A Study On Assessment of Compliances in Medical Records Department in Accordance with NABH Standards at The Mission Hospital ,Durgapur

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INTRODUCTION

- Medical records department plays important and silent role in the back office of hospital
- The Medical Records Department is maintaining the medical records which a legal document is providing a bunch of information of patient medical history and care. Physician, nurse practitioner and other health care team may take entries in the medical record
- The Medical Record Contains types of documentation of each and every information including recording consultants observation, dietician notes, nursing department assessment, drug therapies, lab reports, radiological reports etc.

RESEARCH QUESTION

Is Medical Records Department Compliant as per the NABH Standards?

OBJECTIVES

- To Assess the Compliances of Medical Records Department according to the NABH Standards
- To Review the existing system of Medical Record Department and to find the GAPS which require improvement
- To Make a request for proposal for E-MRD and do a Market Research

LITREATURE REVIEW

The study has been conducted at the hospital to find out Assessment of Adherence to Protocol in Medical Record Documentation in accordance with NABH Guidelines. The main objective of this study was to study medical record department of the hospital, to audit were manually done according to the NABH standards and to highlight major observations to recommend implementable solutions. Out of the 347 in patients records 130 were taken for this study

It was found that many medical records were not sufficiently well documented to provide adequate evidence of continuity of care. It was found that in the four various parameters assigned Admission request form, Doctors initial evaluation form, condition of the discharge time mentioned and birth certificate matter comes into the poor segment, whereas Elements in medical records and patients' daily progress comes into the excellent parameters

The study needs further exploration as to identify the gaps in process flow department wise. For the same reasons, the forms should be redesigned. Medical Records contents for discharged patients should be arranged prior to filing. Qualitative analysis of Medical Records contents should be done on regular basis to monitor completeness of information. It is recommended that entries will be recorded as closely as possible to the time of the encounter

A second study has been conducted at the Mumbai in 450 bedded hospital on A Study Audit of Documentation of Medical Record main purpose of the study To assess whether the documentation is being done as per the SOPs of the hospital To recommend effective solutions wherever required

It is observed during the study Medical records forms a very important and critical part of the hospital working. These records are very vital for legal purposes the importance of the same should also be communicated to the staff. Periodic audits of the medical records will help to determine the deficiency in keeping records which can be improved and worked upon by the hospital. It is necessary to follow documentation is being done as per the SOPs of the hospital

RESEARCH METHODOLOGY

- **Study Area** – The Mission Hospital, Durgapur
- **STUDY DESIGN** - Descriptive study
    - **SECONDARY DATA –** This data has been by observing the practices followed in The Mission Hospital, Durgapur
- **TYPE OF STUDY** – Retrospective Study
- **STUDY POPULATION**
    - **INCLUSION** – IP General and MLC Files
    - **EXCLUSION –** Day care IP files
    - **STUDY TOOLS** – NABH Standards Checklist
    - **Study DURATION** – 4th February – 3rd May 2019
- **Sample size** – 315 IP files
- **Sampling Technique** – Convenience Sampling

WORKFLOW - COLLECTIONS OF FILES FROM EACH FLOOR TO MEDICALS RECORD DEPARTMENT

WORKFLOW

All the files get collected from Nursing Station (after patients get discharged from the hospital) with the help of Discharge list and M.R.D. Checklist

- **Collection of Discharged Files**

Receive in the Excel sheet (as per excel sheet Sr.No) and files get Stacked by the serial no.(as per excel sheet) & Discharge date

