

Assessment of the Quality of Diagnosis Documentation in Bed Head Ticket in a Selected Ward of a District General Hospital in Sri Lanka

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Abstract: Effective planning, policy making, and decision making depend on the availability of accurate hospital information. Hospital information storage is done through international accepted International Classification of Disease 10th revision. Accurate diagnosis is vital for accurate coding. Ministry of Health has issued a circular (No-01/05/99) for the documentation of Bed Head Ticket (BHT) including writing the correct diagnosis. Objective of the study was to assess the quality of documentation in Bed Head Ticket in a ward of the District General Hospital Sri Lanka. One of the medical wards randomly selected for the study. Descriptive cross-sectional study was done to achieve objective. Three hundred eighty-four BHTs of selected ward belonged to the last quarter of 2025, were assessed by using data extraction sheet to check that diagnosis are according to the circular No-01-05/99. Out of 384 BHTs diagnosis was available in 350(91%) BHTs meanwhile legibility to read was 339 among available BHTs. In 32(9.5%) BHTs were written block capital letters as in circular 01-05/99 of 26/02/1999. Abbreviations were used to write diagnosis in 130 BHTs (38.3%). As current activities and future developments of the hospital are based on accurate information. Therefore, priority should be given to appropriate hospital information management process. Accurate coding is dependent on comprehensive and accurately written diagnosis. Therefore, it is essential to enter comprehensive and accurate diagnosis in the BHTs. An interventional package to improve documentation of diagnosis and further comprehensive studies on improving quality of diagnosis documentation are recommended.

Keywords: Bed Head Ticket, Diagnosis, Availability, Legibility, Adequacy).

I. INTRODUCTION

In Sri Lankan health care setting, episodes of inpatient hospital care are recorded in Bed Head Ticket (BHT). In these episodes patient may have taken in patient treatment for acute / chronic illness, undergone procedures. Bed Head Ticket (BHT) or Medical Record is a written collection of information about patients. It is defined as a compilation of pertinent facts of a patient's life and health history, including past and present illness and treatments were written by the health professionals contributing to that patient's care (1) (2). At the time of discharge, final Comprehensive diagnosis should be written in the appropriate space given at front sheet of the BHT by the medical officers including intern house officer. Director General of Health services have issued a circular about procedure to document BHT (3).

Hospital information storage is done through internationally accepted coding system. Coding of the disease is done by medical record officers (MRO) based on diagnosis of the disease.

As current activities and future developments of the hospital are based on accurate information on diseases (4). Accurate coding is dependent on comprehensive and accurately written diagnosis (5). Therefore, it is essential to enter comprehensive and accurate diagnosis in the BHT. Writing inappropriate / inaccurate diagnosis is not only causing difficulties to coding but also challenges to policy makers and administrators to make correct decisions. Intern house officers who change six monthly mostly enter the diagnosis. Medical Record Officers (MRO) sometimes complain about errors seen in entering

diagnosis in the BHTs. Entering accurate diagnosis will improve the accuracy and validity of information(6) and ultimately it will improve existing health care. In order to minimize incompleteness and inaccuracy, Ministry of Health and hospital administration have taken different measures.

Are these measures being implemented or are there any deficiencies? It is responsibility of clinicians, administrators and MROs to take necessary action to improve the situation. In order to suggest recommendations, it is a paramount need to study current situation. Though there are few studies done in different hospitals on writing diagnosis, this study also important as causes may differ from setting to setting.

Objective

To Assess the Quality of Diagnosis Documentation in Bed Head Tickets in a Selected Ward of District General Hospital Avissawella,

II. METHODOLOGY

Study Design:

This study followed a prospective observational cross-sectional model. A descriptive cross - sectional study was conducted to assess quality of documentation of diagnosis as entered in BHTs of selected ward in Government District General Hospital in Sri Lanka.

