



Original Article: **Exploring Clinical Documentation Practices among Healthcare Staff: A Clinical Audit of National Hospital Galle, Sri Lanka**

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Abstract

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Introduction: Valid and trustworthy clinical documentation improves patient outcomes, boosts hospital data accuracy, and enhances reflective action to improve healthcare service quality and safety. In Sri Lanka, the bedhead ticket (BHT) is the legal documentation record for inpatients. In 2022, the Ministry of Health (MoH) issued new rules for the correct maintenance of BHTs.

Objective: This clinical audit's objective was to assess the in-patient clinical documenting practices at National Hospital Galle (NHG), Sri Lanka.

Methodology: A total of 384 randomly selected BHTs from the record room, which belonged to patients who received inward care from April 2023 to September 2023, were included in this clinical audit. A checklist and a marking scheme were prepared according to MoH guidelines and filled out after going through each BHT.

Results: The level of completeness of the first page was good in 96% of BHTs. Maintenance of continuation sheets was average in 82% of BHTs and good in only 2%. Around 67% of BHTs obtained good marks for the level of completeness of entries. Only 1% of BHTs had entries with a signature placed at the end. The date and time of the entry were recorded in 73.5% and 64.3% consecutively.

Conclusion: Adherence to the MoH guidelines for clinical documentation practices was satisfactory at NHG, and regular audits and staff awareness and training are required to maintain the standards.

Keywords: Clinical
documentation, BHT, Karapitiya

Introduction

Clinical documentation is an important aspect of the healthcare field from a clinical, administrative, and legal point of view (1). A valid and reliable clinical document improves

patient outcomes(2). Globally, documentation regulations have grown significantly in response to the expansion of universal health standards, with a clear increase in the norms and recommendations established by regulatory bodies(3).

In Sri Lankan healthcare settings, inbound patient information, including care performed, is documented in the BHT, a paper-based medical record created during inpatient admission to the hospital(4). A general circular from the Sri Lankan Ministry of Health in 1999 established a set of principles for clinical documentation (5). In August 2022, the Ministry of Health introduced a new set of guidelines for the proper maintenance of the Bed Head Ticket(6).

National Hospital Galle (NHG) is the third-largest hospital in Sri Lanka and the largest in the Southern Province. More than four thousand healthcare staff are currently employed at NHG, including more than hundred consultants, seven hundred medical officers, and one thousand seven hundred fifty-five nursing officers.

Objective

The objective of this clinical audit was to assess the inward patient clinical documentation practices among health care staff at National Hospital Galle.

Methodology

BHTs, which belonged to patients admitted to medical, surgical, and pediatric wards between April 2023 and September 2023, were considered as the study population of this clinical audit. Based on the 95% confidence interval, 0.5 for prevalence, and 0.05 for precision, the following formula was used to calculate the study's sample size:

$$n = \frac{z^2 P(1-P)}{d^2} \quad (7)$$

The study sample consisted of 384 bedhead tickets acquired using a simple random sampling procedure. A checklist was created based on the Ministry of Health Sri Lanka's most recent set of instructions for the proper maintenance of bedhead tickets. After speaking with specialists and completing extensive literature research, a marking scheme was developed and confirmed. A medical officer went through each BHT and completed the checklist.

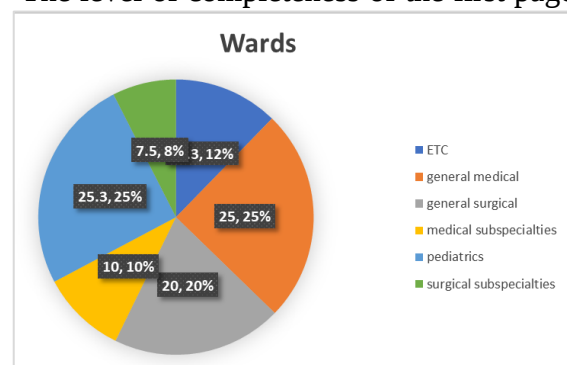
Data was analyzed using a statistical package for social science software. The hospital director provided administrative clearance.

Results

The total sample of BHTs belonged to general medical, medical subspecialties, paediatrics, general surgical, surgical subspecialties, and emergency treatment short stay (ETC) wards.

Figure 01: Distribution of samples among different categories of wards

The level of completeness of the first page



was good in 96% of the BHTs, while 4% of them showed average marks.

Around 82% of the BHTs obtained average marks for the general maintenance of continuation sheets. Only 2% of the BHTs

were observed to have good marks, while 16% were marked as poor. Numbering of the subfolders and having separate sections for different categories of staff were not practised in any ward that was included in the study.

