the client's services and care from the time the patient comes on admission until discharge (Jefferies, Johnson, & Griffiths, 2010). Studies have shown that documentation in the nursing and midwifery professions is characterized by half-finished and deficient of steadiness on the psychosocial traits of patients (Hooks & Roberts, 2007; Hyde et al., 2004; Irving et al., 2005; Voutilainen, Isola, & Muurinen, 2004). Often documenting the psychosocial aspect of both nursing and midwifery care has received little attention. Ordering patients care in terms of priority are often done by midwives and nurses , however documenting such care is neglected (De Marinis et al., 2010). Realistic ways of evaluating service, care developments, and implementation must come from the reviews of documented data of care accordingly (Ford, Menachemi, Huerta, & Yu, 2010). The exact documentation practices to assess reliability have been evaluated to identify whether midwives document the care they give to clients (Greatrex-White & Moxey, 2015)

Conventionally, paper-based patients' health records were the order of the day and student nurses and midwives were and are educated in documentation and record keeping skills by writing the information on clients and patients under mentors' direction (Baillie, Chadwick, Mann, &

Brooke-Read, 2013). The change from paper held record to electronic health record is a global phenomenon. This has led to extensive development of application of Electronic Health Record (EHR) in the health sector (Boonstra, Versluis, & Vos, 2014). The development of EHR documentation system was thought to guarantee the meeting of high quality and dependable care of patients/clients. However, EHR must incorporate the nursing care process through the correct tools, best practices, and evidence-based as suggested by (Hripak et al., 2014; Keenan et al., 2012). United State of America's acceptance of EHR was because of the incentives from the Health Information Technology for Economics section and Clinical Health (HITECH) Act (Mennemeyer, Menachemi, Rahurkar, & Ford, 2016). The adoption of basic EHR systems promote the prompt accessibility of any documented information about a client to all concerned in the care. This grasps the immeasurable hope for improvement in health care documentation practices (Meyerhoefer et al., 2016). Although nurses and midwives form the majority of health care professionals who generate information about pregnant women and also are handlers of documented information, they have inadequate knowledge on documentation to enhance their practice (Asamani, Amenorpe, Babanawo, & Ofei, 2014). This is necessary because midwives do most documentation on treatments and observations of the clients (Nursing & Midwifery Board of Ireland, 2015). Furthermore, Lerberghe et al. (2014) stipulated that even though documentation standardization project was meant to restructure patient data, it also advanced the effectiveness of the electronic health record. However, legibility and readiness do not certainly result in proficiency and usability as stated.

1.1 Problem Statement

Although accurate documentation of midwifery services is essential to ensuring and improving quality of care, it is found to be mostly inaccurate, incomplete and in some instances

left undone in some instances. A cross-sectional study conducted by Kebede et al. (2017), found that only 37.4% of the participants practised good documentation. Dike et al. (2015) also found that although midwives have good knowledge about documentation, their attitude and practice towards documentation was poor. Again, it has been established that pregnancy-induced hypertension and post-partum hemorrhage are the leading causes of maternal mortality in the Greater Accra region. Although the report did not capture the underlying factors leading to midwives' inability to stop these deaths; perhaps proper, complete, accurate, timely and prompt communication of findings of care, observations and examinations on clients could have saved the lives of many mothers (MOH, 2013, 2014, 2015, 2016, & 2017). A study conducted in Ghana (Adu-Bonsaffoh, Obed, & Seffah, 2014) found that 30% of all diagnosed complications for two months periods during pregnancy were hypertensive disorders in pregnancy. Documentation of the pregnancies complicated with PIH ended up in Caesarian sections forming 45.7% of all Caesarean Section cases in Korle-Bu Teaching Hospital (KBTH) at the time of the research. The researcher is a registered midwife with over nineteen years of working experience. Through her experience, she has found that with specific reference to Maternal Health Records (MHR), vital information that can lead to proper maternal risk assessment of the pregnant woman and the unborn child are left undocumented. According to (Asamani et al., 2014) nursing documentation cannot be compared to that of the high income countries as 46% care given were not documented and 63% of daily monitoring notes are not recorded in their study. This confirmed the researcher's personal assessment of 100 maternal health records booklets retrieved from pregnant women in four purposively selected health facilities within the Greater Accra Metropolis which revealed that critical aspects of these booklets were either not properly filled or were incomplete. Sections such as the first antenatal visit vital signs especially the blood pressure which forms the basis for

diagnosing pregnancy-induced hypertension was 37% to 58% documented. The area of documenting, the major risk factors were 48% to 61% complete. The documentation of major risk factors could help prevent mortalities occurring in mothers who had suffered a previous pregnancy induced hypertension and post-partum haemorrhage.

An anecdotal report from the researcher's involvement in maternal death audit meetings points to either no documentation on services such as advice, counseling or treatment given to clients and family members. This suggests a deficiency in proper monitoring and management of women during pregnancy and after delivery. One may extrapolate that this deficiency contributed to the high maternal deaths in the Greater Accra Region. Not many studies have highlighted the relevance and benefits of midwifery documentation on the health of pregnant women and their unborn babies during the antenatal and babies during the postnatal periods. The groundbreaking steps taken by the government of Ghana to escalate women's access to healthcare such as the adoption of Focus Antenatal care is not bringing down maternal mortality in Ghana (Ghana Health Service, 2016). Therefore, the documentation in the maternal health record book by midwives needs more attention and supervision. Moreover, a study on midwives' experiences on documentation practices in the Greater Accra region is limited. In addition to this, the exploration and research into the documented care of these maternal mortalities is unavailable, suggesting that there is dearth or paucity of data on midwifery documentation on services provided to pregnant women.

Granted the above, it is plausible to suggest that there are other compelling factors that are impacting negatively on safe delivery but which are not granted the requisite attention. One of such factors is the documentation among midwives during antenatal care, labour and delivery and post-natal care of women. Indeed, previous studies have highlighted the significance of proper

midwifery documentation on safe delivery (Aune, Amundsen, & Aas, 2014; Bergh et al., 2015). It follows that the quest to reduce maternal mortality should take into consideration highly neglected practices, including midwifery documentation. Even though there are numerous studies on nursing documentation, there is no such research on midwifery documentation practices.

The primary aim of this study was to broaden and delve into the practices of documentation of midwifery services by practicing midwives. In this study, the Donabedian Quality Model of Structure, Process, Outcome (SPO) was used as an organizing framework to help meet the research purpose.

1.2 Purpose of the Study

To explore midwives' experiences with documentation practices of maternal health records in the Greater Accra Region.

1.3 Specific Objectives

Specific Objectives are to:

1. Identify the structures necessary for documentation practices by midwives in relation to maternal health records (MHR)
2. Describe the processes involved in documentation practices by midwives.
3. Assess the experiences of outcomes of the documentation practices of midwives.

1.4 Research Questions

1. What are the midwives' experiences of the required structures necessary for midwifery documentation practices?

2. What are the essential processes required in midwifery documentation practices among midwives?
3. What are the expected experience outcomes of midwifery documentation among midwives?

1.5 Significance of the Study

It is expected that policy makers and administrators would use the study findings to formulate and establish policies respectively in relation to quality documentation for midwifery and nursing professionals. The findings will also be of importance to Ghana Health Service (GHS) and Nursing and Midwifery Council for the development of policy and guidelines on midwifery documentation practices. Subsequently, the majority of stakeholders in health care delivery such as Facility Heads, GHS, will be tasked to implement the policies so as to give midwifery issues the needed attention. Student midwives will be trained and equipped by Heads of Midwifery Training Schools with the necessary skills and knowledge in midwifery documentation so as to deliver quality service to women of the reproductive age, pregnant mothers during pre-natal, intra-natal, and post-natal periods. Maternal and Neonatal deaths occurring as a result of a lack, omission or improper documentation will be made an issue of national importance to all stakeholders by policy makers. Again, high-quality documentation in midwifery practice may be adapted and integrated into the normal routines of care rendered to mothers and children. The study findings will contribute to enriching the literature regarding documentation practices in midwifery care and will stimulate researchers to conduct further studies into the midwifery documentation practices (MDP).

The findings will help inform health policy makers, health service administrators, health service providers, and other stakeholders to focus on the content and process of documentation practices of antenatal care services and not only the number of contacts (Hodgins, D'Agostino, &

Practice, 2014) It is necessary to first explore the practice of midwifery record-keeping to comprehend why midwives must document to a high standard (Kerkin et al., 2017; Patterson, Kerkin, Lennox, & Patterson, 2017). It is anticipated that the findings would create awareness of common challenges including lack of infrastructure and resources. It will help to bring to light the quality of midwifery documentation in Ghana. The findings can help policy makers to ensure curriculum reforms on documentation. This study finding could help midwives to prevent litigation by making them document every service delivered to clients. The study will help to discover the efforts of midwifery record-keeping and to scrupulously understand why midwives ought to document to a high standard. Finally, the study is significant because its findings may add up to boost information on midwifery documentation practices.

1.6 Operational Definition of Terms

1. **Documentation:** Any written or electronically generated information that describes the care or service provided to a pregnant woman (client or group of clients from the time of conception to 42 days post-delivery).
2. **Practices**: the actual application or use of an idea, belief, or method as opposed to theories relating to it.
3. **Experience:** Midwives knowledge, understanding and subsequently their skills in practical involvement in midwifery documentation.

1.7 Organization of the Study

Below is how the thesis was organized:

Chapter one presented the introduction of the study on the Midwives' experiences with documentation of the care given to clients, the problem statement, purpose of the study and the objectives. Chapter Two dealt with applicable readings in the area of MDP and the related articles.

Studies associated with the area of midwifery and nursing documentation practices, structures for MDP, processes involved in MDP, outcomes from MDP, and after analysis three emerged themes on challenges with MD, attitude to electronic health records and ways to improved MDP were reviewed. Chapter Three describes the methods used for the study. Participants' recruitment and how the semi- structured interview guide was piloted before its use to conduct the interviews have been described. Again it reported on the account on how data was managed and analyzed had been presented.

Chapter Four presents the findings of the study in the form of narratives from the participants representing their views on their experiences on MDP. Chapter five discusses the findings in relation to pertinent literature on the research topic. Detailed discussion made using the current findings of the study to known previous studies that are either in favor or against the current findings. The last chapter of the thesis covered the conclusion from the findings, knowledge gained and the study findings' implications. The study's recommendations are geared towards specific organizations to help change the direction of MDP in order to produce quality care to women in the reproductive age.

CHAPTER TWO

2.0 Theoretical Framework and Literature Review

This section reviews relevant literature on midwifery documentation practices. The purpose of this framework was to allow the researcher to have detailed explanations of practicing midwives' experiences with midwifery documentation. The theoretical framework for the study is described first followed by the literature review

2.1 Theoretical Framework of the study

Even though other models such as plan behavior model, the theory of reasoned action and others were considered, constructs in them do not make them suitable for achieving the aims of the study; therefore, they were not used. The Donabedian Quality Assurance Framework is well-known for its tractability for easy compliance at all levels of the healthcare systems (Berwick & Fox, 2016) . The constructs of the theory were drawn from three parameters: Structure, Process, and Outcome (SPO). The purpose of this framework was to allow detailed explanation of practicing midwives experiences with midwifery documentation

2.2 Donabedian Quality Assurance Framework

The study used the Avedis Donabedian Structure -Process-Outcome (SPO) as a theoretical foundation to explore midwives' experiences with documentation practices of maternal health records in the Greater Accra Region of Ghana.

Structure-Process-Outcomes were defined by Avedis Donabedian as a concept of Healthcare quality which presumes that the extent of Healthcare quality should be based on three components. These are the structure, the process and the outcome (El-Sharkawy et al., 2006; Mahler et al., 2007). The scrutiny of structure, process, and outcome is used as a measure of reference in the field of healthcare quality. The Donabedian framework was chosen to guide this study because it falls in line with the objectives of the study; it helped and gave a broader scope of documentation practices among midwives.

2.2.1 Structures relevant to midwifery documentation practices

The structure refers and relates to the resources of the provider such as the comparatively fixed features like personnel who provide care and the settings where the care is delivered. The structure includes the availability of equipment, safety devices, adequacy of the facility's staffing, the infrastructure and organizational settings in which care is provided (Donabedian, Wheeler , & Wyszewianski, 1982). The availability of good physical structure such as drugs, and supplies, guidelines, and protocols, trained human resources, and supervision is very important (Hanae, Mohamed, & Noureddine, 2013). Islam, (2016) conducted a study in Bangladesh using a mixed method and found that structures for quality care such as availability of logistics, qualified staff, adequate supervision and availability of protocols but their lack hampered the quality of care provided.

2.2.2 Process relevant to midwifery documentation practices

Process epitomizes all the activities during the delivery of care to the patients. It concerns the way in which care is delivered in relation to other aspects. There is a technical aspect that denotes the use of up-to-date therapeutic knowledge and expertise to maximize the balance between benefits and risks. This aspect concerns the timeliness and accuracy of diagnosis, the appropriateness of care or the service, the complications and incidents that may occur during treatment and the coordination between the various stages of the care delivery (Vermeir et al., 2015). There are two characteristics of process, the appropriateness and the skills with which the actions are carried out in terms of quality of care and services in Health Institution (McConville & Lavender, 2014).

2.2.3 Outcome of midwifery documentation practices

The outcome measures the quality of care and can be assessed in terms of whether the goals of care were achieved. It includes apart from the health-status indicators, other indicators related to the cost of care and patient satisfaction which are as a result of care rather than a component of care. Outcome is directly or indirectly influenced by the structure and process of care.

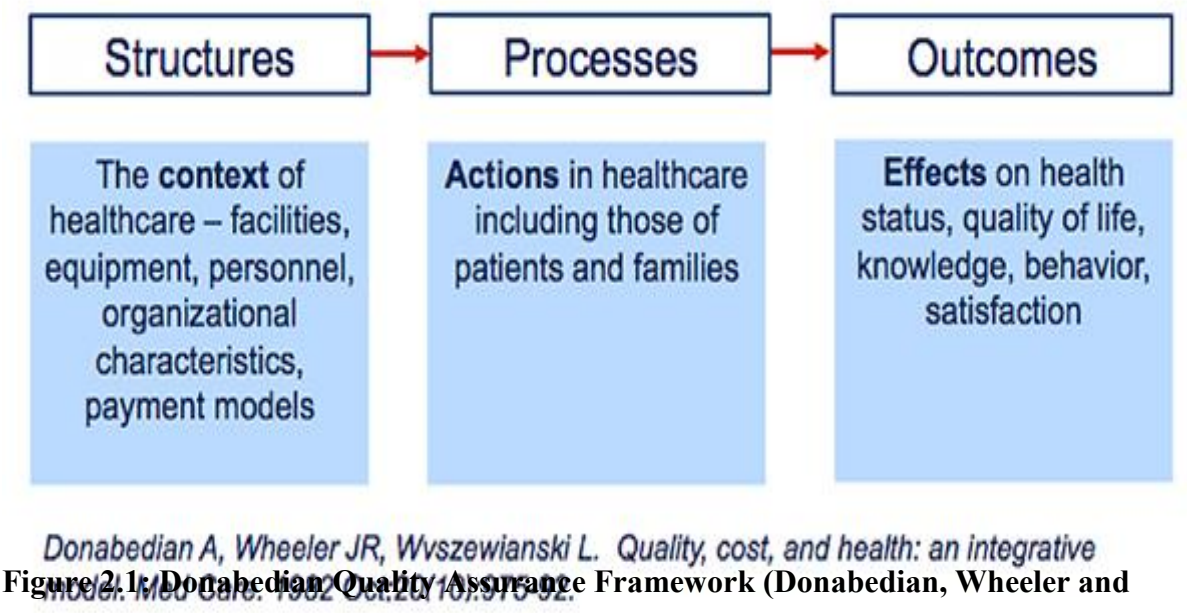

Figure 2.1: Donabedian Quality Assurance Framework (Donabedian, Wheeler and Wvszewianski (1982)

2.3.0 Literature Review

Key electronic databases including PUBMED, MEDLINE, CINAHL, Google Scholar and Science direct among others were accessed using the constructs of the theory. The keywords such as Documentation, Midwifery practices, structures used in documentation in midwifery practices, processes in documentation practices, Outcomes of documentation practices and midwife's perception of documentation were used to retrieve relevant literature in directing the context of the research. Notwithstanding the far-reaching search for relevant research works on midwifery documentation practices by the researcher, it was difficult to find such studies and therefore resorted to the use of related studies. Even though the researcher wanted to use literature from 2013 to 2019 for this study, she ended up using few literature from the early 2000 years because they provided good sources of information.

