ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

THE COMPLETENESS OF OUT PATIENT INDIVDUAL FOLDER MEDICAL RECORDING IN GEDO HOSPITAL, WEST SHOA, OROMIA REGION, ETHIOPIA

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A Capstone project Submitted to the School of graduate studies of Addis Ababa University in partial fulfillment of the requirements for the degree of Masters of Health care and Hospital Administration

Addis Ababa

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DECLARATION

I, undersigned declare that this capstone project on completeness of outpatient individual folder medical documentation in Gedo hospital was my original work that has been presented for a degree of Masters of Health Care and Hospital Administration in Addis Ababa University College of health science, School of public health and all sources of materials have been fully acknowledged.

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ACKNOWLEDGMENT

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Last but not least my thanks goes to Gedo hospital senior management team, Gedo hospital staff and West Shoa zonal health department for their cooperation to provided me data related to my study and training.

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Abbreviation

ART - Anti retroviral therapy

CPA - Capstone project advisors

DC- Data collector

DEC-Data entry clerk

EHRIG - Ethiopia hospital reform Implementation guide line

HMIS- Health management information systems

ID - Identification card

IP- Impatient

MCH - Mother Child health

MHA -Master in hospital and health care administration

MPI- Master patient index

MR- Medical record

MRD –Medical record department.

MRO –Medical record officer.

MRN - Medical record number

OPD- Outpatient

PI- Principal Investigator

LIST OF TABLES

Abstract

BACKGROND: the completeness of outpatient individual folder medical/health documentation are used to document patient's medical history, illness and treatment procedures. Properly documented medical records are important in patient care. This study is designed to improve the completeness of outpatient medical /health documentation at Gedo hospital.

METHODS (project design): , 50 individual patient folder medical recording were randomly selected on pre-intervention and 62 post-intervention after training was provided on medical records.

The completeness of each medical records was checked against a EHRIG standard. The pre –intervention was conducted on September, 2011 and post- intervention on March, 2012

RESULTS: The outpatient individual folder medical records completeness was found 34.81% in the pre and has improved later in post intervention to 82.3. It is found statistically significant at (P-value <0.001)

CONCLUSION: Capstone project on the completeness of out patient individual folder medical documentation in Gedo hospital was improved after intervention from 34.81% out of 50 medical documentation which were completed in pre- intervention to 82.3% medical documentation completeness level with overall statistically significant result of (P-value <0.001). There were positive relationships also between each of the intervention elements & an increase in improving medical documentation in Gedo hospital.

RECOMMENDATION: Availing medical record supplies, refresher training and Sustainable monitoring and evaluation is important to achieve the ultimate result of medical record completeness

BACKGROUND

Organizational Description

Gedo hospital is district hospital founded in April 2002 E.C. Gedo hospital is located in Gedo town, West Shoa zone, Oromia .It is 178kms West of Addis Ababa. Its mission is to reduce morbidity, mortality and disability, and improve the health status of people through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health service via a decentralized health system.

Gedo hospital provides emergency, outpatient, in patient and delivery service; with catchment area population of 5887093. Currently, It has 50 clinical staff and 48 supportive staff. It has 50 operational beds. The average out patient waiting time is one hour and fifty five minutes It serves aproxmetly 14,248 out patients per year.

INTRODUCTION

Medical records (MR) are a written collection of information about patients health and treatment. The MR is a multifunctional document that is used to communicate and document critical information about patient medical care among health care professionals. Comprehensive medical record is a cornerstone in the quality and efficiency of patient care during the hospitalization and in subsequent follow up visits, as they can provide a complete and accurate chronology of treatments, patient results and future plan for care. Despite the importance of medical documentation of high quality and efficient care, the completeness of medical records in Gedo hospital is very low. This project aimed to improve the completeness of out patient medical/health documentation in Gedo hospital.(3)

AIM OF THE CAPSTONE

The aim of this capstone project is to help medical/health record workers in Gedo hospital to develop and manage the medical/health information service in an effective and efficient manner.

Public health relevance

Medical/health documentation is the central documentation of the patients visit to health care facility.

A well-managed MR system is critical to providing efficient and high quality patient care.

