

# Assessment of Medical Documentation Process in Poison Control Center Ain Shams University

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## Abstract

**Background:** Medical documentation is the primary source of health information. Documentation is as important as the quality of patient care given. Healthcare professionals are accountable for their actions and their omissions in record keeping. **Aim of the work:** To assess the current status of the medical documentation process in the Poison Control Center Ain Shams University Hospitals (PCC ASUH), and its extent of completeness and quality to reduce liability for litigations. **Methods:** This retrospective study was conducted on 150 Files from the archive of PCC ASUH, 50 files from each studied group (ER, inpatient, ICU). Files belong to patients who visited the PCC for medical help from January 2022 to December 2022. Assessment and evaluation of each file according to a designated checklist, which included presence of facility policy supporting proper medical documentation, and the fulfillment of the necessary documentation components. The acquired data were scaled according to degree of fulfillment, tabulated, and statistically analyzed. **Results:** The current study revealed that no written, declared, accessible clinical documentation policy was found. The comparison showed some items, such as patient personal data, emergency contact, main complaint, fluid chart, and discharge instructions were significantly different between studied groups. Other items were not statistically different, as either because they were equally absent in all groups, such as allergies, critical incidents form and follow up appointment after discharge; or because they were fulfilled in all groups, such as admission date, time, and reason. **Conclusion:** The current study revealed that the documentation process in the inspected patients' files during the period from January 2022 to December 2022, were not up to the documentation standards.

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## Key words

Ethics, Medical documentation, Poison Control Center

## Introduction

Good documentation is central to good clinical practice, healthcare professionals are accountable for both their actions and their omissions in record keeping (Douglas-Moore et al., 2014). Extending the risk management dimension, failure to document relevant data is a significant breach of and deviation from the standard of care (Gutheil, 2004).

Documentation completeness and confidentiality are rights of the patient and protected by the law. The main purpose of the medical record is to record patient care. At any time, a health care provider should be able to look in a patient's medical record and know exactly what the plan of care is for the patient. The medical record also serves as the main communication tool among members of the health care team (Sugiarti, 2020). It could be the first line of defense. Good records always provide a good defense (Srinivasulu et al., 2016).

The legal system relies mainly on documentary evidence in a situation where medical negligence is alleged by the patient or the relatives (Thomas, 2009; Parekh, 2020). In such situations the principle of "not written not done" is prevailing (Marinic, 2015).

The WHO declared that the efficiency of healthcare systems in identifying health issues, setting priorities, finding creative solutions, and allocating resources to improve health outcomes will be

determined by the appropriate gathering, managing, and application of documented medical data within the systems (Sani et al., 2016).

High-quality documentation is essential for providing safe patient care in medical settings (Almuqbil et al., 2023). The doctor's bad handwriting causes fatal injuries. It kills more than 7,000 people annually (Desira, 2019). According to recent studies, up to 87%–88% of medications have been incorrectly documented (Feleke et al., 2015).

As good documentation is the good defense against litigations, bad documentation may represent the first proof for negligence. Research conducted in developed countries reveals that medical errors and inadequate documentation result in over a million injuries and one fatality per year (Krishna and Khyati, 2017).

The medical documentation practice is a huge challenge in developing countries, especially in Africa, due to the insufficient use of digital technology in the healthcare industry and the desire of individuals to improve their health through the consumption of health information (Kasaye et al., 2022).

In spite of numerous initiatives in recent years to enhance clinical documentation, completing quality clinical documentation remains a challenge for those working in the medical field (Cowan, 2000).

According to data from south Africa, just 42.9% only of healthcare professionals are skilled at patient information documentation (Zhandire et al., 2021).

Considering all of the above, the study at hand was conducted to assess the current status of the medical documentation process in PCC ASUH. The ultimate objective will help achieving improvement and excellence in medical documentation process.

## Materials and Methods

### Ethical Considerations

The study protocol was approved by the research ethics committee of the faculty of medicine at Ain Shams University (FWA 000017585) on January 15, 2023.

Official permission was obtained from the manager of PCC ASUH. All patients' data were kept anonymous to ensure the confidentiality of records.

### Study Setting:

Data about medical documentation process were obtained from patients' files in the archive of the PCC ASUH.

### Type of Study

It is retrospective study.

### Study Population:

#### Inclusion criteria:

- Files of patients who visited the PCC ASUH for medical help from January 2022 to December 2022.
- Files were randomly selected using simple random sampling.