2.3.2 Structures necessary for documentation practices by midwives

The structure in this study describes all the inputs required for quality midwifery documentation. These are the services or care on which the documentation should be made by the qualified personnel with appropriate equipment and other resources. Midwives form the majority of staff who provide maternal health services which take place in the various facilities. For midwives and nurses to deliver quality services, the need for the availability of proper infrastructure is very significant. A study conducted in Eastern Uganda reported the critical need of good physical environment and its positive effect on mothers when they access these services (Tetui et al., 2012). Quality documentation through clinical governance effort showed little improvement in a study conducted by Mahler et al. (2007). Strengthening and regulation on documentation practices using relevant principles in the nursing and midwifery education transformation was recommended by World Health Organization (WHO, 2016). Once more, the

recruitment of staff should take into consideration those who have gone through the expected standard in the use and maintenance of equipment (NMC-UK, 2012). The International Confederation of Midwives (ICM), an organization which helps in the proper strengthening of midwifery globally, in their review of ICM competences, had some of the competences rejected from 2010 to 2013. Greater portions were endorsed in the area of core midwifery practice especially respectful mother care (Butler, Fullerton, & Aman, 2018), however, there was no mention of proper midwifery documentation practices which can project the image of the profession through its services.

The progress of change in structures, policy of the public evaluation and its influence on health delivery either positively or negatively is now gaining audience (Arcaya, Arcaya, & Subramanian, 2015; Islam, 2016). Associates for low income countries have enlarged the provision of financial funds for building quality and safe structure for the delivery of health care not overlooking faculty material for knowledge and training (Bvumbwe & Mtshali, 2018; Law, Akroyd, & Burke, 2010). Midwifery professionals in high income countries mostly have well-regulated standards and guidance on documentation practices which directs them in the course of their duties. The Code by the NMC United Kingdom, for instance, assists midwives in maintaining accurate records. The maintenance of high standard of documentation practices are expected and required by all professional midwives (NMC-UK, 2017).

Each health facility must engage midwifery staff to provide quality midwifery services in line with their scope of practice. However, the working environment for midwives should be safe, well equipped and good to portray midwifery as an attractive and respectable profession to the general public (Renfrew et al., 2014). Even though Ghana is in dire need of degree midwives and nurses to manage severe health necessities, a study by Bell, Rominski, Bam, Donkor, and Lori

(2013) found that qualified candidates for midwifery were rejected simply because of inadequacies of infrastructure, preceptors, and capacity of faculty. Nurses and Midwives who form the majority of the personnel in the health care sector have a lower ratios to pregnant women to one midwife or nurse (World Bank Collection, 2012) In addition, there are efforts to bring to bear the consequences of unintended inequalities as well an assessment evaluating to find out which policy work on DP otherwise (Haynes, Service, Goldacre, & Torgerson, 2012)

Organizational characteristics are essential factors that may influence DP by midwives. Policies for good remunerations for midwives after training helps develop their career pathways (Araújo, 2013). UNFPA 2014 with its vision for quality midwifery care from now to 2030 has develop the dimensions which include quality availability, accessibility and acceptance (Hoope-Bender et al., 2016) Assuming that, midwifery personnel are trained with international standards buttressed with efficient systems in health, 87% of women and neonate care can be taken by midwives alone as stipulated by a report from UNFPA (2014). The inclusion of stringent measures to ensure that documenting these services were omitted by UNFPA during the report. Universal goals to achieve quality coverage in health can be realized through midwives associations and groups. These associations' contributions to policy and decision making is backed with information and experiential knowledge in midwifery (Lopes, Titulaer, Bokosi, Homer, & Hoope-Bender, 2015). This could help raise the standards of care to women through the review of MD

2.3.3 Process: Activities in healthcare influencing MDP

The process in all midwifery and nursing documentations ensures that records are objective, precise, complete and up to date on the history taking or observations made. Documentations must be properly signed as well. Likewise, documentation should safeguard the care of the client by providing continuity of quality services and care given. In battling legal issues

in the health profession, clinical documentation or records, legibility, accurateness, data security, the confidentiality of client history and accessibility by clients are of relevance. It is worth noting that, there are quality outcomes in health when midwives and nurses communicate well with clients and family as a result of comprehensive MD. In a qualitative study using content analysis by Loghmani, Borhani, and Abbaszadeh (2014), they found that enablers such as passionate support, spirituality, and obstructions cause confusion in treatment regimes. The innovation in communication between midwives and clients as a new means in improving care and documenting service could prevent maternal and neonatal deaths. Again, the short period spent in most health facilities and hospitals after birth adequate MDP calls for client continuity of care, although limited evidence exists to prove that the formation of core strategies by midwives to improve continuity of care yielded benefits for mothers when implemented. This was done by changing, forming and maintaining a relationship with other health care professionals for the continuity of care by midwives in their joint success in a study by Barimani and Hylander, (2012). Furthermore, in the recent past, involving patients and their families in their care has become very important across all levels of healthcare. Therefore, such involvement should be clearly indicated when midwives are documenting client care.

The increasing interest of clients and family members in the care of themselves and their loved ones has now come to stay in the health system. Alston, Paget, and Halvorson (2012) in their studies, proposed a partnership between clients, midwives and nurses. Kerse et al., (2004) in their study on client/provider relationship, attributed a distinct value on the relationship care givers exhibit in their line of duty all over the world as an important aspect of their care which must be documented. Similarly, a study by Mimura and Norman, (2018) found it is unclear that relationships between care providers and clients have effects on clients' health outcomes.

In addition, the study reported that slight negative effects on health outcomes depended on relationships clients have with their care givers. Pomey, Hihat, Khalifa, Lebel, and Néron (2015) postulated changes in the professional relationship with the involvement of clients in healthcare services. They recognized the powerful controlled character of clients bringing high improvement to the team. The ratio of the midwife to pregnant women in the world is difficult to calculate as the number of live births is mostly the factor used in the calculation, neglecting care needed and given during the early pregnancies. Furthermore, encouraging patient partnership in their care has an alteration and benefit in the improvement processes of clients' care.

Institutional documentation differs but the most frequently used means are the admission notes, flow sheets and pictorial diagrams among others. However, snapshots are now accepted as evidence in the law court with the advancement in technology. Regrettably, professional midwives and nurses use mostly the inscribed format as against documenting with pictures. In a descriptive correlational study by Henderson, Harada, and Amar (2012) in the USA with nurses at an emergency department on how to document for forensic purposes, only 13% reported that they have had no education in formal forensic, with just 2% getting an education in forensic, formally

Although there has been an increase in the ratio of the number of midwives to pregnant women from 2001 to 2012, Tolofari, (2014) suggested other coexisting factors such as aging populace, ill-health as a result of workplace pressure experienced by midwives which make them leave the profession at early ages affecting negatively on workload and DP. Employers of providers of maternal health services have not adopted the recommended midwife-to-mother ratios, due to budgetary cuts. as published by Pat Brodie, (2013) that 15% to 20% of all pregnancies

end in the middle of the second trimester. This could be due to the non-existence of documented information.

Even though, nursing and midwifery documentation is supposed to be systematic and tell what the situation was from the beginning to the end with all interventions as well as actions taken, Öhlén, Forsberg and Broberger (2013), found in their research that documentation by nurses in an advanced home care was disjointed. Documentation in midwifery and nursing practices should be unprejudiced and recorded at the time of the event or when service is rendered. In a situation of a lawsuit the most adopted phrase 'if it is not recorded, it has not been done"(De Marinis et al., 2010), must be a guiding principle in service delivery by midwives. Kirk (2013) in her writing in the guideline for maternity service documentation acknowledged that although best practices demand the above, any retrospective documentation done must be stated as such. There is therefore the need for midwifery workforce to have continuous supervision on MD. A mixed method study in London with university students articulated the desire to have more lecturers as their mentors in the area of supervision (Foster, Ooms, & Marks-Maran, 2015).

2.3.4 Outcome: Midwifery Documentation Effects on Health Status

The basic process of documentation by midwives and nurses worsen during the mid-shift and towards the end of the shift, especially with the use of partograph. Bailey, Wilson and Yoong (2015) reported that documentation is best at the commencement of shifts and poorer towards closing time. Documentation excellence is affected by the length of time spent at work. Maternity data completeness was systematically reviewed by Hawley, Janamia, Jackson, and Wilkinson, (2014) and reported that no studies were found prior to their work. Through their study, it was evident that there exists a knowledge gap concerning completeness of information in maternity records both in paper hand records and electronic health records. Again, a study by Hikita et al.

(2018) reported the likelihood of mothers to read their MCH handbook.. According to Kerkin et al. (2017), midwifery documentation can possibly be used to improve normal care through continuity, inter-professional communication and positive protection of neonates and mothers. Dhalwani, Tata, Coleman, Fleming, & Szatkowski, (2013) reported that documentation on pregnant women is incomplete even though this practice has seen some enhancement after the execution of quality assurance strategies.

2.4 Summary of Literature Review

Research works on documentation practices in the health care system is dominated by nursing documentation. The few studies on midwifery services were on providing midwifery documentation on care continuity, reflective practices, education and the need for rapport among midwives and other health care providers. Literature reported the significance of the unavailability of proper infrastructure, not enough personnel and lack of consistence supervision on MD. Again, the processes involved in the activities during care and its documentation processes were reported to have many inadequacies with numerous retrospective documentations. Finally, it was also found that MD could improve the health of clients and inform and influence policy on the health of women of the reproductive age and their unborn and born babies. However, there was paucity of data on the documentation practices among midwives locally and internationally.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter describes the research process employed in this study. The research design, setting, target population, sample and sampling method, tool and method of data analysis are explained in the chapter. The ethical issues, management of data collected to ensure data quality and rigour were discussed.

3.1 Research Design

Research design spells out the basic strategies that researchers adapt to answer questions and to test their hypotheses (Polit & Beck, 2010). This study employed an exploratory descriptive research design within the qualitative paradigm as this helped to elicit the views of the midwives on their documentation practices. A qualitative method was used because it helped the researcher to understand issues happening in the social world (Moen & Middelthon, 2015). In addition, a qualitative approach was most appropriate as it is more concerned with personal meanings and takes place in a natural environment. The descriptive nature of a qualitative method also provided more in-depth results.

The exploratory design helped to present the world view of the phenomenon from a participant's point of view (Sargeant, 2012). The design is also descriptive because, it involves the accurate and objective representation of characteristics under study (Polit and Beck, 2010). The narratives of eligible purposively recruited participants were audio-recorded, transcribed, coded, thematically analyzed and interpreted within the context of the natural environment. According to Moen and Middelthon (2015), using exploratory descriptive design helps to gain an understanding

of underlining opinions and motivations. It also gives insight into the problem and helps to develop ideas for potential research. Compared with other designs, this approach is flexible and allows the researcher to discover the perspectives of participants. The researcher used the design in exploring and describing the phenomenon under study. This design facilitated the researcher to acquire an in-depth knowledge on midwives' experience with documentation practices with the maternal health records. The design assisted in gathering enough data which were useful to the researcher (Lather & St. Pierre, 2014).

3.2 Research Setting

Research setting refers to the physical location and conditions in which the data collection takes place (Polit & Beck, 2010). The research setting for this study was a selected health facility located within the Greater Accra Region (GAR) which made it easy for the researcher to get her target participants (midwives). The GAR is an urban area within Ghana which is divided into 11 Sub Metropolis and has an estimated land area of 173 square kilometers and a total population of 1,658,937 which grows at 3.1 % annually (Ghana Statistical Service, 2014a). The population of Accra is expected to go beyond 4 million by the end of the year 2020. The northern and western part of the Metropolis is made up of the Ga East with a district capital Abokobi, Ga West, holding Amasaman as the district capital and Ga South District is capitalized by Weija (Accra Metropolitan Assembly, 2014). On the southern border of the Metropolis is the Gulf of Guinea from Gbegbese to La. The Ledzokuku-Krowor Assembly is on the eastern part of Accra which has Tema Metropolitan Area and a population 292,773 people according to the(Ghana Statistical Service, 2014b). Tema General Hospital was the selected facility from which midwives were designated for the study. Built in 1954, it is now a District Hospital and the largest

Public Health Institution with a catchment area that includes the Tema Metropolitan area and its settlement towns. The hospital has 14 wards with a bed capacity of 294 and serves as a primary referral hospital for road traffic accidents victims due to its location by the Tema motorway, the Tema Akosombo highway, and Tema Aflao highway. This facility was chosen because most of the departments of the hospital work 24 hours to enhance patient care. The hospital runs clinical and non-clinical services which include Obstetrics /Gynecology services that see the largest number of pregnant women in the Tema metropolis. Other services include Internal Medicine, Surgical /Orthopedics, Genitourinary, Pediatrics, Accident and Emergency, Theater services, Anesthesia, Ophthalmology, Ear Nose and Throat clinic, Dental care, Public Health, Antenatal services, Physiotherapy, Diagnostic services (Laboratory, X-ray, Ultrasound, and Electro-Cardiogram), Blood Bank, Pharmaceutical, Mortuary, and Record services. The non-clinical services are (Administration, Supply Chain, Catering, Laundry, Estate, Security, Social welfare and Transport). Considering the number of women in their reproductive age who access the facility, and the number of midwives in the maternity section of the hospital, permission was sought through an introduction letter from the School of Nursing and Midwifery, University of Ghana, Legon, together with the approval letters from both Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana and also a letter to the Ghana Health Service Ethical Review Board. The setting was chosen because it is the main referral point in the Tema metropolis for all the districts and towns around Tema.

3.3 Target Population

Moen & Middelthon, (2015) referred to the target population as a group of people the researcher wishes to draw inferences from after completing the study. Such individuals are

believed to have the experience to provide significant information. The target population for this study was the practicing midwives in the selected facility TGH who are working in the maternity units (Antenatal, labour, postnatal units).

3.4 Inclusion Criteria

The inclusion criteria were all practicing midwives who have worked in the maternity units within the last two years either in the antenatal, labour and postnatal units. The inclusion criteria were midwives who are involved in the generation of all maternal health records.

3.5 Exclusion Criteria

The exclusion criteria were all midwives who are working in other units other than the maternity units specifically the antenatal, labour and postnatal units. Secondly all rotation midwives in the maternity units in the selected facility were excluded from the study. Furthermore, midwives who were on leave or either were emotionally or psychologically unstable were likewise not accepted to take part in the study. Lastly, all midwives who had not practiced midwifery for the past two years were excluded from the study.

3.6 Sample Size and Sampling Method

Sample size is the total number of participants included in the study (Sargeant, 2012). The sample size of a qualitative study is achieved when the researcher does not get any new concept or idea after repeatedly interviewing participants (Fusch & Ness, 2015). The size of the sample depends on the researcher getting the quality of information and experiences from participants. Dissimilar to a quantitative approach, there is no specific formula for calculating sample size in qualitative research. The purposive sampling technique was used in the identification and selection

of participants which aided the achievement of the study's objectives that meant only those who were qualified, were included. The aim was to choose participants who could provide the information needed based on the aim of the study (Moen & Middelthon, 2015). This was achieved by selecting participants believed to be best to provide the relevant information for the study. The sample size of 13 for this study was recruited since data saturation was achieved with 13 participants. The most important aspect here is to achieve data saturation with sizable participants. Until then, the researcher continued to interview the participants. With the support from the senior midwives in the selected facility, midwives who fell within the inclusion criteria were identified. The selected midwives were requested to join the study and their participation was based on their interest and willingness to be part of the study.