In addition, the MR function supports for planning, surveillance and audit hospital activities

PURPOSE

For the continuining care of the patient when they require health care in the future, provide accurate information who the patient is and who provide health care and What , when, why and how services are provided

Has four major sections

1 Administrative, which includes demographic and socioeconomic data

2 Legal data, including a signed consent for treatment

3 Financial data relating to the payment of fees for medical services and hospital accommodation

4 Clinical data of the patient weather admitted to the hospital or treated as an out patient or an emergency patient.

The main use of the MR in Gedo hospital are:

- vital role in planning
- To document the course of the patients illness and treatment
- To communicate between attending doctors and other health care professionals providing care to the patient
- For research of specific disease and treatment and To collection of health statistics.

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STATEMENT OF THE PROBLEM

Globally a limited literature were available on completeness of hospital outpatient individual folder medical/health documentation.

There is scarce literature on completeness of hospital outpatient individual folder medical/health documentation in Sub Saharan Africa. The evidence on individual patient folder medical record documentation is also scanty in Ethiopia

Medical record documentation in Gedo hospital outpatient individual folder is incomplete by 65.2% of the 50 cards in baseline assessment

Among EHRIG & HMIS standard mentioned I was did comparative analysis and selected the following main incompletes which inclusive in individual out patient medical folder

- Demographic data
- Tracer card
- Laboratory request
- Laboratory report
- Final diagnosis
- Summary sheet

Root cause analysis

The causes of the incompleteness an individual out patient folder of medical documentation are:

1 Lack of training to staff on EHRIG and HMIS medical/health record implementation. On September,2011when I was conducted survey among the 68 staff who participated in medical records only 39 were trained in handling medical/health documentation .

2 **No porters**: Standard number of porters in district hospital are three (3), Gedo hospital has 0/3. The relation between porter and medical documentation are porters bring individual patient folder to clinical staff, and the one who receive medical document will signed on tracer card and avoid lost card, and if no porters the one assigned in record unit must be disseminate an individual patient folder to the clinicians. So due to shortage of time medical documentation could be incomplete

3 Lack of medical record supplies: Tracer card is never available in Gedo hospital MR room whereas the other components of the medical record were available.

INDICATORS

Process indicators are the following:

1 Provide training for all concerned staffs

2 Recruit one porter

3 Printing tracer cards .

4 Weakly based all concerned cause teams should have self evaluation.

. **Out came** Increase completeness of Medical documentation.

LITERATURE REVIEW

CLINICAL AND SERVICE DOCUMENTS

In each patient visit, clinical and service records are hand written on different forms by health professionals and administrative staffs. These documents are held together and are pup in to in the individual's medical record folder. The medical record folder hence constitutes number of forms, which are used for a specific purpose, and service.

The basic sets of forms that are commonly seen in the patient's medical records folder include:

1. **Demographic sheet :** The basic patient identification should be written on the demographic sheet paper in each medical folder contents include:
    - **M**edical record number (unique)
    - Date of registration
    - Full name of the client, sex and address
    - Emergency contact

1 **Summary sheet** : summarize date**,** identification, final diagnosis, and cost in each visit. It is completed by one of the clinical unit staff offering the service.

2 **Laboratory request and Results**: are collection of investigation that are sent back to the requesting client. Should be attached to individual's medical record.(1)

Quality Issues for medical records services

Over recent years, the quality of documentation in the medical/health documentation has became an important issue, no only with the need to promote better health care, but also, the need by governments to reduce health care costs.

To evaluating content of medical documentation include:

- The consent form for treatment has been signed by the patient;

Patient identification details (name and medical record number) are correct and entered on all forms;

- Doctors have recorded all essential information;
- Doctors have signed and dated all clinical entries;
- The front sheet has been completed and signed by the attending doctor;
- Nurses have recorded and signed all daily notes regarding the condition and care of the patient;
- All the orders for treatment have been recorded in the medication form and signed;
- Medication administration has been recorded and signed;
- The anesthetic form (if any) has been completed and signed;
- The operation form (if any) has been completed and signed;
- The main condition/principle diagnosis has been recorded on the front sheet;
- Operations and/or procedures have been recorded on the front sheet; and
- The MRO or staff member responsible for coding has accurately coded the main condition/ principle diagnosis and any other condition listed (if required)(1,3).

Again a study questionnaire should be prepared and target determined, e.g, achieve 100% compliance.

Individual patient folder medical/health documentation completeness is critical for sustaining a process of preventive, promotive, curative and rehabilitative health care service delivery and utilization. It's an individual life time record and is documented and kept in a health institution.(4)

Individual medical /health documentation is performed and kept in medical record unit (card room)

Tools of integrated medical record

Based on new health management information systems integrated paper based medical records main cards and forms are nine (4) .