- **At the Department**

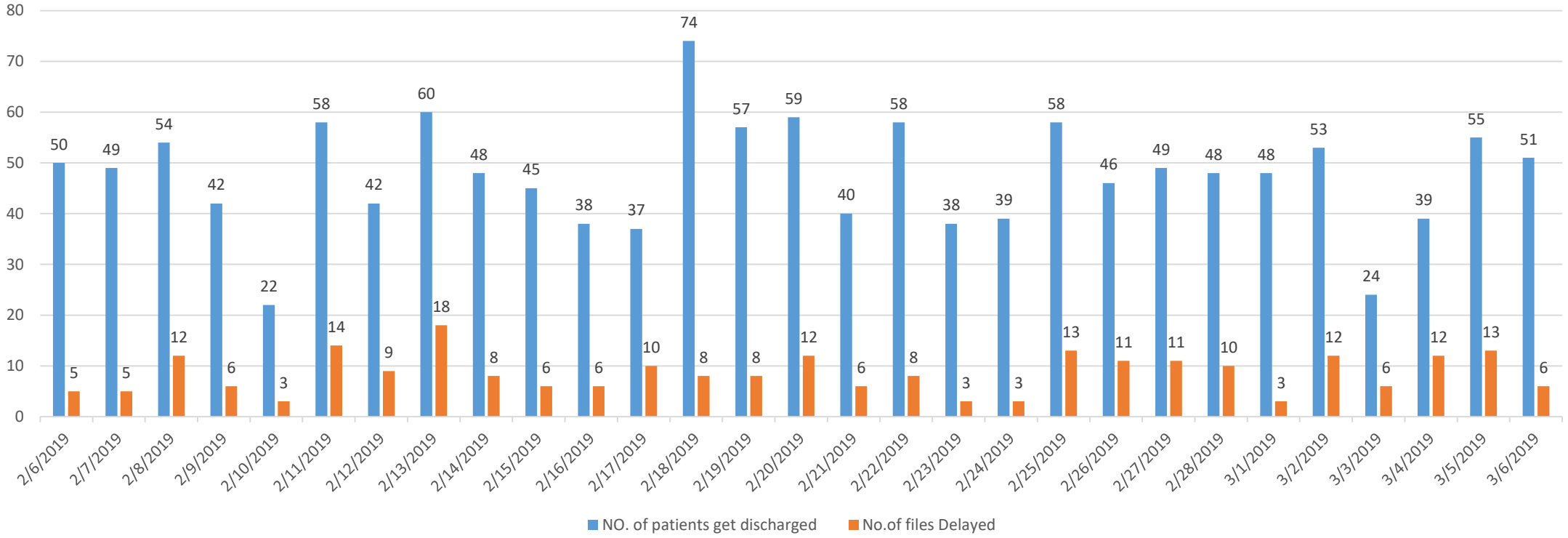
ICD coding allotted to each file

MLC Cases and General files kept separately

As per the Discharge Date vertical filing is done in the M.R.D. Department

- **Arranged in the Racks**

PROBLEMS WERE IDENTIFIED

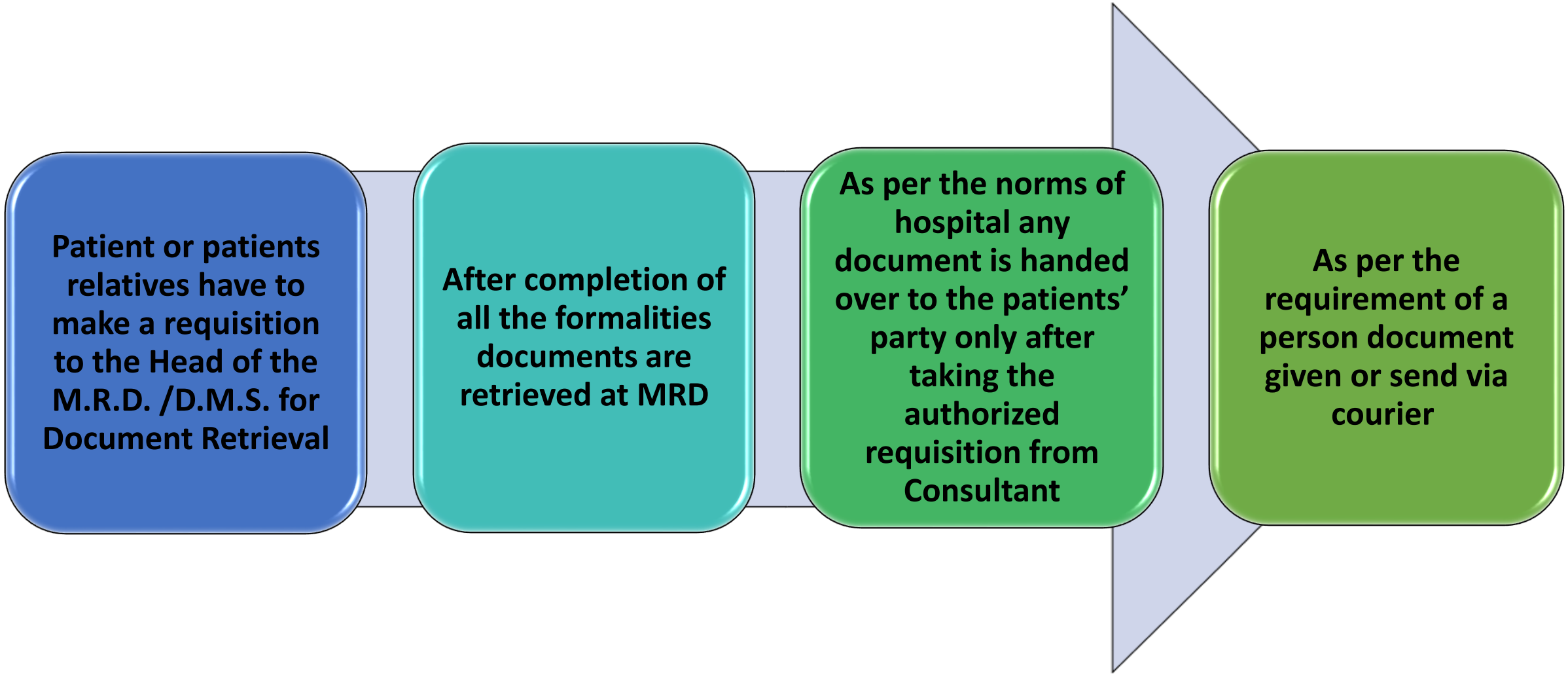


Daily 10 files Delayed on an Average

SR. NO	FLOOR	NO.OF INCOMPLETE FILES	Required Documents
1	8th Floor	8	Billing card
2	7th Floor	40	Billing card
3	6th Floor	14	Billing card
5	5th floor	1	Billing card
6	4th floor	4	Billing card
7	2nd floor	13	Billing card
8	1st floor	84	Billing Card

- At every floor list was made as per the Sr.No., IP.No., Pt. Name, Date of Discharge and Required documents
- The list hand over to the floor in charge person and Billing Department to complete the files with required documents as soon as possible and send by the GDA to the Medical Records Department

For Document Retrieval Procedure



QUALITY PARAMETERS

SR. NO.	HEAD	PARAMETER	STATUS
1	Regulatory	1. Births Reporting 2. Death Reporting 3. MLC Intimation 4. Notifiable Disease Reporting	1. Maintained 2. Maintained 3. Maintained 4. Maintained

SR. NO	HEAD	PARAMETER	STATUS	Recommendations	IMPLEMENTATION
2	Arrangements	1. MRD File 2. Labeling 3. Tracer Card	1. Vertical Filling 2. Labelling is not Maintaining 3. Yes	2.There should be proper labelling Acc. Files(Stamps are using instead) 3.Information on some Tracer card is missing sometimes	2.Labelling process is in progress 3.Tracer Card is maintain now