3.7 Tool for Data Collection

Data was collected using a semi-structured interview guide (appendix D). The semi-structured interview guide comprised of two sections developed from the objectives of the study which was guided by the theory of Avedis Donabedian SPO 1982. The first part of the interview guide had the demographic information of the participants with the second section being the questions on the views of the midwives on their experiences on the MDP. Pre-testing of the interview guide was conducted at the La General Hospital with three midwives to clear all obscurities and the data generated from the pre-testing were not included in the main study.

3.8 Data Collection Procedure

A proposal for the study was submitted for approval from both Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana (appendix A), and also the Ghana Health Service Ethical Review Board (appendix B). Permission was sought from the heads of Tema

General Hospital with a letter (appendix C). The developed semi-structured interview guide was pre-tested at LA General Hospital with three practicing midwives who met the inclusion criteria that facilitated the refinement of the questions to fit the objectives of the study. The information sheet (appendix E) was used to explain the research to staff in the units or wards where recruitment was done. Eligible potential participants received further information and were given the opportunity to ask questions. Participants who accepted to participate in the study were asked to sign a consent form to indicate their agreement. In addition, participants were made aware that there were no direct benefits to the researcher but the findings of the study will help in policymaking in improving the MD among midwives and to widen their knowledge of maternal health with regards to DP among midwives. A convenient interview dates were arranged with all participants. Reminders and voice calls were placed a day before the interview.

A private room was secured for the interview to ensure privacy and limit background noise on the audio recording. Participants were informed about a face-to-face interview which was conducted using a semi-structured interview guide. Formulated guiding questions based on the key research questions were posed followed by additional probes that were dependent on participant's responses. All interviews were audio-recorded in order not to miss out on any information provided for transcription. Field notes and journals were used to capture observations and relevant information that could not be audio-recorded. Each participant was encouraged to answer the questions as they wish with no compulsion and was free to withdraw at any time. Each interview lasted about 40 to 60 minutes, and it was done in English. Participants were given code names to ensure anonymity. Further explanation was provided under the ethical issues.

3.9 Data Management

Sequential numbering of participants was given from one to sixteen (1-16) in order of when their interviews were conducted. Data saturation was achieved on the thirteenth (13^{th}) participant. Verbatim transcription was done immediately after the interview. Each recording was replayed over and over to ensure accurate transcription to reduce oversights and mistakes. To ensure confidentiality, the numbers allocated to participants were replaced with pseudonyms. All audio recordings, transcribed data, field notes and documented information given by the participants were kept safely. A folder was created to contain each transcription file, and this has been saved with a unique identification. Hard copies of the interview would be kept for five years at the School of Nursing and Midwifery. Storage for this duration implies that these documents and audio recordings can easily be retrieved when the need arises until such time, they cannot be deliberately destroyed (Noble & Smith, 2015). Furthermore, demographic data of participants was detached from hard copies. Electronic copies of the transcription have also been kept in a folder on a computer with a password to ensure the safety of the data.

3.10 Analysis of Data

The purpose of data analysis is to organize, provide structure to and elicit meaning from data (Polit & Beck, 2010). This is the approach by which the researcher takes the reader into the setting, with content and the context in mind to give an interpretation of the data (Pierre & Jackson, 2015). Data collected was transcribed verbatim by the researcher and then content analysis used to analyze the data. Content analysis is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts. It involves data reductions, data display, conclusion drawing and verification (Miles, Huberman, Huberman, & Huberman,

1994). However, Ngulube (2015) also reported on the process of labeling qualitative information to interpret and identify patterns in raw data. All words from Ghanaian languages used during the interviews were translated into English by the researcher after which member checking was done for credibility. The researcher then read and re-read the transcripts to identify recurring themes. Coding is the process of organizing, sorting and the basis for developing data analysis (Sargeant, 2012). Data were examined for similar ideas, words, and phrases which were used to generate codes. Similar codes were summarized into themes and subthemes. The themes and subthemes were listed, and meaning was given to each with abbreviations to identify each subtheme which was given codes to differentiate them. The transcribed data were coded in the order in which the interviews were conducted. Thematic code frame was used to develop the entire data, as all sentences belonging to a particular code was labeled and separated from one another. The researcher created a separate file for all information belonging to a particular code and read over many times. The transcribed interviews and field notes were printed with margins. The supervisors helped the researcher to discuss and analyze the first two transcribed interviews before the subsequent ones were done. Comment of importance were noted in the margin. The findings were then described in detail using the themes and sub-themes to make meaning. In this process, each aspect of the data was considered.

3.11 Methodological Rigour

Qualitative researchers aim to design and incorporate methodological strategies to ensure the trustworthiness of findings (Polit & Beck, 2010). Rigour in qualitative research measures the constancy of data collection, analysis, and interpretation which is often compared with reliability and validity in quantitative research (Noble & Smith, 2015). According to Lincoln and Guba

(1985), rigour is described under four areas which are; Credibility, Transferability, Dependability, and Confirmability. Lincoln and Guba (1985) have outlined the following procedures to establish trustworthiness in qualitative research.

3.11.1 Credibility

Credibility stands for the confidence or truth of the data and their interpretation (Noble & Smith, 2015). This was accomplished by purposefully recruiting participants who fitted the criteria, this was ensured by interviewing participants who claimed to be involved in the daily documentation of care given to their clients. Most of the participants gave in-depth information on their experiences on midwifery documentation practices. Participants were again given enough time during the interview to talk and express their experiences. After each interview, the audio recording was played back for the participants to listen to and confirm whether the information given was what they reported. Also, member checks were used to consider and verify responses of participants by discussing the themes, the researcher arrived at with the participants. The researcher also put aside her prejudices in order not to influence the findings. Finally, the researcher ensured credibility by spending more time on the field to familiarize herself with the participants and thereby creating a congenial and friendly atmosphere for the interview sessions.

3.11.2 Dependability

Dependability is the constancy of the data over time and conditions; thus, the study findings will not change if another study is conducted with similar participants in the same environment (Cheng & Metcalfe, 2018; Moen & Middelthon, 2015).

To ensure dependability, a detailed description of the research setting, methodology, and background of participants who took part in the study have been provided. Also, all participants

were interviewed with the same interview guide. In addition, each transcript was subjected to the same method of arriving at themes and subthemes. All documents have been kept for an audit trail.

3.11.3 Confirmability

Confirmability refers to objectivity that is, the interpretation of the data must represent the information participants provided (Cheng & Metcalfe, 2018). This was achieved by the researcher being mindful of her own attitude and perception and professional knowledge on the topic so as not to impose them on the data collected. Also, an audit trail such as the interview transcripts, field notes which included date and time of the interview, and how consent was sought before the interview from participants were documented by the researcher so that others can follow to confirm the findings.

3.11.4 Transferability

Furthermore, transferability represents the extent to which qualitative findings can be transferred to other settings or groups (Anney & Studies, 2014). To realize transferability, a detailed description of a research setting, methodology, and background of study participants have been provided, so that should it can be imitated by other researchers who want to conduct similar or same research in same or different setting. Finally, Noble & Smith, (2015) suggest that the more rigorous the research process is, the higher the chance of the findings to be significant and considered trustworthy.

3.12 Ethical Considerations

An ethical consent was sought from the Institutional Review Board (IRB) (appendix F) of the University of Ghana at the Noguchi Memorial Institute for Medical Research, GHS Ethical Review Board (ERB) (appendix G) and the Tema General Hospital (appendix C) with an

introductory letter from the School of Nursing and Midwifery, University of Ghana. The researcher introduced herself and explained the aim, benefits and potential risks of the study to the participants. The participants were assured of confidentiality, the right to leave the study, voluntary participation, anonymity, privacy, and compensation. The interviews were performed in the participant's preferred languages. A follow-up was done to confirm their participation in the study. Potential participants who accepted to be part of the study were given consent forms to sign. Participants were furthermore informed that after signing the consent forms, they still had the right to withdraw from the study without any consequences. They were also assured that all the information they provided would be kept safe and not in any way be used against them. To hide their identity, participants were given numbers chronologically in order of recruitment as this ensured anonymity. In this thesis, numbers were replaced by the pseudonyms where participants were quoted. Participants were assured that the audio- recordings, the consent form, and the information they gave would be kept in the researcher's custody for at least a period of five years after the study has been conducted.

CHAPTER FOUR

STUDY FINDINGS

This chapter presents the findings of the study. The findings are presented based on the constructs of the Donabedian Quality Model of Structure, Process, Outcome and the objectives of the study. The demographic characteristics of the participants are presented first followed by the themes developed from the data.

4.1 Demographic Characteristic of Participants

The ages of participants ranged from 21 to 60 years, with the majority of them being Christians (92.3%, n = 12) and (7.7%, n=1) being a Muslim. Most participants (69.2%, n = 9) were married whilst a few (30.8%, n = 4) were single. The lowest level of education of participants was a midwifery certificate and the highest was a degree with a certificate in Nursing Administration. The ranks of the midwives ranged between Staff Midwives and a Principal Midwifery Officer. Participants' years of practice as midwives were between four (4) years and eighteen (18) years. Most of the participants have stayed in their current units/wards at the time of data collection between one (1) and ten (10) years. Languages spoken by these midwives were between two (2) languages and six (6) languages. Details on the demographic characteristics are shown in table 4.1 on page 36.

Table 4.1: Demographic Characteristics of Participants

Demographic	Characteristics of participants	Frequencies	Percentages of characteristics
Age range	21-40	10	**76.92%**
	41-60	3	23.08%
Marital status	Married	9	**69.2%**
	Single	4	30.8%
Religion	Christian	12	**92.3%**
	Muslim	1	7.7%
Education	Post basic/Diploma	10	**76.92%**
	Degree	3	23.08%
Rank	Junior staff	6	46.15%
	Senior staff	7	**53.85%**
Years of practice	4-10	9	**69.23%**
	11-18	4	30.77%
Duration in the current unit	1-6 years	10	**76.92%**
	7-12years	3	23.08%
Language spoken	1-3	7	**53.85%**
	4-6	6	46.15%
Current unit	ANC	4	30.77%
	LB/PN	9	**69.23%**

4.2 Organization of Themes

Organization of themes for this study was guided by the objectives of the study and the concepts of the Donabedian Quality Framework; Structure, Process, and Outcome (SPO) approach. In all, five (5) main themes were identified from the data. Three (3) were consistent with the SPO framework whilst the

remaining three (3) major themes were extra themes that emerged from the analysis of the data. The table (4.1) below shows the major theoretical and emerged themes with their corresponding sub-themes.

Table 4.2 Organization of Themes

THEME		SUB-THEMES	CODES
Theoretical themes	**Emerged themes**		
1. Structures for documentation		• Stationeries used for Midwifery Documentation Practices (MDP) • Personnel for MDP • Logistics used for MDP • Supervision of documented records • Protocol and Guidelines used for MDP • Principles used for MDP • Availability of NHIS	STRCH
2. Process: Steps involved in MD		• Timeliness and accuracy of documentation • Appropriateness of documentation of care • Coordination between the various stages of MDP • Use of patient relatives as support persons	RROC

Table 4.2 Organization of Themes continued

THEME		SUB-THEMES	CODES
Theoretical themes	**Emerged themes**		
3. Outcome- the results from MDP		• Positive effects of documentation on the outcome of patients care • Negative effects of documentation on the outcome of patients care • MDP effects on babies and the family • Patient satisfaction	DOTCOM
	Emerged themes		
	4.Challenges with midwifery documentation	• Lack of stationeries • Interference during documentation • Poor working conditions • Poor staff strength • Work overload • Effects of writing into so many books on one client	CHAMD
	5.Attitude towards electronic documentation	• Failure of management to adopt electronic health records • Perceptions about electronic documentation	ATED

4.3. Structures used for Documentation Practices

The structure in this study describes all the inputs needed for quality documentation. The structures include stationeries, personnel needed for documentation (midwives), the logistics, protocols and guidelines, principles and supervision techniques used during midwifery documentation. The availability and use of these structures come together to generate midwifery documentation.

4.3.1 Stationeries used for documentation

Stationeries are the material resources described by the midwives as important for effective documentation. All the midwives mentioned that their documentation practices are done through writing with different kinds of pens into the various registers, notebooks and sheets. Most of these stationeries are specially designed by the Ministry of Health (MOH) and the Ghana Health Service (GHS) through the medical stores to the various health facilities stores, then to the department for subsequent requisition and supplies for use by midwives. The midwives enumerated many stationeries which are categorized into three: the first group consisted of stationeries such as antenatal, delivery and post-natal care registers; the second group was made up of notebooks which were used mostly for reports on admissions and discharges of clients, for inventories and incidences that happen in the wards. The last group was the various sheets used for specific procedure documentation such as delivery summary sheet, partograph, observation sheets among others. One of the midwives, Guau stated that:

> *Our documentation is done by actually writing with paper and pen, that's what we use and it's a bit difficult and tedious sometimes. But that's our basic here and that's what we use at the moment. We use the report book, the admission and discharge book, the incidence book, and the delivery book. We have a lot of books, anything you do for a client, there's a book that it goes into. (**Guau)***

Maya also specified the reasons why they use specific stationeries for particular clients and periods and thinks some of the sheets, books and the registers could be merged to make documentation easier for midwives:

> *We use pens and we have different colours; we use red and blue. Mostly the red is for the night cases and for surgery cases like Caesarean Sections. We have the various sheets that we may have to document a particular condition such as the partograph and general observation sheet. We also have the boards on the walls which capture clients who are being induced. We have the marker which is used for documentation as well. We have our delivery books, delivery statistics section book, general report book, PMTCT book for clients who are tested for HIV in the labour ward. We have various books for balancing of drugs, the incident book where, assuming there is an adverse event on the ward, you'll want to document in for subsequent care. Yes, referral books for referred in and out cases. We have those that we receive and then feedback book, we have the referral forms as well. The stationeries are more than enough such that sometimes we think that some should be merged into the others. So that you pick one sheet, you are able to get everything on. **(Maya)***

The midwives also disclosed that even though midwives have to report on all clients that access their services daily, specifically designed registers, books and sheets are used by specific wards. Meanwhile, documenting into specific registers, sheets and notebooks depend on the particular units and the state in which a client is seen by the individual midwife.

> *We have report book: if it is delivery, we have delivery books, if it is antenatal; we have antenatal books where we do entries of information on clients that come to visit us. We record their names, their ages of gestation and the number of times that they have been pregnant. We report on every client that comes into the ward. When we talk of the labour ward we have report book that we document everything about a client in to. Then we also have a delivery book in which we document the date of birth of the baby, the sex, the Apgar score, whether the woman bled or not. Every finding concerning a delivery is entered into this book. Books are our major tool for documentation. **(Julie)***

MD is done manually with different pens, into registers, notebooks as well as various specialized sheets under specific conditions and circumstances which makes MDP very tedious depending on the units/wards where participants find themselves.

