Audit of Documentation of Inpatient Medical Record

Presented By:
Dr. Ilma Farooq
MBA HM 22
Roll No-0577

Outline

- Introduction
- Purpose of the study
- Objectives
- Research Methodology
- Data Collection
- Findings
- Data Analysis
- Observations
- Root cause analysis
- Recommendation
- Limitation
- Conclusion

Introduction

SURYA HOSPITALS,JAIPUR

- Surya Hospitals, Jaipur is one of the Rajasthan's fastest growing tertiary care hospital.
- It is a 122 Bedded full fledged Women and Children Super Specialty Hospital.
- It has a state-of-the-art infrastructure and amenities including Rajasthan's one of the best 42 bedded Neonatal ICU,10 Paediatric ICU , 5 Bedded adult ICU and many more latest facilities.
- Surya Children's Hospital was started by Dr. B.S. Avasthi in 1983 with a vision to provide quality neonatal care in city of Mumbai.
- The Jaipur branch which was started in May,2018 is lead by Dr. Suhasani Jain Facility Director at Surya Hospitals, Jaipur.

Introduction

- Medical records are the document that explains all detail about the patient's history, clinical findings, diagnostic test results, pre and postoperative care, patient's progress and medication.

- 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 .

Purpose of the study

- To check for the level of completeness of files as part of the regular auditing process of the MRD.
- To help the organization in NABH preparedness.
- The medical record documentation plays an extreme role in legal matters, it is necessary to check documents for better orientation of the doctors and nurses and to avoid any medico legal problems.

Objectives

- To study the existing system of medical record documentation.
- To check compliance of various parameters of documentation.
- To identify the gaps in the medical record documentation.
- To suggest ways to bridge the gaps in the documentation.

Research Methodology

- **Study Design-** Descriptive, Cross-Sectional Study

- The files are separated in
  - **Active Files** -the files which are still in the respective wards and the patients are yet to be discharged from the hospital
  - **Passive Files** - the files received in MRD after the patient has been discharged
- **Location**- Surya Hospitals, Jaipur

- **Duration**- 2months (1st March to 30th April)

- **Sampling Technique**- Convenience sampling(Non-Probability Sampling)

- **Sample Size**-240 files (120 active files and 120 closed files)
  Inclusion-General Ward, Private Ward, LDR ,OT Recovery, PICU
  Exclusion-NICU files

- **Data Collection Tool**- Medical Record Audit Checklist

Data Collection

Medical Record Audit Checklist

The aspects that were included in the Medical Record Checklist for the purpose of collecting the data of In-patient files are-

- Date
- IPD No.
- Patient Name
- Consultant/Specialty
- Provisional Diagnosis and treatment details available
- Care plan documented
- Care plan counter signed with name by the clinician
- History sheet
- Investigation Summary

Cont.

- Nutritional Assessment by Dietician
- Vital Monitoring Sheet & Input output chart
- Initial assessment in ward documented and completed
- Clinical progress sheet/progress notes as per reassessment frequency or at least twice a day
- Nursing initial assessment documented and completed
- Nursing care plan is documented and signed
- Nursing progress notes and handover properly documented
- All required consent forms

Cont.

- Consent forms signed by correct persons
- Consent forms completely filled
- Consent forms signed by Doctor
- Legible Handwriting in medication chart
- Medicine order in Capital letter
- No prone abbreviation in medical record
- ICD coding
- Discharge Summary

Data Analysis

- A total no of 240 files were checked from both active and closed sections.
- Each parameter and its sub parameters were marked with Compliance (C) and Non-Compliance (NC).
- The findings were observed on the basis of compliance more than or equal to 90% or less than 90%.

