A study on assessment of patient related documentation in tertiary care hospital

Submitted By

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INTRODUCTION

- Documentation is a communication tool that helps in the exchange of information between caregivers. It is one of the key areas to determine the standard of care rendered by hospital services which enhances professional autonomy as well as critical thinking skills and development of professional knowledge and nursing education.
- Execution of documentation should be done in a way that ensures continuity of care, planning and liability as well as in the furtherance and advancement of practices based on evidence. Good record care also ensures that the hospital's administration is working efficiently, give evidence of the hospital's accountability for its procedures and they form a key source of data for medical research, statistical reports and health information systems.
- Incomplete patient report persistently causes doubts and inculpate in the legal jurisdiction since only the fully complete documented medical cases are accepted by the legitimate medical group for verifying and validating medico-legal cases (as Statistically reported from developed countries showed that 74% of the cases are errors of healthcare providers which were reported to judicial authorities).
- the "Golden Rule" in documentation i.e. "If it isn't written down, you didn't do it"

METHODOLOGY

Research questions:

- What is the compliance rate of the documentation in the facility under consideration in accordance to NABH standards?
- What are the key causes of non –compliances in documentation at the facility under consideration?
- Are the forms and formats in use obey the corporate/ hospitals policies?

Research objectives:

- To assess the compliance of documentation as per NABH standards.
- To list the major casual factors for non-compliance in documentation as per the NABH standards.
- To assess and identify any gaps in the forms and formats currently in use at the facility.

Research design: Descriptive Cross-sectional study.

Study setting:

1) The study was conducted at Shri Mata Vaishno Devi Narayana super speciality Hospital, Katra, Jammu and Kashmir with help of the Medical administration and quality department. The study was conducted through 1April 2021-31 May 2021.

2) Files for the active and passive patients and consent forms were observed and the non-compliances was noted.

3) All the forms and formats from all departments (clinical and non-clinical) across the facility were observed for non-compliance and updating.

Study population:

Inclusion criteria- Files from both Active and passive patients are taken; only admitted patients are taken.

Exclusion criteria-

- MLC and DAMA files are not considered
- Files of COVID patients are not considered.
- Files of gynaecology patients are not considered.

Research procedure/approaches: Mixed (Quantitative and qualitative assessment)

- **Study approach**:
- **Study duration**: 3 Months
- **Sampling technique**: Convenience sampling
- **Sample size**: 200 files of patient
- **Study instrument**: Data collecting format for Active and Passive files, consent forms and format of all the forms and registers used in organisation.
- **Statistical method**: Microsoft excel

RESULT

- To check the documentation in consent forms:
- Different consent forms in files of the patients were observed (n=200)in different departments of hospital. The departments from where the consent forms are obtained are general ward, ICU, ITU, PICU etc., various parameters were identified.

NAME OF CONSENTS	FREQUENCY
General Consent	100
Operational/Procedure Consent	70
Anesthesia Consent	29
Serology Consent	46
Diagnostic Consent	56
High Risk Consent	19
Transfusion Consent	16