4.3.2 Personnel for documentation

Personnel in this study refer to practicing midwives whose main duty is to provide and document care given to women of reproductive age. Depending on where these midwives find themselves, they attend to emergency clients, multiple clients at a time, and yet they are required to document into so many books at a time. The increased workload and the length of time used to do these documentations put much pressure on the midwives. In expressing their views on the urgency of care given in some of their units, most participants had similar stories:

> *The labour ward is such that it's an emergency unit and so every client who comes is seen as an emergency. The most number of staff on duty are three (3) and at least is one (1). Any client who comes, you need to really assess and time is of the essence. Image you have just assessed a client and you are now writing the admission report or writing on the triage form and another client comes in bleeding. You wouldn't want to finish writing before you go and attend to that client. You need to move and attend to that client when she's settled then you can have time to document. Most of the time in such situation important information may not be documented. So, you find gaps in the report but when the staff strength is good and the number of clients at a particular point is not that much, you realize that the documentation is perfect. So, staff strength really affects the documentation.* ***(Cram)***

Another midwife asserted that even though they have a place designated for quick assessment of emergency clients the place is still vacant:

> *We have a triaging room which is supposed to be staffed with other midwives for emergency cases, but unfortunately, we are doing everything together at the labour ward, for now, because we don't have many people on the ward. They have to come to the labour ward for the triaging to be done there. The midwife patient ration is a bit problematic but in monitoring the patient, we use triaging which makes care easier because those in red, yellow and green, we know how to balance the care.* ***(Guau)***

Janu emphasized that when clients outnumber the staff strength MDP becomes poor:

> *The staff is few and the clients coming in are so much, so there is workload, workload you see; you will like to see all clients; therefore, you are in a rush. Maybe you will write but you will not be able to complete. You start and another one is coming in, therefore, it's all due to lack of adequate staff, if we have enough staff and then the rooms are many, I think recording of care given will be more complete.* ***(Janu)***

The ratios of the clients that access the services and the midwives is alleged to be wide which make participants to rush in an attempt to be able to care for all clients making MDP to be inadequately done.

4.3.3 Provision of logistics used for documentation

The provision of logistics such as the infrastructure and organizational setting emerged as a sub-theme. Almost all the midwives expressed their sentiments on the size, shape, content, and quality of most of the registers. Secondly, participants complained about the physical structures of the midwives' consulting rooms for antenatal care because they were reportedly too small. All the midwives registered their displeasure about the kind of materials used in making the antenatal, delivery and the post-natal registers. To them, these registers are of inferior quality. Participants grumbled on the repetition of the same information on the same client. The repetition makes documenting in these books very difficult as narrated by some of them.

> *We have big registers for antenatal delivery, postnatal and referral. These books are too big and too long. You have to open and by the time you get to the middle of the book, the first and second pages are torn out. The book is too big and the things are too many in the book and after you assess the person you go back to the table to document. We have a table that we pile our books on, so if I have assessed the person in the first stage room or second stage room you have to come out to the nurse's table. You come and write your findings over there.* ***(Jeuna)***

The safekeeping of this documented information was of great importance to these midwives, for future reference. Some of the midwives were worried about the safe keeping of records of their client care and this was shown in the lamentation from Pari:

> *We have a place that we keep our old record books, but it is not the best because it is paper which is soft as I reported so anything can happen to it. We are supposed to keep them safe for future reference, so, we try as much as possible to keep them for future reference. Keeping them after use is another problem. Our report books are still paper so it can get torn, someone can mistakenly sprinkle water on it. Also, when it rains and there is a leakage it can get destroyed. How sure are we that we can get all that information may be in some years to come when we need them? There can be a fire outbreak at where we store our things especially with the records. If there is fire outbreak how do we get peoples' folders but if it's on a system we know that we have a backup but with the paper documentation how do we get a backup? Nothing so if something bad goes on, even animals these rats and all that they can spoil the papers because it's paper anything can happen to it* ***(Pari)***

The physical structure of the ANC consulting rooms where most of the documentation is done was reported to be uncomfortable. The midwives exhibited their displeasure about the immediate environment with these quotations:

> *The rooms are too small and the books that we write in, the antenatal register are very big so sometimes if you open the book and you don't take your time you can even knock the mother with it. I am sorry, room one (1) has a small table with a small chair and there's not even space to turn yourself and record everything in the book at the same time and because the place is small, only one midwife can attend to the clients.* ***(Janu)***

Some of the physical structures such as the consulting rooms, registers and the midwife's stations were disclosed to be causing discomforts and putting impediments on their MDP.

4.3.4 Supervision of documented records

Supervision forms part of the logistics in the structures earmarked for quality documentation practices. The midwives detailed that supervision is done both internally by their supervisors and externally by teams from the region or the metropolis. Participants alleged

supervision helps them to prepare for facility and any peer review, and compilation of monthly statistical reports. The external teams normally target the documentation on still births and triaging sheets among others. On supervision, almost all the midwives attested to the fact that the internal supervisions are done mostly by the in- charges of the various wards as reported by Janu:

> *Yes, most of the time supervisors from Metropolitan Health Directorate come to check and see our records on how we record and how we use our books. Monthly, quarterly and annual reports are periodically checked in this facility. Our in-charges do a lot of supervision on staff performance. The facility DDNS always come to the ward to check on what we have been doing. Doctor in charge always comes and check on what we are doing using the records. Maternity in charge always comes to check on what we have been doing and they look through our books all the time.* ***(Janu)***

Coota gave an account on how strict the in- charges are on the use of the partograph:

> *our in-charges monitor the partograph especially recently there was monitoring on the partograph so you have to make sure that every client that comes, those who came in active phase, the partograph was used to monitor them. The in-charge takes it one by one ensuring that we were able to monitor the client well on the partograph and then after the delivery, it is closed properly on the partograph. Now we have a form called triage sheets, the in-charge come around to go through whether every portion on the triage sheets is filled as expected.* ***(Coota)***

The external monitoring and supervision teams that come around are from the metropolitan health directorate and the regional health directorate. According to the midwives, these teams are more interested in reviewing Still Births (SB) and supervising the triaging sheets before going into their registers and books.

> *Our stillbirths (SB's) are being monitored by an external body. So when you have a stillbirth, you have to take pictures of the folder, or you have to make photocopies of the folder and then you have to document everything that happened before the patient came in, how the patient came in, during the monitoring whether patient came in with an Foetal Heart(FH) or not or whether it is during the monitoring that the FH went off or whether there's something significant that really caused the foetal death, yes, I know about that one and I know about the triaging form too. I know about an external body that comes in to pick the triaging form randomly to see how it's being done, whether it's being done*

> *effectively or not and I think the maternal mortality too, they pick folders at random and they check on them too.* **(Guau)**

Although supervision was disclosed to be part of the various in charges responsibilities, it did not target the entirety of MDP but rather specifics such as partograph, triaging forms and monitoring on still births were first on the priority list.

4.3.5 Protocol and Guidelines used in documentation

Protocols and Guidelines are documents which could be in the form of books, booklets, sheets needed to control the provision and documentation of care and services given to clients. The midwives listed some of these protocols, talked about the protocol's availability in their facility and their uses. Development of protocols for use was stated to be carried out by the government of the country and international bodies, but could also be undertaken by the individual facility as reported by some midwives. Pari highlighted the need to document after using the protocol to manage the client:

> *With the protocol, it's a written guideline meant to be followed to manage your client. It's there so you look on it and you follow the steps, now as you follow the steps you need to document it. The little problem is that what you did, did you document because you are looking at the protocols that have been given to you as you need. Yes, I did that let's say PPH, you are preventing post-partum haemorrhage; there's a regime of using any of the drugs like tablet Cytotec. It is written, how much you gave, if you gave the three tablets of Cytotec you need to document it.* ***(Pari)***

Protocols are normally developed by the authorities in the Ministry of Health and there are many as narrated by Cram:

> *The protocols as we know, we don't work independently so we adhere to it. We have some in form of booklet, books like the Job Aid, like the Maternal Health Guide, like the Referral, referral we have a Referral Book, Feedback Book we have others, for example, the neonatal side we have HBB (Helping Babies Breath), Helping Mothers Survive protocol (HMS). We have a lot of protocols we have them in books and then in handouts and*

> *sometimes even the facility own them. The facility head will also sit down to see the challenge that we have here and liaise it with the region or the Ministry of Health to come out with one.* ***(*Cram*)***

Commenting about the availability of the protocols and guidelines in the various wards, almost all the midwives knew of their availability. They were able to list some of them and they were used as recounted by Jeuna;

> *In the ward, most of the protocols were given out by the administration and we have most of the protocols pasted on the walls. So probably if you forget something, you just review and go back and look at what is there and you get to know. We have the magnesium sulfate protocol, we have Hydralazine protocol, we have a protocol for PPH how to manage and then antepartum haemorrhage as well.* ***(Jeuna)***

Additionally, another participant had this to say:

> *Most of the times, we have some of the protocols available. So that is what sometimes when you are facing any problem, we refer to it. Some are also in the file on the nurse's table. We have the PIH protocols, Mag Sulphate protocols, hypo-glycaemia protocol, newborn care, resuscitation guide, safe motherhood books.* ***(Cede)***

Participants reported of the availability and use of many protocols but disclosed that documenting such use is not done.

4.3.6 Principles used in documentation

In posing the question on principles used in midwifery documentation to the midwives, it was observed that most of the midwives changed their facial expressions to that of "shock" which showed that they were not conversant with it. However, some of them managed to talk about the principles of client focus. The self-regulation of documentation was mentioned as directed by the clinical practice. The narration of their documentation practices was in a reliable sequence, and some were in accomplishment of legal requirements by the Midwifery Council. About two thirds (2/3) of the participants had no idea about principles used in MDP. Talking about the principle on Client Centeredness documentation, a few midwives narrated that they documented detailed

information about their clients. Participants testified about documenting on the state in which clients are brought in for care and the outcomes of the care given. The midwives furthermore reported signing the reports after documentation:

> *If I'm admitting a client, the person's name, age and the address of the person are supposed to come. We are supposed to record everything about the person that you are managing. Thus the state in which the person came in with and after you have recorded it in the book, write the report and you are supposed to sign against your name indicating that it was you who recorded this admission of the person at that time.* ***(Juna)***

Self-regulation of documentation practices is the focus of these midwives during their clinical practice. This was exhibited by the accuracy of reports that was full of honesty and free from forgery. Frebe had her own opinion about principles used and narrated it this way:

> *You don't document before you start a procedure; you always document right after you've done a procedure so you don't forget, you don't do chart free. I think when you make a mistake you don't clean it with tipper or correction fluid. You just rule a line and sign against it. I also know that when you document you should sign against it so that everybody will know that you are the one who is doing the documentation, you don't add you don't subtract, write what you did*. **(Frebe)**

The fulfillment of the midwife's statutory requirement of them as a legal backing in the course of their services to clients was mentioned:

> *Any documentation should have a date and a time. It should really reflect the situation or the condition on the ground. Whoever, is writing should write such that the handwriting can be read; it should be legible enough. The salient points must come out rightly. Each report on every client or every situation that has a report written on should, I have talked about the date and time, right? Yes, it should have signatures appended to it. It should be legible and it should be timely. I mean it should be timely. As I reported, it should reflect what is happening at that particular point in time. So basically, those are some of the principles.* ***(Maya)***

Almost two-third (2/3) of the midwives had no idea on the principles used in midwifery documentation (MD) practices. Expressing her ignorance on the principles of MD, Jeuna had this to share:

> It is *basically what the doctor writes and what we ask the clients based on what they tell me. Yes, it also guides me in writing my reports.* ***(Jeuna)***

The majority of the midwives were surprised on hearing the questions on the principles used for MD which meant that they lacked knowledge on these principles which are of great importance in MDP.

4.3.7 Availability of National Health Insurance Scheme (NHIS)

The payment of services and care together with its documentation in the health facility was reported to be free as a result of the existence of the National Health Insurance Scheme (NHIS). All midwives who took part in this study emphatically indicated that no charges are taken for the care provided. The majority of the midwives explained the availability of NHIS as follows.

> *No, it's free they don't pay anything.* ***(Juna)***

Pari also had this to say:

> *What I know is that they don't pay for their antenatal book, it's free and then the stationeries that we use, I have not seen it on the costing sheet of the hospital.* ***(Pari)***

Additionally, Cram described the payment mode for those who are not on the NHIS before accessing care.

> *So, regarding the payment for care and documentation, we don't charge them. A maternal health record book is free, payment of care for maternal health services everything is free so far as the person has subscribed to the National Health Insurance. If the person doesn't have, she has to go and pay at the Record Departments and get her receipt. (****Cram)***

The mode payment for services rendered to pregnant women in the facility being NHIS and free for clients on the scheme encourages most clients access the facility. For this reason the patronage of midwifery services is always high, with few clients paying with cash before care**.**

4.4. Steps Involved in Midwifery Documentation

Process in MDP was expressed by participants as the way and manner activities are carried out during the period of care delivery to the client. Participants described these activities to be unbiased, truthful and comprehensive. Processes involved in MDP were described in four categories: timeliness and accuracy, appropriateness of documentation of care, coordination of MD and the use of patient relatives as a support person in the provision of care.

4.4.1 Timeliness and accuracy of documentation of care

Although care is supposed to be recorded at the time of the event or the time the service is rendered, it was revealed by some participants that documentations are done long after the services due to work overload. The accuracy of documented records on clients is used as baseline data for comparing current states of the client's condition for prompt interventions. Timeliness and accuracy of documentation were described by the midwives as basic, yet it was not practiced. Cram shared her thought on timeliness and accuracy as follows:

> *We also do accurate history taking that's another basic thing that we do at the antenatal services that help us to manage the client well. We take the social history, and the present pregnant history and the past obstetrical history if she has any other risk factors and again that will help us to manage her.* ***(Cram)***

Most midwives testified that documentation is done whenever pregnant women come in to access care. Good history taking and assessment through examination leads to the detection of high-risk clients. Paying particular attention to the high-risk groups for subsequent preparation and prompt intervention is important as reported by Pari:

> *If after assessment, it comes out that she has got any risk factors; I have to get ready and get the protocol that will back me or that will give me the knowledge to be able to manage the client. I can take hypertension to be an example, if I know the client has already gotten*

> *the history of hypertension, I know how to manage my client in labour. So, with their antenatal records, I can have a fair idea to manage my client. I have to make sure to see her old BP and compare with the current investigation.* ***(Pari)***

Also, documentation is done whenever care is provided to clients. The right documentation is done using appropriate sheets**.** Maya, one of the midwives, reiterated the appropriate timing for documenting.

> *Yes, documentation is done anytime midwives come into contact with pregnant women who seek midwifery care, and documentation is actually done during and after the care. During the care, you document, you interpret, you deliver care and then you assess again and document to compare to see whether what you had before and what you are now have after your intervention, what has happened and so documentation is done once you come into contact with a pregnant woman or any other person involved in the midwifery care before, during and after the care.* ***(Maya)***

MD was disclosed to be timely, accurate and done whenever a midwife render care to clients.

4.4.2 Relevance of documentation of care.

Appropriateness of documented care was stated by most of the midwives to be key to client satisfaction and quality of care. Participants described the appropriateness as the skills and the knowledge of the previous health status and the current health status of the client. Participants specified that appropriateness of documentation helps to defend them in cases of lawsuits and continuity of care by other health care team members:

> *With proper documentation, I will be able to defend myself very well. It also helps in the continuation of care to clients among colleagues. Then to the clients too when we are able to appropriately document everything that we have done, the client will be able to receive good care that she deserves at each moment.* ***(Coot)***

Another participant reported that most midwives always go through the maternal health record books of all mothers for comparison of current and past records of client's status of health. This, they reported guides them to give appropriate care for subsequent documentation.

> *When clients walk into the unit, we take their antenatal cards and go through. So, in going through we are looking for client BP and Hb during antenatal among other things. If the BP is low and after checking or examine the client the BP is high, we know what we have to start with. We then do a urine protein test before starting Mag Sulphate if you realize client has severe pre-eclampsia. We look out for Hb for instance, if it is low, we do a full blood count for every client that comes with Hb of 5 and we know that we have to transfuse. So, we even start the initiative before the doctor even comes in to come and document.* ***(Noev)***

Jeuna, on the view of giving treatments to their clients, stated that some midwives were of the opinion that suitable documentation of treatment regimens must be adhered to all the time.

> *If one needs to give treatment to the client may be Antihypertensive or Metildopa, one needs to document the time one gave the drug, observe the intake and output and also measure her urine output, because hypertensive and sickle cell cases you need to get their intake and output, to know how much is going in and how much is coming out. And then the treatment form for anyone who picks it to know that probably the patient is on Nifedipine protocol I need to document on the observation form with the time and the amount it was administered.* ***(Peal)***

The significance of proper MD was described as always being remembered whenever participants were giving service to clients for better care continuity.