#### Exclusion criteria: none

### Sample size:

- Total inspected files were 150 files 50 files from each group (ER, inpatient, ICU).
- The number of the studied files was calculated using PASS 11 Power Analysis and Sample Size Software (2011). NCSS, LLC. Kaysville, Utah, USA, ncss.com/software/pass. Due to lack of recent studies an expected proportion of 50% is used as it yields the maximum sample size. A sample size of at least 45 medical records produces a two-sided 95% confidence interval with a width equal to 0.3 when the sample proportion is 0.5.

### Data Analysis and Statistical Study

The collected data were revised, coded, tabulated and introduced to a PC and analyzed using statistical package for social sciences (IBM SPSS 20.0). The following forms of statistical analysis were done:

- Descriptive statistics

These were made to quantitatively describe the main features of collected data, including percentages.

- Inferential statistics

The following tests were used: Kruskal-Wallis and Mann-Whitney to compare between the three studied groups.

In all tests the probability ( $P$ ) was used, if  $P < 0.05$  the comparison was significant, if  $P > 0.05$  the comparison was non-significant.

### Study tools

The medical documentation process in each file was evaluated according to a designated checklist. The items on the checklist and the criteria for each

item have been selected from the accessed scientific literature. Which included items of the:

- Facility or organization policy of supporting proper medical documentation and documentation components (Lapum et al., 2020; Myrick, 2019; Hall, 2004).

Based on the careful inspection of the files, checklists items in each file were scrutinized for evaluation as being not present (0), present and incomplete (1), present and complete (2) according to the criteria required for each item.

Accuracy and consistency of evaluations were achieved by unifying the reviewer and clear demarcation of components of each item after full discussion and agreement by the research team.

In the present study, the reviewer was the main researcher.

## Results

Table (1) shows that no written, declared, accessible clinical documentation policy was found. No healthcare providers' education workshops were evidenced. Also, there was not a list of abbreviations and list of symbols that are approved to be used in the PCC. Consent forms were present, such as treatment plan consent, but the Center hadn't tailored consents for every procedure or intervention that would be done during the patient stay. However, the accessibility to appropriate, reliable, and available documentation equipment was easy, as Ain Shams University Hospitals provide the PCC with records according to needs. As well easy to retrieve medical records with permission to keep patient confidentiality and well organized in PCC-ASUH archive.

Table (2a) shows that "patient personal data" was present and incomplete in 4 ER files (8.0%) but complete in 46 ER files (92.0%) and in all inpatient and ICU files. "Admission date", "time", and "admission reason" were complete in all groups' files. "Emergency contact" was present and complete in 42 ER files (84.0%) and all inpatient and ICU files. "Allergies item" was not present in all three groups' files. Item of "other health issues" was complete in 46 ER and inpatient files (92.0%), although 42 ICU files (84.0%) were complete and fulfilled. "Main complaint" was not complete in 50 ER files (100.0%), 49 inpatient files (98.0%) and 43 ICU files (86.0%) but complete in 1 inpatient file (2.0%) and 7 ICU files (14.0%). "Family history" was not present at any file of three groups. "Past history" was not fulfilled in 7 ER files (14.0%), 5 inpatient files (10.0%) and 8 ICU files (16.0%) but fulfilled in 43 ER files (86.0%), 45 inpatient files (90.0%) and 42 ICU files (84.0%).

Table (2b) shows that "patient personal data" had statistically significant difference between ER and ICU groups at one hand, and ER and inpatient groups at the other hand. This was because ER files showed more incomplete patient personal data in 8% of files and 100% of inpatient and ICU files were complete. "Admission date", "time", and "admission reason" were not statistically significant as they were complete in all groups' files. "Emergency contact" had statistically significant difference between ER and ICU groups at

one hand, and ER and inpatient groups at the other hand. This was due to presence of incomplete data in 16% of ER files while complete at 100% of inpatient and ICU. "Allergies item" was not significantly different as it was not present in all three groups. There was not statistically significant difference in between groups regarding the item of "other health issues". The item of "main complaint" showed statistically significant difference between ER and ICU groups, and inpatient and ICU groups since ICU files showed more complete data in 14% of files. The item of "family history" was not significantly different since it was not found at any file of the three groups. "Past history" item also was not significantly different but because it was fulfilled in almost all groups.

Table (3a) shows that "progress note" was incomplete in all groups except in 2 ICU files (4.0%). "Medication administration record" was incomplete in 49 ER files (98.0%), but complete in (100.0%) of inpatient and ICU files. "Fluid chart" was not present in 100.0% of ER and inpatient files, but it was present, yet, incomplete in 23 ICU files (46.0%) and complete in 27 ICU files (54.0%). "Kardex" or summary sheet and "critical incidence form" were not present at any three groups' files. The item of "treatment plan consent" was incomplete in (100.0%) of all groups' files.

