ABSTRACT

A cross-sectional descriptive study on completeness of medical record documentation and quality of disease coding was conducted in West Yangon General Hospital to assess completeness of medical record documentation as well as quality of ICD-10 coding of discharge diagnosis. In order to get the quality of documentation, 162 medical records were randomly selected from medical, surgical, OG and child wards among all discharged patients during last week of June, 2015. Documentation of all records was evaluated using general and specific checklists, developed by Guard Book of Medical Records and WHO guideline. The assessment was done on the Admission and Discharge Form (MR-1), History and Physical Examination Form (MR-2) and Progress notes and Treatment Record (MR-3). The completeness of MR-1 was satisfactory except discharge date and time. The documentation of patient identification in MR-2 and MR-3 as well as provisional diagnosis in MR-2, signature of doctor in MR-3 was not complete in this study. The perception of assistant surgeons in medical, surgical, OG, child ward and emergency department on medical record documentation was explored with the in-depth interview. All the respondents answered that the medical record documentation was important and they told that complete medical record documentation gave strong evidence for treatment given. Regarding to the facing difficulties, lack of knowledge, lack of disciplines, insufficient human resources, inadequate medical records especially MR-3 forms, overcrowding of patients and limitation of time were the main problems. The quality of ICD-10 coding of discharge diagnosis for morbidity and mortality statistics showed 85%. The consistency between discharge diagnosis and coding diagnosis, and correctness of ICD-10 coding done by medical record technician was more than 85%.Therefore, the result of this study pointed out to develop the medical record documentation guidelines and to train medical professionals in pre-service curriculum and in-service training to get better medical record documentation and appoint fair doctor patient ratio. The frequent supervision and counterchecking of ICD-10 coding was needed to improve the quality of coding and health statistics.