

## COMPLETENESS AND ACCURACY OF INFORMATION IN DIABETIC AND HYPERTENSIVE PATIENTS FAMILY HEALTH RECORDS AT MEET-OKBA FAMILY HEALTH CENTRE, GIZA, EGYPT

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### ABSTRACT

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**Background:** Improving medical record completeness services is an important step towards improving the quality of healthcare. It can also provide valuable information to help measure progress and effectiveness of involved service provided. The medical record has become an important legal document; good medical records "in terms of completeness and accuracy of recorded information" are essential not only for the present and future care of the patient but also as a legal document to protect the patient and the hospitals from litigation. Many studies have been carried out to assess the completeness of family health records; but this data must be checked regarding its accuracy. The current study will determine to what extent the recorded data represent the true situation by interviewing the patients at the selected family health center. The current study will focus on family forms specific for the most prevalent chronic diseases among adults in Egypt Hypertensive and Diabetic patients as evidenced by the latest Demographic and Health Survey, 2017.

**Aim of the Study:** To measure the completeness and accuracy of the family health record forms specific for diabetic and hypertensive patient.

**Design:** descriptive Cross-sectional study.

**Patients & Methods:** A convenient sample of 200 fully functioning files for Hypertensive & Diabetic Patients were included in the study. The study was conducted at an accredited center (Meet Okba family health center, Giza Governorate Feb, 2019). Two Study Tools were used; first one for checking the Completeness of Family Records through medical record assessment checklist, second one for checking the accuracy of Family Records through Interview questionnaire to Hypertensive and Diabetic Patients whose fully functioning files (200 files) were selected to be included in the study sample.

**Results:** Regarding completeness; 76%, 57% and 34% of the personal data form, investigation form and clinical exam sheets respectively showed completeness more than 80% (according to standard scoring level). Regarding accuracy; inaccurate results were found as (73.5%, 63.4.0% and 90%) of the follow up of diabetic-hypertensive patient, investigation and clinical exam sheets respectively.

the least item to be accurate and complete in personal data form was the social, behavior hist., (8.5%), Most of the recorded clinical examination items (e.g. Color and temp of foot, head and neck

*examination, reflexes & signs of fungus infection) were almost recorded complete but inaccurate ranging from (82.5-83.0%);*

***Conclusion:** To improve the quality of Medical Record we need regular auditing, training and good orientation of medical personnel for accurate record practices.*

***Key words:** Medical records, health care services, and family folder*

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## **INTRODUCTION:**

Family practitioners and other staff working in primary care require comprehensive and accurate data on patients at the point-of-care in order to provide high quality health services to their patients<sup>(1)</sup>. Medical records are an effective method of achieving this objective<sup>(2, 3)</sup>. A patient medical record provides two important functions; the first helps to support direct patient care by assisting physician on clinical decision making and provides communication. The second provides a legal record of care given and helps as a source of data to support clinical audit, research, resource allocation, monitoring and evaluation, epidemiology, and service planning.<sup>(4,5)</sup>

The family folder is the compilation or grouping of a set of patient care documents. Usually for an entire family or household, that is retained or stored in a cardboard file box container. This file box, commonly referred to as the "family file folder," contains several documents that have been designated as a permanent part of the patient's medical records. These documents represent a picture of the family household from several perspectives. For instance, they reflect the socioeconomic and demographic data of the family unit, children's ages and levels of educational achievements are noted in the file. The file folder contents also summarize the health history of the family unit, identifying family member's specific diseases and illnesses as well as a list of the names of all members of the household<sup>(6)</sup>

All entries in the medical record must be complete. A medical record is considered

complete if it contains sufficient information to identify the patient; support the diagnosis /condition; justify the care, treatment, and services; document the course and results of care, treatment and services; and promote continuity of care among providers. All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided<sup>(6)</sup>