Integrated individual medical folder, Patient card (form), Integrated reproductive health card, Women's card, Master patient index, Service ID, Appointment card, Tracer card, admission & discharge card.(2)

Recording Procedure

Basically, all clients who appear seeking health care should pass through MRD to insure registration and or update of their medical record (1).

Standard Medial record room should have : Health information technician, card room clerks, card room clerks, adequate room with 2 windows for fast track, standard and adequate shelve and MPI.

Operational standards for medical record management.

1 The hospital utilizes, master patient index with single, unique medical record number for each patient.

2 The hospital utilizes a single, unified registration systems for all patients, including in patients, outpatients, emergency patients, and specialty clinics.

3 The hospital utilizes a paper-based or computer- based systems to track where the medical record is located at all times.

4 The hospital utilizes a uniform set of forms that comprise a complete medical record for the duration of a patient's care.

5 The hospital has orientation and training program for all medical records personnel to ensure awareness of and competency in medical record management procedures.

6 The hospital has medical records management guidelines for proper handling and confidentiality of medical records.(5)

Quality problem in low- income countries, medical record management is often lacking setting rural hospital in Ethiopia.

A rural hospital in Ethiopia, 2009 study conducted shows 6.5% pre-intervention and 45.7% post- intervention result,(p-value 0.001)

Recent study result of first published online July 2009 accessibility and completeness of the medical record like hood of finding medical record number of returning patient increased significantly from before the intervention to after the intervention (14%pre intervention and 87%post intervention p-value <0.01

The study found that simple set of interventions could be accomplished to significantly improve the accessibility and completeness medical records in resource –limited setting.(4)

Patient care includes a systematic and chronological record at care and treatment which necessitates the establishment of medical record department in the hospital .The medical

record is a storehouse of knowledge concerning the patient .It is a yard-stick by which the quality of work done by the physician and hospital personnel may measured.

Well designed form are needed for keeping comprehensive medical records properly designed forms serve to provide for easy and quick records ,for compact information storage.(5)

OBJECTIVE

General Objective

To improve the completeness of out patient individual folder medical/health documentation in Gedo hospital which was a baseline taken on September 2011,at the end of April 2012.

Specific objective

To improve the individual patient folder of the following items by the end of April 2012

1 Tracer card from 0% to 60% .

2 Laboratory request from 22% to 60%

3 . Laboratory report from 30% to 60%

4 Final diagnosis from 48% to 60% .

5 Summary sheet from 32% to 60%.

6 Demographic data from 78% to100%.

Methodology

Study area and study period:

Study Area: Study area was Gedo hospital, West Shewa Zone, Oromia, Ethiopia.

Study period: Pre-intervention data were collected in September 2011

- Intervention period was January to February 2012
- In March, one month after intervention 62 medical records were audited.

Design: Pre and post intervention design

- ✓ Pre-intervention baseline assessment
- ✓ Intervention
- ✓ Post-intervention assessment

Source Population: Gedo hospital individual patient folder

Study Population: an individual folder of out patients who attended OPD service on September 2011 & March 2012

Inclusion criteria : all individual out patient folder in record unit recorded as outpatient services during the data collection days (period)

Exclusion criteria: All individual patient folders of inpatient medical records during the study period in the record unit

SAMPLE SIZE CALCULATION

Sample size: calculation formula for comparing two population proportions

Formula

$$n = [Z1-\alpha/2\sqrt{2p(1-p)} + z\beta\sqrt{p1(1-p1)+p2(1-p2)}]^2$$

$$(P1-P2)^2$$

Where $Z1-\alpha/2 = 1.96$

$P = 0.475$

$Z\beta = 0.84$

$P1 = 0.35$

$P2 = 0.60$

$$N = [1.96\sqrt{2x0.475(1-0.475)} + 0.84\sqrt{0.35(1-0.35)+0.60(1-0.60)}]^2$$

$$(0.35-0.60)^2$$

n= 62

Where n= minimum sample size required

$P = (p1+p2)^2$

P1= pre-intervention assessment

P2= post intervention assessment

z= at 95% confident interval.