PARAMETERS

SNTD of Patient

SNTD of Attendant

SNDT of Witness

Name of Procedure

SNTD of person performing

Risk and Benefits Mentioned

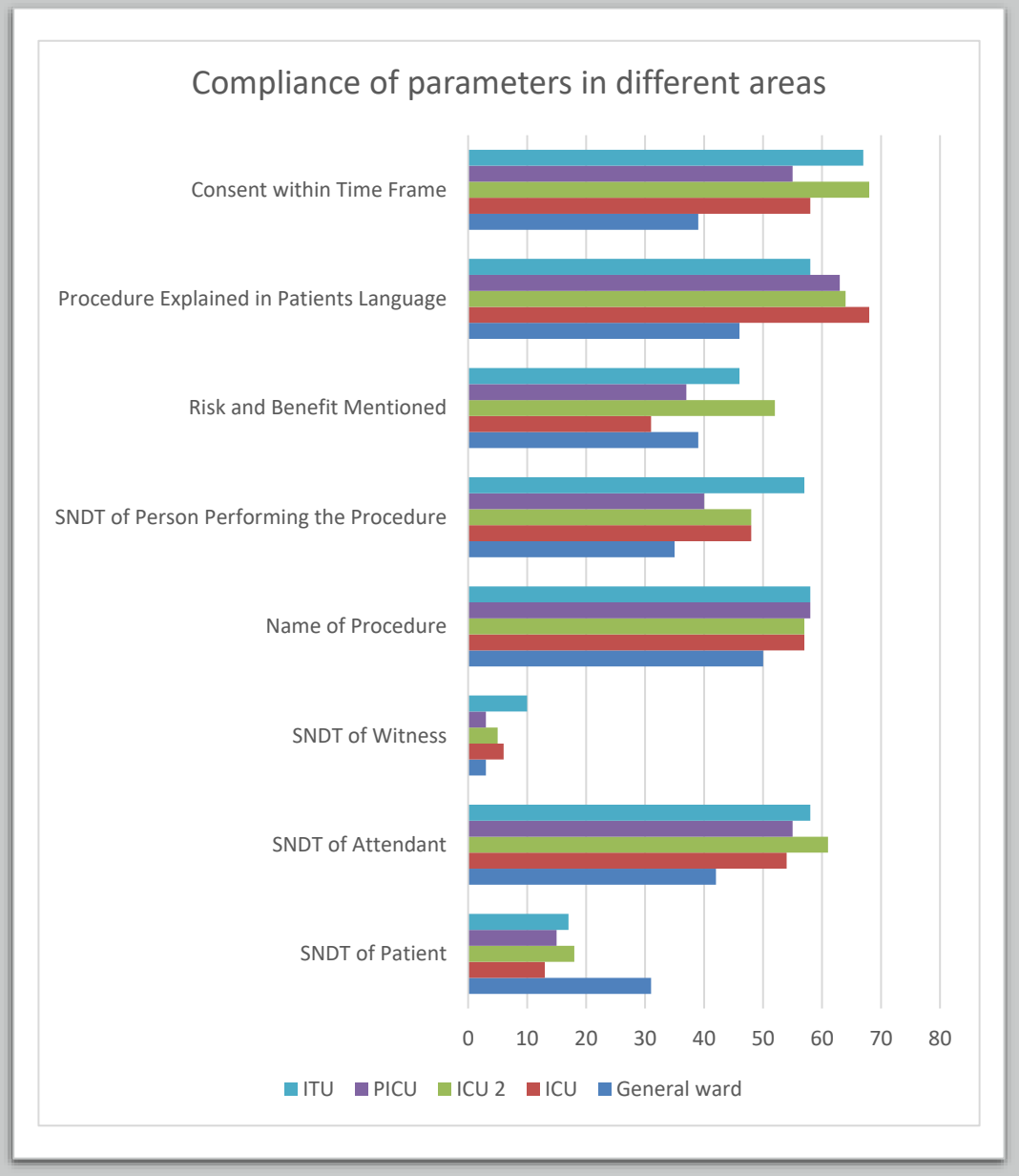
Explained in Patients Own Language

Consent within Time Frame

Area wise distribution of consent forms

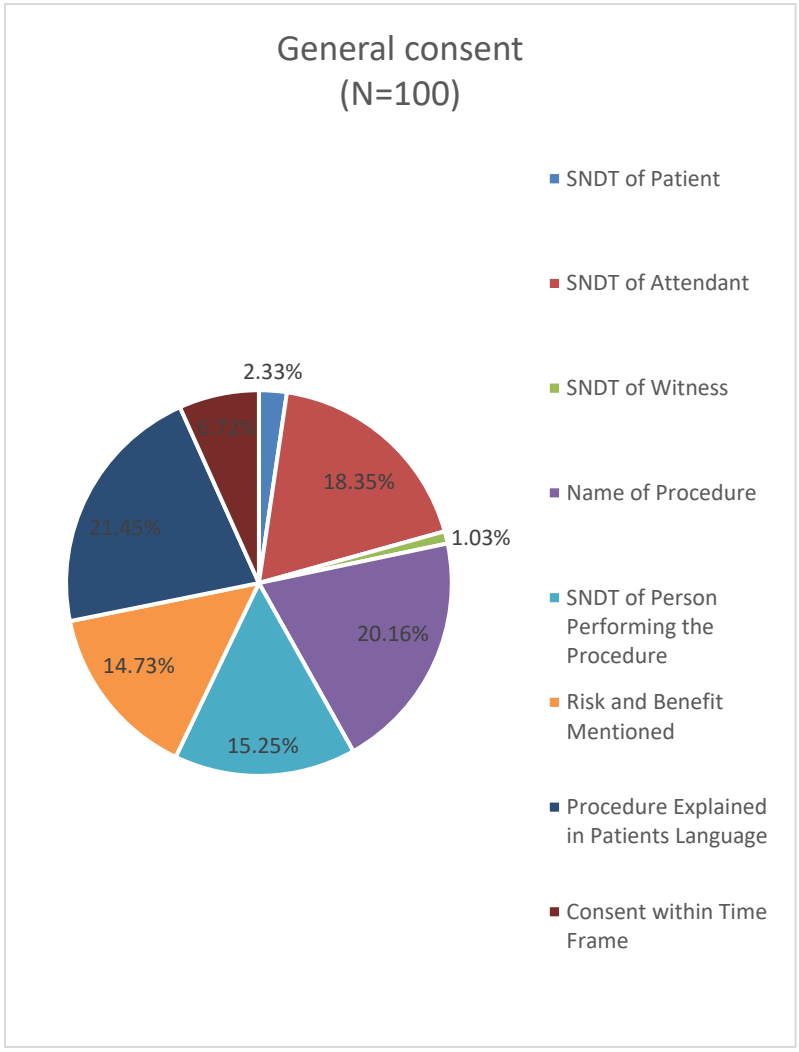
AREA	SNDT of Patient	SNDT of Attendant	SNDT of Witness	Name of Procedure	SNDT of Person Performing the Procedure	Risk and Benefit Mentioned	Procedure Explained in Patients Language	Consent within Time Frame	Total
General ward	31	42	3	50	35	39	46	39	63
