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Review Article

A Clinical Audit of Documentation of Inpatient Medical Record (Admission Note)- Medicine Department in Sea Ports Corporation Hospital – Port Sudan – Red Sea State – Sudan on May 2022

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Abstract

Objective:

- Assessment and evaluation of medical records (admission sheets).
- Emphasizing the importance of proper documentation in medical records.
- Step towards professional practice.

Methodology:

- The standards of proper medical records were identified using different references and literature reviews, then Standardized questionnaire was generated
- Consisting of 18 questions related to proper admission sheets documentation.
- The data were collected retrospectively from inpatients medical records (admission sheets) in Sea Ports Corporation Hospital- medicine department in May 2022.
- A total number of 101 admission sheets were inspected
- The data were collected manually within 1 week.
- Then data were analyzed use SPSS 22.

Conclusion:

- There is clearly large discrepancy between the standards and local hospital medical records.
- The Medical records must provide an overall accurate description of each patient care and the way of communication between care providers.
- The medical records are vital, legally and for future hospital planning so must be a point of concern.
- Regular check of medical records should be performed by a senior consultant and quality improvement team. Periodic audit in different departments must be done and re auditing is very important for quality improvement.

Keywords: *Documentation is the a vital part of professional practice, It is the main predictor of patient care and outcome but it wasn't given its importance by medical staff who was only depending on verbal communication*

This study is mainly to reflect the importance of accurate and complete medical record and the reason behind poor documentation, So it is to attract the attention towards good medical practice which can be achieved through staff training and document sheath modification. This study is considered as Step towards evidence based practice and quality improvement.

Introduction

Clinical audit is quality improvement process that seeks to improve patient care and outcomes through systemic review against explicit standard criteria and implementation of change in practice if need [1]. Medical audit is the way towards evidence based practice and not an opportunity to name, shame or blame. A qualified Medical record should enable health care professionals to plan and evaluate patient's treatment and continuity of care among multiple care providers [2]. It is the Vital part of professional Practice. The purpose of documentation [3]

- Documentation is the way of Communication & continuity of care among physicians & other health care Professionals involved in the patient care
- It provides Peer review and continuity of education through audit and research
- Proper document reflects high Quality of care, professionalism & competency
- Documentation guarantees Legal protection for medical staff
- The confidentiality of medical records should be fully maintained and should be consistent with the requirements of medical ethics and law.

Types of data in medical record: [2-5]

There are two types of data in medical records

The objective data: this is the facts, it is measurable, Nonjudgmental and it is what you see, hear, smell or palpate e.g.: examination findings, Lab reports

The subjective data: this is the information that received from patient or Co- patients. e.g.: Chief complains HPI, PMH, FH, SH etc.

Aims and Objective

- Assessment and evaluation of medical records (admission sheets).
- Emphasizing the importance of proper documentation in medical records.
- To make Step towards professional practices.

Methodology

- the standards of proper medical records were identified using different references and literature reviews, then Standardized questionnaire was generated consisting of 18 questions related to proper admission sheets documentation.
- The data were collected retrospectively from inpatients medical records (admission sheets) in Sea Ports Corporation Hospital- medicine department in May 2022.
- A total number of 101 admission sheets were inspected.
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Results

The data were assessed and valued as (satisfactory, borderline, unsatisfactory) according to explicit criteria and standards of admission sheets. Personal data are 75 % borderline, that means there is no complete personal data, specifically. No concentration on residence area, marital status, tribe, occupation and telephone number of the patient and no one can deny the legal value of complete and satisfactory personal data. Chief complain fortunately satisfied 60% and it is the area that took doctors concentration. History of presenting illness, this must contain analysis of the main complaint and systems involved but in this study it is found that it hasn't been done properly and satisfied only 20%. Systemic review was satisfactory by 5% and this big and important questioning area. Past medical and surgical history are vital parts of patient history specifically in medicine where most of the illnesses are complications of past diseases and operations, so doctors must take their time in taking detailed past history, in our research it is satisfactory by only 15%. Good physician must have solid therapeutic package and Drug history must take its value, in our research drug history is 47% unsatisfactory. The Family history is satisfactory by only 4% and this rises many questions as why doctors didn't take family history although most of the diseases run in families.

The Social history is 82% unsatisfactory, this rises the question of is there awareness to take patient as human being and not just a disease, and also social background has a correlation with diseases. When we come to physical examination, the Vital signs recorded in80%of the cases. General examination 20% which is borderline. Specific system examination is recorded in 60 %of cases which is borderline. Investigation is documented and 55% satisfactory but there is no specific area in the sheet to write them down so they are impeded within the history and follow up sheath. Fortunately the ER sheet is adherent to the admission file so that the Initial plan documented in ER sheet by 94% satisfaction. Working diagnosis is 14% satisfactory to highlight that is our guidance in patient care and daily patient follow up so must have clearly problem list from the start till have provisional diagnosis which in our audit 33% satisfactory. Doctor name and signature must be Cleary written as it has a legal value in this study It is 90 % unsatisfactory. Unfortunately We have not found a registrar or senior review space in the file so mostly not written in the record.

Conclusion

- There is clearly large discrepancy between the standards and local hospital medical records.
- The Medical record must provide an overall accurate description of each patient care and the way of contact among hospital staff.
- The medical records are vital legally and for future hospital planning so must be point of concern.
- Regular check of medical record should be performed by a senior consultant and quality improvement team. Periodic audit in different departments must be done and re auditing is very important for quality improvement.

Recommendation

- Reformulation of medical record sheets to generate local hospital standards.
- Encouraging the hospital staff to give a lot of importance to good medical records keeping.
- Training of hospital staff in the professional way of documentation.
- Increase the number of admitting doctors to minimize the work load.

Proper documentation need MDT cooperation.

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