Many studies were conducted in different countries worldwide on patient medical records completeness and revealed that developing world had poor medical record management system compromises patient care at different levels<sup>(8)</sup>. In Egypt, a previous study in a family health center in El-Shorouk city revealed that (65%) of records were properly organized; Personal data was the most frequently recorded item (100%); the least recorded was general examination (51.5%). It was found that (88.5%) of records had completeness scores from 80-100% from standards, so they had passed the assessment as the minimal passing score is (80%);<sup>(6)</sup>

Regarding the main causes of record incompleteness; a study mentioned that despite (70%) of doctors perceived the importance of medical records in managing patient & (56.67%) of doctors reported that medical records reduce medical errors; on the contrary (20%) of physicians said that medical record were not worth time and effort consumed in them, and (57.9%) reported that they didn't complete the medical records as they were difficult to be completed<sup>(6)</sup>.

Egypt Nowadays is experiencing a huge reform in the health sector in accordance with the approval and starting the implementation phase of the new health insurance law; there will be a quality and validation authority to accredit the qualified hospitals and health care units; and according to the new health insurance plan complete and accurate family health record for families and sub file for every member will be crucial for the process of accreditation and good standards of care for Egyptian citizens.

The current study was implemented to assess the completeness and accuracy of filling of family records in a family health center in Giza governorate as a step in the improvement cycle of health care sector.

**AIM OF THE STUDY:**

To measure the completeness and accuracy of the family health record forms specific for diabetic and hypertensive patients.

**Design:** descriptive Cross-sectional study

**PATIENTS & METHODS:**

**Study setting:** -The study was conducted at Meet Okba family health center, Giza Governorate. This medical center is an accredited center that provides health care services for (14605) households; the estimated population that the center serves is about 77402 according to MOHP information Centre in 2020

Total medical files in the health center were 1423files, the total number of completed files was 526 &the total number of functional & active files\* was 454

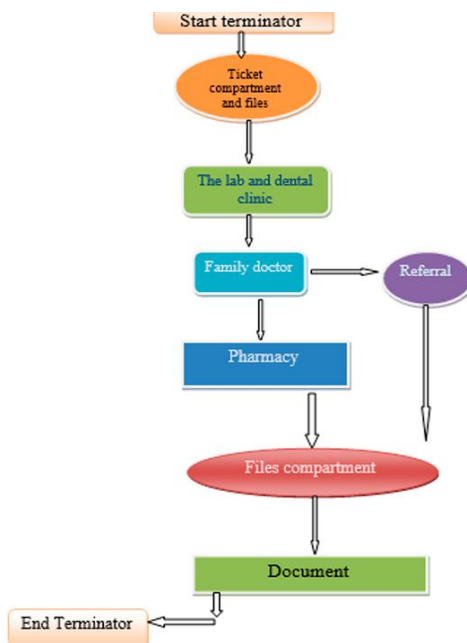
\*Functioning& Active File is defined as: when 80% of the family members were thoroughly screened & one of the family members visited the PHC continuously throughout the current year<sup>(7)</sup>.

**Study duration:** Six months for data collection (from July 2019 to December 2019).

**Study Population:**

Hypertensive & Diabetic Patients whose files were functioning and active, were included in the study sample

The following flow chart shows the pathway of the patients’ medical record in the family health center.



**Sample Size & method:** A sample size of 200 family folder containing at least one diabetic &/or one hypertensive patient was sufficient to achieve the study objectives based on data retrieved from previous study carried out by *Anwar et al.,2016*<sup>(6)</sup> who found that (88.5%) of the records had completeness score from 80-100% of standard, sample size was calculated based on confidence level of 99% using Open EPI Version (3)

The accuracy of information in the forms was obtained by interviewing same number of patients.

### **Sample type:**

A purposive sample:

A total of 200 files of diabetic &or hypertensive patients was selected on purpose from the 454 total functional & active files.

### **Study Tools:**

#### **1- Checking for data Completeness**

Medical record assessment checklist: it was formulated by the researcher based on the most relevant items retrieved from selected forms of family folder (e.g. personal data form (11) items, investigation data form (11) items and clinical exam data form (36) items.

The checklist was validated by four experts; two in the field of public health, one in the field of family medicine and the director of PHC in Giza Directorate, MOHP.