ICU	13	54	6	57	48	31	68	58	74
ICU 2	18	61	5	57	48	52	64	68	72
PICU	15	55	3	58	40	37	63	55	70
ITU	17	58	10	58	57	46	58	67	68

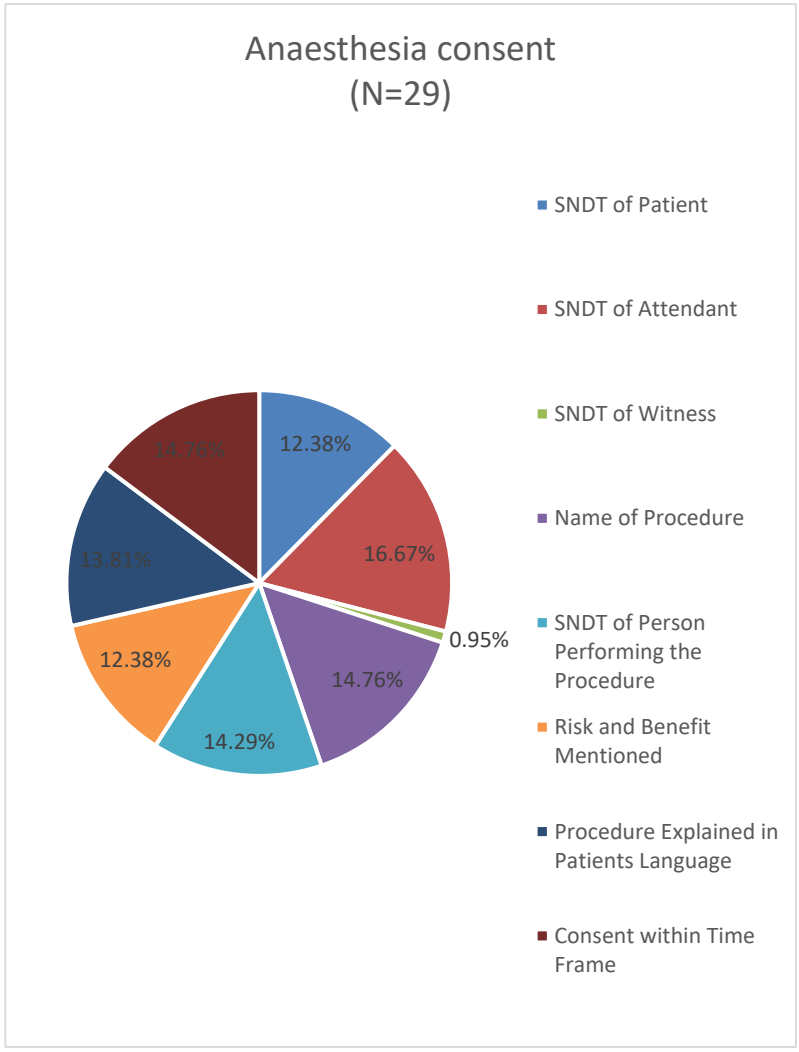
From above observation that general ward is the area where consent with the time frame, procedure explained in patient language, SNDT of the person performing the procedure, SNDT of witness, SNDT of attendant, Name of the procedure was least in documentation and ICU is the area where consent of risk and benefits and SNDT of patients was least in documentation as compared to other areas.

