ASSESSMENT OF COMPLETENESS OF RECORD DOCUMENTATION AND QUALITY OF CODING OF MODIFIED TRAUMA REGISTRY FORM IN NAYPYITAW GENERAL HOSPITAL

WIN NAING
M.B.,B.S, Dip. Med. Sc (HA)
Master of Medical Science
(Hospital Administration and Health Management)
M.Med.Sc (HA&HM)
University of Public Health, Yangon
2016

ABSTRACT

A cross-sectional descriptive study on assessment of record documentation and correctness of ICD-10 coding of modified trauma registry form from July to September 2016 was carried out in Naypyitaw General Hospital (1000-Bed) during September to December 2016. To assess the completeness of record documentation and quality of ICD-10 coding, (1041) modified trauma registry forms were reviewed. To identify the perception, practice and difficulties on medical record documentation, (8) data collectors and (2) supervisors of medical record department were in-depth interviewed. Regarding the completeness of medical record documentation, there are only (1) out of (30) components in Part A and (12) out of (21) components in Part B that did not meet the fully completeness and all the (5) components in Part C showed fully completeness. The weakness and incompleteness of medical record documentation is mainly found in Part B portion and among the incomplete variables of Part B, 'respiratory rate' (4.9%) and 'history of consciousness' (0%) variables are the worst to complete the form. With regard to the correctness of ICD-10 coding of 'external causes of injury', there are only (0.8%) inconsistency cases and (0.9%) incorrectness cases and the overall quality of ICD-10 coding is (99.1%). In the correctness of 'final diagnosis', the overall quality of ICD-10 coding is (100%). All the respondents of in-depth interview are well trained staffs and have good perception and practice on record documentation and well organized supervision system. Half of the respondents (50%) have some difficulties on recording modified trauma registry form, especially, Part B. They also replied that there is no medical audit for medical record documentation and suggested that trainings, time and human resources are needed. Therefore, the result of this study pointed out to review the job allocation and human resources, to revise the hospital forms to one summarized form, to reconsider some components of modified trauma registry form for better quality of record documentation, to

establish the medical audit in medical record department, to give regular and refreshment training programs and to sustain well organized medical record system.