4.4.3 Coordination of midwifery documentation

Organization of MD was one of the major issues reported by the majority of the midwives. The coordination of care together with its documentation was of boundless importance to the midwives. Management of clients as well as documenting their services was described by participants to have both positive and negative effects. The midwives reported that proper coordination of MD helps them in continuing client's care. Again, harmonizing MD aids with the use of the documented midwifery records as baseline data for research by some of the midwives. Management of MD was supposedly done by these participants with various stationeries. Furthermore, few participants explained how poorly coordinated documentation of MD leads to

delays, poor service delivery with poor outcome. Lastly, it was reported that coordination of MD is for national statistics on maternal health.

Positively, Maya described how statistics are generated every month from the records done by midwives to the district and region on the maternal health services for national statistics.

> *Yes, as a district hospital, we provide a lot of statistics, and these statistics are gotten from the documentation done on clients in the various wards. The Metropolitan Health Directorate always comes in to demand particular figures. These statistics are obtained through the documentation that has been done.* ***(Maya)***

The majority of the participants held a positive attitude about the coordination of MD as most of them testified that it helps with continuity of client's management. Care and its documentation practices were described to be a continuum by the midwives. This was reported to be done through the reviewing of the maternal health book and other stationeries used in MD at any given time when one wants to start or continue any treatment or care for pregnant women.

> *It helps in the continuity of work. When I document everything, I have done since the beginning of my shift till the close from shift; I don't have to talk plenty. My other colleague starting her who does know anything about the client, but when I give her the folder to read, she will be able to continue from where I ended. It makes you yourself the midwife feel good about your profession.* ***(Peal)***

There were statements from a number of midwives about poorly coordinated documentation which resulted in delays in treatment, Jeuna reports:

> *Normally, we receive severe pre-eclampsia clients but on the referral notes, at most times there were no documentation on time that the Mag Sulphate was given. One had to go and ask the client because you need to also continue with the treatment and without stating the time it was given, it becomes difficult. So, you had to go again and ask client* ***"ye mawo aduro bi, woho hyehye wo''*** *meaning were you given any medicine that you experienced burning sensation all over your body. You see, it takes extra time. One could have used that time to do something else and because documentation was poorly done. You had to spend time again to you ask questions to get your results so that you can also continue care.* ***(Jeuna)***

Coordinating MDP well will help promote quality MD whiles poorly managed MD was reported to delay care with its consequences on the client's health.

4.4.4 The use of client relatives as support persons

When the participants were asked about the involvement of client relatives in the care of the clients, they indicated that family members deemed it to be very important in giving support. Relatives are involved in errands such as making or collecting folders, giving emotional support and encouragement in times of need. All participants attested to the fact that relatives are used for running certain errands such as buying of prescribed drugs from town, sending specimens to the laboratory, and accompanying sick babies to NICU. Three of the midwives recounted their activities with the relatives

> *Yes, for the client's relatives and their support persons, they are really helpful to us because they do a lot of the errands for us such as sending specimen to the laboratory, asking them to help us get drugs for the clients, assuming we don't have those drugs on the ward, we prescribe for them and they purchase the drug for us.* ***(Cede)***

Accompanying sick babies is usually done by relatives as mothers are most often deemed to be tired, especially within the first 24 hours, and Pets had this to say:

> *When we are also sending sick and premature babies in cases or when there is a problem that the baby needs to be sent to NICU (Neonatal Intensive Care Unit). Family members also come in, because you cannot just send the baby there without the client's relatives knowing and being aware of where the baby is sent to. So, we also involve them in sending babies to NICU. They assist us in picking some of the luggage because as the ward aid is pushing the client to the post-delivery ward however sometime, the relatives do not carry the luggage.* ***(Pets)***

It was also inspirational to note that the majority of the midwives reported of relatives' involvement in the pregnancy school. Relatives are encouraged to give support to the clients in

times of need as in cases of uncooperative clients and language barrier. This was shared by Noev and Frebe:

> *We involve the relatives, we invite them to come and stand by, in most instances some come and speak their local dialect and the clients understand better with clients who come and we can't communicate with them or we can't understand their language. We always make sure a relative is around to translate for us anytime we are assessing the client.* ***(Noev)***

Frebe had to share:

> *For instance at the ANC we always encourage our clients to come or to bring their husbands and families and then, you mostly see them during pregnancy school. Because we have some programs in the pregnancy school, they came to a lot and those who have time come during normal ANC visit. They come with their husbands so when they come into the room you talk to them, you welcome them and then you allow them to ask questions or give you anything, complaints or any other thing they want to say to you.* ***(Frebe)***

The practice of involving client's relatives in their care was described as both beneficial to the family members, clients as well as the study participants. Client's relatives feel happier serving family members in need.

4.5. Outcome

The outcome was specified to be the end results of care due to MDP and its effects on client care. The outcome was also reported to include results on babies and entire family members. These outcomes were categorized into either positive or negative effects on both mother and foetus together with the family. Effects of good documentation outcome on client's care were enumerated as physical, economic, and psychological. It was also reported that it could also save participants from litigation. Poor MDP was mentioned and related to negative health care outcomes leading to an increase in morbidity or eventual death of clients.

4.5.1. Positive effects of midwifery documentation practice on the outcome of clients' care

Participants stated that there are many effects of MDP on the health and life of clients. Positive effects were mentioned by the majority of the midwives as MD having a diverse consequence on the physical, psychological and economic effects on both clients and relatives. Some of the midwives were of the view that good MDP helps with continuity of care. Julie commended on good documentation practices in the area of physical outcome and thinks that it makes the continuity of referred clients easy.

> *Well, I think accurate documentation in general actually helps. In fact, it even helps you the midwife especially when a client comes from a different facility to your facility. Clients who have accurate documentation help you to continue from where they left off. When a client comes in and there are some empty spaces in the referral letter or has not been well documented it makes care difficult. (**Julie)***

Pets shared her views on the benefits of MDP serving as reminders in clients care. Secondly, in situations where midwives face medico-legal issues, documentation is used as legal evidence. Thus, when faults are being pursued against midwives by clients and their relatives in the care or services rendered to them, participants mentioned that MD is the only thing that they can use to defend themselves. This is how Pets put it:

> *To me as a midwife, it will save me from a lot of situations because it's a legal document. I can use it to defend myself in cases of law suits. It also helps me to know what to do for my patients within the necessary minutes or hour and the immediate care that the client will need depending on the situation at hand. It makes my clients comfortable as I attend to them from time to time. **(Pets)***

Furthermore, a participant added*:*

> *"I think good documentation helps us to know in the first place how to manage your client very well starting from antenatal. MD guide midwives to give mothers injection like Anti D" to negative mothers if it is well recorded from ANC. MD helps us to know what to give babies immediately, they are born with complication. Especially protocols for every Retro baby before sending them home. **(Noev)***

4.5.2 Negative effects of midwifery documentation practice on the outcome of the client's care.

Poor documentation on client care and services were attested to have had negative effects on the continuity of client's care, increase morbidity or eventual death. Economically, most of the midwives asserted to the fact that poor or no documentation on drugs, specific treatment before, during and after discharge also affect clients this way:

> *It makes clients condition worse so family members had to spend a lot of money to care for the client and also it wastes their time. This is because some of them instead of them getting the treatment at that right time, or leaving on the day of discharge, they had to spend endless hours or days waiting for midwives to document the right information at times. An example is documentation of immunization of babies prior to clients discharge.* ***(Coota)***

One participant lamented on how poor or inadequate documentation practices sometimes increase morbidity or eventual death of clients as Peal puts it:

> *The client was brought from a different unit to this place within a short time the client delivered. The records presented on her didn't look like any highly risked person. Not knowing she had many bad medical histories and was booked for emergency Caesarian Section. When she complained of the urge to bear down, she was brought in to the labour ward and delivered soon afterward without any proper coordination between the two wards. The MO was waiting to do the surgery. Not knowing client's kidneys were shut down and she died soon.* ***(Peal)***

Janu stated that providing care to many different clients and recording later may lead inaccuracies due to forgetfulness on the part of the midwives.

> *At times we have to leave the documentation and go and take care of the clients. It makes you forget what you have to write so it's it doesn't make the documentation accurate. Because you need to attend to other clients at the same time, by the time you finish and come back to come and write all, you forget some, but you have to force to put something there because you're not supposed to leave your sheets blank so you are forced to fill in all the spaces on the sheets. So, it's hard.* ***(Janu)***

Leaving midwifery documentation undone until later may make participants forge the exact care rendered and resort to forgery which is unacceptable in midwifery practice.

4.5.3 Midwifery documentation practice effects on babies and the family

A number of the midwives' responses about the effects of MDP on babies and the family were grouped under maternal and neonatal morbidities and mortalities. Participants alleged that a few maternal and neonatal deaths are associated with poor midwifery documentation practices. In addition, an overdose of treatment was also expressed by some of the midwives; Coota and Julie had this to say:

> *"Sometimes it affects them a lot because you couldn't document properly for the continuation of care and the mother's change in condition or the baby's change in condition. Relatives has to be involved by spending extra money, time, running up and down to look for medicine and look for help so it affects the relatives. You bring your clients to the hospital fine but due to improper documentation you lose your baby, you lose your wife it is very bad, yes. Maybe if that information was written well and communicated to another person well, or written boldly for the next person to see maybe that death wouldn't have happened. (Coota)*

Additionally, Jeun also mentioned that:

> *I felt so bad because I thought I did the right thing but because of inappropriate documentation, a life was lost. You can't blame colleague for death, and you can't fish people out and just hits them with their human error, but life has been lost which is very sad two lives which is very sad. (***Julie***)*

Furthermore, one participant stated that:

> *"If you don't document that you have given vitamin K, another person will come and give it. In cases of retro-exposed babies, if Nevirapine syrup is given and you don't document someone else will give which will become an overdose. With live babies, if you don't write their sex, the name of the mother and don't give wristband then you will find yourself in trouble. If the mother wants a boy and she gave birth to a girl, without the wrist band, if she doesn't want the baby, she will tell you, madam, I had the opposite sex of what she really gave birth to. What will be your proof?* ***(Peal)***
>
> Poor, inadequate, and insignificant MDP could put participants in trouble when there are no proofs of care given to clients in case of lawsuits.

4.5.4 Patient satisfaction

Clients' satisfaction were reportedly expressed through client's interaction with midwives. Most midwives stated that although they receive praises from clients, these are not documented. Secondly, client satisfaction is ascertained through surveys by the facility. The majority of the midwives reported that mothers and their relatives call them at any time, and articulate their gratitude by saying "thank you" to them. They think that "thank you" and "may God bless you" are enough signs of satisfaction. These midwives had this to say about client satisfaction:

> *Some of the patients will say "madam me daase Nyame nhyera wo" meaning madam thank you and may God bless you. Relatives come in and "oo madam yeda moase Nyame nhyera mo" meaning oo madam we thank you all very much and may God bless you all, but we don't have a place where we document client satisfaction. The survey done through questionnaires and researches; we don't really get to know the results. Like some researchers came and interview some clients and they do not tell us the results. The results are usually given to our senior colleagues and then at the end of the year, quarter half and end, they give us the results but without motivation anyway.* ***(Peal)***

Juna and Guau also described their clients' satisfaction as a state of happiness shown by their clients. They indicated that:

> *As for my clients, they are always happy to have me to be their midwife. They always appreciate what we are doing for them and call to say thank you for what you have done, because they always ask questions and I'm always ready to answer them all. They tell me they are ok with me. Because, they call at any time and discuss their problems me. My clients are happy to have me.* ***(Juna)***
>
> *We had one done at the old building, we had our pictures on the wall (the midwives) and as they do that research, they make clients points at the picture of one particular midwife, who has been good or bad to you. I think there was a point they give it to one of our colleagues that she has been one of the best midwives.* ***(Guau)***

Maya added that sometimes the facility also conducts client's satisfaction surveys:

> *It is done through a survey. The facility conducts a survey every year and so they have the training unit prepares the questionnaires and they have a way of issuing it out to the clients*

> *to get information about their satisfaction. On the ward, personally, the client's satisfaction is expressed through their actions after care has been given. You will know that this client reaction tells you that the client is really satisfied with the care that has been given.* ***(Maya)***

Yearly, client satisfaction survey is done by the facility and in addition participants were reported to be happy when clients and relatives call or come back to thank midwives, although there was no documentation of such action as a proof.

4.6 Challenges with Midwifery Documentation.

Another major theme that emerged from the data was the challenges midwives faced with documentation of care rendered. The difficulties and impediments that hinder the process of documentation mostly experienced by midwives were stipulated to originate from other people and the environment. The poor documentation or lack of knowledge on MDP was described as a challenge. Challenges such as lack of stationeries, inadequate documentation from referring centres, interference from the relatives and other health team members, attending to non-attendants, workload, language barrier, and low staff strength were reported.

4.6.1 Lack of stationeries for midwifery documentation practice

The midwives reported the use of different stationeries in documenting the various care and services they give to their clients. For effective documentation practices, these stationeries must always be available to be used. Participants reported about periodic shortages of these stationeries, and this seems to have been experienced by almost all departments in which the participants work. The majority of the participants complained about shortages of stationeries which cause them to improvise for documentation as expressed by some of the midwives in this way:

> *The challenge where some of the forms that you have to document on get finished and we don't know what to do. We sometimes are roaming about going to other wards to borrow, but they too don't have. The most frequently unavailable ones are treatment sheets, the temperature chart, lab requests forms. When the information on these forms is not around it makes the work difficult. You'll be writing then your pen is not coming then you don't know to want to do. So, these are some of the challenges. These are some of the challenges we face in writing.* ***(Coota)***

Cede also stated:

> *Sometimes the shortage of especially this new antenatal card that is given to the mother before delivery and after delivery the weighing cards, sometimes drugs, drugs that are needed to be served and all that.* ***(Cede)***

Frebe adds:

> *Lack of stationeries, they are such that your labour summary is finished or your nurse's note is finished so you now have to improvise, and then for the challenges like I reported in the antenatal room where the cubicle is so small that you have to struggle to be able to do your documentation. All of those things are contributing factors that would make you not document properly.* ***(Frebe)***

Lack of various stationeries and poor infrastructure were some of the contributing factors in their inadequacies on MDP.

4.6.2 Interference during documentation

Interruptions from both relatives of clients and other health team members were alleged to have been experienced by the midwives. Since the facility is a referral centres for both government and private hospitals and clinics, they receive many referred cases and most of their referral notes are poorly written. Pari had this to say:

> *Referral documentation is a little bit challenging because we do well to communicate with them when they call to document everything that they have done for the client. We asked them what the client has gone through and it's like when referring, they make very quick documentation and then they bring the client.* ***(Pari)***

Interference from many causes was reported by the midwives as their biggest challenge. In their documentation practices, relatives delay or prevent them from managing their clients properly.

> *Mostly, the interferences come in when assuming a client needs to go for caesarean section, you have counseled her, she is willing but she tells you her support person is not willing so if you can talk to her support person for her, it comes up that way sometimes. Yes, so that's when you have a client's husband or mother saying no, I will not allow you to carry on with the caesarean. Sometimes when there is an incident and you want to describe it the way it happened, especially with the other team members, you see the doctors, you call in a doctor at a particular time, he doesn't come and you document, sometimes there are a lot of friction and grudges why you have documented.* ***(Maya)***

Julie reported on the language barrier that they have been experiencing with some clients who access the facility.

> *Like a client comes to you and you know sometimes language barrier and then the client might not also have a well-known idea of what you are asking her. A client can come and you even ask her of her age and she doesn't know her age. It is a big challenge to us a client can come and you ask her lots of questions and because she doesn't understand what you are saying it makes it difficult to get the facts that you want to document* ***(Julie).***

Challenges with reading another person's handwriting as a the problem of writing into so many books were narrated by Coota as a big challenge.

