УДК 61
DOI 10.21661/r-555746

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ПРОВЕРКА АКУШЕРСКОЙ ДЕЯТЕЛЬНОСТИ – ГАРАНТИЯ КАЧЕСТВА И БЕЗОПАСНОСТИ

***Аннотация**: первичная медицинская документация прослеживает путь пациента во время лечебно-диагностического процесса и воссоздает в письменном виде все лечебные и диагностические процедуры, терапевтическое поведение, диету, уход и все, что связано с пациентом визуальное представление данных, позволяет отслеживать изменение состояния и терапевтическую реакцию пациента на лечение.*

Целью настоящего исследования является изучение медицинской документации и проверок, проводимых учреждениями в двух медицинских акушерских учреждениях в Варне. Материалы и методы: Прямой анонимный опрос был проведен среди 232 респондентов, из которых 124 врача и 108 медицинских работников.

***Ключевые слова**: безопасность, аудит, акушерство, медицинская документация, гинекология.*

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AUDIT OF ACTIVITIES IN OBSTETRIC PRACTICE – A GUARANTEE OF QUALITY AND SAFETY

***Abstract**: primary medical documentation traces the patient's path during the therapeutic and diagnostic process and recreates in writing all therapeutic and diagnostic procedures, therapeutic behavior, diet, care and everything related to the patient visual representation of data, allows you to track the change in the condition and the therapeutic response of the patient to the treatment.*

The aim of the present study is to study medical documentation and inspections carried out by institutions in two medical obstetric structures in Varna. Materials and

Methods: A direct anonymous survey was conducted among 232 respondents, of which 124 medical doctors and 108 medical workers.

***Keywords**: audit, medical documentation, obstetrics, gynecology, safety.*

Results: Analysis of the protocols of the inspections carried out by the Regional Health Inspectorate and the Medical Supervision Agency refer to complaints from patients due to dissatisfaction with medical care, specific medical persons, mainly related to the end result of the treatment and/or adverse events (complications or adverse outcome). The most serious omissions are found by inspections of the Regional medical insurance in relation to the volume of activities performed, the maintenance of medical records and criteria for hospitalization or dehospitalization. In the 81.99% of protocols refer to the default of the algorithm of treatment and diagnosis for the implementation of clinical pathways, during dehospitalization. 74.3% refers to the missing signatures or names of the doctor, the hour of the examination or diagnostic manipulation, the missing details in the epicrisis, the missing signature of the patient to receive the epicrisis.

Conclusion: Management should exercise continuous control over elements and structures. Conducting an audit of medical documentation and medical activities allows management to ensure the objectivity of the processes of admission, treatment and discharge of patients, as well as changes in their health status.

Introduction

Primary medical documents are regulated. The general law regulating the collection and processing of medical information for citizens is the Law on Health [2; 3; 5]. According to him, health information is personal data related to the state of health, physical and mental development of people, as well as any other information contained in medical prescriptions, prescriptions, protocols, certificates and other medical documentation [6].

A medical document (cardboard, medical history, etc.) is the main source of information for planning patient care and documenting the relationship between the patient and the contractor of activities in the field of healthcare and services [3; 4; 11].

The medical dossier is designed to ensure that the documentation complies with institutional, professional or legal regulation in the field of healthcare. A medical document has legal significance and represents the chronological history of the disease (diagnosis, treatment, care, etc.) of each individual patient [2; 3; 4; 5]. Medical documentation directly connects the patient with the activities carried out and the care of his state of health [7]. Every medical specialist is obliged to know the relevant medical documents and forms of training, to be able to fill them out correctly, clearly and legibly, with facts and reliable information [8; 12].

The compilation of individual medical documents is regulated by the National Framework Agreement on Medical Activities for Contractors of Medical Care (hospital and outpatient) [5]. Medical documentation is subject to accountability to national health insurance through specialized hospital software. This requires continuous daily, ongoing and final monitoring [1; 10].

The control is aimed at timely monitoring and correcting gaps in the preparation of primary medical documents and their coding [8]. Bringing activities to regulatory requirements is an element of audit as the main function of the management of a healthcare organization [10]. Audit is a process that is defined as a quality improvement process that seeks to improve patient care and outcomes by systematically reviewing care according to certain formulated criteria and applying changes. Clinical audit is slowly coming into practice and is used to assess the quality of medical care provided by patients [9].

Material and methods

Survey method – A direct anonymous survey was conducted among 232 respondents, between August 2019 and June 2020. An analysis of the protocols of inspections carried out by control institutions.

Statistical methods – MS Excel 2016 was used for the graphical presentation of the data.

Results

An observation and a survey was conducted among 232 medical specialists from the obstetric care hospital in the city. Varna, and more than half of them are defined as

a high workload in the workplace. The load is caused by the nature of the work, the urgency of completing tasks, sudden complications associated with pregnancy, childbirth or extragenital conditions (diseases of various organs and systems, Covid infection, etc.).