Findings

Process Flow In MRD

Receiving of medical records within 24 HRS from various departments after the patient is discharged

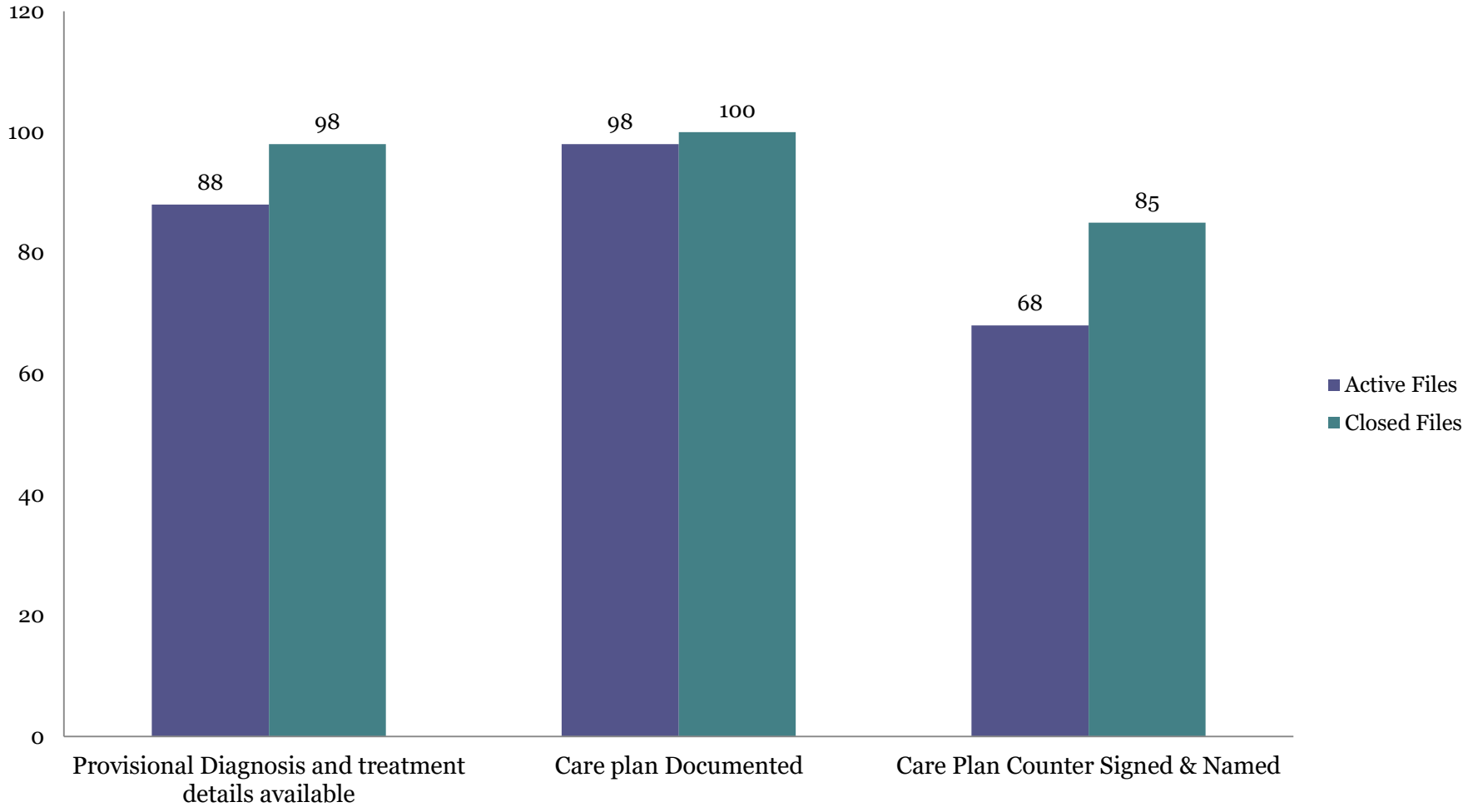
Files checked in MRD by MRD assistant to see the document compliance by Doctors and Nurses