Table (3b) shows that "progress note" was not significantly different since it was incomplete in almost all groups. "Medication administration record" showed statistically significant difference in between ER and ICU groups and in between ER and inpatient groups as ER showed incomplete data in 98% of files and complete in 2%. The "Fluid chart" item exhibited statistically significant difference in between ER and ICU groups and in between inpatient and ICU groups, given that this item was not present at any of ER or inpatient file, but present in 100% of ICU files

(incomplete in 46% and complete in 54%). "Kardex" or summary sheet and critical incidence form had no statistically significant differences as they were not present in all three groups. Likewise, "treatment plan consent" showed no statistically significant differences as it was incomplete in all three groups.

Table (4a) shows that "discharge date and time" were incomplete in 100.0% of ER files while complete in 100.0% of inpatient and ICU files. "Final diagnosis" was incomplete in 100.0% of all inspected files. "Status at discharge", "discharge medication" and "discharge instructions" were not present in 100.0% of ER files and incomplete in 100.0% of both inpatient and ICU file. The following items: "how the patient is getting home", "follow up appointment", "nutrition guidance in terms of the patient's diet after discharge" and "information about when to seek healthcare after discharge" were all not present in 100.0% of three groups' files.

Table (4b) shows that there was significant difference between ER and ICU groups and ER and inpatient groups regarding "discharge date and time" as ER showed more incomplete data in 100% of files while inpatient and ICU files were complete. "Final diagnosis" had no statistically significant difference due to incomplete records in all three groups. Regarding "status at discharge", "discharge medication" and "discharge instructions", there was significant difference in between ER and ICU groups as well as in between ER and inpatient groups as data was missing in 100% of ER group while present, but incomplete, in all inpatient and ICU files. The following items: "how the patient is getting home", "follow up appointment", "nutrition guidance in terms of the patient's diet after discharge" and "information about when to seek healthcare after discharge" were not significantly different in between groups as they were not present in all groups' files.

**Table (1): Evaluation of the PCC policy of supporting proper medical documentation.**

Checklist Item	Score
1. Presence of clinical documentation policy and guidelines.	0
2. Presence of courses or scientific sessions for training all members of a health team regarding medical documentation.	0
3. Presence of a list of abbreviations and list of symbols that are approved to be used in clinical documentation.	0
4. Presence of consent forms for various medical interventions	1
5. Easy access to appropriate, reliable, and available documentation equipment	2
6. Accessibility of medical records :easy retrieving of data and well organization of files.	2

0= Not Present, 1= Present and Incomplete, 2= Present and complete

**Table (2a): Distribution of admission sheet elements in the three studied groups (ER, inpatient, ICU).**

Checklist Item	Score	ER N=50	Inpatient N=50	ICU N=50
1. Patient personal data	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	4 (8.0%)	0 (0.0%)	0 (0.0%)
	2	46 (92.0%)	50 (100.0%)	50 (100.0%)
2. Admission date	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	50 (100.0%)	50 (100.0%)	50 (100.0%)
3. Admission time	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	50 (100.0%)	50 (100.0%)	50 (100.0%)
4. Admission reason	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	50 (100.0%)	50 (100.0%)	50 (100.0%)
5. Emergency contact	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	8 (16.0%)	0 (0.0%)	0 (0.0%)
	2	42 (84.0%)	50 (100.0%)	50 (100.0%)
6. Allergies	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
7. Other health issues	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	4 (8.0%)	4 (8.0%)	8 (16.0%)
	2	46 (92.0%)	46 (92.0%)	42 (84.0%)
8. Main complaint and history of current illness	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	50 (100.0%)	49 (98.0%)	43 (86.0%)
	2	0(0.0%)	1(2.0%)	7 (14.0%)
9. Family history	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
10. Past history	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	7 (14.0%)	5 (10.0%)	8 (16.0%)
	2	43 (86.0%)	45 (90.0%)	42 (84.0%)

0= Not Present, 1= Present and Incomplete, 2= Present and complete

**Table (2b): Statistical comparison between the three studied groups regarding elements of admission sheet (Kruskal-Wallis and Mann-Whitney tests).**