SR. NO	HEAD	PARAMETER	STATUS	Recommendations	Implementation
3.	Documentation	1. Closed File Audit 2. Medical Audit Committee Meeting 3. Death Review Committee Meeting	1.Close file audit done on Monthly basis(January audit is in process) 2.Once in a three month (last-15th march 2019) 3.Once in a three month	1.Close file audit of previous month should be done in the next months first week	1.Close File Audit is in Process

Sr. No	HEAD	PARAMETERS	STATUS	Recommendations	Implementations
4.	Staff Awareness	1. Vision, Mission & Values 2. Codes 3. Employee Rights & Responsibilities 4. Fire Safety 5. Hand Hygiene 6. Staff Should Read Information Board, Employee Handbook & Concerned policies	1.No information 2.Safety Code information displayed & absence of Code BLUE Switch 4.Only Fire Extinguishers are available 5. Usage of Hand rub only 6.There is not a such a dedicated notice board	1.Vission,mission values should be display at the department 2 & 5.Mock drills should be taken once in a six month and also medical switch should be placed 3.For Awareness HR training should be done once in a year 7.Regarding Departmental Information notice board and employee handbook and concerned policies are missing	1.It is displayed now 2.Safty codes mock drills were taken 3.HR Training is scheduled on 10th May 6.Notice Board is displayed in the department