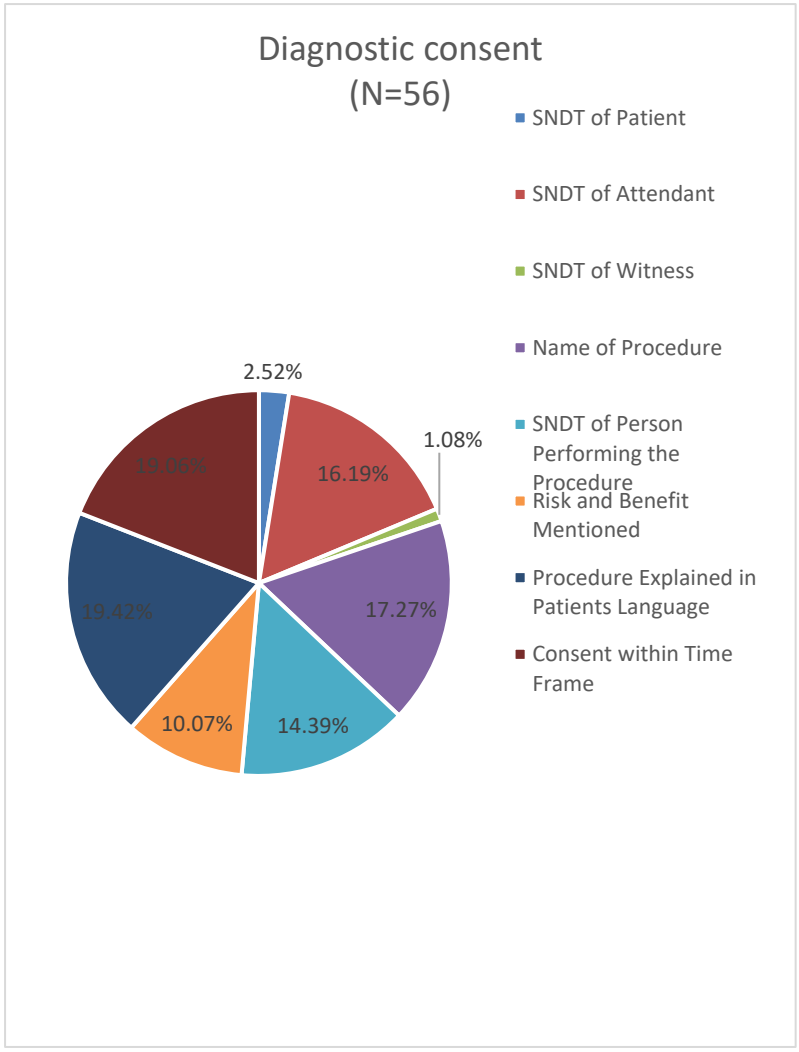


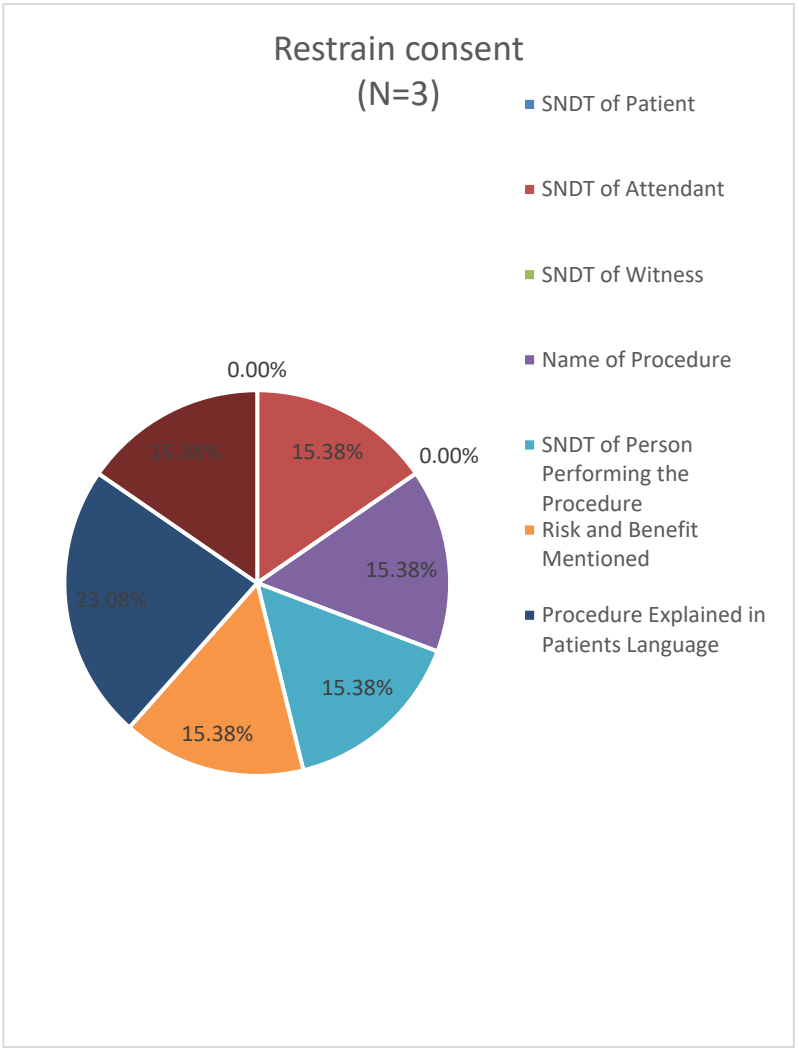
Parameters in different consent forms

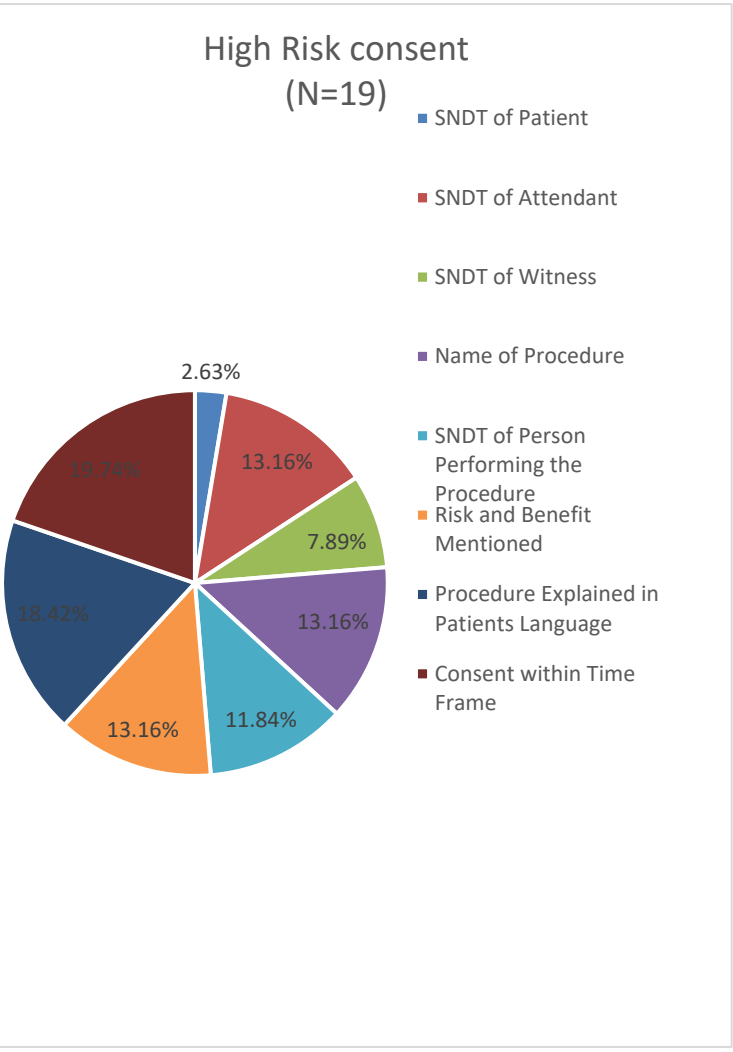
Consent Name	SNDT of Patient	SNDT of Attendant	SNDT of Witness	Name of Procedure	SNDT of Person Performing the Procedure	Risk and Benefit Mentioned	Procedure Explained in Patients Language	Consent within Time Frame	TOTAL
General consent	9	71	4	78	59	57	83	26	100
Anesthesia consent	26	35	2	31	30	26	29	31	37
Diagnostic consent	7	45	3	48	40	28	54	53	56
High Risk consent	2	10	6	10	9	10	14	15	19
Operation/Procedure consent	40	59	10	57	50	34	58	57	70
Restrain consent	0	2	0	2	2	2	3	2	3
Serology consent	6	37	2	41	29	37	45	42	46
Transfusion consent	5	13	1	15	12	11	14	15	16

