ASSESSMENT ON COMPLETENESS AND QUALITY OF MEDICAL RECORD DOCUMENTATION IN YANGON GENERAL HOSPITAL, 2020

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ABSTRACT

Medical records are vital for keeping fully and accurately coded patient data because they are the most common source of health information. Medical record completeness is a key performance indicator that is connected with healthcare delivery services in the hospitals. Incompleteness and poor quality of medical records may lead to obstacles in performance of health services. Hence, this study attempted to find out the completeness on filling of patient medical records and consistency of ICD-10 coding from discharge diagnosis. A cross-sectional descriptive study by processing secondary data analysis was conducted to assess the quality of medical record documentation in Yangon General Hospital from April to August 2022. To examine the completeness of medical records (MR-1, MR-2, MR-3, MR-4 and MR-7) and consistency with ICD-10, 195 records of discharge cases 1st July to 31st December, 2020 were randomly selected from the medical, surgical and ortho wards. The medical record documentation was checked using checklist developed by Guard Book of medical records. Among the studied MR forms, the completed items were (8.7%) inMR-1, (81%) in MR-2, (34.9%) in MR-3 and (43.3%) in MR-7. There were no documents with all items completed in MR-4. On the assessment of consistency between discharge diagnosis and coding diagnosis, there was (68.7%) found but the assessment of overall quality of medical records was found to be sub-optimal. The result of this study can contribute the better performance of medical record documentation system. For the hospital statistics to be of higher quality, doctors and nurses must follow proper procedures when documenting any type of medical information. Moreover, the regular monitoring and supervision was needed to assess the trend of completeness of medical record documentation in order to improve hospital statistics and which in turn improve the health service of our country. It was hoped that the findings of the study can be used as a baseline data to improve the health care by implementing an effective medical record management system