Sr. No	HEAD	PARAMETERS	STATUS	Recommendations
5.	Miscellaneous	1. ICD coding (International Classification of Diseases) 1. Access to current & past medical record 2. Retention Record 3. Destruction of Records 4. File documents arranged in Chronological order	1. Following as per the ICD 10 (version 2016) In Process 2. Yes 3. All the Documents are retained 4. Have not done yet 5. YES	4.Should be done for general (IPD) cases after 10 years as per the norms

As per following NABH Standards the compliance of medical records department has been done

- NABH Standards – 13
- Objective Elements - 39

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC
1.	**AAC.4.I** (Compliance)	1. The care plan is countersigned by the clinician in-charge of the patient within 24 hours	1.Compliance
2.	**AAC 13 b,c,d** (Compliance)	1. Medico legal case documentation 2. LAMA case file has discharge summary and risk explained	1 .Compliance 2.Compliance

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
3.	**AAC 14 b,c,d,e,f,g** (Partial-Compliance)	1. Discharge summary (pt. name,UHID no., DOA,DOD etc.) 2. Cause of death in case of death summary 3. Discharge summary acknowledge by patient/family 4. Check for completeness of consent documents I. procedure II. blood transfusion III. moderate sedation IV. Anaesthesia V. surgery VI. research VII. MTP,HIV 5. General consent 6. Language consent	1.Compliance 2. Compliance 3. Non - Compliance 4. Partial -Compliance 5. Partial- Compliance 6. Non- Compliance	3. While explaining discharge summary by nurse signature in all copies should be taken from patient party 4. To take consents in proper format as per legal obligations 5.All the consents should get signed with date, time 6.Should be in the bilingual language

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
4.	**COP.12.** Documented policies and procedures guide paediatric services (Non- Compliance)	1.Patient assessment includes detailed nutritional, growth, developmental and immunization assessment 2. The children‘s family members are educated about nutrition, immunization and safe parenting and this is documented	1.Partial - Compliance 2.Non-Compliance	1.Stict adherence to the policies 2.Nutritional advise and parenting should be given on the advise on safe parenting
5.	**COP.15. d.f.g.** Documented policies and procedures guide the care of patients undergoing surgical procedures	1. Surgical safety checklist ,operating notes, recovery criteria, post operative plan of care	1.Compliance	
6.	**HIC 3 (Compliance)**	1. In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities	1.Compliance	

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
7.	**FMS 6.A**	1. The organization has plans for fire and non-fire emergencies within the facilities	1. Non -Compliance Currently Department have fire extinguisher only	• Mock drills should be done once in a six months • No provision for emergency exit • As per the standards fire proof cabin should be there • Trolley and segregation of the documents should be done as soon as possible

Sr. No	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
8.	**IMS.3.A-H** The organization has a complete and accurate medical record for every patient	1. Every medical record has a unique identifier 2. Organization policy identifies those authorized to make entries in medical record 3. Entry in the medical record is named, signed, dated and timed 4. The author of the entry can be identified 5. The contents of medical record are identified and documented 6. The record provides the organization has a documented policy for usage of abbreviations and develops a list based on accepted practices 7. A complete, up-to-date and chronological account of patient Care 8. Provision is made for 24-hour availability of the patient‘s record to healthcare providers to ensure continuity of care	1.Non - Compliance 2.Compliance 3.Partial – Compliance 4.Partial- Compliance 5.Compliance 6.Partial - Compliance 7. Partial - Compliance 8.Non - Compliance	1.There should be a unique identifier for each document 3&4.To ensure the completeness of all files before collection 6.Only medicines ordering abbreviations are updated 7.There should be chronological order 8.MRD should be in operations for 24 hour

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
9.	**IMS 4 A-H** The medical record reflects continuity of care	1. The medical record contained information regarding reasons for admission, diagnosis and care plan 2. The medical record contains the results of tests carried out and the care provided 3. Operative and other procedures performed are incorporated in the medical record 4. When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital 5. The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel 6. In case of death, the medical record contains a copy of the cause of death certificate 7. Care providers have access to current and past medical record	1. Partial - Compliance 2.Compliance 3.Compliance 4.Compliance 5.Partial Compliance 6.Compliance 7.Compliance	1.Information should be documented and sign should be taken from Patient or their relatives 5.Each and every copy of the discharge summary should be signed by appropriate and qualified personnel