Hospital has ten wards. Because of time factors and unavailability of resources study has been done in a ward only. Among them two medical ward, two surgical ward one Gynaecology ward have intern medical officers. Ward was selected randomly and selected ward is comprised of 55 beds for in ward care with Medical specialties All BHTs of the selected ward in the last quarter of 2025 were selected for the study. Because of the limitation of resources and practical issues representative sample was selected. The calculated sample size was 384. The sample was selected through a simple random sampling technique. The data Extraction sheet was used as a study instrument to record data from the BHT. The data Extraction sheet (DES) consists of 7 questions which include closed-ended questions and Yes/No type answers were required.

Definition for selected terms are given below (7)

Availability - If a diagnosis is documented in the relevant space provided or anywhere on the front sheet of the BHT, it is considered that the diagnosis is available;

Legibility - If diagnosis is readable at a glance without the help of another party, in the Medical Record room with adequate light, it is considered a legible recording of diagnosis;

Adequacy – Diagnosis should be written in, block capital letters without using abbreviations, disease written as diagnosis Surgical procedures, any medical procedures, and diagnostic procedures shouldn't be written as the diagnosis. Diagnosis should be compatible with a disease condition, examination findings, and investigations findings written in the BHT

Statistical Analysis

Data collection was done by the investigators. The data was entered into excel sheet. Descriptive analysis was performed.

III. RESULT AND DISCUSSION

Director General of Health services have instructed about procedure pertaining to medical records and hospital statistics by his circular no: 01-05/99 of 26/02/1999. Comprehensive diagnosis should be written in the appropriate space given at front sheet of the BHT. Diagnosis of the patient should be clearly written in block capital letters. Abbreviations, clinical symptoms aren't allowed. Diagnosis of the patient is written according to International Classification of Diseases (ICD) 10th revision. Diagnosis should be accurately written according to evidence stated in BHT. A retrospective survey of BHTs was done on 384 BHTs. These BHTs belonged to the last quarter of 2025, randomly selected 384 BHTs were assessed by using data extraction to check that diagnosis is according to the circular No-01-05/99. No previous similar study done at District General Hospital Avissawella.

Out of 384 BHTs diagnosis was available in 350(91%) BHTs meanwhile legibility to read was 339 among available BHTs. Availability and legibility should be 100 percent because MROs are non-medical people and find it difficult to perform coding of diagnosis. Legible 339 BHTs was considered for assessing adequacy of diagnosis documentation. Table 1 shows the adequacy of diagnosis.

Table 1. Adequacy of diagnosis

Item	Number of BHTs	Percentage (%)
Diagnosis written in block capital letters	32	9.5
Written in block letters	177	52.2
Is abbreviation used	130	38.3

According to the circular 01-05/99 of 26/02/1999, diagnosis should be written in block capital letters. In 32 (9.5%) BHTs diagnosis were written in block capital letters. Abbreviations were used for writing diagnosis in 130 (38.3%) BHTs. Mishra A et al (2009) [8] have surveyed the adequacy of Medical Records in Bir Hospital Kathmandu Nepal. 130 diagnosis summaries were studied. Availability and legibility were hundred percent and using abbreviations when writing diagnosis was 73.8% which was higher than the value for this study (). However, using abbreviation should be zero percent. Table 2 shows accuracy of diagnosis documentation.

Table 2 Accuracy of documentation of diagnosis

Item	No of BHTs	Percentage (%)
Disease written as diagnosis	290	85.5
Procedure or Investigation written as diagnosis	41	12.1
Non relevant	08	2.4
Total	339	100

Out of legible BHTs 290 consists of disease as diagnosis meanwhile 8 BHTs was consists of irrelevant diagnosis as missing, Left Against Medical Advise....etc.

IV. CONCLUSION

As current activities and future developments of the hospital are based on accurate information, priority should be given to appropriate hospital information management process. Accurate coding is dependent on comprehensive and accurately written diagnosis. Therefore, it is essential to enter comprehensive and accurate diagnosis in the BHTs.

The diagnosis was not available in 34 (8.9%) BHTs and Diagnosis were illegible in 11(3.1%). In 32(9.5%) BHTs were written block capital letters as in circular 01-05/99 of 26/02/1999. Abbreviations were used to write diagnosis in 130 BHTs (38.3%). Eight BHTs contains nonrelevant words were written as diagnosis

An interventional package to improve documentation of diagnosis is required and Further, comprehensive studies also recommended

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