



IMPROVING QUALITY OF DOCUMENTATION IN PAEDIATRIC WARD AT MALAMULO ADVENTIST HOSPITAL (MAH)



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THE PROBLEM

Poor documentation in patient files by health workers.

AIM

Files should have soapie, complete personal data and vital signs as well as a discharge diagnosis

FLOW MAP OF PRESENT STATE

1. Data is entered into registry by patient attendants
2. Data is compromised
3. No set quality improvement ward targets

FLOW MAP OF FUTURE STATE

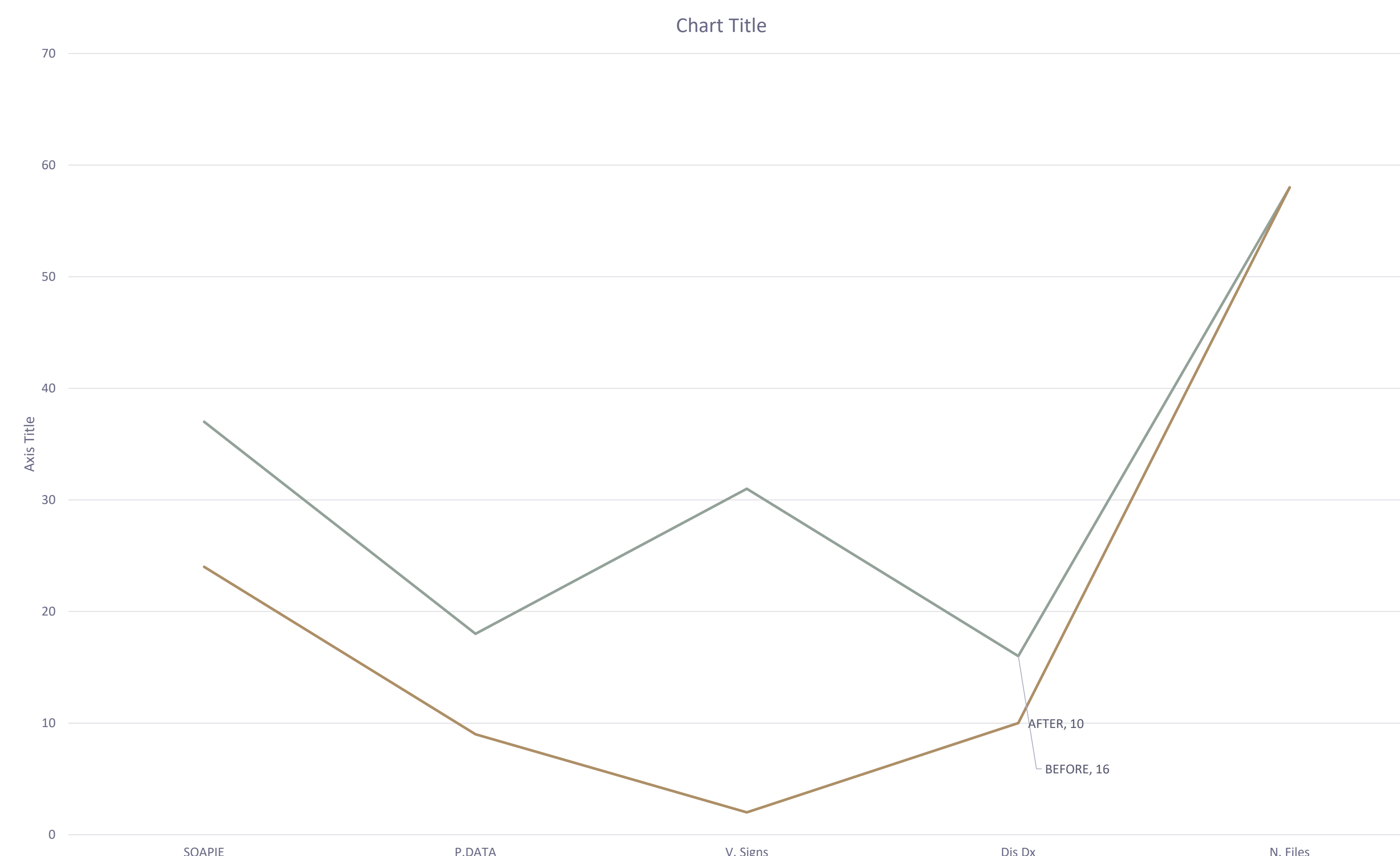
- 1. adopt use of qualified clinical staff for data entry
- Improve data quality and Validity
- Set quality improvement ward targets
- Attain the targets

PLAN DO ACT STUDY CYCLE



DATA

- GRAPH COMPARING BEFORE AND AFTER IMPLEMENTATION.



RESULTS

- Our findings are categorized into two as pre intervention and post intervention. For pre intervention findings the following are the results: 58 admission files were audited in March of these; 37 (65.5%) lacked soapie, 31 (53.4%) did not have personal data, 18 (31.0%) had incomplete vital signs and 16 (27.6%) did not have a discharge diagnosis.
- For post intervention a similar number of admission files were audited in August as follows: ; 25 (43.1%) lacked soapie, 9 (15.5%) did not have personal data, 2 (3.4%) had incomplete vital signs and 10 (17.2%) did not have a discharge diagnosis.
- Our results shows that we have managed to reduce incidences of poor documentation exponentially as follows: soapie reduced by 22.4% (12), personal data by 37.9% (22), vital signs by 27.6% (16) and discharge diagnosis by 10.4%

SUMMARY

- Team work is always the best in every project
- It has improved patient monitoring and has contributed towards reduction of mortality

FUTURE STEPS/ WHAT'S NEXT?

- Will recommend adoption of the system for quality improvement in other wards
- Will you work on a similar process? Or is there another part of the problem that you want to work on? Will complement the current methodology with other strategies particularly on audits