SR. NO	NABH Chapters	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
10.	**IMS 5 A-G**	1. Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information 2. Safeguarding of data/record against loss, destruction and tampering 3. Technology for improving confidentiality, integrity and security 4. Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient‘s authorization 5. A documented procedure exists on how to respond to patients/physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.	1.Compliance 2.Compliance 3.Non – Compliance 4.Compliance 5.Compliance	3. **E-MRD** Proposal is on request process

SR. NO	NABH Standards	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATION
11.	**IMS.6.** Documented policies and procedures exist for retention time of records, data and information	1. Documented policies and procedures are in place on retaining the patient‘s clinical records, data and information 2. Maintainace of confidentiality and security at all stages 3. Methods of destruction of medical records, data and information	1.Compliance 2.Compliance 3. Non - Compliance	3.Destructions of medical records should be done as soon as possible as per The Clinical Establishments Act 2012
12.	**IMS.7.** The organization regularly carries out review of medical records	1. Medical Record Audit – Frequency ,sample size, person authorised,timeliness,legibility and completeness ,active and discharged patient records	1.Non-Compliance	1.Quarterly meetings should be taken
13.	**ROM 2**	1. Communication of notifiable diseases to concerned authorities	1.Compliance	

FINDINGS

After Assessing the Compliances in Medical Records Department it is found that out of 39 Objective Elements following Compliances ,Partial Compliances and Non-Compliances are Observed -

No.of compliances	No.of Partial-Compliance	No.of Non-Compliance
20	10	09

RESULTS

It is observed while the study that M.R. Department is Compliant 51% which include most of the Regulation of Documented Policies and Medical records Documentation (includes Completion of the documentation etc.)

26% of Partial Compliance is observed and most of those are in progress (for ex. The children‘s family members are educated about nutrition, immunization and safe parenting and this is documented etc.)

When it is come to the Technology for improving confidentiality, integrity and security organization is looking forward for accepting E-MRD as soon as possible and shows 23% Non-Compliance

CONCLUSION

Medical records forms a very important and critical part of the hospital working. These records are significant for legal purposes and for future planning of the hospital services for medical care.

Hence, all purposes and for future planning of the hospital services for medical care. That's why all the possible steps should be taken to ensure that all medical records are maintained in systemic and orderly manner.

The importance of the same should also be communicated to the staff. Open file audits of the medical records will help to determine the deficiency in keeping/missing of medical records which can be improved and worked upon by the hospital

Ethical consideration

- Hospital Record is the Patient's Property
- It is a Confidential Information and Cannot Be Released without Doctor's Permission
- Any Information from the Patient's Medical Records Should be Released on Written Request from the Patient e.g. To Employer or to Insurance Company

RECOMMENDATIONS

- **INFRASTRUCTURE**
  - Blue Code switch should be allotted as soon as possible
  - Provision for Emergency exit should be there
  - Stores should be in hospital premises
  - For Document Safety fire proof Cabin should be there

- **TECHNOLOGY**
  - Implementation of E-MRD

- **AUDITS**
  - Open File Audit should be done on daily basis and report to the Floor In-Charge
  - Close file audit should be done monthly
  - Mortality Audit Should be done once in a Three Month
- **MISCLLENEOUS**
  - Mock Drills – Safety Codes Mock Drills should be taken regularly
- **MANPOWER**
  - As per the workflow of the Department two more people should be recruit as soon as possible

Government of West Bengal
Department of Health & Family Welfare
Public Health Branch
The West Bengal Clinical Establishment Rules, 2012

SCHEDULE VI Standards for Records, Reports & Registers

Part I. Introduction

2. Preservation

2.1. All records should ordinarily be preserved for a minimum period as mentioned below: (a) **All OPD records for 5 years** (b) all IPD records for 10 years (c) all Medico-legal records for 15 years (d) all accounting records for 5 years.

STATUS – only Executive Health check up OPD documents are stored

Recommendation – Each and every OPD Prescription should get stored in soft copy (by scanned) or retained it as a photocopy for 5 years


Electronic
Medical Record
Department

THE WEST BENGAL CLINICAL ESTABLISHMENT (REGISTRATION, REGULATION AND TRANSPARENCY) ACT, 2017

Chapter II.—Registration and Standards.—Section 7.