For a long time, the lack of standards for certain medical specialties increased uncertainty in the performance of relevant activities, referring exclusively to the provisions of the framework agreement and clinical protocols. In their work, physicians and healthcare professionals work with incomplete information from the patient, which contributes to the rapid application of therapeutic and diagnostic measures. The evaluation criteria are determined by the current national framework agreement, which also defines the criteria for internal regulation, according to which the treatment and diagnostic process is carried out and subsequent control by the National Health Insurance (NHI), respectively, the Regional Medical Insurance (RHI), the Regional Health Inspectorate (RHI), the Ministry of Health (MH), etc.

As for the inspections carried out by the RHI and Executive Agency Medical Supervision (54), an analysis of the causes over the past 3 years in the obstetric structures of 2 hospitals in Varna shows that the bulk of complaints are related to dissatisfaction with medical care, specific medical persons, mainly related to the end result of the treatment and / or undesirable events (complications related to pregnancy, childbirth and the postpartum period). In order to reduce uncertainty regarding the administration and documentation of medical activities, especially in an epidemiological situation, the majority of medical specialists (213–91.81%) declare the need for an official to carry out timely follow-up control over medical documentation and clearly understand the need for training, and daily training in this.

Regional health inspections relate to patient complaints, as well as the establishment of compliance with the requirements of the structure. More than 50% of complaints, according to patients, concerned unregulated payments made on the occasion of examinations or during hospitalization. The results of the inspections provide for correctly performed medical and diagnostic measures, compliance with existing medical standards, compliance with the principles of accessibility, timeliness and adequacy

of medical care. Patients do not know the rules, the right to access medical care and refusal of hospitalization or medical supervision do not take into account the consequences of the choice made. As a result of the choice made, serious medical and legal consequences arise.

Inspections by the Executive Agency for Medical Supervision of the Ministry of Health show that the bulk of complaints are related to dissatisfaction with medical care, specific medical persons / institutions, mainly related to the end result of the treatment and /or adverse events (complications or adverse outcome). Inspections are carried out on the basis of medical criteria in accordance with medical standards, according to which medical care is carried out, rules of organization of activities and prescribed protocols of behavior in a medical institution in various medical specialties, analyzing the patient's path and the behavior of medical teams, serious medical and legal consequences arise (Fig. 1).

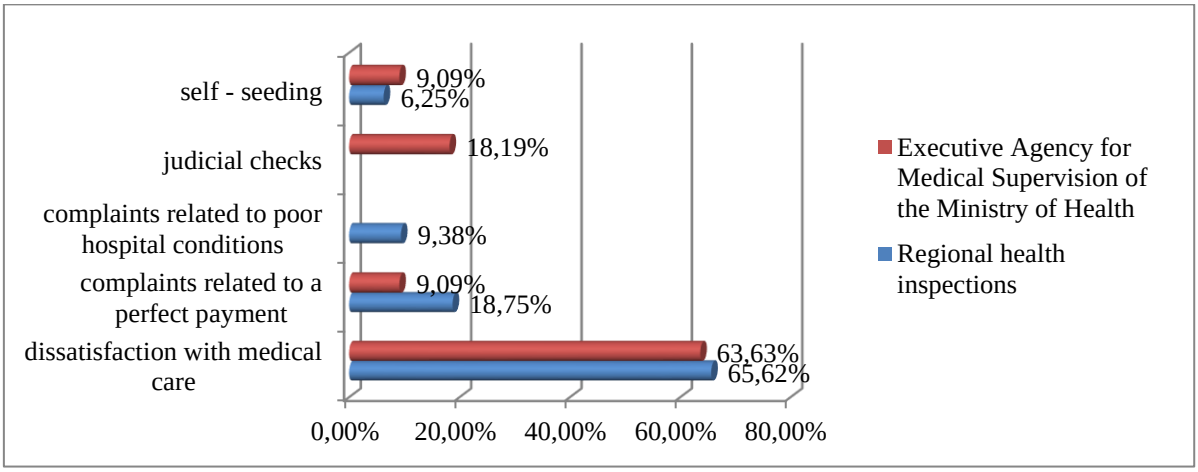

Fig. 1. Checks carried out depending on the basis

Only in 2% serious gaps were found regarding the way of organization or untimely medical care. The most affected are hospital structures that provide obstetric care due to the urgency of care, rapidly occurring complications and insufficient information about the health status of patients.

The most serious omissions are found by checks of regional health insurance in relation to the volume of activities performed, the maintenance of medical records and criteria for hospitalization or dehospitalization. In 81.99% of regional health insurance protocols relate to the default of the algorithm of treatment and diagnosis for the

implementation of clinical pathways in accordance with the current dehospitalization agreement. 74.3% refers to the missing signatures or names of the doctor, the hour of the examination or diagnostic manipulation, the missing details in the epicrisis, the missing signature of the patient to receive the epicrisis (Fig. 2).

