

ORIGINAL ARTICLE

## The Quality of Patients' Files Documentation in Emergency Department; a Cross Sectional Study

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### Abstract

**Introduction:** Emergency departments as one of the most important wards of hospitals, provide the emergency therapeutic care to decrease the mortality and disability rates among patients. The management and evaluation of emergency activities are possible through timely, accurate, and complete registration of information, based on standard rules. Thus, the aim of this research was detecting the observance rate of documentation standards in the emergency department of Al-Zahra Hospital, Isfahan, to find patients' files documentation failures and eliminate them. **Methods:** I This was a cross sectional study performed in the emergency department of Al-Zahra Hospital, Isfahan, 2009. For data gathering, a checklist included 23 questions in two parts was used. The first and second parts had 9 and 14 questions to detect observance rate of patients' characteristics documentation and nurse reports documentation, respectively. Based on Likert scale, the answer of each option includes blank (score 1), illegible (score 2), incomplete (score 3), and complete (score 4). Therefore, the minimum and maximum reachable scores were determined 9-36 in the documentation of patients' characteristics and 14-56 in the nurse reports. Data was analyzed using SPSS 8 and Chi-squared test and Fisher's exact test were applied to compare qualitative data. Student's *t*-test was used to compare quantitative information, too.  $P < 0.05$  was considered as significant. **Results:** 300 documents were studied in this research. The average of reached score in the quality assessment of patients record completion was  $24.66 \pm 17$  (15-34), (the maximum reachable score was 36). The total score of emergency patients records was  $61.8 \pm 4.8$  (45-74) from total of 92 reachable scores. The average of total reached score for nurse reports was  $37.2 \pm 3.7$  (28-46), (with the maximum reachable score of 56). No significant difference was seen in the accuracy of patients' documentation according to referring shift ( $p = 0.37$ ) and being close or not ( $p = 0.61$ ). **Conclusion:** Based on findings of the present study, status and quality of observance in registration standards of files did not have desirable level. So that most of failures in recording of patients' characteristics were related to registrations on the file and other indexes; the comments' signs with date and time documentation and also finishing the comments by the physician were seen, too. Most of documentation failures in nurse reports were related to not finishing the end of report with a straight line, lack of explanation about the cause, status, and type of refer, and not enough statements regarding the patient's general condition.

**Key words:** Documentation; emergency medicine; patient safety; information management

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