Considering the level of completeness in BHT entries, overall, 67% of BHTs obtained good marks, while 31% and 2% of BHTs were marked average and poor consecutively. BHTs that belonged to pediatric wards had the highest marks for the completeness of entries, followed by

surgical subspecialty wards and general surgical wards. Writing the name at the beginning of each entry was observed in 78.5% of BHTs, whereas the designation of the person making the entry was written in 89.8% of BHTs. Only 73.5% of BHTs had entries with the date noted down. The time of the entry was recorded in 64.3% of BHTs. Only 1% of BHTs had entries with the signature placed at the end.

None of the sample BHTs included the expected procedure for deleting or amending a documented record.

Table 1: Marks scored by different categories of wards

Component	Ward category	Marks		
		Poor	Average	Good
Level of completeness of First page	All wards	0%	4%	96%
	ETC	0%	0%	100%
	General medical	0%	9%	91%
	General surgical	0%	6%	94%
	Medical subspecialties	0%	0%	100%
	Pediatrics	0%	2%	98%
	Surgical subspecialties	0%	0%	100%
Maintenance of continuation sheets	All wards	16%	82%	2%
	ETC	18%	82%	0%
	General medical	17%	79%	4%
	General surgical	6%	93%	1%
	Medical subspecialties	57%	43%	0%
	Pediatrics	4%	95%	1%
	Surgical subspecialties	27%	73%	0%
Level of completeness of entries	All wards	2%	31%	67%
	ETC	8%	62%	30%
	General medical	0%	33%	67%
	General surgical	3%	25%	72%
	Medical subspecialties	0%	72%	28%
	Pediatrics	0%	7%	93%
	Surgical subspecialties	3%	13%	84%