> *At times we do find challenges with the handwritings a lot because your colleagues are in a hurry to write. At times we come for night duty and you are feeling sleepy yet you a whole lot of clients to take care of. You work throughout the whole night; you are tired of working. The moment you sit by the notebook to write then you are "dozing" at times some of the things you write, you cannot read them yourself because you were tired at the time you were writing.* ***(Coota)***

Challenges with language barrier, interferences from client's relatives, other health team members, and poor handwriting of staff together with work overload were reported to make participants tired most of the time.

4.6.3 Poor working conditions

The working environment of these midwives was described to be poor by the participants. The consulting rooms where they see pregnant women at the ANC and midwives' stations from where most of the documentation is done were reported to be uncomfortable. The midwives exhibited their displeasure about the immediate environment with these quotations:

> *I have worked in consulting room one, room two and room three. Those are very small rooms and then you have your couch there, you have your table so you have to squeeze things inside. So, it is not easy when flipping your books, the book is very long and big and the table is small so is like it makes things difficult. Three rooms with that situation, it makes it difficult so it's not good that with our ANC setting "dea" meaning is not good (laughs) is not. You know if you are comfortable psychologically, physically you are okay so you do what you are supposed to do but if you are straggling, definitely every other thing you do will struggle as well.* ***(Frebe)***

> *Of course, as for the complaints we make complaints, but your superiors will tell you it will be done. Where we sit to document, the whole place is warm, you sweat and sweat. We have complained several times. At least a small air condition (AC) should be fixed there for us at least so we feel comfortable oh we will do it today; we will do it tomorrow. Okay fine if you are not getting the AC because you think it's expensive, get us a small fan, standing fan at least so we also feel okay. It is not coming, today, tomorrow, today, tomorrow, is not coming so and you can't say you won't work.* ***(Peal)***

4.6.4 Work overload

All the midwives complained bitterly about their workload. The number of clients participants have to manage during their shift was reported to be too many. This makes them leave documentation for the incoming staff to start or continue with care rendered.

> *The workload is a lot, is huge, so immense documentation becomes a problem especially where you have to document here, document there, document there, document there, lot of books so you write some and you leave some.* ***(Frebe)***

Jeuna also stated that:

> *Today I have like nine cases for theatre from the ward and emergencies will cross us and we are two, I went to the theatre and the person left in the ward is making sure she is*

> *getting everything up to date so when I come I will help in. So the lack of staff, I will say, is having effect on the documentation.* ***(Jeuna)***

Pressure on midwives was reported to be due to increased clients seen per day and its effects on documentation. Clients feel they are being neglected when midwives are documenting into the various registers. Pets and Julie narrated their experiences:

> *When we are even attending to one, some clients may also be waiting for us thinking we have wasted much time on one person. But they don't know that we have to make sure the vital key or the information that you need to ask and write them so they may feel neglected.* ***(Pets)***
>
> *But for this facility, the pressure here and sometimes the staff strength are not equal. So, we do not really get to document some of the things. In my facility, we have a problem with the staffing, even now I am the only staff on duty with about 30 plus bed capacity, this my ward, we run both the ward and the theatre. So basically, I run between the theatre and the ward. And with the ward, I have to check my B/Ps serve medication, check the foetal heart rate for every woman before my duty ends.* ***(Julie)***

Workload was revealed to be so heavy on the few midwives who reportedly to overwork themselves. In some cases they are forced to run between two wards at the same time when they are on duty.

4.6.5 Poor staff strength

Staff strength and its effects on documentation practices of clients care and services were unearthed as one of the sub-themes. Midwives in this study openly expressed their opinions on the outrageous numbers of clients who access their facility as against the number of staff on duty most of the time. This has propelled them to the adoption of many strategies to cope with their work.

> *The number of staff is small and the number of clients that come here is more than the staff's strength, so it can be that we have few staff members and then the clients are many, so we have to balance and say how many members of staff will be able to see clients within one's shift. We need to take the statistic. Because at most three staff will be on duty and clients who come into the labour ward within the 24 hours is more than fifty. About 25-35 deliveries a day as against poor staff strength means the staff find it very difficult to do the documentation. A lot of this documentation is left for the next shift. Shortages sometimes*

> *become so serious that you can even have one staff with a student or rotation midwife on duty. You want to do a lot of deliveries before coming to sit down and then write whatever management that you have done for the person.* ***(Pari)***

Documenting into many books was problematic for these midwives because of the amount of time spent documenting one case, Guuta lamented;

> *You see even in one admission there are a lot of books you will have to write in. They are many that one person handling them is difficult. But with my formal station, the staff strength was ok, so the pressure was not that much so you will say the documentation there was ok, was better than here with me. Secondly it's a big problem because if you are staff strength is inadequate, it affects the documentation because you can't document everything as and when because you might forget. Because if someone needs my attention, you have to leave and quickly rush and by the time you come back you might have forgotten what you have done for her check for what you have done for the person to write but maybe you have done what am supposed to but the documentation you will not be able to do it.* ***(Guuta)***

Cede was very angry about the number of entries that midwives had to do on a single client's care and had this to say:

The challenge is about the number of books that we enter. You write this, you have to write that you write this you have to write that. Those are the challenges. One client, you write so many things about her not in one book but in so many different books at the end of the care. ***(Cede)***

4.7 Attitude towards Electronic Health Documentation

Electronic Health Records (EHR) was reported to be one of the means of documenting clients care adopted by the private health facilities in the metropolis. The majority of the participants called for the adaptation of electronic midwifery documentation practices. These participants reported that EHR will help ease the accessibility of information on clients.

4.7.1 Perception of electronic documentation

Suggestions came from most of the midwives that midwifery documentation should be scaled up from the paper and pens or manual writing to an electronic version. They called for computerization of all the stationeries for easy documentation of client's care. Some of the midwives had these to say:

> *"The change from writing into electronic health records you know will help us. Something simple that we can use as software because when you go to the private hospitals it makes documentation easy. When you go you just put your card there and then you go to see the doctor. Is just your card, when they open the system, they get information they need about you. If we get something like that in the public health facilities, it will help. Because the paper works are too much and the papers can even get torn.* ***(Jeun)***

For minimization of writing Cede reported:

> *I think there will be a way of having one system where a client comes, you is able to enter everything about the client into one system. Again, you don't need to go back into another book, I think it will help.* ***(Cede)***

Commenting on the means to make midwifery documentation a bit easier in the situation of high clients' patronage as against the low staff strength. In her opinion:

> *Documentation will be much easier because I have so far, I can count a number of facilities that have a computerized system. You key in the next person comes you don't give clients folders anymore. You don't use sheets anymore. All you do is the care you have given the client. You just come and sit and key in the next person that come key in. This client came this morning this this this has been done. This is what the doctor reported, the medication and everything is given, it helps so you don't end up I can't find my folder.* ***(Peal)***

The study midwives were of the opinion that having an electronic documentation would help prevent the use of physical paper folders and many registers and sheets which will make MD much easier.

4.7.2 The need to adopt electronic health records in MD

Participants were of the view that most government facilities are without electronic documentation. Most of the midwives knew the benefits of using electronic means to do MD as against the use of manually generated records.

> *There, at the northern region, I realize that when the clients come in you only need to enter the name of the client and every information about the client you get it so right from even postnatal the client come in after delivery you get information as far as when the client started the antenatal but here sometimes you come they don't even come with their antenatal records and they will tell you they attend clinic.* ***(Noev)***

For appropriate care to be given to clients, the adoption of electronic health records for use in MDP was suggested by Cram:

> *The use of the laptop had more of yes or no when you tick. It gives you a clue even if you forget to do something. There is always a red beep so that it will bring your attention that this thing wasn't done so you go back and do it. Let's say for instance maybe a woman comes with the blood pressure of 142/80 sometimes then you forget to do the urine protein, it will give you an alert.* ***(Cram)***

Coota stated that it helps with the generation of midwifery statistics on maternal health:

> With *the use of the electronic documentation, it helps a lot because at the end of every month, the care we rendered to our patients, everything is there. You know the number of clients you took care of, the number of deliveries, all those things, it helps you to improve when everything is done satisfactory then you know we are doing well with just a click, so it helps, it helps a lot. (Coota)*

Participants suggested the adaptation of computerization of midwifery care rendered to clients.

4.8 Summary of Findings

The findings of the study showed that the study participants were between the ages of 29 -56 years with the majority of them being Christians. Most of the participants were married with a few single ones. The lowest educational level of participants was midwifery certificate and the highest was a degree with a certificate in nursing administration. Participants' ranks were mainly

Staff midwives and a Principal midwifery officer. Participants' years of practice as midwives were between four years and eighteen years. Most participants have stayed in their current units or wards for periods of one year to ten years. Languages spoken by these midwives were between two and six languages.

The study revealed that for quality MDP, the midwives needed certain structures such as stationeries for MD including ANC, PNC and Delivery registers, notebooks for report writing, and different sheets for specific documentation. Shortage of personnel's for MD was revealed. Principles used in MDP, protocols, and guidelines for MDP, supervision use in MDP were all reported as well as the effects of the availability and use of NHIS. The process involved in MDP was discovered to be the timeliness and accuracy of documentation, appropriateness of documentation of care, coordination between the various stages of MDP, and the use of patient relatives as support persons. The findings from this study also revealed positive and negative effects of documentation on the outcome of care of the clients, client's babies and their relatives. Furthermore, the findings of the study revealed that the majority of the midwives reported many challenges which were impediments to proper MD.

Another remarkable finding of the study was the call from the participants for the need to adopt electronic health documentation in MD. Finally, the majority of the participants were of the opinion that adopting electronic health records in MDP could help improve client care.

CHAPTER FIVE

5.0 DISCUSSIONS OF FINDINGS

This chapter discusses the findings of the study. The discussion is organized according to the main themes as presented in chapter four.

5.1 Demographic Characteristics of Participants

The midwives who participated in the study were all within the working class with more than two-thirds of them (77%, n = 10) within the age range of 29 to 40 years, whiles 23% (n = 3) were within the age range of 45 to 56 years. Their ages also fall within the expected working-class age of Ghana. More women are found within the midwifery profession and this applies to the Greater Accra region, especially the setting where this study took place. The majority of participants were married (69.2%, n = 9) and had children ranging from one (1) to four (4). Also, 23.0% (n = 3) of the participants were single and 7.7% (n = 1) was a divorcee. The participants can be described as gainfully employed in a profession which mandates them to document every care that they render to their clients. Furthermore, some of the midwives have worked in their wards for five (5) to ten (10) years.

Findings from the study indicated that the majority of the participants (92.3%, n = 12) were Christians, while 7.7% (n = 1) was a Muslim. Ghana is believed to be largely dominated by the Christian religion (Ghana Statistical Service, 2014b). It must be pointed out that religion was not used in any way in making conclusions from the study findings. It was found that the educational background of participants was: 38.4% (n = 5) had basic education up to the senior high school level in addition to their professional certificates. Then, 30.8% (n = 4) had a diploma in midwifery, 23.1% (n = 3) had a degree in nursing with 7.7% (n = 1) having a certificate in health administration. All participants were in formal employment with the Ghana Health Service of the

Ministry of Health. One can, therefore, use participants' employment to form the basis for their involvement and experiences in MDP.

5.2 Structures used for Documentation Practices

Requisite structures necessary for accurate MDP were found to include resources such as stationeries, personnel, logistics, protocols, guidelines, principles and supervision on MD. The study found that the structures mostly used for documenting midwifery services were paper-based. The number of forms that the midwife needs to copy the same information about a client and/or her child onto also adds another burden to documentation. This made record keeping and retrieval difficult. It was also revealed that since documentation of clients' information is done manually, most of the recordings were not legible and lacked clarity. This finding is congruent with a study in New Zealand that found among the barriers to nursing and Midwifery Documentation (MD), lack of comprehension and accuracy as well as timely documentation (Blair & Smith, 2012). It was also found that lack of frameworks to follow during documentation led to distorted information. This observation is in line with Blair and Smith's (2012) study which found that implementation of frameworks such as the North American Nursing Diagnosis Association (NANDA), problem-oriented nursing notes, and integrated care pathways (ICP) increased clarity and reduced the errors in nursing documentation. MDP has not seen any improvement as disclosed by some of the participants. This is in line with a study conducted in Iran by (Dehghan, Dehghan, Sheikhrabori, Sadeghi, & Jalalian, 2013) which stipulate that for nursing and midwifery documentation to be better, governance in clinical documentation packages should not just be made as a model but as a requirement in all facilities to practice under stringent supervision.

The study also recognized that the high ratio of women seeking midwifery care to midwives and the number of high-risk pregnant women on the ward was associated with poor

documentation practices of the midwives. Participants disclosed that when clients outnumber the midwives, midwives considered hands-on-care to be more important than documentation of the care provided. As such, the care rendered is usually neglected until the end of the shift for the procedure to be documented, leading to most vital points not being captured. Interestingly, Bailey et al. (2015) did not find any effect of the number of midwives on duty and the number of high risk cases on the quality of basic midwifery note keeping, a finding contrary to that of the current study. Yet, the authors found that midwifery documentation errors increased closer to the end of the shift and that agrees with the findings of this study. Notwithstanding, the findings of the study are in tandem with the findings of Blair and Smith (2012) who found that, the hands-on bedside nursing and/or care, take pre-eminence over documentation of the same care thereof. Even though this attitude promotes patient wellbeing and contact time with the care provider, evidence of the care rendered is lost and hampers continuity of care (Prideaux, 2011). Midwives were also found to have difficulty in coping with increased workload and accurate documentation, suggesting that the quantum of work is inversely proportional to the quality of MD, a finding, well documented in the literature (Bailey et al., 2015; Blair & Smith, 2012; Shihundla, Lebese, & Maputle, 2016).

On the provision of logistics used for documentation, it was realized that institutional set ups were not favourable for good midwifery documentation. Heavy notebooks, lack of computers and unavailability of simplified charts, made documentation cumbersome. Some of these logistics were not readily available since different wards had to share the limited registers and notebooks for record-keeping. Again, the study findings revealed unsuitable working environment such as inadequate space to place their registers during documenting clients' care as well as poorly furnished midwives' stations had a negative effect on MD. This finding confirms other studies' findings which shared that found that using a well-designed computer technology in addition to

provision of suitable structural set up improved the nursing and midwifery quality and accuracy of documentation (Saranto et al., 2014). Also, when charts are simplified and accessible at the click of a button, midwives demonstrated good attitude to documentation and errors were also reduced (Bailey et al., 2015; Blair & Smith, 2012; Nakate, Dahl, Petrucka, Drake, & Dunlap, 2015; Prideaux, 2011).

To improve the accuracy of documentation, the study recognized that the midwives were supervised by the ward-in charges. The superiors scrutinized the comprehensibility and the appropriateness of the written reports. Inaccuracies and omissions are queried and corrections are effected. Other measures that the study found to check on the documentation practices of the midwives were maternal mortality and still births audit. These audits are done quarterly and sometimes, annually. Although these measures ensured that tallies and statistics are right, they did little to improve the quality of the content of the written report. This outcome is congruent with a study in Uganda that found that supervisory roles played by superiors enhanced midwifery documentation (Nakate et al., 2015). However, staff shortage and lack of appropriate logistics thwarts the efforts of the superiors to improve documentation.

It was also identified that none of the midwives had ever attended any workshop specifically on MDP. This could possibly explain why midwives, even though are aware of the fact that care undocumented is care denied yet leave many reports undocumented. As the personnel practice over time, they ignore the importance of care documentation. This findings confirms the fact that to be able to produce clear, succinct, legible and legally prudent midwifery reports, regular workshops on documentation practices are indispensable (Blair & Smith, 2012; Kerkin, Lennox, & Patterson, 2018). The lack of workshops and in-service training on MDP explains the shock

expressions the majority of (69%) of the participants showed when they were asked questions on the principles used for MDP.

