

Is Having More Experience in Medicine Means You are “Bad” in Documentation?

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Abstract Introduction: Clinical record keeping is an essential component of good professional practice and delivery of quality healthcare. Hence, documenting a proper history is crucial for patient care and can help with both medicolegal purposes and future research. Therefore, many projects have focused on improving this aspect of healthcare. This audit project aimed to evaluate the current practice at Al Ain Hospital, and its impact after education. Methods: We reviewed all admission notes between January 2019 and March 2019 for patients aged > 16 years who were admitted to Al Ain Hospital with acute appendicitis and focused on the documentation of “past surgical history” in the admission note. After educating the healthcare staff, a review of the admission notes from January 2020 to February 2020 was conducted to compare the results. Results: The initial collected data showed a deficiency of documentation. After presenting of the data and instruction of the health care workers, a re-auditing was obtained. The new data showed good improvement of the documentation between 16- 50% increase, however experienced physicians were still lacking. Conclusion: Proper documentation of patient’s medical record is important and essential to obtain correct management. Educating all healthcare workers regardless of their experience is one of the ways to improve documentation.

Keywords: *surgical history, medical record, electronic, documentation*

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1. Introduction

Medical records keeping is a necessary component in a good clinical practice. In modern times many hospitals have moved from paper to electronic patient records. There are many advantages including legibility, storage, and record sharing across facilities. However, with templates and large numbers of data fields it becomes difficult to accurately fill in all the requirements and errors can ensue. Furthermore, many health care workers are not trained in the electronic data handling and are focusing on minimal information. As a lot of electronic record systems are available, it is also difficult to fulfill all the requirements due to the construction of the electronic health record. This and the fluctuation of many physicians to different hospitals with different electronic records is a major challenge. Therefore repeated problem addressing, training and education is needed to fulfill the required quality [1]. The aim of this retrospective study was to assess the accuracy of documented “past surgical history” as an essential item for formulating a diagnosis and adequate care and aid in the future researches

2. Method

Between January 2019 until March 2019, all electronic records of patients above 16 years of age admitted to the general surgery department in Al Ain Hospital with acute appendicitis were assessed. Focus was on the documented past surgical history (PSH) in the admission note (H&P note). Once data was collected and reviewed, feedback and education was provided to the surgical team including surgical residents, specialists and postgraduates. 9 months later, the analysis was repeated from the period of January 2020 until February 2020 with the same criteria.

3. Results

The first audit data included 44 patients with acute appendicitis that were admitted between January and March 2019. Each file was checked for having past surgical histories documented. From those patients, general surgery (GS) residents wrote 24 admission notes, specialists made 4 notes and postgraduates residents did 16 notes.

From GS resident's notes, only eight were documented to have PSH. In none of the specialists and the postgraduates notes PSH was reported. (Figure 1).

So, the GS residents with 33.3 % reported PSH were more accurate and careful in documentation compared to the postgraduates and specialist (0%).

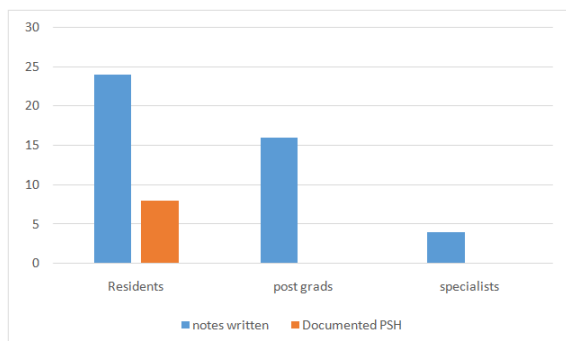


Figure 1. showing the number of admission notes and documented past surgical history written by different level of surgical team in the first audit cycle

After acquisition and analysis of the data, they were presented in an institutional quality meeting. Subsequently the whole General Surgery team was instructed and once more educated about the importance of an accurate documentation.

For the second audit cycle data files of patients with acute appendicitis were scanned from January 2020 until February 2020. 53 cases were collected, two notes were written by internal medicine and GS were consulted after the admission, so those patients were removed from the study. 26 cases were written by the GS residents, of them 22 cases were documented to have a past surgical history. The postgraduates made 19 notes; seven of them were documented to have a past surgical history. The specialists did six of the notes, and only one note was found to be containing documentation about past surgical history (Figure 2). Thus making good improvement of proper documentation compliance to be for GS residents at 84.6%, postgraduates to be 36.8% and specialists to be 16.6%.

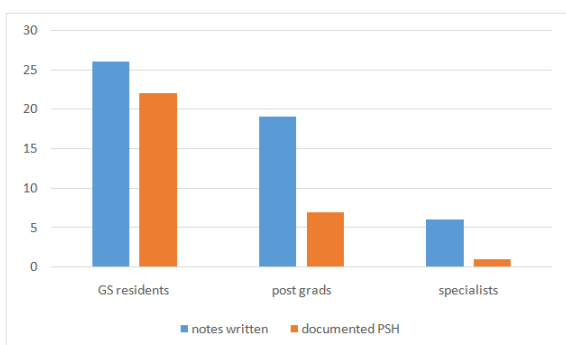


Figure 2. showing the number of admission notes and documented past surgical history written by different level of surgical team in the re-audit

4. Discussion

Electronic Medical Records (EMR) are being used now for both administrative as well as clinical tasks, having major implications for patient safety and quality of care.

They are a way of improving the availability, legibility and completeness of patient information. EMRs decrease medical errors by providing complete patient information and history [2].

Most studies suggest that EMRs provide accurate and complete patient records [3]. However, a study was done in Australia to check how accurate electronic medical records are and a part of the study was to see how much percentage of the EMR has had information that was not recorded, and after an intensive study, it was found that around 36% of the EMR's had non-recorded information [4].

Another study was done in Canada which was focusing also on the completion of medical records, this study showed that around 24.4% of the records were incomplete, among which history of present illness was the most incomplete followed by past surgical history, the latter of which was seen with our study as well [5]. Hence, this is an issue that is occurring worldwide, and many studies have been done to improve this aspect by identifying the possible causes and help in solving them to aid in delivering a good quality healthcare system [6].

Some researchers suggest that the reason for miss-documentation can be due to the overload of the work on the healthcare worker [7]. Another reason that was studied via retrospective measures, has compared the time spent in documentation before and after the electronic system initiation, and it was found that the time spent on the documenting in the patient's file after the introduction of the electronic system had increased from 16% to 28% among physicians and from 9% to 23% among nurses [8].

During our education to our surgical team, it was agreed that the overload on the duty made them not document the past surgical history. Among other reasons were communication issue with the patients due to language barrier, inability to obtain reports from other private facilities and recall bias from some patients not remembering their procedures.

The team also indicated that getting hand-written reports from other facilities that were not written clearly, or even obtaining previous paper based records increased the burden on them, and was associated with non-proper documentation.

However, despite all of this, many quality projects were done to improve the healthcare system. Even the Royal College of Physicians England have made some guidelines to ensure proper physicians clinical documentations [9].

Our study showed that a continued reminder to the team can make a difference and help in improving the quality of the documentation, however, this also indicated that despite all of the effort to encourage a proper documentation, the "more experienced" physicians didn't improve much. Not sure if the reason for that was the need for longer time to document in the electronic records or if they were busier as compared to the "younger" physicians, as after all, the more experienced ones "specialists" are the ones with privileges to operate in our facility. Nonetheless, this needs to be investigated to know why they were reluctant to improve?!

The intervention to support a good quality improvement in the healthcare system can be costly, nevertheless, simple low cost education through reminder emails and meetings can be as effective and efficient and even better

sometimes than high cost measures. In this study that was done in Swindon, it was shown that a sustained improvement of over 80% was made with simple low cost-effective measures like education [10].

Multimodal measures is needed to improve the healthcare system and support a proper documentation to ease on the patients diagnosis , management and help in future researches [11]. And the proper way to identify and solve issues is by developing an information system where the issue can be raised , and feedback to be obtained and discussed [12] . Hence , promoting quality projects in hospital settings among the healthcare workers is needed for a useful and legitimate improvement . As shown in multiple researches and studies , there is a definitive improvement in any system that has feedback and re-audits [13].

5. Conclusion

Accurate documentation is undoubtedly very important and facilitates proper patient monitoring. This simple study found that initially almost all of the H&P documents were lacking in documentation of PSH. After education sessions the quality has improved, however more and repeated education about the importance of documentation needs to be implemented as regular assignment both for the specific departments and the quality division of every health care center. More experienced physicians need to embrace the new technology, are called to overcome their perceptions and help in improving the system.

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