Checklist Item	P <sup>a</sup>	Contrast	P <sup>a</sup>
1. Patient personal data: their name, age and date of birth, gender, contact information/address	<b>0.017 (S)</b>	ER vs. Inpatient	<b>0.042 (S)</b>
		ER vs. ICU	<b>0.042 (S)</b>
		Inpatient vs. ICU	1.000 (NS)
2. Admission date	1.000 (NS)		
3. Admission time	1.000 (NS)		
4. Admission reason	1.000 (NS)		
5. Emergency contact	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.003 (S)</b>
		ER vs. ICU	<b>0.003 (S)</b>
		Inpatient vs. ICU	1.000 (NS)
6. Allergies	1.000 (NS)		
7. Other health issues	0.329 (NS)		
8. Main complaint and history of current illness	<b>0.004 (S)</b>	ER vs. Inpatient	0.317 (NS)
		ER vs. ICU	<b>0.006 (S)</b>
		Inpatient vs. ICU	<b>0.028 (S)</b>
9. Family history	1.000 (NS)		
10. Past history	0.670 (NS)		

<sup>a</sup> P>0.05 = not significant; P≤0.05 = significant

**Table (3a): Distribution of patient's record items in the three studied groups (ER, inpatient, ICU).**

Checklist Item	Score	ER N=50	Inpatient N=50	ICU N=50
1. Progress notes	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	50(100.0%)	50 (100.0%)	48 (96.0%)
	2	0 (0.0%)	0 (0.0%)	2 (4.0%)
2. Medication administration record	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	49 (98.0%)	0 (0.0%)	0 (0.0%)
	2	1 (2.0%)	50 (100.0%)	50(100.0%)
3. Fluid chart	0	50(100.0%)	50 (100.0%)	0 (0.0%)
	1	0 (0.0%)	0 (0.0%)	23 (46.0%)
	2	0 (0.0%)	0 (0.0%)	27 (54.0%)
4. Kardex sheet or summary sheet	0	50(100.0%)	50 (100.0%)	50(100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0(0.0%)	0 (0.0%)
5. Critical incidents form	0	50(100.0%)	50 (100.0%)	50(100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
6. Treatment plan consent.	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	50(100.0%)	50 (100.0%)	50(100.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)

0= Not Present, 1= Present and Incomplete, 2= Present and complete

**Table (3b): Statistical comparison between the three studied groups regarding patient's record items (Kruskal-Wallis and Mann-Whitney tests).**

Checklist Item	P <sup>a</sup>	Contrast	P <sup>a</sup>
1. Progress notes	0.134 (NS)		
2. Medication administration record	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.000 (S)</b>
		ER vs. ICU	<b>0.000 (S)</b>
		Inpatient vs. ICU	1.000 (NS)
3. Fluid chart	<b>0.000 (S)</b>	ER vs. Inpatient	1.000 (NS)
		ER vs. ICU	<b>0.000(S)</b>
		Inpatient vs. ICU	<b>0.000 (S)</b>
4. Kardex sheet or summary sheet	1.000 (NS)		
5. Critical incidents form.	1.000 (NS)		
6. Treatment plan consent	1.000 (NS)		

<sup>a</sup> P>0.05 = not significant; P≤0.05 = significant

**Table (4a): Distribution of discharge sheet items in the three studied groups (ER, inpatient, ICU).**

Checklist Item	Score	ER N=50	Inpatient N=50	ICU N=50
1. Discharge date and time	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	50 (100.0%)	0 (0.0%)	0 (0.0%)
	2	0(0.0%)	50 (100.0%)	50 (100.0%)
2. Final diagnosis	0	0 (0.0%)	0 (0.0%)	0 (0.0%)
	1	50 (100.0%)	50 (100.0%)	50 (100.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
3. Status at discharge	0	50 (100.0%)	0 (0.0%)	0 (0.0%)
	1	0(0.0%)	50 (100.0%)	50 (100.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
4. Discharge medication	0	50 (100.0%)	0 (0.0%)	0 (0.0%)
	1	0 (0.0%)	50 (100.0%)	50 (100.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
5. Discharge instructions	0	50 (100.0%)	0 (0.0%)	0 (0.0%)
	1	0 (0.0%)	50 (100.0%)	50 (100.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
6. How the client is getting home	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
7. Follow up appointment	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
8. Nutrition guidance in terms of the client's diet after discharge	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)
9. Patient health education: information about when to seek healthcare if the client experiences specific symptoms, adverse effects, or complications	0	50 (100.0%)	50 (100.0%)	50 (100.0%)
	1	0 (0.0%)	0 (0.0%)	0 (0.0%)
	2	0 (0.0%)	0 (0.0%)	0 (0.0%)

0= Not Present, 1= Present and Incomplete, 2= Present and complete

**Table (4b): Statistical comparison between the three studied groups regarding discharge sheet items (Kruskal-Wallis and Mann-Whitney tests).**

Checklist Item	P <sup>a</sup>	Contrast	P <sup>a</sup>
1. Discharge date and time	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.000 (S)</b>
		ER vs. ICU	<b>0.000 (S)</b>
		Inpatient vs. ICU	1.000 (NS)
2. Final diagnosis	1.000 (NS)		
3. Status at discharge	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.000 (S)</b>
		ER vs. ICU	<b>0.000 (S)</b>
		Inpatient vs. ICU	1.000 (NS)
4. Discharge medication	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.000(S)</b>
		ER vs. ICU	<b>0.000(S)</b>
		Inpatient vs. ICU	1.000 (NS)
5. Discharge instructions	<b>0.000 (S)</b>	ER vs. Inpatient	<b>0.000(S)</b>
		ER vs. ICU	<b>0.000(S)</b>
		Inpatient vs. ICU	1.000 (NS)
6. How the client is getting home	1.000 (NS)		
7. Follow up appointment	1.000 (NS)		
8. Nutrition guidance in terms of the client's diet after discharge	1.000 (NS)		
9. Patient health education: information about when to seek healthcare if the client experiences specific symptoms, adverse effects, or complications	1.000 (NS)		

<sup>a</sup> P>0.05 = not significant; P≤0.05 = significant

## Discussion

The importance of clinical documentation was recognized early in the history of medicine. It dates back to ancient times and has since undergone several modifications in content and scope. For the past two centuries, what they called "Casebooks" was a type of document created by literate people, including medical records. Théodore de Mayerne, the famous Huguenot and royal physician, had the most complete collection of casebooks of what he called "observations medicine" (Kassell, 2014).

Recording medical records is always emphasized due to the applicant's data requirements. In addition, the main reason why insurance organizations impose deductions comes from making document errors. It was also emphasized that documentation is the primary duty of every authorized person to achieve patient care (Asghari et al., 2016).

Involvement of physicians and other stakeholders in clinical documentation improvement projects is necessary to ensure and sustain the success of any project, however, this may not be enough to improve the quality of documentation without the commitment of higher authorities of any organization (Leventhal, 2014).

This study has been conducted in order to throw light on medical documentation main standards as facility or organization policy of supporting proper medical documentation and documentation components. In order to assess the situation in PCC ASUH according to checklist items, it is worth mentioning that the total number of assessed files was 150 files from year of 2022 and to examine all types of files in the PCC, three groups of patents' files were inspected ER, inpatient and ICU.

### ➤ Facility or organization policy of supporting proper medical documentation and Documentation components.

#### I. The PCC policy of supporting proper medical documentation.

In the current study, after checking with the administration, no written, declared, and accessible documentation policy was available.

Mashoufi et al., (2006) reported that medical records are the most valuable and important criteria for evaluating the performance of hospital staff. Many studies have been conducted on medical record recording methods. In 52.2% of files, documentation guidelines were not considered.

Kassie et al. (2023) revealed that good knowledge, a supportive attitude towards documentation, training, and availability of documentation guidelines within the organization are factors that influence documentation practices. Providing documentation training and improving knowledge, attitudes, and availability of documentation guidelines will increase the documentation practices of healthcare professionals. Documentation process is crucial in reducing errors in medication, maintaining consistent patient care, improving communication among professionals, and facilitating evidence-based decision making.

The absence of department documentation policy and procedures included non-availability of abbreviations and list of symbols approved for use in

the documenting process. Also, there were not any proofs for training sessions for health team to how document in the proper

Meidani et al. (2017) reported that since accurate recording of medical records is considered one of the criteria of a physician's scientific skill, there is a need to improve the physician's recording behavior by designing effective interventions with objectives as training, encouragement and feedback, ongoing education, and reminders.

Although abbreviations allow a large amount of information to be conveyed in a small space, this examination demonstrates that most of that information is not recognized by reference standards. Pediatric and other medical professionals who use pediatric literature have difficulty understanding acronyms. Although none of these led to misinterpretation because most employees were familiar with their usage, they concluded that some form of standardization of acronyms was necessary (Sheppard et al., 2007).

Another study of the use of abbreviations in daily progression note concluded that unacceptable abbreviations were used (Manzar et al., 2004).

Hamiel et al. (2018) reported that misunderstanding abbreviations can hinder a doctor's efforts to provide the highest quality health care to their patients a printed reference list of common abbreviations should be included in the medical record.

In the current study, consent form for treatment plan was found, but there was not specific form for different intervention procedures.

Ten percent of the documents explained how the process is carried out, and less than one-third contained information regarding the procedure itself.

In the majority of hospitals, information related to the procedure's name and method of execution was never typed, not much information was offered regarding the advantages, hazards, or alternatives of the procedure. The hospital that was the exception was situated in Louisiana, a state with strict laws regarding the identification of procedure-specific hazards in the Informed consent forms (Spatz et al., 2020).

The current study showed that documentation equipment was available.

As Ain Shams University Hospitals provide the PCC with records files and tools according to needs.

In the current study, records in PCC ASUH archive were well organized and can be retrieved easily with permission to keep patient confidentiality.

Waegemann et al. (2002) reported that the capacity to make information easily found is known as retrievability. The usage of standardized nomenclature, acronyms, coding, templates, and macros are all required to achieve this.

#### II. Documentation components.

##### 1. Admission sheet

"Patient personal data" in the current study showed statistically significant difference as ER files showed incomplete patient personal data in 8% of files, while 100% of inpatient and ICU files were complete.

Regarding “emergency contact”, there was significant difference due to presence of incomplete data in 16% of ER files, while complete data in 100% of inpatient and ICU.

This could be attributed to the unique, complex, and dynamic environment of the emergency department. This leads to high risk of errors and incomplete documentation (As-Sanie et al. 2005; Mousavi and Baigi, 2022).

Also, emergency departments face risks from poor documentation and an urgent need for accurate records, this happens due to frequent staff changes, prominent levels of activity, overcrowding, frequent interruptions, time pressure, unknown patient access patterns, and many other factors in such environments (Lorenzetti et al., 2018).

In alignment with our findings, Ranya et al. (2019), stated that more than 70% of records in the El-Obour health insurance hospital reviewed included all of the patient identification part's documentation components.

Also, Saravi et al. (2016) found that average data registration rate for patient identification in a teaching or university hospitals was 53%, whereas it was 52% in other institutions.

In the current study, “admission date”, “time” and “reason” were complete and fulfilled in all three groups. Regarding past history, it was almost fulfilled in all groups.

This came in line with Blake-Mowatt et al. (2013), who stated that admission date and time were complete in 94% of total 90 records were reviewed.

On contrary, the document recording the completeness of the admission sheet content as the main page of the application was evaluated with a score of 32.7% in teaching hospitals, 32.2% in private hospitals and 29.4% in social security organization in an undesired condition (Babae et al., 2002).

In the current study, “allergies” and “family history” items were absent in all three groups' files.

According to Smith and Cavell (2004), information about drug allergy is extremely important in this document. Failure to accurately record drug allergy can harm patients due to medication errors (this is estimated at 1.8% of all hospital admissions)

In line with the current study Srinivasulu et al. (2016) discovered that adverse drug effects were not mentioned in any case sheet, and no case sheet included drug allergy notes.

Allergy data should be in place to ensure administered medications, are safe and suitable. Medications should not be dispensed until this information is available and confirmed to be accurate (Roehr, 2008).

In the current study, “other health issues” item was incomplete in 8% of ER and inpatient files and in 16% of ICU files; this difference was not statistically significant.

The item of “main complaint and history of current illness” showed statistically significant difference as ICU files had complete data in 14% of

files, opposite to 0% and 2% in ER and inpatient files, respectively.

This agreed with Mahjoob et al. (2010) who reported that the average of documentation of patients' history data was 38% also the completion of information was poor and not totally fulfilled in this study.

On the other hand, Blake-Mowatt et al. (2013), found that 98% of records include doctors' documentation of the patient's previous complaints, medical history, and physical assessment of the patient at a referral hospital in Western Jamaica.

Davenport et al. (2008) reported that getting a precise history is crucial at the emergency department more than anywhere else. Some have suggested that medical staff should be able to accurately present a case in as little as “three minutes” due to the need for a swift, focused, and effective examination and presentation.

## 2. Components included in a patient's record.

In the present study it was noticed that “progress note” item was incomplete in all groups, except in 4% of ICU files where it was complete.

This agreed with Esmaili et al. (2010), who reported his study that performance evaluation of assistants and interns was “poor” in progress note documentation.

Also, Ranya et al. (2019) reported that in the three hospitals under study, clinical progress note documentation is thought to be extremely poor.

Evaluation of completeness of inpatient clinical progress indicators, including daily progress notes, physician orders, and patient histories. Doctor's orders and daily progress notes were not routinely documented.

This might be because daily progress reports and doctor's orders had to be completed throughout the entirety of the patient's stay at the facility. Inadequate tracking and recording of patients' progress could result in premature discharges and inadequate care (Lodge et al., 2020).

On contrary Saravi et al. (2016), study revealed that in teaching hospitals, the average data registration in the disease progress notes was 75%, while in non-teaching hospitals was 86%.

In the current study, “medication administration” item had statistically significant difference in between ER and other groups as ER showed incomplete data in 98% of files.

This could be explained by the multistep nature of the medicine delivery process makes it prone to errors. The variety of services provided, the individuals engaged, and the complicated nature of the processes also contributing factors (Jessurun et al., 2023).

In healthcare settings, medication errors are common and can result in higher patient morbidity, death, and healthcare expenses (Batel Marques et al., 2016; Berdot et al., 2013; Panagioti et al., 2019).

In the current study, “fluid chart” item had statistically significant difference between ICU and the other groups, since this item was missing at ER and inpatient files but present in 100% of ICU files (incomplete in 46% and complete in 54%).



Numerous articles state that these charts are frequently filled out incorrectly or insufficiently, which reduces their use in therapeutic settings. Similar experiences occurred in our practice at Kettering General Hospital, only 25% of the ward's charts had precise measurements, 20% had daily totals that were right, and 14% had comprehensive records of all intakes and losses, according to data from baseline measurements (*Madu et al., 2021*).

Also, *Asfour (2016)* stated that 65 % of fluid balance charts at an Egyptian hospital's ICU were accurately documented.

This could be explained by the evidence of insufficient staffing or time, as well as poor compliance and inaccurate information as the causes of incomplete fluid chart data. A number of high-profile incidents have linked patient dehydration in health and institutions to mortality. An individual's health and well-being can be impacted by how they manage their input and output. Precise observation can aid in diagnosis and eventually direct the selection of the most suitable course of action (*Holroyd, 2020*).

The most frequent explanations for inadequate documentation in fluid balance charts were inadequate training for nurses and other healthcare professionals, poor staff communication, technical faults with the fluid infusion machines; an increase in workload and ineffective time management (*Reid et al., 2004*).

On contrary *Alani and O'Malley (2018)* reported that out of 27 patients, 21 had completed fluid balance charts.

In the present study it was noticed that "Kardex" or the summary sheet and critical incidence form were not present at any file of all three groups.

*Namnabati (2017)* reported that Kardex is a useful instrument that provides concise access to patient information.

Statistically, according to *Goekcimen et al. (2023)*, only one out of every three studies discussed remedial measures taken within healthcare facilities; more attention must be paid to these measures and the lessons learned from critical incident reporting systems (CIRS). Fragmented or incomplete cycles of reporting and communication may also reduce the potential benefit of CIRS.

The current study showed that "treatment plan consent" item was also incomplete in all three groups.

This agreed with *Srinivasulu et al. (2016)*, who reported that in medical practice, informed consent is required, and it was incomplete in 92 case sheets.

Even with exceptional efforts to ensure that patients comprehend and are given accurate information, patients still lack adequate information. Studies on the defects of consent have not stopped for 30 years. Nine percent of the 1057 audio-taped consent interactions in the study satisfied the authors' criteria for completeness for informed decision-making. A significant percentage of consent problems in a different audit involving 100 specialists did not follow professional or regulatory requirements (*Shokrollahi, 2010*).

On contrary, *Pandit (2014)*, reported that about 91% of medical records contained patient signatures or fingerprints on treatment consent form.

This was not in agreement with *Cassileth et al. (1980)*, who reported that 60% of participants in a Philadelphia study stated that they comprehended the intent and nature of the medical procedures for which they had signed it just one day prior.

### 3. Discharge sheet

In the current study, "discharge date and time" showed statistical significance difference between studied groups, as ER had more incomplete data in 100% of files although inpatient and ICU files were complete.

This could be attributed to the fact that most of ER patients were discharged at same day of admission, so doctors do not pay attention to document date and time of discharge.

In the current study, "final diagnosis" was incomplete in all three studied groups.

*Ranya et al. (2019)* study revealed that the final diagnosis was documented in only 40.5%, 55%, and 78% of files at Kafr El-Sheikh General Hospital, El-Obour Health Insurance Hospital, and El-Mahalla El-Kubra General Hospital, respectively.

*Somi et al. (2004)* found that final diagnoses were recorded in 80.8% on admission and discharge sheets.