5.3 Steps involved in midwifery documentation

This theme describes the processes and the manner in which midwifery services and care are documented. According to the study, the process of MD has been categorized into four by the participants; a) timeliness, and accuracy, b) appropriateness of documented care, c) coordination of MD and d) the use of patient relatives as support persons. These processes reportedly influence the unbiased, honest and comprehensive nature of the written reports.

Even though the midwives demonstrated the desire to ensure accurate MDP, the timing of the documentation was poor. Instead of being progressive, the reports were usually written long after the care had been rendered. This behaviour was found to affect continuity of care as well as proper communication among health care providers. This finding supports a wealth of evidence that suggest that there is a lot of data incompleteness which in turn distorts communication among health professionals. This, inadvertently, has a negative effect on the recovery of the client (Asamani et al., 2014; Hawley, Janamia, Jackson, & Wilkinson, 2014).

Regarding the appropriateness and coordination of documented midwifery services, the researcher recognized that the midwives knew what to include in their reports. Clients' past medical histories, drug history, familial history of chronic disease, parity, and history of previous deliveries among other facts were reported to be included in the report. In as much as some of the reviewed reports lacked these important aspects, most of the clients' reports had these additions. Similarly, a study in Jamaica found a high knowledge level of nurses on documenting complete details of the clients (Blake-Mowatt, Lindo, & Bennett, 2013).

Also, it was identified that most mothers did not know vital information about themselves concerning their haemoglobin level, hepatitis B and HIV status and discharge education consistent with their condition. Interestingly, Flink et al. (2015) also found that primary healthcare documentation was poor in terms of patient-centredness as many clients did not know or had little knowledge on their treatment plans.

Furthermore, the researcher observed that well-coordinated, succinct and legible documentation enabled the midwives to offer precise intervention for high risk mothers. This is similar to a New Zealand study findings which emphasized that the value of practice experiences of midwives gives them the confidence in low risk clients management (Hunter, 2017). Undue delays were prevented and complications halted when reports about clients were detailed and concise. When clients' particulars lacked clarity on past medical history and reports on past deliveries, those clients tend to have more complications and interventions were delayed as the care providers were unsure where to begin. In line with this, several studies have found that good health delivery outcomes and provision of spot-on midwifery interventions hinges on the quality of the clients' report (Bailey et al., 2015; Blair & Smith, 2012; Kerkin et al., 2018).

The study reported that proper management of MD helps the midwives with continuity of client's care which was described to be a continuum by these midwives similar to findings of a previous study (Aquino, Olander, Needle, & Bryar, 2016; Mathioudakis, Rousalova, Gagnat, Saad, & Hardavella, 2016).

Participants disclosed that continuing with treatments that have undocumented time of the start of treatment makes continuation of care very difficult. This current finding is similar to a study conducted in Sweden by Öhlén et al. (2013), which found disjointed documentation by nurses in the advance home care makes following the nursing process problematic. With the

advancement and increase of medico-legal issues, in order for midwives to defend themselves in the courtrooms in cases of lawsuits, all MD must be done accurately.

The study found that clients' relatives are used as support persons during the execution of services to clients. Participants indicated that the client's family members always deemed it imperative to support their family members when they come in to access midwifery care as reported in the literature (Pomey et al., 2015). The present study also found that relatives are reported to be helpful in running certain errands such as getting prescribed drugs, transferring specimens and results to and from the laboratory. Again, relatives were reported to be helpful in giving emotional support and encouragement to patients/clients in times of need and accompanying sick babies to the neonatal intensive care unit (NICU). This is in line with findings of Loghmani et al. (2014) on the effect of the client and relative relationship on care. It was inspirational to note that relatives' involvement in the pregnancy school during the antenatal period created a rapport with clients and encouraged effective midwifery care. Nevertheless, lawsuits discourage midwives and bring down the ability of midwives to be supporters for women. Building such a relationship with relatives' involvement should be encouraged as it gives and boosts the psychological states of both clients and relatives. This would also create a lasting bounding relationship among midwives. It is recommended that, this aspect of care giving by client's relatives and family members could also be documented.

5.4 Outcome

In this study, the outcome was described by the participants as the effects of MD on clients' health outcomes. The consequences of MDP on the client, baby, and the entire family are multi-dimensional and may be positive or otherwise. Positively, the majority of the midwives stated that MD is of great significance. Some midwives were of the view that good MDP assists with

continuity of care and helps them to know at first hand, how to manage their clients. In high-risk mothers, precise documentation of clients' report enables the midwife to envisage and prepare for labour complications. According to the participants, properly documented maternal records play significant role in reducing obstetric complications and/or maternal mortalities and stillbirths. Available evidence suggests that as a practitioner of normal childbirth, the midwives' roles revolve around the information they receive about their clients. The ability to apply evidence-based strategies to ensure safe delivery depends on the care provider's knowledge of the history of the clients (Hammond et al., 2013; Luyben et al., 2017; Russell, 2018). Hence, the findings of the study lend credit to existing knowledge.

It was revealed that when midwives are faced with medico-legal issues, it is this document that is used as a legal backing for their actions. Some midwives were of the hope that their documentation will save them from many situations because it is a legal document. They alleged that they can use it to defend themselves in cases of legal issues with unsatisfied clients. In the wake of widespread threat of litigations and claims of negligence, studies have found that the only surety of the midwives' defense is a well-documented process of care. Considering that the labour room is a high-risk litigation and claims area, the midwives tend to play defensive roles rather than working in the best interest of the client for fear of legal liabilities (Robertson & Thomson, 2016). Awareness of lawsuits has also been found to limit midwives to practice guidelines and is less likely to empower mothers (Murphy, 2019; Robertson & Thomson, 2016).

This study also discovered negative effects as a result of MDP on the outcome of the client's care. It was unveiled that poor or improper MDP have negative effects on the continuity of the client's care, which they alleged contributed to the increase in morbidity or mortality in both neonates and mothers. This becomes serious when high-risk clients are presented as normal cases.

Again, most midwives emphasized on the fact that poor or no documentation on drugs, specific treatment before, during and after discharges affect clients economically. Similarly, Zegers et al. (2011) also reported of unreadable, insufficient, not comprehensible records and disordered nursing documentation, as predicting poor quality of care. This confirms the fact that some errors could result from these poor practices leading to morbidity and mortality.

The participants reported that poor MDP contributes to deterioration of clients' condition, prolonged hospital stay and increased use of health facilities. In turn, the family members will have to spend a lot of money during client care and also waste their time. Furthermore, most participants explained and described how they had to care for large numbers of clients before documenting these services. Participants are reportedly forced to forge information on clients if there was a long lap's time between services given and documentation. This finding supports the assertion that poor documentation practices are positively associated with high rates of adverse effects and/or under-assessment thereof. Most documents are forged to represent what happened during complications. Most midwives are compelled to provide results for statistics and as such false policies are forged (Melberga, Dialloc, Storenge, Tylleskära, & Molanda, 2018; Zegers et al., 2011).

Another cardinal finding in this study is patient satisfaction (PS) of the care which comes as a result of MDP**.** PS was reported to be expressed through the client's deeds and relationships with midwives after clients have accessed care. The participants alleged to have always received appreciation for what they do for their clients. They claimed that their clients normally call to articulate their gratitude by saying thank you to them. They think that "thank you" and "may God bless you" are enough signs of satisfaction. The majority of these midwives explained that their clients sometimes call them to say *"madam me daase Nyame nhyira wo"* meaning "Madam thank you and may God bless you". This indicated that most of the participants were satisfied with their

job. Similarly, a study by Baffour-Awuah, Mwini-Nyaledzigbor, and Richter (2015), in the Ghanaian setting, calling the name of God to bless someone is a great honour and a sign of appreciation from whoever says that. "May God bless you" is therefore accepted as a representation of client satisfaction.

Furthermore, it was specified that a client satisfaction survey is conducted every year because the facility has a training unit which prepares the questionnaires and administers them to clients to get information about their satisfaction. However, most midwives stated that although they receive praises from clients, participants do not have a place where they document client satisfaction, therefore these are not documented. For posterity's sake, such documentation on the gratitude from these mothers and their relatives could also be documented to motivate midwives. When care is well orchestrated using evidence-based practices, clients become satisfied and goals are achieved (Hammond et al., 2013).

5.5 Challenges with midwifery documentation

Challenges were found as one of the major themes that emerged after data analysis. The midwives reported to have been facing many difficulties in documenting care rendered to clients. The study revealed such difficulties and impediments as lack of stationeries, inadequate documentation from referring centres, interferences from the relatives and other health team members, workload, language barrier, and low staff strength. The above-identified challenges were testified to have hindered the process of documentation by midwives. The participants also stipulated that the challenges on MDP are believed to originate from other people and the environment, likewise the poor or lack of knowledge on MDP.

Lack of different stationeries was discovered to have been experienced during MDP by all participants. The frequent shortage of stationeries on which the midwife documents care, and

other reports compels the personnel to move from one ward to another in search of these sheets and forms. They specified that the most frequently used charts which are most often scarce include treatment sheets, the temperature charts, laboratory request forms, new antenatal cards, weighing cards, labour summary sheets and nurses' notes. The participants reported that periodic scarcity of these stationeries, hampered documentation. The study revealed that the majority of participants who complained about shortages of stationeries resorted to improvising for MD. In this study, midwives reported of the lack of stationeries in documenting the various care and services they give to their clients. This finding highlighted the results obtained by Nakate et al., (2015) that shortages of stationeries played an important role in hindering the documentation practices of nurses and midwives in Uganda.

Some of the study participants complained about interferences encountered from clients' relatives during MDP and other health team members as their biggest challenge. In line with their work, midwives reported that relatives delay or prevent them from getting the required information on the client. The midwives described situations where they have client's husband or mother refusing to allow staff to send a client to the theatre for Caesarean section and therefore will not sign the consent form for documentation. In addition, midwives are also compelled to write reports that suit their superiors and doctors when incidents occur. They are persuaded to water-down the real culprits to save other colleagues. The participants described situations such as doctors arriving late to attend to clients. If such situations are recorded by midwives, they result in grudges between the midwives and the doctors. This confirms the idea that the midwife does not only need practical knowledge and skills but must be empowered to be confident so as to offer continuous support and manage situations (Patterson et al., 2019).

Inadequate staff strength and its influence on documentation practices of clients care and services were unearthed as one of the sub-themes. Midwives described the ratio of clients-to-midwives to be more than 30:1. It was revealed that on the average, two midwives come to duty at a time and they are expected to perform about 25-35 deliveries in some facilities. These high clients turn-out, put undue pressure on the limited number of qualified midwives. The study found that the midwives delegate documentation to student midwives and/or health care assistants while they engage themselves with the more technical aspects of the patient care. Students and lower cadre of midwives and nurses taking over such important aspect of care continuum is inevitably associated with errors and omissions. Staff shortages coupled with numerous bureaucracies in documenting midwifery care results in poor documentation practices. Equally, many studies have illustrated that increased nurses' and/or midwives' workload due to low staff strength is associated with incomplete and/or unavailability of clients' information, legible, and inaccurate documentation (Bailey et al., 2015; Blair & Smith, 2012; Kerkin et al., 2018; Nakate et al., 2015; Shihundla et al., 2016).

5.6 Attitudes towards Electronic Health Documentation

The findings of this study indicated that the majority of the participants knew of the existence and benefits of Electronic Health Records (EHR). It was reported that it is one of the means of documenting clients' care which has been adopted by most private health facilities in the Tema metropolis. The participants disclosed that the adoption of simplified computer software can help synchronize fragmented patients' data, improve legibility of reports as well as centralize patients' information. The study participants advocated for computerization of all the stationeries for MD to make documentation of client's care less stressful. Likewise, many studies have underscored the benefits of electronic patient health records such as safety of patients' data,

decreased paper-based records and cost effectiveness as well as improving the quality of documentation (Ann, 2014; Prideaux, 2011; Secginli, Erdogan, & Monsen, 2014).

In summary, using the Donabedian quality assurance to guide this study has facilitated unearthing structures that are necessary for the execution of quality MD that is associated with quality care rendered to clients. The description of the processes such as accuracy, timeliness, appropriateness and coordination of thoughts which are expected to be followed when documenting clients' care leads to client's satisfaction. Again, the study found outcomes of MDP to be either negatively or positively affecting client's health. The use of the model moreover helped with the discovering of some emerging themes from the data in line with challenges experienced during MDP. The attitudes of participants towards the EHR was revealed as positive. Finally, various means of improving MDPs were recommended by participants to the policy makers and the institutions involved in the provision of maternal health services.

CHAPTER SIX

6.0 Summary of the Study Findings, Implications for nursing and midwifery practice, Limitations, Conclusion, and Recommendations

This chapter presents the summary of the entire study and discusses the implications of the findings for nursing practice and nursing research. Limitations of the study are presented, and conclusions are made. Finally, recommendations based on the implications of the findings are outlined.

6.1 Summary of the Study

Comprehensive documentation of midwifery services is considered as the foundation of building midwifery knowledge, serving as a benchmark for the learning experiences of midwifery students, and a baseline for midwifery research. However, among midwives in the Greater Accra region, MDP is done amidst many challenges. This study, therefore, explored midwives' experiences with documentation practices of maternal health records in the Greater Accra Region using the Donabedian Quality Assurance Framework of 1982 as an organizing framework. The study objectives were expressed using the constructs of the Structure-Process-Outcome of Donabedian framework (1982). An exploratory descriptive qualitative research design was used to engage thirteen (13) practicing midwives who willingly volunteered to express their views on MD. The study was conducted at a district hospital in the Tema Metropolis. Ethical clearance was sought from both the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana and the Ghana Health Service Ethical Review Board. A semi-structured interview guide was used for data collection after a pre-test at the La General Hospital with three midwives who facilitated the refinement of questions to fit into the context of the study. Purposive sampling technique was used to select the participants who were all assisted to sign a

consent form before the interviews. All interviews were audio-recorded and transcribed verbatim. Concurrent transcription and analysis of data using thematic content analysis were done.

The study found that MDP mostly dealt with the availability of structures including stationeries, personnel, principles, protocols, guidelines, logistics, and supervision which contribute to the quality of MD. The participants believed that for quality MD to be produced, midwives must be supplied with the necessary stationeries which they categorized into ANC, PNC, delivery registers, and notebooks for reports and specific sheets for various stages of care. Availability of personnel, logistics, protocols and guidelines, supervision, together with the adherence to the principles on MD were also mentioned as important.

The process of generating MD was identified to have four significant steps which included timeliness and accuracy of MDP, coordination of MD, appropriateness of MDP, and the use of patient relatives as supports. The participants were of the view that swift, detailed and proper care given to clients and MDP involving client relatives can make midwifery work noticeable. With respect to the positive and negative outcome of MDP, the effects on mother, baby together with the family were identified to have inordinate influence on the lives of clients, babies and family members. The study participants attributed the positive effects of MDP to good care outcomes which were preferred by participants. Poor MDP was associated with maternal and neonatal mortality and morbidity.

Furthermore, challenges concerning MDP such as lack of different stationeries affected participants DP. Interferences during MDP from relatives of clients and other health team members were reported to obstruct participants' MD. Poor referral documentation practices, language

barrier between clients and staff as well as unreadable staff handwriting were disclosed to contribute to inadequacies in MD.

Shortage of staff, heavy workload and the repetition of the same information on clients were all found to thwart proper documentation practices. It was also found that attitude of participants towards EHR was that of welcoming for computerization of MD. The participants disclosed that the benefits of Electronic Health Records (EHR) to MD outweighed that of manually generated records. The midwives in their quest for quality MDP advocated for computerization of all the stationeries for MD for easy documentation. Electronic health records are believed by participants to solve the problem of repetition of information and the use of several stationeries.

6.2 Implications

The findings of the study had implications on documentation practices and midwifery research.

