Measurement of Completeness of Medical Records in Family Health Centre in El Shorouk City

Submitted by

Reham Abd Elghany

M.B.B.Ch

In Partial Fulfillment of Master Degree
of Family Medicine

Supervised by:

Prof. Dr. Wagida Anwar

Professor of Public Health and Preventive Medicine
Department of Community, Environmental and Occupational Medicine
Faculty of Medicine, Ain Shams University

Assist. Prof. Dr. Nahla Fawzy

Assistant Professor of Public Health and Preventive Medicine
Department of Community, Environmental and Occupational Medicine
Faculty of Medicine, Ain Shams University

Dr. Doaa Elhossiney

Lecturer of Public Health and Preventive Medicine
Department of Community, Environmental and Occupational Medicine
Faculty of Medicine, Ain Shams University

Faculty of Medicine
Ain Shams University
2015

سورة البقرة الآية: ٣٢

Acknowledgement

First of all, all gratitude is due to ***God*** *almighty for blessing this work, until it has reached its end, as a part of his generous help, throughout my life.*

Really I can hardly find the words to express my gratitude to ***Prof. Dr. Wagida, Anwar,*** *Professor of Public Health and Preventive Medicine, Department of Community, Environmental and Occupational Medicine, Faculty of Medicine, Ain Shams University, for her supervision, continuous help, encouragement throughout this work and tremendous effort she has done in the meticulous revision of the whole work. It is a great honor to work under her guidance and supervision.*

I feel deeply thankful to ***Assist. Prof. Dr. Nahla Fawzy*** *Assistant Professor of Public Health and Preventive Medicine, Department of Community, Environmental and Occupational Medicine, Faculty of Medicine, Ain Shams University, for her continuous unlimited help, unlimited patience and close supervision throughout the entire work.*

I would like also to express my sincere appreciation and gratitude to, ***Dr. Doaa Elhossiney*** *Lecturer of Public Health and Preventive Medicine, Department of Community, Environmental and Occupational Medicine, Faculty of Medicine, Ain Shams University, for her continuous directions and support throughout the whole work.*

I thank members of family health centre in El Shorouk City for their help in collecting data .

Last but not least, I thank my family, whom without their sincere emotional support, pushing me forward this work would not have ever been completed.

Abstract

Introduction: Medical records play a vital role in the planning, development and maintenance of health care services. A well designed family folder system provides useful summary data on the demographic profile of the family **OBJECTIVES:** 1-To measure the completeness of the family medical records in a family health center in EL-Shorouk city. 2-To identify main causes of record incompleteness including knowledge and attitude of physicians towards medical records. **Methodology:** The study was conducted in a family health centre in El-Shorouk city using across sectional study, a sample of 200 out of 1000 records was estimated to be reviewed. **Study tool:** 1-Medical record assessment check list. 2-Structured questionnaire. Ethical consideration: Administrative approval was taken and confidentiality of data in medical records was considered. **Results**: Out of 200 records, 130(65%) of records had properly organized. Personal data was highest recorded item (100%).The lowest criterion recorded was general examination (51.5%). (88.5%) of records had completeness scores from 80-100% from standards, so they had passed the assessment as the minimal passing score is (80%)**. Conclusion:** To improve the quality of Medical Record, regular auditing, training and good orientation of medical personnel for good record practices. **Key words:** Medical records, health care services, and family folder.

Contents

List of Abbreviations

DHCP ..... Decentralized Hospital Computer Program

EMR ..... Electronic Medical Record

EPI …… Expanded Program on Immunization

FCA..... Family centered approach

FHM …….. Family Health Model

FHU ….. ….Family Health Units

HMIS ..... Hospital Management Information System

HRN ..... Health Record Network

IMCI ……. Integrated Management of Childhood Illnesses)

JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations

MCIT ..... Ministry of Communications and Information Technology

MOHE ..... Ministry of Higher Education

MOHP ..... Ministry of Health and Population

MR ..... Medical Record

NCI ..... National Cancer Institute

PHC ……. Primary Health Care

UNDP ..... United Nations Development Program

WHO ..... World Health Organization

List of Tables

List of Figures

INTRODUCTION

Family practitioners and other staff working in primary care require comprehensive and accurate data on patients at the point-of-care if they are to provide high quality health services to their patients. Medical records are an effective method of achieving this objective **(McConnell, 2004).**

Huffman (1994) defines a medical record as "a compilation of pertinent facts of a patient's life and health history, including past and present illness and treatment(s), written by the health professionals contributing to that patient's care. The health record must be compiled in a timely manner and contain sufficient data to identify the patient, support the diagnosis, justify the treatment, and accurately document the results."