If found incomplete , sent back to the concerned department/ward for completion

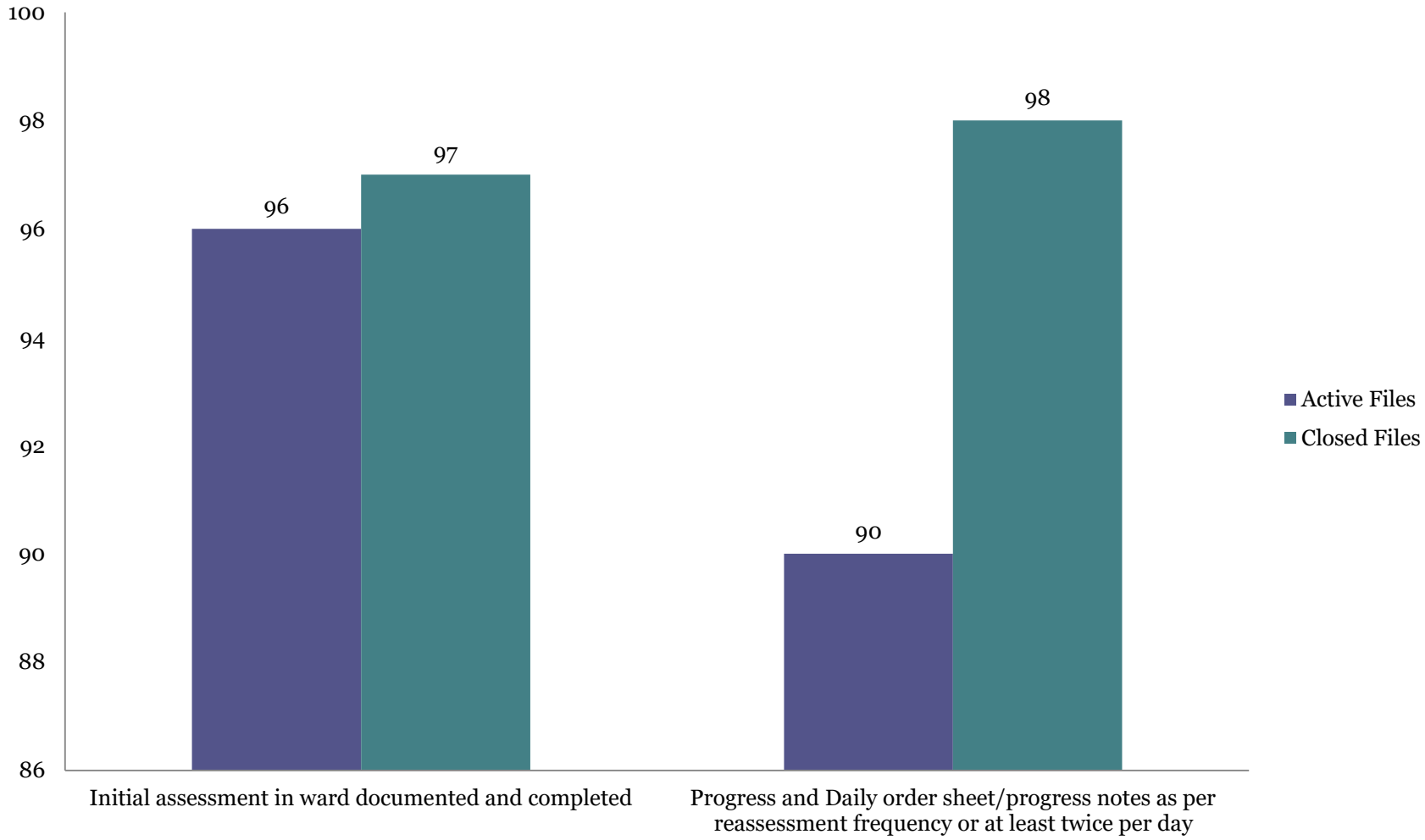
Files received back and rechecked for completeness by MRD assistant

Files are racked after the coding and indexing is done as per the ICD coding and as per the admission number of the patient respectively

