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Abstract

Clinical Coding is a method of translating a clinical description of a disease or procedure in to a standard code. The International Classification of Diseases – 10th Revision (ICD – 10) is the WHO recommended system of coding of morbid entities. Coded data are used for planning of health services, epidemiological surveillance, cost analysis, and comparisons of morbidity and mortality data between hospitals, regions and countries.

Sri Lanka adopted ICD –10 in 1997 and this study was under taken with the objective of assessing the quality of ICD coding and to identify some factors influencing. A sample of 1091 Medical Records was selected from 6 hospitals of Colombo District representing all categories of hospitals. Accuracy of the diagnosis was assessed using WHO guidelines on recording of diagnostic information for coding and the General Circular No. 01-05 / 99 of 26.02.1999 of Department of Health as gold standards. Quality of coding was assessed by using Australian Coding Benchmark Audit (ACBA), a coding quality assessment tool developed by National Centre for Classification in Health, Brisbane.

The availability of the final diagnosis on front sheets of Medical Records was satisfactory (94.7%), but the accuracy of the diagnostic statement was unsatisfactory (54%). Out of 6 hospitals studied, only the Teaching Hospital (TH) and the Peripheral Unit (PU) were practicing coding. The over all rate of

accuracy of ICD coding in the Hospitals of Colombo District was 31%, which is quite unsatisfactory.

Out of all the hospitals in Colombo District (n = 24), Only TH and Special Hospitals were found to be having adequate physical facilities and human resource in Medical Record Departments for ICD coding.

All the Coders (n = 31) in the Hospitals of Colombo District were studied for socio demographic profile, coding practices and their attitudes towards coding. Of the Coders, 29% had confessed that they actually do not code and use alternative methods to prepare IMMR, and 25% were having unfavourable attitudes towards coding.

Training opportunities should be made available to the Coders, in ICD – 10 and other related subjects. Medical Record Departments should be adequately staffed and provided with necessary physical facilities. Efforts should be made to improve the familiarity of the Medical Officers with the WHO guidelines on recording diagnostic information for ICD coding.