SAMPLING PROCEDURES/ TECHENQUE

Three days of the week were used during pre and the post intervention assessments .Base line data were collected in Sebtember2011,50 individual patient folder medical records were randomly sampled over two morning and one after noon. In March, one month after the intervention 62 medical records were audited using the some procedures.

A medical record was rated as completed if included the following items; demographic data, Tracer card, Laboratory request, Laboratory report, final diagnosis and summary sheet, on each page patient information in the individual folder medical/health documentation.

DATA COLLECTION METHODS

Data Source: An individual out patient folder

Data collectors: Two data collectors were employed and trained by PI

Data collection tools: Medical record questionnaire (checklist) adapted from standard EHRIG's format used by the hospital

Data quality assurance:

- ✓ Provision of training for data collectors
- ✓ Supervision of the data collection process
- ✓ The use of 'Individual out patient folder' in the hospital , which is an official document and EHRIG's standardized format

Data processing: Retrieved data was entered into table(format) & Simple scientific calculator was used for computation purpose

Data analysis: Pre and post data were compared using chi-squared, and significance level: $P<0.05$

Ethical Considerations: Ethical clearance was obtained from Addis Ababa University, School of public health, MHA program & Consent for the data collection was obtained from the Gedo hospital management bodies as well as Confidentiality of the collected data was maintained and will not be used individually for purposes other than this study

Dissemination of results: It will presented to Gedo hospital management bodies and staff, and disseminated to those governmental and non-governmental organizations that could potentially benefited from the study. Publication will be sought.

INTERVENTION STRATEGIES

The study was done in collaboration of senior management team, card room staff members and zonal health department to apply problem solving and quality improvement techniques to define the problem, understand its root causes, set objective, consider alternative strategies to address the problem and fulfils the objective, select a strategy implement a set of planned tasks and evaluate the impact of the intervention. The study was defined the problem as frequent missing or incomplete individual patient folder medical/health documentation. To identify root cause and scope of the problem. The study was conducted a pre-intervention assessment in the September 2011. The pre intervention assessment revealed that the hospital has no tracer card and due to lack of tracer card 4% medical card was lost.

Further more, most clinical information/health records documentation were not completed.

The intervention included the following components

(1) To avoid lost of medical documentation hospital senior management team planned and allocated budget to printing 20,000 tracer card for 2012 physical year , and it was printed according to the plan.

(2) Training was provided for 17 staff on medical/health documentation for one day on site by PI on February 2012.

12 staff was trained by zonal HMIS coordinator on health management information system reform for 5 days on February 2012.

39 staff already trained on HMIS reform at the beginning of 2011 physical year in collaborative with Oromia health bureau,CDC, and Tulane university for 5 days.

(3) One porter was recruited to avoid medical/health documentation lost by submitting and collecting outpatient individual folder timely.

(4) Weekly based cause team self evaluation continuously conducting to evaluate all activities including medical documentation which was performed in the week.

(5) Supportive supervision was conducted to strengthen sustainability of improving medical/health documentation every 2 weeks by quality committee.

Results

Pre and post- intervention change in individual out patient folder medical/health documentation in Gedo hospital

Table 1 shows demographic data pre-intervention assessment 39/50(78%) whereas in the post intervention assessment situation was improved significantly <0.001 p-value, that was 62/62(100%) achievement obtained after the post intervention assessment

Demographic data	Pre-Intervention Result n=50		Post Intervention Result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
Facility name	42	84	62	100	8.41	<0.004
Full Name	41	82	62	100	9.82	0.017
MRN	43	86	62	100	7.02	0.008
Age	42	84	62	100	8.4	<0.004
Sex	36	72	61	98.4	16.61	<0.001
Date	34	68	60	96.7	16.9	<0.001
Address	34	68	62	100	23.15	<0.001
Cumulative	39	78	62	99.3	12.74	<0.001

Demographic data analysis

Demographic data	Pre	Post		X^2	P-value
Yes	39	62	101	12.74	0.001
No	11	O	11		
	50	62	112		

since 12.74 is greater than 3.84 reject the null hypothesis, and accept there is statistical difference in pre and post demographic data medical/health record use at $P<0.05$

Table 2 shows Tracer card pre-intervention assessment 0/50/(0%) where as in the post intervention assessment the situation was improved significantly <0.001 p- value that 33/62(53.2%) achievement obtained after the post intervention assessment .						
Tracer card	Pre Intervention Result n=50		Post Intervention Result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
	0	0	33	53.2	35.7	<0.001

Tracer card data analysis

Tracer card	Pre	Post		X^2	P-value
Yes	0	33	33	35.7	<0.001
No	50	29	79		
	50	62	112		

since 37.53 is greater than 3.84, reject null hypothesis, and accept there is statistical difference in pre and post tracer card medical/health record use at P<0.05

Table 3 shows Laboratory request pre-intervention assessment 11/50(22%) where as in the post-intervention assessment the situation was improved significantly <0.001 p-value that 61/62(98.4%) achievement obtained after the post-intervention assessment.