In the current study, regarding "status at discharge", "discharge medication" and "discharge instructions" were significantly different between ER and other groups, as data were missing in all ER files, opposite to being present in all inpatient and ICU files, yet they were incomplete.

The current study showed that the following items: "how the client is getting home", "follow up appointment", "nutrition guidance in terms of the client's diet after discharge" and "information about when to seek healthcare after discharge" were not present in any of three groups.

This could be explained according to *Lin et al. (2012)*, who stated that patients are frequently released from the hospital with inadequate planning, instruction, and information due to lack of coordination between the medical staff and communication between the hospital and the community.

*DeSai et al. (2021)* reported that when a patient ignores medical discharge instructions, such as by neglecting to take prescribed medication, ignoring alarming symptoms, or skipping follow-up appointments, unfavorable results may result. Healthcare personnel should try to make sure that patients understand the discharge instructions completely.

On the contrary, results in the study were not in agreement with *Blake-Mowatt et al. (2013)*, who reported that discharge planning and patient teaching of the records examined, 92% had written evidence that medication, dietary or treatment side effect discussed with patient. 94% of records had evidence of discharge planning and 14% had evidence of patient teaching. There were no significant differences in recording practices among the three wards studied with regard to discharge planning.

## Conclusion

The current study revealed that the documentation process in the inspected patients' files during the period from January 2022 to December 2022, were not up to the documentation standards.

No remarkable variation between the three studied patients' groups (Emergency, inpatient and ICU).

## Recommendations

- The study confirms the need for having and execution of departmental policy and guidelines for the medical documentation process and its continuous improvement.
- Workshops and training courses for the healthcare givers will help improving attitude towards medical documentation and enhance achieving high standard of documentation and reduce liability to medico-legal litigation.
- Regular and random documentation audits will be of great value to spot deviations of the documentation practice away from the targeted performance.

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## قياس عملية التوثيق الطبي في مركز علاج التسمم بجامعة عين شمس

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### الملخص العربي

**الخلفية العلمية:** التوثيق الطبي هو المصدر الرئيسي للمعلومات الصحية. حيث ان التوثيق الطبي لا يقل أهمية عن جودة الرعاية المقدمة للمرضى. ويتحمل الافراد القائمين علي الرعاية الصحية المسؤولية عن أفعالهم وإغفالاتهم في حفظ بيانات المريض. **الهدف من العمل:** تقييم الوضع الحالي لعملية التوثيق الطبي في مركز علاج التسمم بمستشفيات جامعة عين شمس ومدى اكتمالها وجودتها لتقليل الدعاوى القضائية. **طريقة البحث:** أجريت هذه الدراسة بأثر رجعي على ١٥٠ ملفاً من أرشيف مركز علاج التسمم، ٥٠ ملفاً من كل مجموعة (قسم الطوارئ، والقسم الداخلي، ووحدة العناية المركزة). تنتمي الملفات إلى المرضى الذين دخلوا المركز للحصول على المساعدة الطبية في الفترة من يناير ٢٠٢٢ إلى ديسمبر ٢٠٢٢. تم تقييم كل ملف وفقاً لقائمة مرجعية محددة، والتي تضمنت وجود سياسة المؤسسة التي تدعم التوثيق الطبي المناسب واستيفاء مكونات التوثيق الطبي الضرورية. تم جدولة البيانات التي تم الحصول عليها وفقاً لدرجة الاكتمال وتحليلها احصائياً. **النتائج:** كشفت الدراسة الحالية أنه لم يتم العثور على سياسة توثيق طبي مكتوبة ومعلنة ويمكن الوصول إليها. أظهرت المقارنة بين المجموعات الثلاث أن بعض العناصر كانت ذات دلالة إحصائية مثل البيانات الشخصية للمريض، والاتصال في حالات الطوارئ، والشكوى الرئيسية، ومخطط السوائل وتعليمات الخروج. لم تكن لبعض العناصر الأخرى دلالة إحصائية حيث لم تتواجد في جميع المجموعات المدروسة مثل الحساسية والابلاغ عن الحوادث الحرجة التي تعرض لها المريض اثناء اقامته بالمستشفى ومواعيد المتابعة بعد الخروج. بينما لم تكن بعض العناصر دلالة إحصائية حيث كانت كاملة في جميع المجموعات مثل تاريخ ووقت وسبب الدخول للمستشفى. **الخلاصة:** كشفت الدراسة الحالية أن عملية التوثيق في ملفات المرضى الذين تم فحصهم خلال الفترة من يناير ٢٠٢٢ إلى ديسمبر ٢٠٢٢، لا ترقى لمعايير التوثيق الطبي.