The family folder is the compilation or grouping of a set of patient care documents. Usually for an entire family or household, that is retained or stored in a cardboard file box container. This file box, commonly referred to as the “family file folder,” contains several documents that have been designated as a permanent part of the patient’s medical records. These documents represent a picture of the family household from several perspectives. For instance, they

reflect the socioeconomic and demographic data of the family unit, children's ages and levels of educational achievements are noted in the file. The file folder contents also summarize the health history of the family unit, identifying family member's specific diseases and illnesses as well as a list of the names of all members of the household **(Forte, 2000).**

Medical records play a vital role in the planning, development and maintenance of health care services. The core of the health information system in the hospital lies in the medical records. As a primary means of communication between health care workers, a properly documented medical record is essential to good clinical care **(Murphy, 2001)**.

Also, documentation in the medical record facilitates diagnosis & treatment, communicates accurate and clear information to other caregivers to ensure patient safety and reduce medical errors, and serves an important medico-legal function as good documentation protects physicians and other health professionals against claims of negligence **(Wood, 2001).**

Accurate, timely and accessible health care data play a vital role in improvement of the quality of health services **(WHO, 2003).** Quality improvement and the timely dissemination of quality information are essential if health authorities wish to maintain health care at an optimal level

(Australian Council on Health Care Standards, 1998). These concerns not only relate to the quality of medical record documentation, but also to the collection of health care statistics at all levels, from the largest hospital to the smallest clinic **(Australian Institute of Health and Welfares, 2001)**.

All entries in the medical record must be **complete**. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. All entries in the medical record must be **dated, timed, and authenticated**, in written or electronic form, by the person responsible for providing or evaluating the service provided **(CMS Manual System, 2009)**.

The incompleteness of medical record may occur for some reasons, one of them is lack of medical record training. Another factor is clinicians who do not fully understand the benefit and purpose of medical records, the gap between perceptions of physician, as a user of medical records, and the perception of hospitals as a provider of medical record form resulted failure on delivery of quality services **(Aritonang, 2011).**

A systematic review conducted at England in **2004** by **Jordan et al.,**. identified 24 studies that examined morbidity coding in primary care by electronic recording found that recording of consultations was generally high (typically greater than 90%), but assigning a morbidity code during each consultation was more variable (66–99% complete). Coronary heart disease was the most commonly assessed disease register in previous studies and completeness of recording was generally moderate (typically around 70%). Positive predictive value of coronary heart disease registers was generally high (typically around 83–100%).

A study was conducted at Indonesia in **2011** and found that the completeness of clinical documentation in Kota Tidore district hospital was still low (24,93%) **(Abdullah, 2011).** Also, a multi centric cross sectional Jordan study was conducted in **2006** and revealed that the completeness of medical record contents ranges from 21% to 95% in all hospitals. The operating notes had the highest completion rate (70%to 95%), while history and physical examination reports had the lowest completion rate (21% to 58%) **(Ajlouni, 2006).**

An Egyptian study was conducted in **2000** at five health centers in Alexandria, and revealed that the completeness percentage of medical records contents varies according to the checked item, for example demographic data

ranges from (64% to 77%), history and physical examination ranges from (25% to68%) and patient complaint ranges from (40% to 62%) **(Forte, 2000).**

The current study conducted a systemic measurement of the completeness of family medical records in one of the family health centers at El-Shorouk city as no such studies were conducted there before.

AIM OF THE WORK

To improve the service in family health center.

OBJECTIVES

1. To measure the completeness of the family medical records in a family health center in EL-Shorouk city.
2. To identify main causes of record incompleteness including knowledge and attitude of physicians towards medical records.