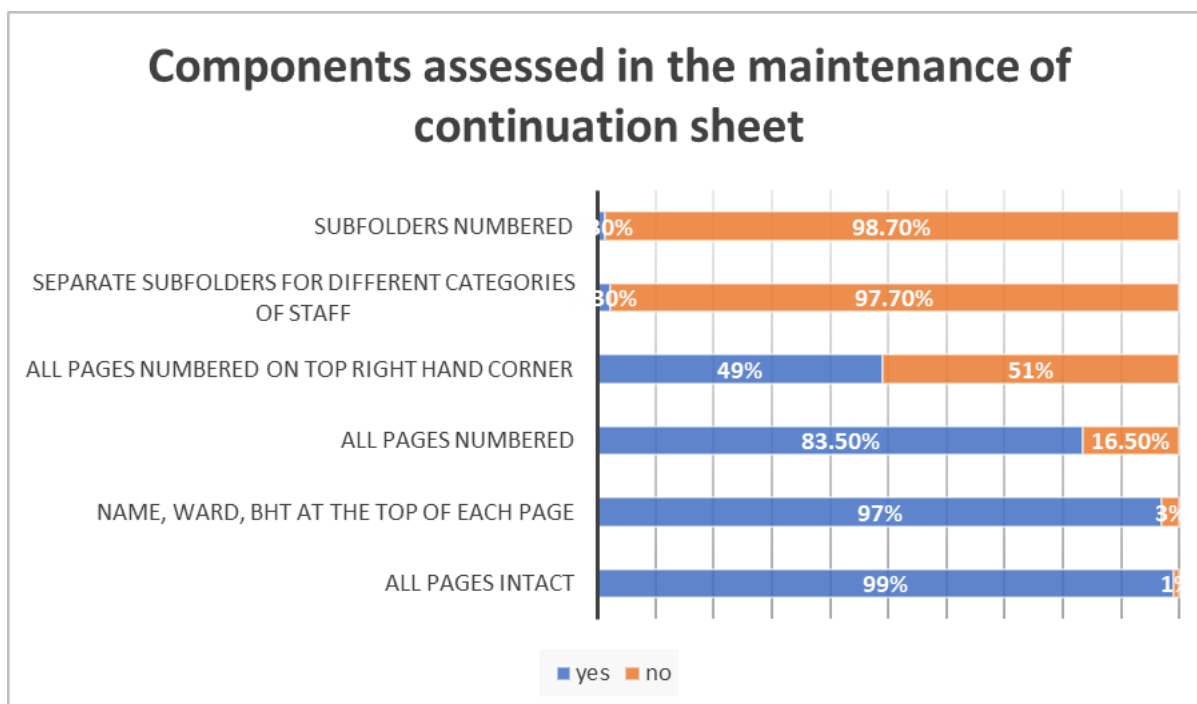


Figure 2: Components assessed in the maintenance of continuation sheet

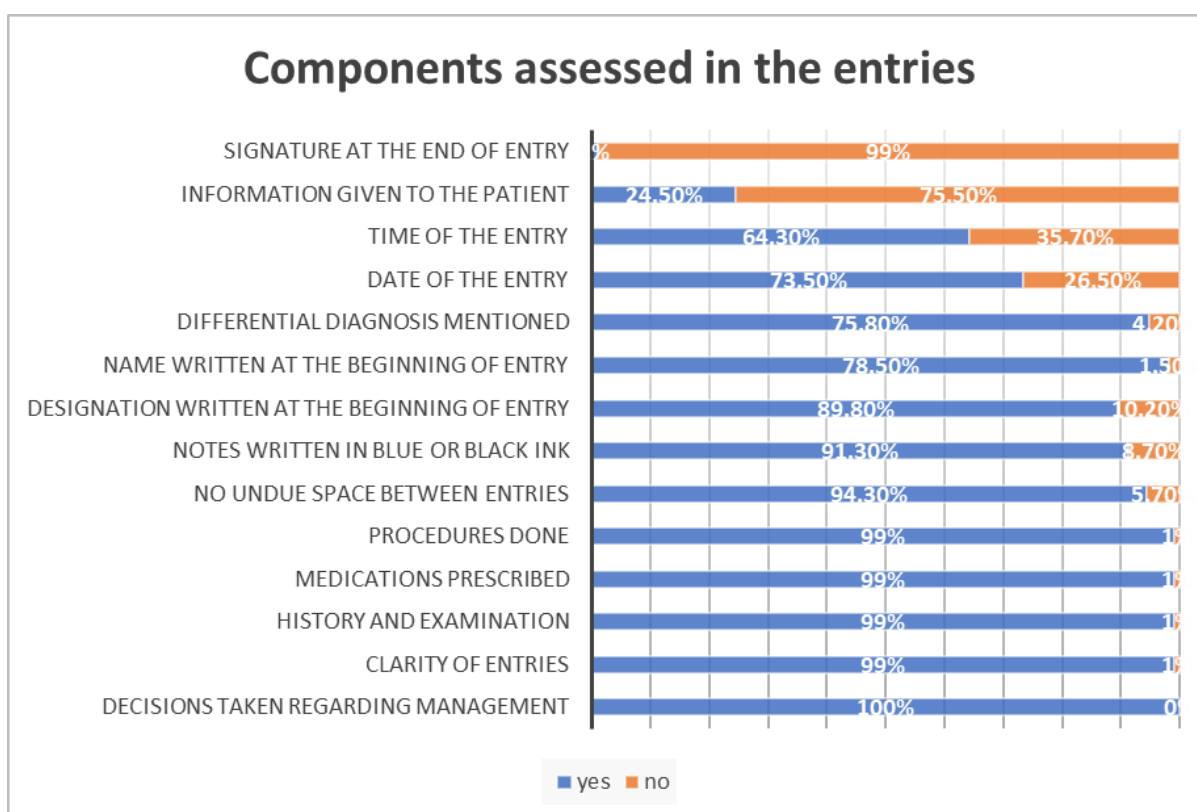


Figure 3: Components assessed in the level of completeness of entries

Discussion

The results of the current study show that NHG's overall clinical documentation level

is either good or average, which suggests that the hospital system for maintaining BHT quality was functional to some extent.

In the Sri Lankan context, the admission sheet is considered the front page of the bedhead ticket. The guideline issued by the Ministry of Health lists four main components for the proper maintenance of the front page: filling out all relevant cages legibly and accurately, documenting allergy status in red, mentioning the blood group in red, and writing the principal diagnosis on the front page(6). Filling out the relevant cages and writing the principal diagnosis were satisfactory in this clinical audit.

In 2021, Mallawarachchi et al. published a study of doctors' medical documentary compliance in government hospitals in Gampaha district, Sri Lanka. The study revealed that only 7.61% of BHTs fulfilled all criteria for the completeness of the final diagnosis, 17.4% had complete entries, and 63.8% had legible notes(5). In comparison, the legibility of notes in our study was 99%, which indicates a bias in the perception of legible handwriting when assessed by different individuals.

In the 2021 study, the results also indicated that 86.3% of doctors were aware that each entry should include the time of entry and the signature of the person putting the entry, and there was a significant association between the distribution of knowledge and the duration of the doctor's service(5). However, according to our study findings, only 1% of the total BHTs had entries with signatures placed at the end, and 64.3% of BHT entries had the time noted at the beginning of each entry.

An article published in 2000 identified existing problems with clinical documentation, such as the absence of dates and times of medical interventions, inadequate records regarding the information given to patients and family

members, failure to mention the designation of the person making the entry, and insufficient details on continuation sheets(9). Similar inadequacies were observed in this study, notably that only 24.5% of the BHTs contained records of the information given to the patients. Although healthcare professionals continue to provide information to patients and family members on a daily basis, failing to document these communications in medical records can create disadvantageous situations.

Conclusion and recommendations

Although the overall level of clinical documentation at NHG is above average, several areas require significant improvement, and certain wards require specific attention. Furthermore, clinical documentation should be precise in order to provide good continuity of care and avoid litigation. Based on this study, we recommended conducting training programs to improve the clinical documentation practices of doctors and nursing officers at medical and surgical subspecialty wards. The staff should be advised to maintain different subfolders for different categories of staff and to number subfolders and put signatures at the end of each entry.

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