6.2.1 Midwifery practice

The study findings revealed the existence of several stationeries used for documentation. Participants furthermore disclosed that shortages and lack of some of the sheets for documentation delay their practice in documenting the care given to their clients. Therefore, to confront this challenge, heads of facilities need to ensure the availability of these stationeries for MD. Periodic workshops and in-service training on the usage of newly introduced and old stationary on MDP for staff and midwives from the referral facilities must be conducted.

In addition, stringent supervision modalities should be put in place for all facilities providing maternal health services to ensure quality MDP. The working environment of all staff must be improved so that psychologically, these midwives would render their services without any stress from the environment.

6.2.2 Future research

The findings of the study indicated many challenges in the structures used in MDP in the district hospital in the greater Accra region, Ghana. However, the provision of these structures and improvement of the processes are beyond the participants; therefore, a consideration by the government of Ghana through the MOH, GHS, to do further research in the documentation practice among midwives is recommended.

Furthermore, detailed research on the reported challenges and ways to improve MDP in this study should be done. Information from these studies may guide policymakers on how to adopt strategies that will focus on the needs of participants to ensure quality MDP.

6.3 Limitation

Although the study has unearthed the challenges and the ways by which midwifery documentation practices could be improved, the study was not without limitation. The first limitation relates to other health team members who are also involved in the execution of MD but were not included in the study. Again, other midwives, who might have done MD but now not in the maternity units, were excluded from the study. Research into individual documentation on procedures and reports should have been done to enable the researcher gain variations of documentations pertaining to specific procedures.

6.4 Conclusion

This study explored the documentation practices among midwives in the Greater Accra region, precisely (a district hospital in Tema metropolis) using the Donabedian Quality Assurance Framework as an organizing framework. It was found that midwifery documentation practices face many challenges and there are numerous ways through which the practice could be improved. These challenges are critical to the production of quality MDP. The participants called for the adoption of electronic health records from handheld documentation. The findings of this study suggest that midwives need to have the necessary structures and processes in place to help with quality MDP with the organization of frequent workshops, supervision and monitoring of MDP. Therefore, these findings have implications for midwifery practice and further research.

6.5. Recommendations

The following recommendations are made to the Ministry of Health, Ghana Health Service and the District Health Management Team, Tema Metropolitan Health Directorate (TMHD) based on the conclusions drawn from the findings of the study.

6. 5.1 Ministry of Health, Ghana

The Ministry of Health (MOH) should:

1. ensure the extensive experiential learning of MDP in the current curriculum of the health training institutions in Ghana for student midwives scheduled for clinical practicum;
2. collaborate with GHS to institute a policy on Midwifery Supervisors (MS) who must be well vested in the structures, processes and the outcomes of MD to do proper supervision and monitoring of the current MDP;

3. call for the national adaptation, implementation and acceptance of EHR which aims at the standardization of MDP.
4. increase midwifery staff strength to improve care giving.
5. collaborate with GHS to re-assess the workload of midwives to help deal with staff shortage in heavily congested health facilities.
6. form and strengthen Quality Improvement Teams (QIT) in the various maternity health care facilities.

6.5.2 District Health Management Team (DHMT), Tema Metropolis

The DHMT under the Ghana Health Service should ensure:

1. the number of midwives on a shift correspond with the total inflows of clients to prevent situations where clients outnumber the staff on duty;
2. collaboration with facility heads to provide continuous in-service training on MDP for midwives;
3. adequate provision of stationeries, guidelines, protocols and principles on MDP is made specific for individual wards in the maternity unit;
4. a safe and conducive working environment for the midwives to document without stress;
5. intermittent organization of in-service training and facility durbars to discuss the need for quality MDP to improve maternal health services;
6. proper supervision of monthly report writing to produce quality MDP in all facilities rendering maternal health service.
7. Development of a policy on MD by the Nursing and Midwifery Council of Ghana to ensure that supervision on quality MDP by practicing midwives is adhered.

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APPENDICES

APPENDIX A

INTRODUCTORY LETTERS FROM SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF GHANA TO NOGUCHI IMR-IRB

UNIVERSITY OF GHANA
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING

Ref. No.:.....SON/A.12..... October 18, 2018

The Chairman
NMIMR - IRB
P.O. Box LG 581
Univ. of Ghana
Legon.

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Yirenkyi Danquah Augustina, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: **"Documentation Practices within a Quality Assurance Framework: Midwives Experience in the Greater Accra Region".**

I hope that the Institutional Review Board will consider the proposal to enable her collect data.

Counting on your usual co-operation

Thank you.

Yours faithfully,

Dr. Florence Naab
Head, Dept. of Maternal and Child Health

COLLEGE OF HEALTH SCIENCES
• P. O. Box LG 43, Legon, Accra, Ghana. • Telephone: +233 (0) 302 513 250 / 0289 531 213
• Email: mch.son@chs.ug.edu.gh • Website: www.nursing.ug.edu.gh

APPENDIX B

INTRODUCTORY LETTERS FROM SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF GHANA TO GHANA HEALTH SERVICE ETHICAL REVIEW BOARD

UNIVERSITY OF GHANA
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING

Ref. No.:.....SONA/12..... October 18, 2018

The Chairperson
Institutional Review Board
Ghana Health Service
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Yirankyi Danquah Augustina, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: **"Documentation Practices within a Quality Assurance Framework: Midwives Experience in the Greater Accra Region".**

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Counting on your usual co-operation

Thank you.

Yours faithfully,

Dr. Florence Naab
Head, Dept. of Maternal and Child Health

COLLEGE OF HEALTH SCIENCES

• P.O. Box LG 43, Legon, Accra, Ghana • Telephone: +233 (0) 302 613 950 / 0289 631 913
• Email: [illegible] • Website: www.nursing.ug.edu.gh

APPENDIX C

INTRODUCTORY LETTERS FROM SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF GHANA TO TEMA GENERAL HOSPITAL

UNIVERSITY OF GHANA
SCHOOL OF NURSING AND MIDWIFERY

SONM/F.11

January 15th, 2019

Ref. No.:.....

The Medical Director
Tema General Hospital
Tema

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Augustina Yirenkyi Danquah, M.Phil Year II student of the School of Nursing and Midwifery, University of Ghana, Legon. As part of the M.Phil programme she is conducting a research on **"Documentation Practices within a Quality Assurance Framework: Midwives' experiences in the Greater Accra region"**. Your outfit has been chosen as her data collection facility.
I would be grateful if you could kindly offer her the necessary assistance needed to enable her collect data for her thesis.

Thank you.

Yours faithfully,

Dr. Florence Naab
SUPERVISOR

COLLEGE OF HEALTH SCIENCES
P. O. Box LG 43, Legon, Accra, Ghana.
• Telephone: (0) 303 970 801 / 0553 089 267 • Email: nursing@ug.edu.gh • Website: www.nursing.ug.edu.gh

APPENDIX D

SEMI-STRUCTURED INTEVIEW GUIDE

Data collection instrument-Interview guide**.**

TOPIC: DOCUMENTATION PRACTICES WITHIN A QUALITY ASSURANCE FRAMEWORK: MIDWIVES EXPERIENCE IN THE GREATER ACCRA REGION.

SECTION A: BACKGROUND INFORMATION FORM

Code number…….

Apart from your name can you tell me about yourself.

I. Age
II. Level of education
III. Years of practice as a midwife
IV. Rank
V. Duration of stay in the present ward/unit/department
VI. Marital status
VII. Number of baby children
VIII. Religion
IX. Languages spoken

SECTION B: INTERVIEW GUIDE

1. What are the structures necessary for documentation by midwives? (Probe) (Maternal health records on antenatal, labour, delivery and post-natal care)

The **contexts** of health care:

I. What type of facility is the one working in now and what kind of services do you render here?

A) Where else have you worked as a midwife?

B) Tell me about any differences between their documentation practices.

C) Do the services rendered by midwives affect their documentation practices?

II. Can you mention the type of equipment you use in documenting care given to clients here? (Probe)

A) Antenatal unit: can you list the books that you expected to document into them after your services to clients.

B) Are there any differences among these books/registers?

C) Are there any similarities

D) Tell me about electronic health records.

E) Benefits as compared to pen and paper

III. How does the type and number of personnel (staff) on duty affect the quality of documentation of your work? (Probe)

A) On the average how many clients do you see during the day

B) Averagely how many deliveries does a midwife conduct during her shift?

C) Who normally does the documentation of services done?

D) On the average how many midwives are on duty during the shift

E) Tell me the process of documentation here

IV. What are some of the principles of nursing and midwifery documentation?

A) Accuracy, timely, contemporaneous, concise, thorough, organized, and confidential.

B) What are the characteristics used in writing a report (documentation)

C) Can you tell me the policies and procedures involved in midwifery documentation?

D) What are the functional documentation systems do you have in this facility

E) How competent are you in the use of computer systems in documentation?

V. Can you share with me some of the reference from nursing and midwifery protocols or books from which you refer to for your documentation practices?

A) Do you receive regular supervision from your superiors?

B) Does (NMC) nursing and midwifery council have a code and conduct specifically on documentation practices.

VI. What influence does the organizational characteristic have on the documentation practices of midwives working here? (Probe)

A) How midwifery documentation is practices audit done in this facility? (Probe)

B) The registers and the books that are used for documentation tell me more about them. Do/did you experienced episodes of periodic shortages

C) Management of

VII. Payment: even though the National Health Insurance Scheme pay for the cost of treatment of clients do you task clients to buy or pay for the maternal health record books or any stationary used for documenting their care.

VIII. Share with me any chance of monitoring and supervision on your documentation practices from superiors(unit in charges, management, monitoring teams from MOH and GHS)

2. What processes are involved in midwifery documentation practices of maternal health record among midwives?

I. When we talk of midwifery documentation, exactly what do you document?

II. When do you do your documentation of care given to a client during your shift?

III. Where is the documentation done and with what?

IV. How documentation is done in this unit?

V. In what way do you include your clients and family in their care (activities in unit)? (Probe) any support or interference from such people

VI. How do you document any negative or positive actions/ inactions or comments from your clients and family? (Probe)

VII. How does the number of clients seen during the day affect your documentation practices?

VIII. What infrastructure do you have for documentation practices? (Probe)

IX. How are you coping with the available infrastructure (Probe)

3. What are the outcomes of documentation practices in the maternal health records among midwives?

Please can you tell me the effects of documentation on?

A. The quality of life of clients and family. (Probe)

I. Mother –physically, psychologically, socially, and economically. (Outcome of pregnancy)

II. Baby- outcome of pregnancy, normal or abnormal (alive or dead)

III. Family - psychologically, socially, economically. (outcome of pregnancy)

B. How does the knowledge on documentation practices affect the outcome of care giving to clients? (Probe)

I. Benefits/advantages,

II. Disadvantages

III. Can share with me any challenges encountered in documenting clients care.

C. How do you normally document the behavior satisfaction of your clients?

I. Client satisfaction survey

II. Praise after supervision/awards from management, /rewards from clients, supervisors.

III. Word of mouth from clients, family members, leadership, management.

How will you rate the documentation practices among midwives in this facility?

Have you been given any training on quality midwifery documentation since you started working as a midwife?

In your opinion what can be done to improve the documentation practices among midwives?

How can documentation practices be used to improve the outcome of maternal health?

APPENDIX E

INTRODUCTORY LETTER FROM NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH, UNIVERSITY OF GHANA

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-303-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

20th November, 2018

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 029/18-19 **IORG 0000908**

On 20th November, 2018, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Documentation Practices Within a Quality Assurance Framework: Midwives' Experience in the Greater Accra**

PRINCIPAL INVESTIGATOR : **Augustina Yirenkyi Duquah, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 19th November, 2019. You are to submit annual reports for continuing review.

Signature of Chair: .....
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

APPENDIX F

CLEARANCE LETTER FROM GHANA HEALTH SERVICE

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: 233-302 681109
Fax + 233-302-685424
Email: ghsers@gmail.com

MyRef. GHS/RDD/ERC/Admin/App 19/047
Your Ref. No.

15th February, 2019

Augustina Yirenkyi Dankuah
School of Nursing and Midwifery
College of Health Sciences
University of Ghana

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC009/12/19**
Project Title	Documentation Practices within a Quality Assurance Framework: Midwives' Experience in the Greater Accra Region
Approval Date	15th February, 2019
Expiry Date	14th February, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
PROFESSOR MOSES AIKINS
(GHS-ERC VICES CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX G

CONSENT FORM

NMIMR-IRB CONSENT FORM TEMPLATE

Title: Documentation Practices Within a Quality Assurance Framework: Midwives' Experience in the Greater Accra Region.

Principal Investigator: Augustina Yirenkyi Danquah

Address: School of Nursing and Midwifery, University of Ghana, Legon

Contact: +233 244613577

Email: augustinayirenkyi2014@gmail.com

General Information about Research

I am a second year MPhil Nursing student at the School of Nursing and Midwifery, University of Ghana, undertaking a study on "Documentation Practices Within a Quality Assurance Framework: Midwives' Experience in The Greater Accra Region" and is solely for academic purposes. You have been selected to voluntarily partake in the study. I would be grateful if you could provide me with an information pertaining t your experiences on documentation practices of midwives. If you accept to participate in this study, yo will be made to append your signature on two copies of an informed consent. Thereafter, you will be require to provide a date and time convenient for you to grant an interview. The interview will be conducted in English Language and will be expected to last between 40 and 60minutes and will also be audio-taped. Befo the interview starts, you will be required to consent to the proceedings. You reserve all the right to terminate your participation in the study without any consequences whatsoever.

Possible Risks and Discomforts

You will not be exposed to any risks or discomfort. Yet, you have to offer your time for the interview to be conducted. There will be intermittent breaks as you deem appropriate for refreshment.

Possible Benefits

There is no direct monetary benefit for joining the study, however, the findings of the study will be used to inform policy regarding training midwives on proper documentation processes. You may cease this opportunity to add your voice in suggesting ways by which documentation of midwifery services could be improved.

Confidentiality

In the course of the interview, no personal identifiers whatsoever will be required from you in order to rende the information anonymous. You are also refrained from mentioning names or locations that can reveal the identity of a third party. The information you will provide will only be accessible to the researcher and the supervisors. The audio recordings will be stored on a password protected computer accessible only to the researcher and the supervisors. The transcribed data will also be stored in a cupboard under lock and key. Tl data collected will be destroyed after five (5) years.

Compensation

There will be no monetary compensation for the information you provide, however, at the end of the interview, you will be refreshed with a bottle of water and a soft drink.

Voluntary Participation and Right to Leave the Research

Your decision to partake in this study is strictly voluntary. You reserve every right to withdraw from the st at any time without any consequences. If you decide to withdraw from the study, all the data you have provided will be destroyed and nothing will be held against you.

Contacts for Additional Information

All questions and concerns about the study can be addressed to the following persons:

Name: Augustina Yirenkyi Danquah

Contact: +233 244613577

Name: Dr. Florence Naab

Contact: +233 / Email:

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "Documentation Practices within a Quality Assurance Framework: Midwives' Experience in the Greater Accra Region." has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date _____ Name and signature or mark of volunteer _____

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date _____ Name and signature of witness _____

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date _____ Name Signature of Person Who Obtained Consent _____

4

APPENDIX D

GHANA HEALTH SERVICE ETHICAL REVIEW BOARD CLEARANCE LETTER

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: 233-302 681109
Fax + 233-302-685424
Email: ghsero@gmail.com

My Ref: GHS/RDD/ERC/Admin/App 19/047
Your Ref. No.

15th February, 2019

Augustina Yirenkyi Dankuah
School of Nursing and Midwifery
College of Health Sciences
University of Ghana

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Project Title	Documentation Practices within a Quality Assurance Framework: Midwives' Experience in the Greater Accra Region
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Expiry Date	14th February, 2020
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- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
PROFESSOR MOSES AIKINS
(GHS-ERC VICES CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra