

Comparison of the status of data recording in discharge patient's surgical forms in educational hospitals of Zabol and Torbat-jam in 2011

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Abstract

Background and Aims: Recording of medical information in hospital is documentation of medical team's activities. Regarding the special position of records in patient's medical history and its importance in making decision, recording the information in a correct way is substantial. This study carried out to compare the status of documentation in surgical forms of discharged patients in educational hospitals of Zabol and Torbat-e-jam cities in 2011.

Methods: In this cross-sectional study 740 medical records of Zabol and Torbat-e-jam hospitals (each hospital 370 cases) were studied by systematic sampling. Data were collected using a check list and analyzed by SPSS software through descriptive statistics.

Results: The survey indicates that 36.4 and 62.9 percent of the data were not documented in surgical forms in Zabol and Torbat-e-Jam educational hospitals, respectively. The rate of data completion in preoperative care sheets, anesthesia sheets, surgery report and post-operative care sheets were 54, 78, 63 and 73.4 percent, respectively in Torbat-e-Jam educational hospital. These amounts in Zabol educational hospitals were determined 32, 43.3, 49 and 0 percent respectively.

Conclusion: As can be concluded from the results, the medical records documentation had serious defects. This can lead to loss of patients' data and adverse effects on the treatment process as well. Regarding the importance of surgical forms, proper solutions should be adopted to eliminate data incompleteness.

Keywords: Surgery special sheets, Documentation status, Data.