Laboratory request	Pre- intervention result n=50		Post- intervention result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
Health professional name	11	22	61	98.4	79.34	<0.001
Signature	11	22	61	98.4	70.34	<0.001
Date	10	20	61	98.4	73.29	<0.001
Cumulative	11	22	61	98.4	70.34	<0.001

Laboratory request data analysis

Laboratory request	Pre	Post		X^2	P-value
Yes	11	61	72	70.34	<0.001
No	39	1	40		
	50	62	112		

since 70.34 is greater than 3.84, reject the null hypothesis, and accept there is a statistical difference in pre and post laboratory request medical/health record use at P<0.05

Table 4 shows laboratory report pre- intervention assessment 15/50(30%) where as in the post intervention assessment the situation was improved significantly <0.001 p-value that 49/62(79.4%) achievement obtained after the post- intervention assessment.

Laboratory report	Pre- intervention result n=50		Post- intervention result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
Health professional name	16	32	55	88.7	42.43	<0.001
Signature	21	42	56	90.3	34.22	<0.001
Date	12	24	25	40.3	3.33	0.067
Attached to documents	9	18	61	98.4	76.31	<0.001
Cumulative	15	30	49	79.4	27.17	<0.001

Laboratory report data analysis

Laboratory report	Pre	Post		X^2	P-value
Yes	15	49	64	27.17	<0.001
No	35	13	48		
	50	62	112		

since 27.17 is greater than 3.84, reject the null hypothesis, and accept there is a statistical difference in pre and post laboratory report medical/health record use at P<0.05

Table 5 shows final diagnosis pre-intervention assessment 24/50(48%) where as in post intervention assessment the situation was improved significantly <0.001 p-value that 55/62(89.2%)achievement obtained after the post-intervention assessment.

Final diagnosis	Pre- intervention Result n=50		Post- intervention Result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
Health professional name	21	42	48	77.4	14.68	<0.001
Signature	31	62	58	93.5	16.88	<0.001
Date	22	44	60	96.8	39..31	<0.001
Cumulative	24	48	55	89.2	10.42	<0.001

Final diagnosis data analysis

Final diagnosis	Pre	Post		X^2	P-value
Yes	24	55	79	17.00	<0.001
No	26	7	33		
	50	62	112		

since 17.00 is greater than 3.84, reject the null hypothesis, and accept there is a statistical difference in pre and post final diagnosis medical/health record use at P<0.05

Table 6 shows summary sheet pre-intervention assessment 16/50(32%) where as in the post intervention assessment the situation was improved significantly <0.001 p-value that 46/62(74.5%) achievement obtained after the post-intervention assessment. But the medical cost recording still not improved due to lack of communication among card room, pharmacy and laboratory case team.

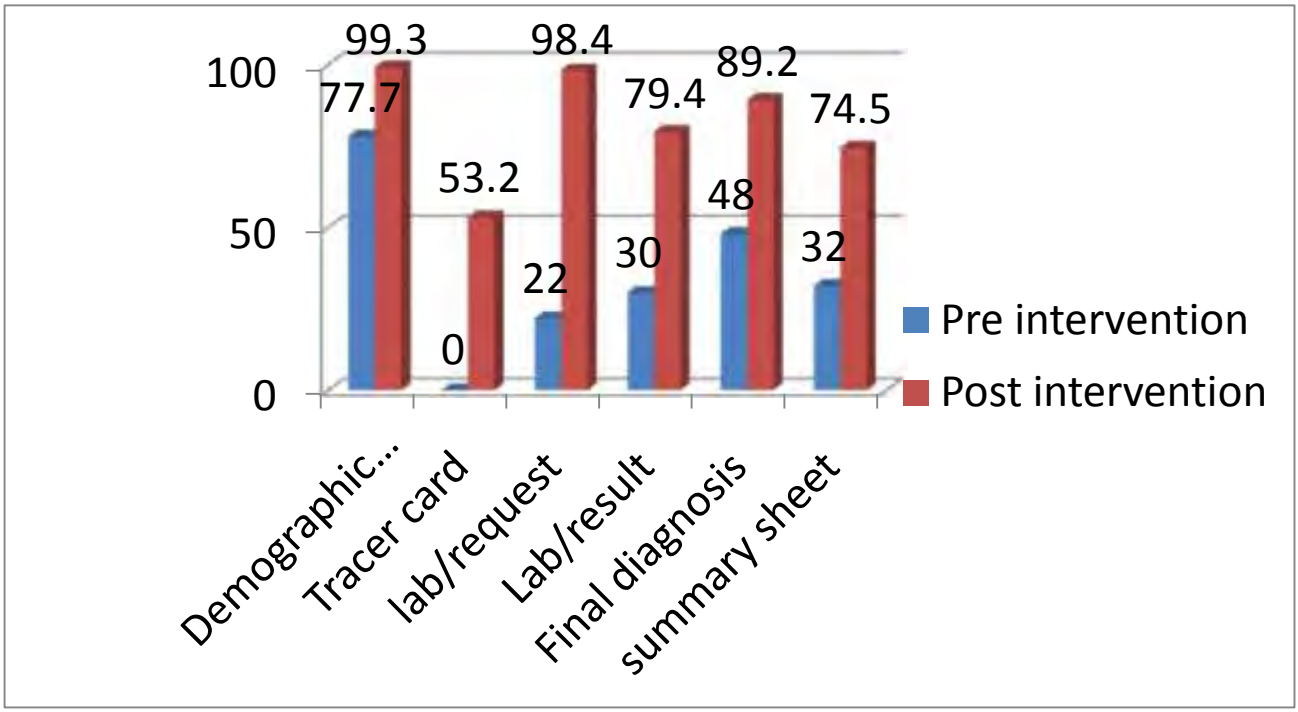
Summary sheet	Pre- intervention result n=50		Post- intervention result n=62		X^2	P-value
	Yes		Yes			
	Number	%	Number	%		
Date	18	36	62	100	55.5	<0.001
Service	18	36	62	100	55.55	<0.001
Diagnosis	24	48	51	82.3	14.68	<0.001
Service number	19	38	56	90.3	34.25	<0.001
Cost	0	0	0	0		
Cumulative	16	32	46	74.5	19.94	<0.001

Summery sheet data analysis

Summary sheet	Pre	Post		X^2	P-value
Yes	16	46	62	19.94	<0.001
No	34	16	50		
	50	62	112		

since 19.94 is greater than 3.84, reject the null hypothesis, and accept there is a statistical difference in pre and post summery sheet medical/health record use at $P<0.05$

Bar graph shows pre and post intervention out patient medical/health documentation in Gedo hospital



Results cont'd

Table 7.1 shows result of individual out patient folder Medical records completeness by variable in Gedo hospital, West Shoa, March 2012

Variables	Yes pre	%	Yes Post	%	X^2	p-value
Demographic data	39	78	62	99.3	13.35	<0.001
Tracer card	0	0	33	53.2	35.7	<0.001
Lab. request	11	22	61	98.4	70.34	<0.001
Lab. report	15	30	49	79.4	27.17	<0.001
Final Diagnosis	24	48	55	89.2	17.00	<0.001
Summary Sheet	16	32	46	79.2	19.94	<0.001

Results cont'd

Table 7.2 shows summary result of an individual out patient Medical record completeness in Gedo hospital, West Shoa, March 2012

Over all medical record data analysis	**Pre N= 50**	**Post N= 62**	**Total**	**DF**	**X^2**	**P-value**
Yes	**17**	**51**	**68**	n-1= 1	**27.02**	**< 0.001**
No	**33**	**11**	**44**			
	50	**62**	**112**			

Since 27.02 is > 3.84 there is statistical difference in pre and post over all individual patient folder medical/health record use at P<0.05 %

Discussion

The study found that a simple set of intervention could be accomplished to significantly improve the outpatient individual folder of medical/ heath documentation in Gedo hospital setting. The simplicity and in expensiveness of this project produced results demonstrated that a well-planned business process re-engineering intervention can improved management and system operations that can facilitate better patient medical health information in Gedo hospital setting. In addition, the intervention resulted in increased training and printing relevant medical/health recording materials, especially tracer cards are extremely important as they enable medical records to be TRACED when not on file. Tracer is a card, usually the same size or slightly larger than the medical record, on which should be written:

1 The patient name

2 The patient's medical record number

3 Where the MR is going(department/responsible healthcare provider)

A tracer can be as a simple as a blank piece of A4 card where the information is recorded and on the return of the medical record the information canceled & the tracer is placed inside the folder. Or it can be printed card with the information recorded in the space provided crossed out after use. As well as, often over looked human resources at hospitals, the medical record room staff. Standardization of individual patient folder medical documentation handling,

filing procedures, adequate training and human resource development efforts for involved staff. An automated tracking system for medical/health documentation checked out of the medical/health record room for patient care is also possible to implement fundamental

medical records. There are some challenges especially to fulfill porters due to under allocation of budget to recruit human resource. Even if there are under allocation of budget the senior management team revises the annual budget and decide to recruit one porters by contract.

The study also helped to keep fundamental medical records in the hospital properly. A rural hospital in Ethiopia, 2009 study conducted shows 6.5% pre-intervention and 45.7% post-intervention result,(p-value 0.001) which is similar to this study. There is also limited literature was available elsewhere on completeness of medical recording.

CHALLENGES

EHRIG and HMIS standard reform of medical record are new reform to be adapted in short period of this capstone project assessment.

Communication barrier is one major problem to communicate with advisors, Addis Ababa University, School of public health and Yale MHA program coordinators due to lack of internet accessibility in my work place.

STRENGTH AND LIMITATION

Strength :

With inexpensive intervention the capstone project improved completeness of an individual outpatient folder medical records and also this study adds evidence to the already scarce evidence available in the hospital.

Limitation: Scanty literature about outpatient medical recording globally, Sub Saharan Arica and in Ethiopia

Conclusion

A capstone project on completeness of outpatient individual folder medical/health documentation in Gedo hospital was improved after intervention from 34.81% out of 50 medical documentation which were completed in pre- intervention to 82.3% out of 62 individual out patient folder medical documentation completeness level with overall statistically significant result of (P-value <0.001), which can be utilized to strengthen the theoretical basis for required regulatory training, printing recording materials, weekly base concerned cause team self evaluation as well as to validate interventions. There fore, it can be concluded that the elements of the intervention successfully increased the general knowledge of improving on individual out patient folder medical/health documentation in Gedo hospital all concerned staff. And also, it can be concluded that there were positive relationship between an intervention elements and an increase in improving medical/health documentation in Gedo hospital for majority staff, but not all of the area.

This study utilized random systematic sampling from Gedo hospital outpatient individual folder which is available in the hospital card room during both pre and post study period.

RECOMMENDATION

Sustainable availing medical record supplies, monitoring and evaluation is important to achieve the ultimate result of outpatient individual folder medical record completeness as well as refresher trainings should be continued periodically.

Annex

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Clinical and service documents of Gedo hospital individual folder out patient medical documentation assessment

1. Demographic information assessment

1.1. Name of facility Yes ☐ No ☐

1.2. Medical record number (unique) Yes ☐ No ☐

1.3 Date of registration ……. Yes ☐ No ☐

1.4 Full name of the client ……...Yes ☐ No ☐

1.5 Sex …….. Yes ☐ No ☐

1.6. Age …….. …Yes ☐ No ☐

1.7. Address…… Yes ☐ No ☐

2. Tracer card ...……..Yes ☐ No ☐

Practice assessment

3.Laboratory requests

Health professional Name ……Yes ☐ No ☐

Signature ……. Yes ☐ No ☐

Date …… Yes ☐ No ☐

4. Laboratory result

Health professional Name ……..Yes ☐ No ☐

Signature ……. Yes ☐ No ☐

Date …… Yes ☐ No ☐

Attached to pt. document …. Yes ☐ No ☐

5. Final diagnosis

Health professional Name …….……Yes ☐ No ☐

Signature ……. Yes ☐ No ☐

Date …… Yes ☐ No ☐

6. Summery sheet

Date……. Yes ☐ No ☐

Service ……..……Yes ☐ No ☐

Diagnosis/complication or service detail……..… Yes ☐ No ☐

Serial number in service registration book…… Yes ☐ No ☐

Cost ……Yes ☐ No ☐