ASSESSMENT ON MEDICAL RECORD DOCUMENTATION IN SURGICAL WARDS OF MANDALAY GENERAL HOSPITAL, 2012

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ABSTRACT

A cross-sectional descriptive study was conducted in surgical wards of Mandalay General Hospital to assess on medical record documentation. In order to get the quality of documentation, 227 medical records were randomly selected among all hospitalized patients during first six months of 2012. Documentation of all records was evaluated using general and specific checklists, developed by Guard Book of Medical Records and W.H.O guideline. The assessment was done on the Admission and Discharged Form (MR 1), History and Physical Examination Form (MR 2), Progress notes and Treatment Record (MR 3), Anesthetic Record Sheet (MR 6) and Operation Report (MR 7). Then, knowledge, attitude and practice of the medical and house officers in the surgical wards were explored with the self-administered questionnaires and the in-depth interview. The formats of medical records in studied wards were greatly diverse and differ from the standardized formats, established in the Guard Book. More than ten percent of missing values were found in MR 3 (16.2%) and MR 6 (18.1%). Nearly all of the respondents assumed that the medical record documentation and its quality were important, however, 71.2% of the respondents did not know exactly the quality of medical record documentation. According to the practice scores, 77% of the respondents were above the median score. The respondents accepted to set the guideline or procedure on medical record documentation and to publish it to all staffs in health care especially the house officers. Therefore, the result of this study pointed out to develop the written guideline and procedure on the medical record documentation and establish for all levels of health care providers.