#### **2- Checking the information recorded accuracy:**

Through Patient Interview questionnaire. Hypertensive & Diabetic patients whose fully functioning files were selected to be included in the study sample were telephoned and invited to attend an educational session at the Family Club In the health center? about Prevention & Control of diabetes & Hypertension and afterwards the study participants were interviewed to

measure the accuracy of the recorded information in their family health records. The Patient Interview questionnaire consisted of three sections (personal data-investigation data clinical exam data) that reflected the same points included in the checklist, then compare the data from the interview with the same recorded data in the file forms.

accuracy of the result done by asking the patient, show all personal document (ID-credit card –family card-insurance card-birth certificate..., - their lab results check if they were copied right or not.

### **Scoring of completeness and accuracy data:**

Follow up of diabetic & hypertensive patient form and the interview questionnaire each included (58) items. Every item took a score (1) point if the item was completed and (zero) if not. All the points were added and the total was divided by Total of possible points (58) then Multiply the product by 100 to calculate percentage score.<sup>(9)</sup>

Classification of scoring level:

If the percentage was 90% or more the file was considered Exempted pass (met).

If the percentage was 80% up to 89% the file was considered partially pass (partially met).

If the percentage was below 80% the file was considered not pass (not met).

The tools were revised and approved by 4 consultants; two in the field of public health & One of the field of family medicine and the director of PHC in Giza Directorate, MOHP.

### **Data Management & Statistical analysis:**

The collected data were revised for completeness and accuracy, coded, entered to PC and finally analysed using SPSS (Statistical Package for Social Sciences) version 20. Qualitative data were presented

as numbers, and its related percentages, data were classified into three categories Complete and accurate - Complete and inaccurate & incomplete. Percentage of accuracy and completeness were calculated and presented in simple frequency tables

**Ethical consideration:**

Ethical committee board approval was obtained. Administrative approval was taken from the Dean, Vice dean for post graduate affairs, the director of PHC in Giza Directorate, MOHP, Manager of Meet Okba family health center. Informed Consent was taken from study participants before interviewing them addressing the objective of the study, risks, benefits and withdrawal rights, Confidentiality of data was assured.

**RESULTS:**

The current study reviewed the completeness and accuracy of 200 fully functioning files containing data related to Hypertensive and/or Diabetic Patients at Meet Okba family health center

This study found that there was a great discrepancy between the completeness and accuracy of the data in the files; where 76% of patient data forms scored exempted pass for their completeness and 2% scored exempted pass for accuracy. Concerning completeness and accuracy of the diabetic/hypertensive investigation forms 57.0% scored exempted pass for completeness and 28% for accuracy. Regarding the clinical examination forms, 34% scored exempted pass for completeness versus 9% for accuracy.

Table1 (1): Overall completeness and accuracy of diabetic hypertensive patient follow up sheet

Dimensions		Exempted pass ≥ 90%		Conditional pass 80% -89%		Not pass <80%	
		N	%	N	%	N	%
Personal data form	Completeness	152	76.0%	11	5.5%	37	18.5%
	Accuracy	4	2%	49	24.5%	147	73.5%
investigation form	Completeness	114	57%	20	10%	66	33%
	Accuracy	49	28%	15	8,6%	111	63,4%
clinical examination form	Completeness	68	34%	58	29%	74	37%
	Accuracy	18	9%	0	0.0	182	90%

Regarding completeness and accuracy of personal data form items of diabetic-hypertensive patient; Name of the patient, Individual order in his family. Type of disease and date of visit were (100%) complete and accurate. No. of family folder, House number and patient new complain

were (83.0%, 81.5% & 62.0%) complete and accurate respectively, hist of current illness, dietary hist and current medication completeness and accuracy ranged from (46.5 to 47.0%), the least item to be accurate and complete is the Social, behavior hist (8.5%) (Table 2).