(n) That every clinical establishment shall immediately after coming into force of this Act, implement e-Prescription, maintain Electronic Medical Records and provide a set of all medical records and treatment details along with the discharge summary at the time of discharge of the service recipient

Electronic Medical Record is a digital version of a patient’s paper chart. EMR is real time, patient-centered records that make information available instantly and securely to the authorized user

MANUAL RECORDING IN MRD

- Need a fire proof storage
- Cost of missing records
- Difficult to track down data
- Limitation of paper documentation
- With age it may become **weak**
- There may be a **colour alteration** in it and it may get yellowed.
- Need of Pest control

ELECTRONIC RECORDS IN MRD

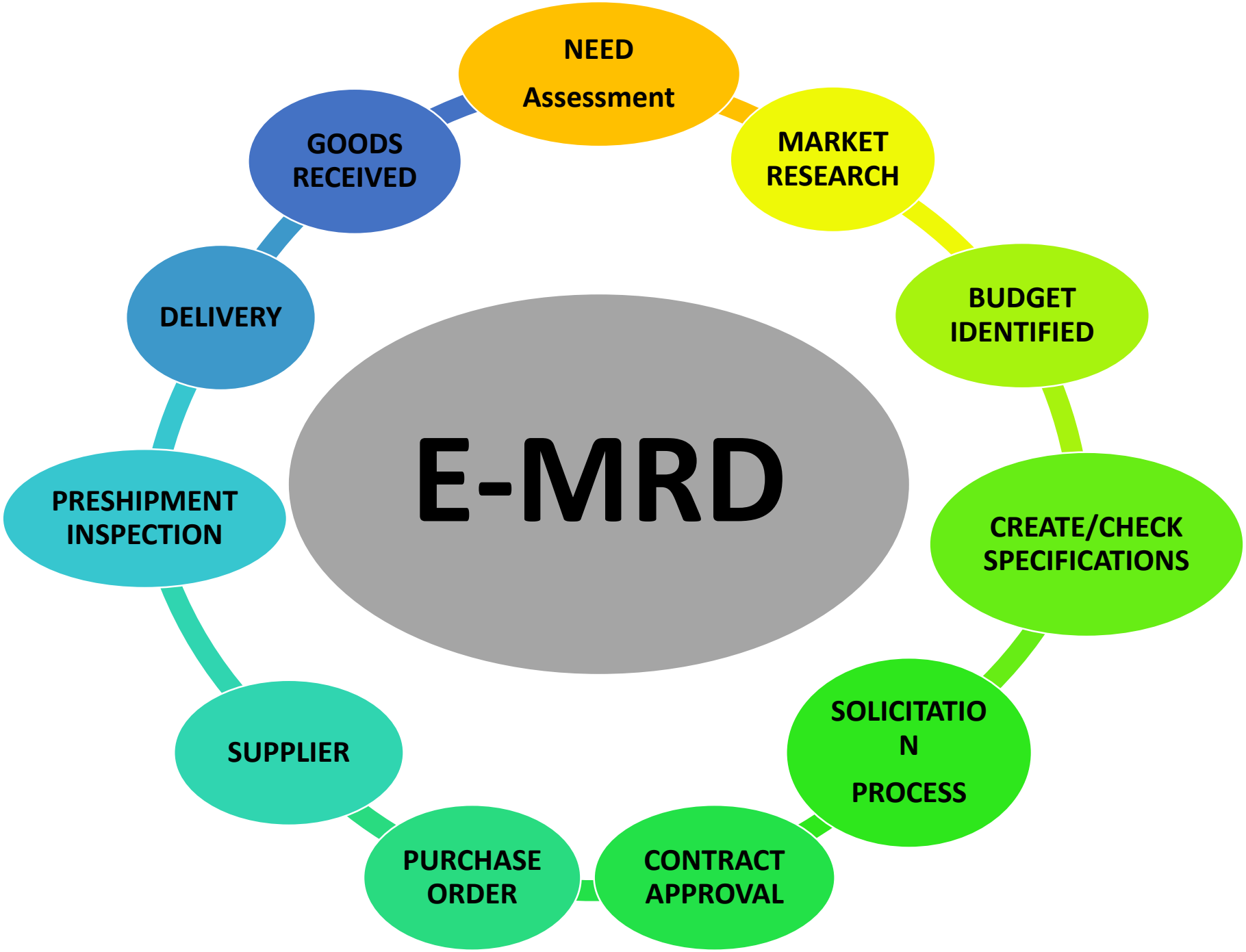
- Storing and maintenance Charges for the no. of files will be lower
- Reduce time to retrieval of data
- Indexing for easy retrievals
- Records will be a just a click away
- Utilize your space optimally
- Save on warehouses and maintenance cost
- Store track and retrieve documents at your convenience
- Authorized person have access(OTP secure Login)
- Cost effective
- Better backup
- User friendly
- Timely saving

