Medical record completeness and accuracy at an HIV clinic in Mozambique, 2005-2006

Peter Young
Batya Elul
Catherine Maulsby
Dina Winchell
Brígida Mavie
Rufino Fernandes
Américo Rafi Assan
Sarah Gorrell
Denis Nash

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Abstract

Objective: Providing and monitoring HIV care and antiretroviral therapy (ART) requires complete and accurate documentation of patient visit information and laboratory test results. We evaluated medical record completeness, accuracy and reliability of certain data elements at a large public-sector outpatient HIV clinic in Mozambique. Methods: We assessed completeness, accuracy and reliability of data elements important in the provision of HIV care and treatment which were available in paper-based medical records at enrollment and follow-up visits during two 6-month time periods (time 1: 1/05-6/05; time 2: 10/05-3/06). Records for 446 adult patients (time 1: n=209; time 2: n=237) who made enrollment visits and 274 (time 1: n=124; time 2: n=150) who made follow-up visits during the study period were included. Results: Completeness across all data elements was 72% for enrollment and 65% for follow-up visits, while overall accuracy was 95% and 84% for enrollment and follow-up visits, respectively. However, many data elements critical to high quality care were not recorded completely or accurately at enrollment or follow-up visits, including weight, clinical disease stage, ART regimen, and to some extent, CD4+ cell count. Additionally, while the reliability of information across data sources on ART status was fair with a Kappa Statistic of 0.73, it was significantly worse for ART regimen, with the Kappa Statistic ranging from 0.12-0.59 depending on the specific tools compared. Conclusions: The study findings highlight the need for streamlined medical records which limit redundancy across and within tools, as well as for regular data quality assessments.
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