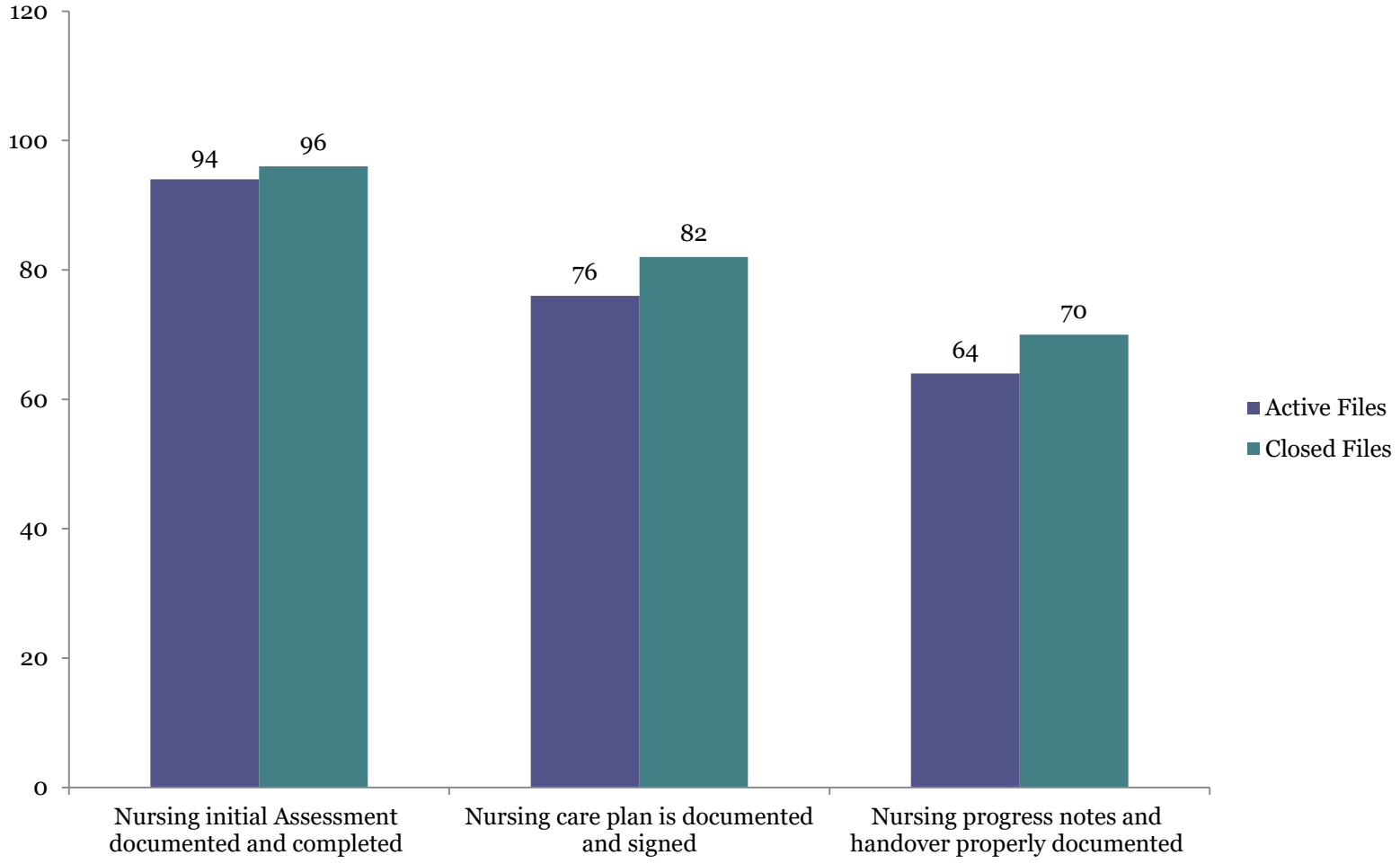
Compliance of Document Parameters of Admission Plan Of Care (%)