✓ Advantages

- Single database shared by all department
- Easy and instant accessibility to many users
- Real time information available
- Comprehensive Information
- Reduced time of clerical functions
- Accuracy and Readability
- Security
- Cost over time

✓ Disadvantage

- Not portable
- Needs down time
- Computer literate staff required
- Affected by disruption in power supply (need a UPS connection only)


E-MRD
NEED Assessment
MARKET RESEARCH
BUDGET IDENTIFIED
CREATE/CHECK SPECIFICATIONS
SOLICITATIO N PROCESS
CONTRACT APPROVAL
PURCHASE ORDER
SUPPLIER
PRESHIPMENT INSPECTION
DELIVERY
GOODS RECEIVED

NEED ASSESSMENT

- A **needs assessment** is a systematic process for determining and addressing **needs**, or "gaps" between current conditions and desired conditions or "wants". The discrepancy between the current condition and wanted condition must be measured to appropriately identify the **need**
- Document retention procedure will be easy and service to the patient as soon as possible

THE WEST BENGAL CLINICAL ESTABLISHMENT (REGISTRATION, REGULATION AND TRANSPARENCY) ACT, 2017

Chapter II.—Registration and Standards.—Section 7.

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MARKET
RESEARCH

Sr.No	OUTSOURCED Vendors	PRICE	NOTES
1.	CBSL Group	• Scanning – 300 dpi/Grey Scale/Simplex – INR – 0.42 /per image	• All rates are exclusive of GST charges • All Charges are applicable only for the ONE YEAR after which an escalation of 10% will be applicable • 5% payment must be in advanced • 150GB space is provided FREE to customer. After Every 1TB is charged at INR 3000 per month
2.	Crown Records Management	• Scanning services - 0.40/image • Indexing Charges – 0.10/per file • For offsite scanning, transportation to and fro charges for setup - 2000	Currently working with • Fortis Hospital • Medica Hospital • Neotia Hospital • AMRI Hospital • Apollo Hospital • Genesis Hospital
3.	SoftAge Information Technology Limited	• Document Scanning for A4 and A5 size page – 0.55/per image • Document Scanning for A3 size page – 0.60/per image	

Sr. No	Vendors	PRICE	Scanning Rates	Storage Rates
1.	CBSL Group	• Scanning – 300 dpi/Grey Scale/Simplex – INR – 0.42 /per image	• Back File – 134090 • Avg. page per file – 60 • Scan Estimate – 4559060*0.38= 1,732,442.8/-	• Back File – 134090
2.	**Crown Records Management**	• Scanning services - 0.40/image • Indexing Charges – 0.10/per file • For offsite scanning, transportation to and fro charges for setup - 2000	• Scan Estimate – 4559060*0.40 = 1,823,624/-	• 60 files/carton (134090/60)= 2235carton*13.50=30173 • 30173*12=3,62,070 • For initial intake 60/-per carton =2235*60=1,34,100 • TOTAL EXPENDITURE = 4,96,170/-
3.	SoftAge Information Technology Limited	• Document Scanning for A4 and A5 size page – 0.55/per image • Document Scanning for A3 size page – 0.60/per image	• Scan Estimate – 4559060*0.50 = 22,79,530/-	• 34/Per File/carton (134090/34)=3994 • 3994carton *17=67,898/- • TOTAL EXPENDITURE =67,898*12 = 8,14,776/-

REFERENCES

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- https://www.lexplosion.in/government-of-west-bengal-issues-the-west-bengal-clinical-establishments-registration-regulation-and-transparency-bill-2017/

THANK YOU