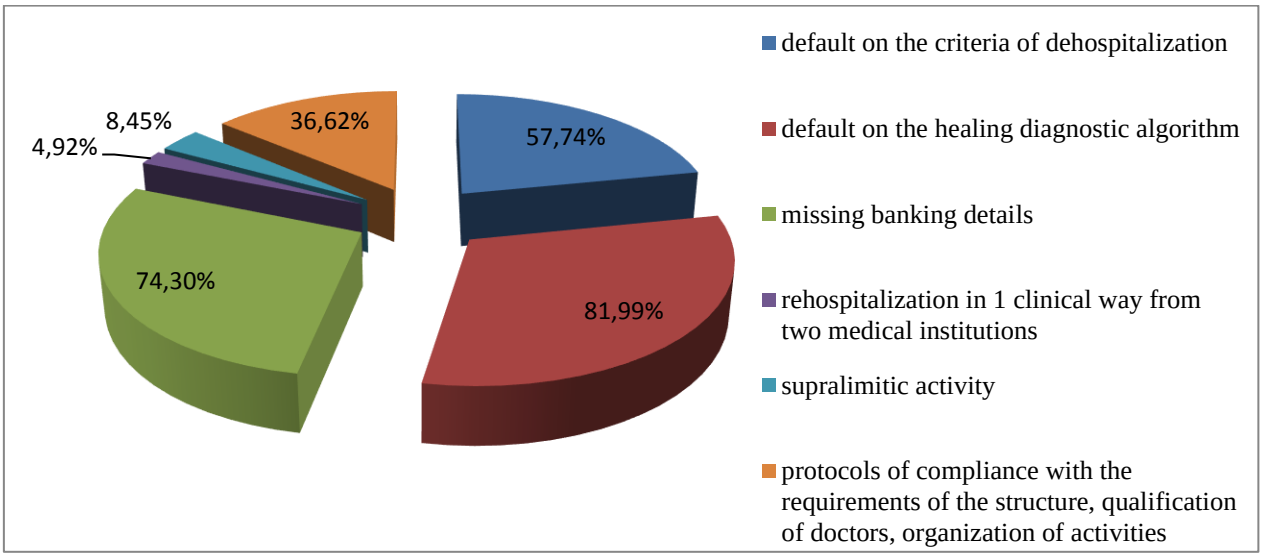

Fig. 2. Grounds for drawing up an inspection report from Regional (National) health insurance

% is more than 100, since the protocols register more than 1 violation along 1 clinical pathway

Certain risks in obstetric structures relate to the quality of these medical services, the qualifications of medical specialists and the treatment and diagnostic plan. Guided by the need for self-improvement, 207 (89.22%) respondents shared that they need trainings in their work in relation to: requirements for activities under the national framework contract; work with new technologies; trainings on working with BIS (hospital information systems). Training as a means of professional development is directed in accordance with the needs of the structure and provides activities in accordance with a regulatory requirement or an emerging need.

The duty of each obstetric structural unit is to sign technical receipts, rules, protocols, algorithms for all performed activities and related auxiliary clinical specialties related to medical services, informed consents (with the presentation of benefits and risks in relation to the performed activities / manipulations/ research), the right to choose a doctor/team and additional requested services provided by the

structure, the right to refuse treatment and all possible activities. This will ensure proper performance of activities, control of medical documentation and, if necessary, timely corrective measures.

Currently, the main guiding principles of activity in medical obstetric and gynecological structures are medical standards, legal and regulatory documents (the law on medical institutions; the Law on Healthcare; the Law on Medicines in Humane Medicine; Resolution 49 On the basic requirements that must comply with the structure, activities and internal order of medical institutions and medical and Social Care Homes; the National Framework Agreement on Activities, according to which medical institutions carry out and report on medical activities; Resolution on the exercise of the right of access to medical care; Resolution 28 On the device, procedure and organization of pharmacies and the Nomenclature of Medicines, etc.), On the basis of which the internal order of hospital structures is determined, the rules of coordination between them are regulated and the order of hospital admission, treatment and dehospitalization of patients is guaranteed.

Conclusion

The study reveals the need for on-the-job training as a leading factor that requires the implementation of a policy for the development of medical personnel. In order to minimize gaps in medical documentation in accordance with the requirements of the national framework agreement, it is necessary to monitor environmental factors by conducting a continuous analysis of the system; analysis of possible risks; vulnerability analysis of the system; creation of a security system; threat assessment.

The end effect is to develop rules of conduct for frequently repeated actions and in emergency situations to eliminate risk and minimize the consequences for resources and structure.

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