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Evaluation of the medical records documentation completeness

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Abstract - *All health providers must document their medical records as a legal and professional responsibility. They contain information on all elements of the patient's care. Despite the importance of medical records in supporting better quality health-care services, poor recording is fairly widespread all across the world.*

1. INTRODUCTION

Medical record documents are an important legal and professional requirement for all health professionals. Despite its importance, there has been little research available that evaluates the overall level of medical records of health professionals. As medical records are a great source of health information, they are essential for maintaining accurate, varied and accurate patient data. They include relevant facts, findings, and observations of a patient's health history including past and present illnesses, trials, laboratory tests, treatments, and outcomes. Medical records, manually or electronically, include information, which describes all aspects of patient care. Doctors, nurses, and other health care providers need medical knowledge to get treatment for patients. These resources mediate relationships between physicians, patients, and other health care providers. Health information results in legal protection for the patient, healthcare providers or hospitals if necessary or problematic. In addition, medical records play a major role in providing financial goals and shaping treatment costs and supporting medical education, health care services, and medical research Well-designed medical records and related clinical documentation procedures allow hospitals and doctors in addition to health authorities and decision-makers to have accurate records of their records. existing status by considering the accuracy and compliance with the maintenance of medical records. International law requires that all actions related to medical services be fully and accurately recorded. The record should be made whenever a health care service is started and this includes all tests, diagnoses, treatments, and nursing care. Medical records are important tools for effective treatment and prevention. In addition, they play a key role in speeding up the process and improving treatment, evaluating the effectiveness of medical staff and nurses, organizing a medical / health organization and making appropriate and important decisions. In addition, the adjustment of hospital patient reports helps physicians to plan for patients' treatment, as well as diagnostics. Incomplete data registration in the medical record will result in the loss of diagnostics and additional costs to patients. In the age of information and technology, medical records are the most important, real and rich source of medical and medical information because they are based on medical facts. As some medical forms are considered to be the most focused forms of patient record and have specific significance such as a summary paper, medical history sheet, continuation note; if they are not in medical records or are incomplete they may result in incorrect diagnosis during hospitalization and even after discharge from the patient. In addition, the complete and complete maintenance and upkeep of medical records is an important part of patient medical management. One of the most important reasons for incomplete records is that doctors and surgeons believed that the medical care or surgery required of patients was important, but data-related documentation was not considered part of their treatment process. a misconception because the time spent on registering and completing patient health records is considered part of the care process. The quality of medical records reflects the quality of health care provided by physicians, and an effective system of medical records facilitates the evaluation and research of health care.

2. Objective of study:

All health providers must document their medical records as a legal and professional responsibility. They contain information on all elements of the patient's care. Despite the importance of medical records in supporting better quality health-care services, poor recording is fairly widespread all across the world.

3. Type of the study and sampling:

This is a descriptive cross-sectional study in which 268 medical records of inpatients were included for analysis from January to March 2022. The sample comprised reviewing the medical records of all patients admitted to the four main wards between January 2022 and March 2022 (General internal medicine, General surgery, paediatrics, Obstetrics/Gynecology Ward). The internal medicine ward had 90 records, the general surgery ward had 127, the paediatrics ward had 23, and the Obstetrics/Gynecology ward had 28.

Study tool:

Six types of forms were studied:

- Admission sheet
- Medical history and examination sheet
- Progress note(including both: the follow-up progress part & the Physician's notes related to the patient's state and details of any improvement or deterioration of the condition).
- Nursing sheet.
- Vital signs sheet
- Operation sheet
- Clinical pharmaceutical sheet

A two level scoring system was used for assessing the level of documentation completeness:

1. Complete documentation: at least half of the items on the sheets were completed.

2. Incomplete documentation: less than half of the entries on the pages were filled in.

For data base construction and statistical analysis, the collected data was entered into a custom-designed Excel worksheet.

4. Analysis:

Table -1: Table Showing Overall Documentation completeness level for the patient's medical records:

Type of the Sheet Include	Good		oor	
	o.		o.	
Admission sheet	9	2.0	09	8.0
Medical History and Examination sheet	00	7.3	68	2.7
Progress/Follow up notes	23	6.01	45	3.99
Progress/Physician notes	3	2	35	7.7
Nursing Sheet	24	6.3	44	3.7
Vital signs sheet	3	0.97	85	9.03
Operation sheet (only for surgery and Gy/Ob)	3	7.74	12	2.26
Clinical Pharmaceutical Sheet	7	3.81	31	6.19

In an overall review, summarizes the study results. It shows that poorly documentation of the patient's records was mainly those related to the Progress / Physician notes (patient's state and details of any improvement/deterioration of the condition: 87.7%), followed by the Clinical pharmaceutical sheet (86.19%). On the other hand, nursing sheet was the least poorly documented part of the records (53.7% poorly documented).

3. CONCLUSIONS

Finally, the current investigation confirmed the clear inadequacy of medical data documentation for inpatient records in the surgery, general internal medicine, and Gynecology / Obstetric fields. This is contained in the Physician notes (patient's status and details of any improvement or deterioration) and the Clinical pharmaceutical sheet. A group of qualified individuals should undertake a hospital-based quality improvement project to boost medical record documentation completion, with periodic random assessments by the Quality Assurance Unit.

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