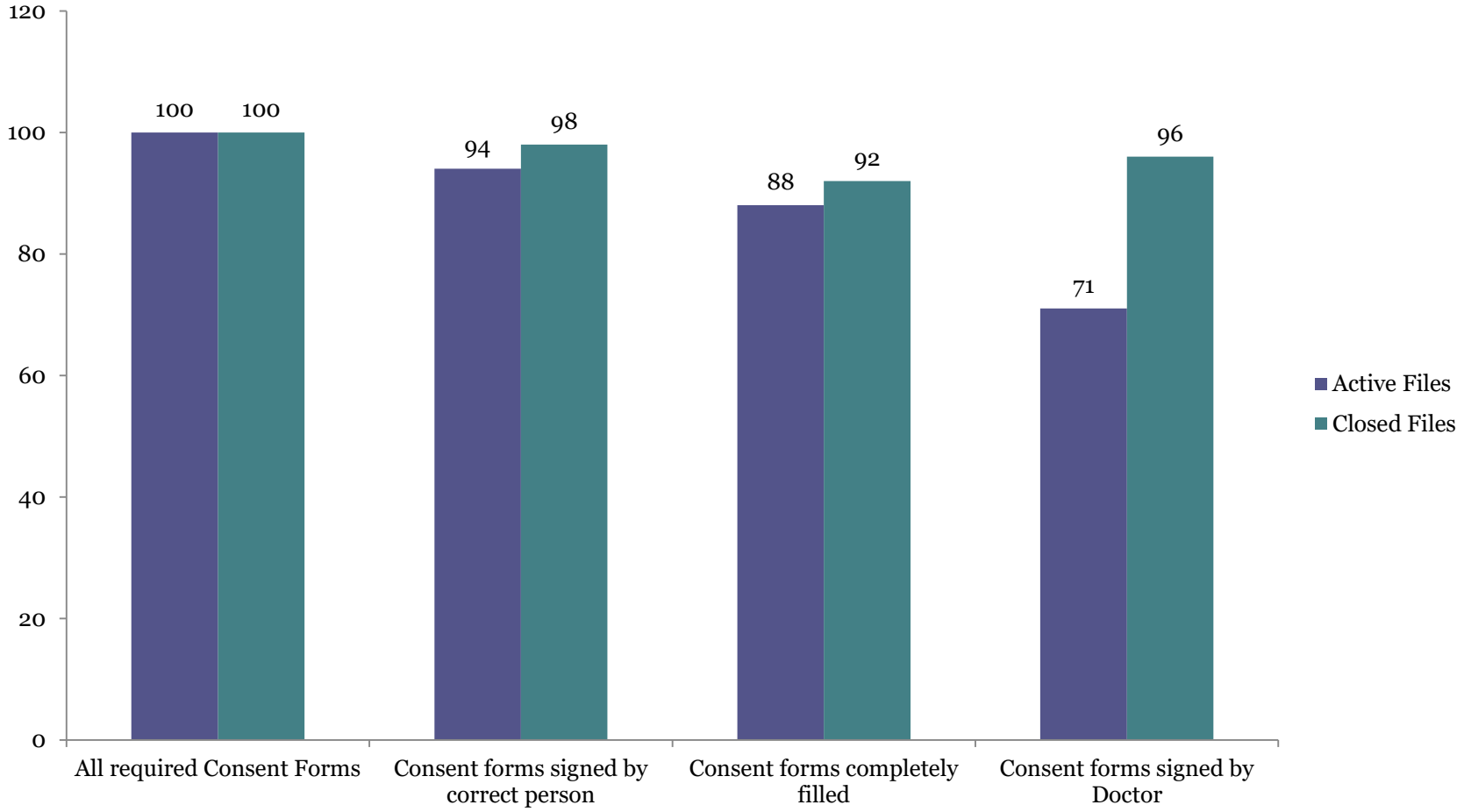
Compliance of Document Parameters of Initial Assessment/Progress Notes (%)



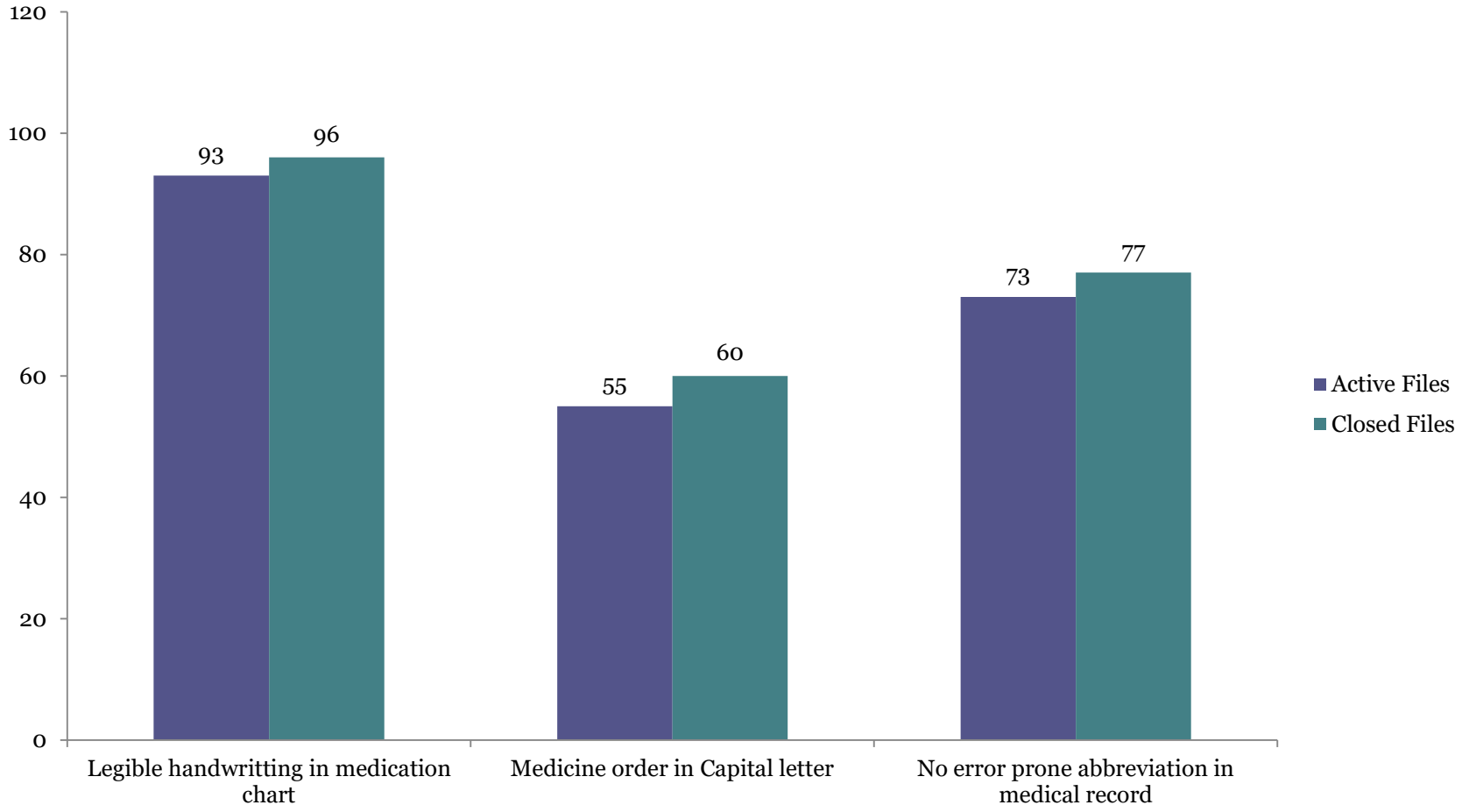
Compliance Of Document Parameters of Nursing Progress Note & Assessment (%)



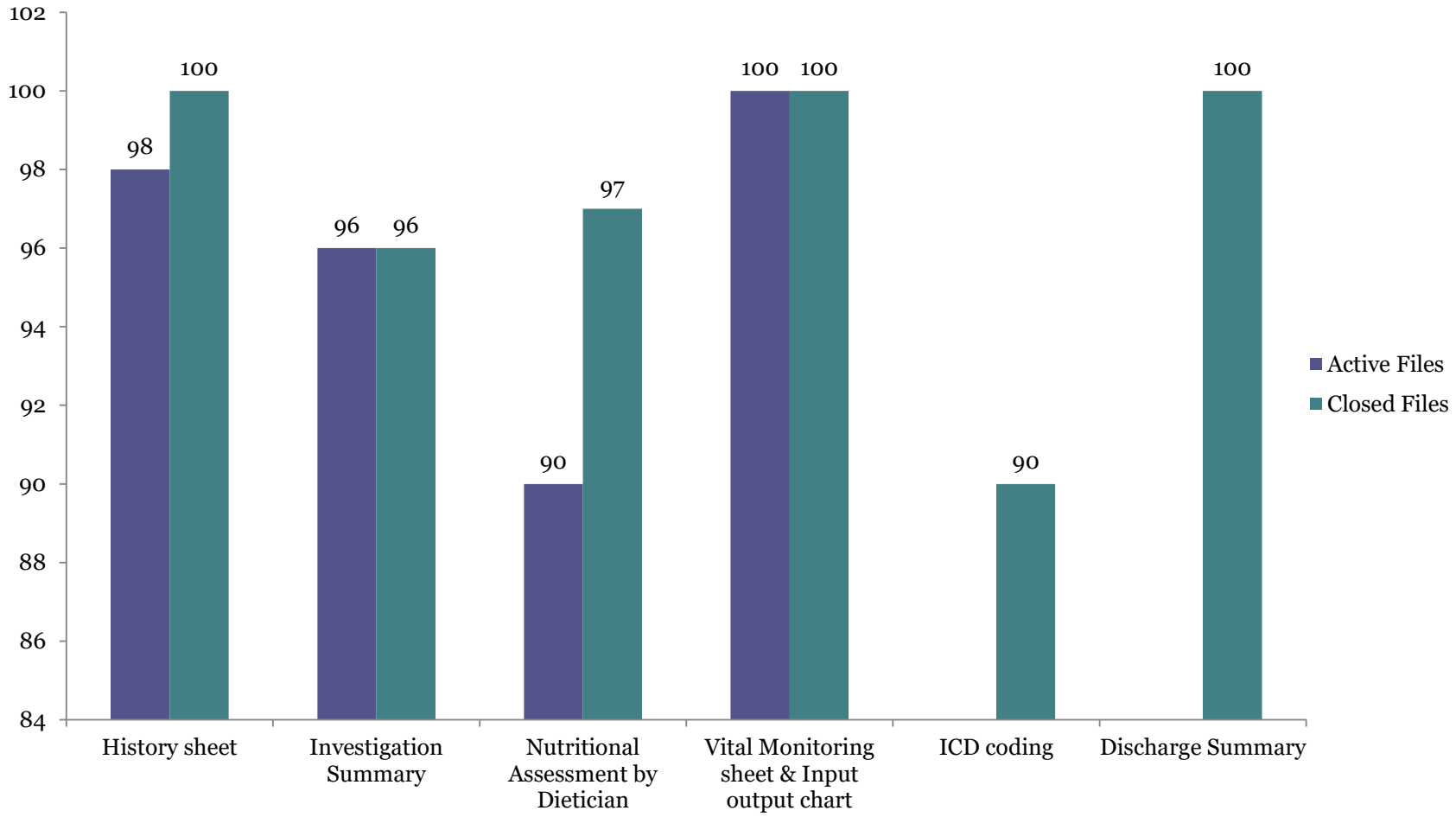
Compliance of Document Parameters of Consent Forms (%)



Compliance of Document Parameters of Medical Chart (%)



Compliance of Other Document Parameters (%)



Observation

- **<u>Equal to and More than 90% compliance was observed in following parameters</u>**

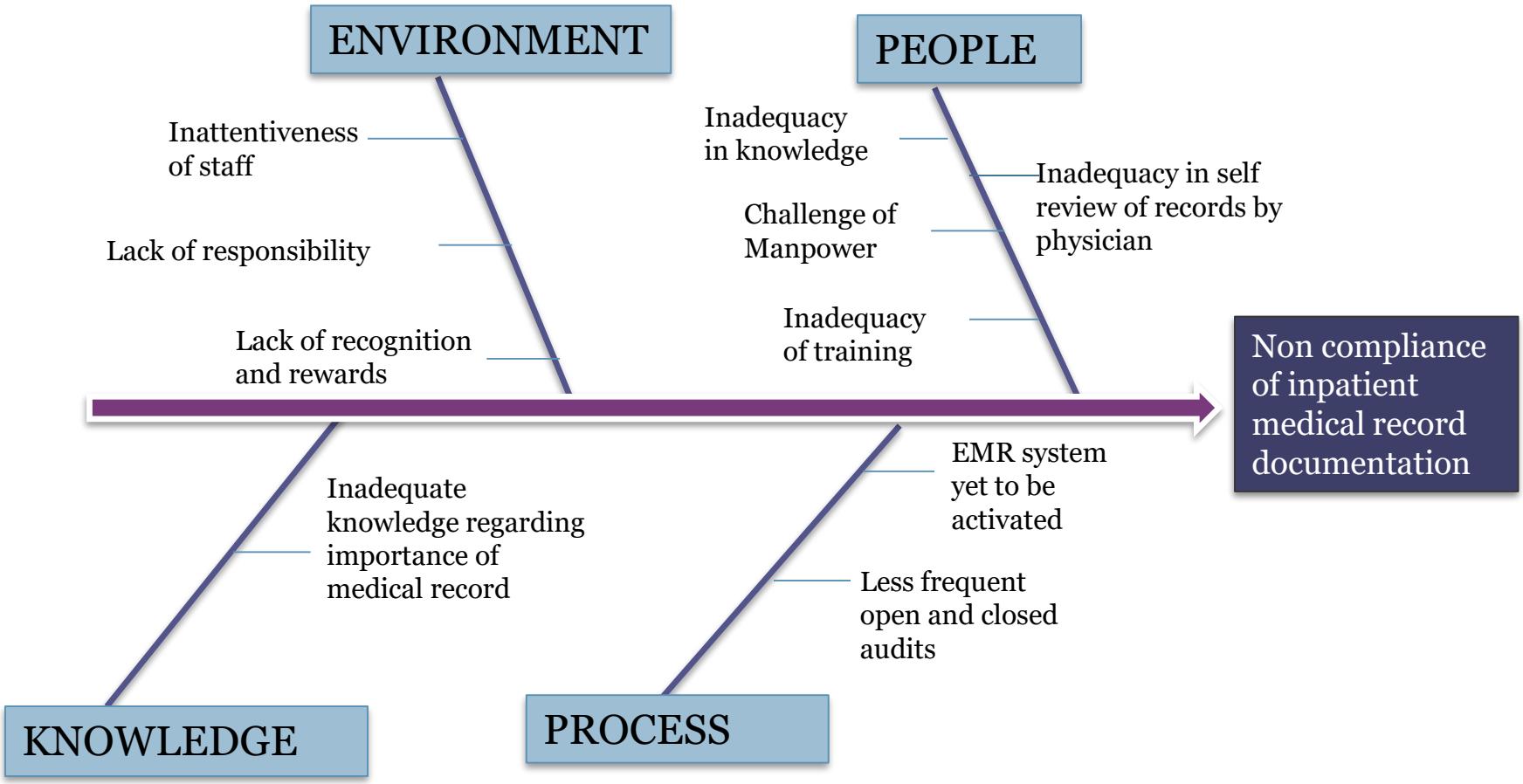
- Care plan documented
- Initial assessment in ward documented and completed
- Progress and daily order sheet/progress notes
- Nursing initial assessment documented and completed
- All required consent forms
- Consent forms signed by correct person
- Legible handwriting in medication chart
- History sheet
- Investigation summary
- Nutritional assessment by dietician
- Vital monitoring sheet and input output chart
- ICD Coding
- Discharge Summary

Observation

- **<u>Lesser Compliance was observed in the following parameters (less than 90%)</u>**

- Provisional Diagnosis and treatment details available
- Care plan counter signed and named
- Nursing care plan documented and signed
- Nursing progress notes and handover properly documented
- Consent forms completely filled
- Consent forms signed by Doctors
- Medicine order in capital letter
- No error prone abbreviation in medical record

Root Cause Analysis



Recommendations

- Creating awareness among the staff about the importance of documentation of medical records.
- Focused training sessions on documentation.
- Tracer audits (to explain and rectify the documentation mistakes done by staff on spot when documentation is going on).
- Recruiting new staffs to decrease the workload so that prompt documentation could be done.
- Peer group discussions inter/intra departments on medical records documentation involving Head of Departments, experienced doctors, nursing superintendent, MRD staff and quality department staff.
- EMR system implementation for inpatient medical records.

Limitations

- One of the major problem in the MRD of the hospital was the shortage of skilled and trained staff.
- The another problem in the hospital was that staff was not aware of importance of completing the medical records.
- The labeling of racks was not there in the MRD so it was difficult and time consuming to retrieve a medical record as and when required.

Conclusion

- Maintaining a complete medical record is not only important to comply with accredition and licensing requirements, but also as a proof to establish that adequate care has been provided.
- MRD has become an essential part of every hospital and is used to achieve regularity and standardization .
- This study shows that the compliance of many parameters of the documentation and can be improved by managing the gaps.


thank
YOU