**Table (2):** Completeness and accuracy of Diabetic hypertensive patient Personal data form:

	Incomplete		Complete but inaccurate		Complete and accurate	
	N	%	N	%	N	%
Name of patients	0	0.0%	0	0.0%	200	100.0%
No of family folder	34	17.0%	0	0.0%	166	83.0%
House no	37	18.5%	0	0.0%	163	81.5%
Individual order in his family	0	0.0%	0	0.0%	200	100.0%
Type of disease (DM*-HTN**)	0	0.0%	0	0.0%	200	100.0%
Date of visit	0	0.0%	0	0.0%	200	100.0%
new Complain	13	6.5%	63	31.5%	124	62.0%
Social, behavior hist	35	17.5%	148	74.0%	17	8.5%
Dietary hist	67	33.5%	40	20.0%	93	46.5%
Hist of current illness	35	17.5%	72	36.0%	93	46.5%
current medication	13	6.5%	93	46.5%	94	47.0%

\*DM: Diabetes mellitus \*\*HTN: Hypertension

The following recorded investigation (Blood urea – LDL – HDL & Triglyceride) were almost complete and accurate ranging from (85.7% up to 95.9%); while the investigations (Thyroid function, FBS-Post prandial & Sugar in urine) were ranging from (40.5% to 57.9%) complete and accurate respectively; however investigations like blood creatinine, total choleste-

rol, ECG and CBC were complete but inaccurate ranging from (65.0%, 66.0%, 89.8% and 95.2%) respectively (Table 3).

Accuracy of the result done by asking the patient, show all personal document (ID-credit card –family card-insurance card-birth certificate...,- their lab results check if they were copied right or not.

**Table (3):** Completeness and accuracy of Diabetic hypertensive patient investigation form:

	Incomplete		Complete but inaccurate		Complete and accurate		Total	
	N	%	N	%	N	%	N	%
FBS-post prandial	35	17.5%	84	42.0%	81	40.5%	200	100.0%
sugar in urine	35	17.5%	77	38.5%	88	44.0%	200	100.0%
Blood creatinine	2	4.8%	40	95.2%	0	0.0%	42*	100.0%
Blood urea	2	4.1%	0	0.0%	47	95.9%	49*	100.0%
LDL*	2	4.2%	0	0.0%	46	95.8%	48*	100.0%
HDL**	2	4.2%	0	0.0%	46	95.8%	48*	100.0%
Total cholesterol	5	10.2%	44	89.8%	0	0.0%	49*	100.0%
Triglyceride	5	10.2%	2	4.1%	42	85.7%	49*	100.0%
Thyroid function	7	36.8%	1	5.3%	11	57.9%	19*	100.0%
ECG^	61	30.5%	132	66.0%	7	3.5%	200	100.0%
CBC^^	61	30.5%	130	65.0%	9	4.5%	200	100.0%

\*LDL: low density lipoprotein, \*\*HDL: high density lipoprotein, ^ECG: Electrocardiogram, ^^CBC: Complete blood count \*N: those were the only number of forms that had the previous lab., data.

Most of the recorded clinical examination items (e.g. Color and temp of foot, head and neck examination, reflexes & signs of fungus infection) were almost recorded complete but inaccurate (82.5-

83.0%); however radial pulse and B.P in supine position were the most accurately recorded items (81.5% & 68.0%) respectively (Table 4).

Table (4): Completeness and accuracy of Diabetic hypertensive clinical examination form:

	Incomplete		Complete but inaccurate		Complete and accurate	
	N	%	N	%	N	%
Plan of treatment	35	17.5%	49	24.5%	116	58.0%
risk factors	22	11.0%	92	46.0%	86	43.0%
signature of doctor	58	29.0%	82	41.0%	60	30.0%
health education in clinic	58	29.0%	41	20.5%	101	50.5%
Date of follow up visit	33	16.5%	142	71.0%	25	12.5%
Weight	35	17.5%	61	30.5%	104	52.0%
Height	40	20.0%	130	65.0%	30	15.0%
waist circumference	56	28.0%	115	57.5%	29	14.5%
BP supine	33	16.5%	31	15.5%	136	68.0%
Blood pressure standing	169	84.5%	31	15.5%	0	0.0%
radial pulse	34	17.0%	3	1.5%	163	81.5%
pop pulse	167	83.5%	33	16.5%	0	0.0%
d p pulse	167	83.5%	33	16.5%	0	0.0%
CVS	34	17.0%	134	67.0%	32	16.0%
Chest	34	17.0%	124	62.0%	42	21.0%
Abdomen	34	17.0%	136	68.0%	30	15.0%
Head and neck	34	17.0%	166	83.0%	0	0.0%
Skin	34	17.0%	166	83.0%	0	0.0%
Joint	34	17.0%	127	63.5%	39	19.5%
Extremities	34	17.0%	136	68.0%	30	15.0%
Sensory	35	17.5%	165	82.5%	0	0.0%
Motor	35	17.5%	165	82.5%	0	0.0%
Reflexes	35	17.5%	165	82.5%	0	0.0%
color -temperature of foot	34	17.0%	166	83.0%	0	0.0%
brittle nail	34	17.0%	166	83.0%	0	0.0%
cracking –cellulitis	34	17.0%	166	83.0%	0	0.0%
fungus infection	34	17.0%	135	67.5%	31	15.5%
Dryness	34	17.0%	166	83.0%	0	0.0%
Ulcer	34	17.0%	127	63.5%	39	19.5%
Sensation	34	17.0%	136	68.0%	30	15.0%
fundal examination	64	32.2%	70	35.2%	65	32.7%
annual physical exam	41	20.5%	130	65.0%	29	14.5%
lab result annually	42	21.0%	91	45.5%	67	33.5%
signature of drafter annual exam	68	34.0%	0	0.0%	132	66.0%

**DISCUSSION:**

Physicians and other staff working in primary care require comprehensive and accurate data on patients at the health care units. Medical records are an effective method of achieving this objective<sup>(3)</sup> so this study aim to detect the completeness and accuracy of the family health record forms specific for diabetic and hypertensive patients

In current study completeness for hypertension and diabetic sheets were found to

be 76% for the follow up sheet of diabetic-hypertensive patient that in accordance with study done by *Singer et al.* who found average rate of completeness related to chronic diseases in electronic medical records (EMR) folder was (72% and 80% ) for hypertension and diabetes folders respectively<sup>(9)</sup>, and other study done in Alexandria by *Noureldin et al.* that compared between (EMR) and paper medical record, he found documentation was 100.0% complete for both in diabetes and hypertension in e-records and 82.2% and

82.8% complete respectively in paper-based records.<sup>(11)</sup>

On the other side, the completeness of the medical record in the current study was lower in investigation and clinical exam sheets where only one third of it were complete that differs with *Anwar et al* study done in Family Health Centre in El Shorouk City, who found (86%) recorded examination item was complete.<sup>(6)</sup>

According to personal data, lab result and date of visit sheets of diabetic-hypertensive patient in the present study were almost complete and accurate for all patients. This agrees with *Anwar et al*<sup>(6)</sup> and differ with *Ajloun* study that was done in Jordan for assessment of Medical Records Services at Ministry of Health Hospitals who revealed that laboratory results show lower result in completeness and accuracy (21% to 58%)<sup>(12)</sup>, and *Forte* study in Egypt for Medical records assessment of family health facilities in five primary health care centers in Alexandria. He found that completeness of demographic data ranged from 64% to 77% in records and laboratory results ranged from 50% to 95%.<sup>(13)</sup>

The current study revealed that inaccurate medical record was found in more than two thirds of included files regarding follow up investigation and clinical exam sheets of diabetic-hypertensive patient. On the other side the study of *Tse and You*, that evaluated the frequency of inaccuracies and incompleteness in EMRs ; found that 39% and 51% of information on allergies and medications, respectively, were inaccurate and were slightly lower than the present study.<sup>(14)</sup>

This disagree with *Hong et al.* study who evaluated the frequency of inaccuracies and incompleteness in EMRs obtained from referring physicians in plastic surgery department. his results indicate that inaccuracies and incompleteness are a frequently occurring problem. He found only (1.48%) were inaccurate and (24.4%) were

incomplete regarding to history of presenting illness, medical history, surgical history, current medications and medical allergies.<sup>(15)</sup>

The variation in the results between current and different studies may contribute to; the lack of standardized methods and places for assessment of quality of data (completeness and accuracy) in health records and the difference in types of medical record as documentation method and electronic medical record also the physician knowledge and attitude towards medical records play a role regarding record completeness

### **Conclusion:**

The current study concluded that personal data forms show highest percentage of completeness as compared to investigation and clinical examinations forms (76% vs 57% & 34%) respectively; while the most accurate form was the investigation form as compared to clinical examination and personal data form (28% vs 9% & 2%). The study showed a great discrepancy between the completeness and accuracy of the data in all forms.

### **Recommendations:**

The current study recommended; regular training for health care team responsible for recording in family folders regarding importance of recording accurate information in the forms, regular auditing to detect the defects, avoid work over load on the family team by assigning fixed number of patient daily to allow adequate time for documentation, recruitment of enough paramedical personnel (e.g. social workers & clerks) should be done to allow time for recording accurate personal data, simplification of forms design to be easily filled by physicians in an accurate way and Implementation of electronic medical records system.



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### **REFERENCES:**

1. Majeed A, Car J and Sheikh A. Accuracy and completeness of electronic patient records in primary care. Oxford University Press, 2008.
2. O'Donnell A, Kaner E, Shaw C and Haighton C. Primary care physicians' attitudes to the adoption of electronic medical records: a systematic review and evidence synthesis using the clinical adoption framework. *BMC medical informatics and decision making*. 2018; (18): 101.
3. McConnell H. International efforts in implementing national health information infrastructure and electronic health records. *World hospitals and health services: the official journal of the International Hospital Federation*. 2004; (40): 33-7.
4. Tavakoli N, Jahanbakhsh M, Akbari M, Baktashian M, Hasanzadeh A and Sadeghpour S. The study of inpatient medical records on hospital deductions: An interventional study. *Journal of education and health promotion*. 2015; (4).
5. Finkelstein J, Knight A, Marinopoulos S, Gibbons MC, Berger Z, Aboumatar H, et al. Enabling patient-centered care through health information technology. *Evidence report/technology assessment*. 2012; 1.
6. Anwar WA, El Ezz NFA, Elhossiney DM and Ch RAAAM. Measurement of Completeness of Medical Records in Family Health Centre in El-Shorouk City. *Egyptian Journal of Community Medicine*. 2016; (34).
7. (Guide for using family file forms and records MOHP, 2018)
8. Nuru M. Improving the Completeness of Medical Records at Inpatient department of Dalefage Primary Hospital, west Afar, Ethiopia. Addis Ababa University, 2014.
9. Guidelines MRR. California Department of Health Care Services, Medical Managed Care Division. 2012; Available at: [https://www.dhcs.ca.gov/provgovpart/Documents/Medical 20% Record 20 % Review 20 % Guidelines.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/Medical%20Record%20Review%20Guidelines.pdf).
10. Singer A, Yakubovich S, Kroeker AL, Dufault B, Duarte R and Katz A. Data quality of electronic medical records in Manitoba: do problem lists accurately reflect chronic disease billing diagnoses? *Journal of the American Medical Informatics Association*. 2016; (23): 1107-12.
11. Noureldin M, Mosollom R and Hassan S. Quality of documentation of electronic medical information systems at primary health care units in Alexandria, Egypt. *EMHJ-Eastern Mediterranean Health Journal*. 2014; 20 ( 2): 105-111.
12. Ajloun M. Assessment of Medical Records Services at Ministry of Health Hospitals in Jordan. 2006; [http:// www. moh. gov. jo/ MOH/ Files/ Health\\_ Research/ Assessment 20% of 20% Medical 20% Records 20% services 20% at 20 % Ministry 20% of 20% Hralth.pdf](http://www.moh.gov.jo/MOH/Files/Health_Research/Assessment%20of%20Medical%20Records%20services%20at%20Ministry%20of%20Health.pdf).
13. Forte M. Medical records Assessment of family health facilities in Egypt. *Technical Report*. 2000; No. 51 available at [pdf. usaid. gov/ pdf\\_ docs/Pdaby132.pdf](http://pdf_docs/Pdaby132.pdf).
14. Tse J and You W. How accurate is the electronic health record?-a pilot study evaluating information accuracy in a primary care setting. *Studies in health technology and informatics*. 2011; (168): 158-64.
15. Hong CJ, Kaur MN, Farrokhyar F and Thoma A. Accuracy and completeness of electronic medical records obtained from referring physicians in a Hamilton, Ontario, plastic surgery practice: a prospective feasibility study. *Plastic Surgery*. 2015; (23): 48-50.

## اكتمال ودقة المعلومات في السجلات الطبية للأسرة في مركز صحة الأسرة

ميت عقبة ، الجيزة ، مصر.

### نبذة مختصرة

**الخلفية:** يعد تحسين خدمات استكمال السجلات الطبية خطوة مهمة نحو تحسين جودة الرعاية الصحية. يمكن أن يوفر أيضًا معلومات قيمة للمساعدة في قياس التقدم والفعالية. أصبح السجل الطبي وثيقة قانونية مهمة؛ تعتبر السجلات الطبية الجيدة "من حيث كتمال ودقة المعلومات المسجلة" ضرورية ليس فقط لرعاية المريض الحالية والمستقبلية ولكن أيضًا كوثيقة قانونية لحماية المريض والمستشفيات من التقاضي. تم إجراء العديد من الدراسات لتقييم اكتمال سجلات صحة الأسرة؛ ولكن على حد علمنا لم يتحقق أي منهم من دقة البيانات المسجلة. ستحدد الدراسة الحالية إلى أي مدى تمثل البيانات المسجلة الوضع الحقيقي من خلال إجراء مقابلات مع المرضى في مركز صحة الأسرة المعتمد بميت عقبة الجيزة. ستركز الدراسة الحالية على نماذج ملف طب الأسرة الخاص بمرضى ارتفاع ضغط الدم والسكري حيث ينتشر هذان المرضان المزمنان بين البالغين في مصر كما يتضح من المسح الديموغرافي والصحي الأخير، ٢٠١٧.

**الأهداف:** قياس مدى اكتمال ودقة معلومات نماذج الملف الطبي الصحي للأسرة الخاص بمرضى السكري وارتفاع ضغط الدم.

### التصميم: دراسة مقطعية

**الإعداد والمشاركين:** تم تضمين عينة ملائمة من ٢٠٠ ملف يعمل بكامل طاقتها لمرضى ارتفاع ضغط الدم والسكري في الدراسة. أجريت الدراسة في مركز معتمد (مركز ميت عقبة لصحة الأسرة بمحافظة الجيزة فبراير ٢٠١٩ م).

**الطريقة:** تم استخدام أداتين للدراسة؛ الأول للتحقق من اكتمال سجلات الأسرة من خلال قائمة التحقق من تقييم السجل الطبي، والثاني للتحقق من دقة السجلات العائلية من خلال استبيان المقابلة لمرضى ارتفاع ضغط الدم والسكري الذين تم اختيار ملفات تعمل بكامل طاقتها ليتم تضمينها في عينة الدراسة.

**النتائج:** فيما يتعلق بالاكتمال ٧٦٪ و ٥٧٪ و ٣٤٪ من المتابعة واستمارة التقصي وأوراق الفحص السريري على التوالي أظهرت اكتمال أكثر من ٨٠٪. فيما يتعلق بالدقة؛ تم العثور على نتائج غير دقيقة مثل (٧٣،٥٪ ، ٦٣،٤،٠٪ ، ٩٠٪) من متابعة مرضى السكري - ارتفاع ضغط الدم، الاستقصاء وأوراق الفحص السريري على التوالي.

**الاستنتاجات:** لتحسين جودة السجلات الطبية، نحتاج إلى تدقيق منظم وتدريب وتوجيه جيد للعاملين الطبيين لممارسات التسجيل الجيدة.