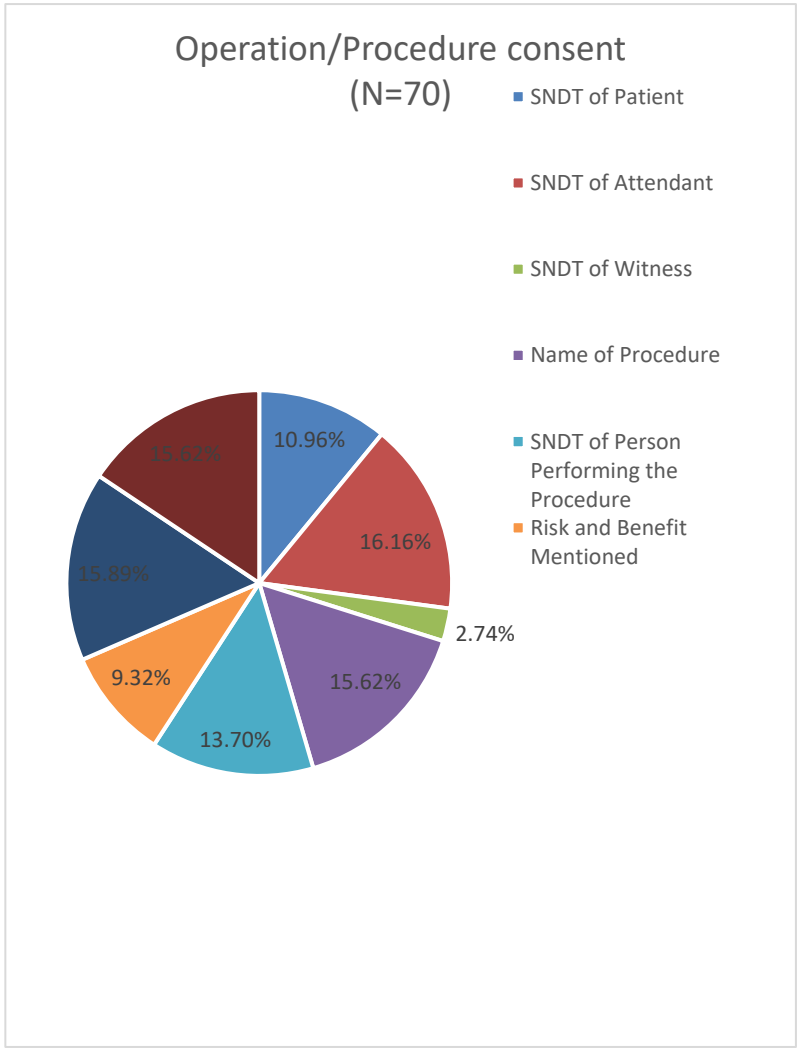

General consent
(N=100)
2.33%
18.35%
1.03%
20.16%
15.25%
14.73%
21.45%
6.72%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned
Procedure Explained in Patients Language
Consent within Time Frame


Anaesthesia consent
(N=29)
12.38%
16.67%
0.95%
14.76%
14.29%
12.38%
13.81%
14.76%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned
Procedure Explained in Patients Language
Consent within Time Frame

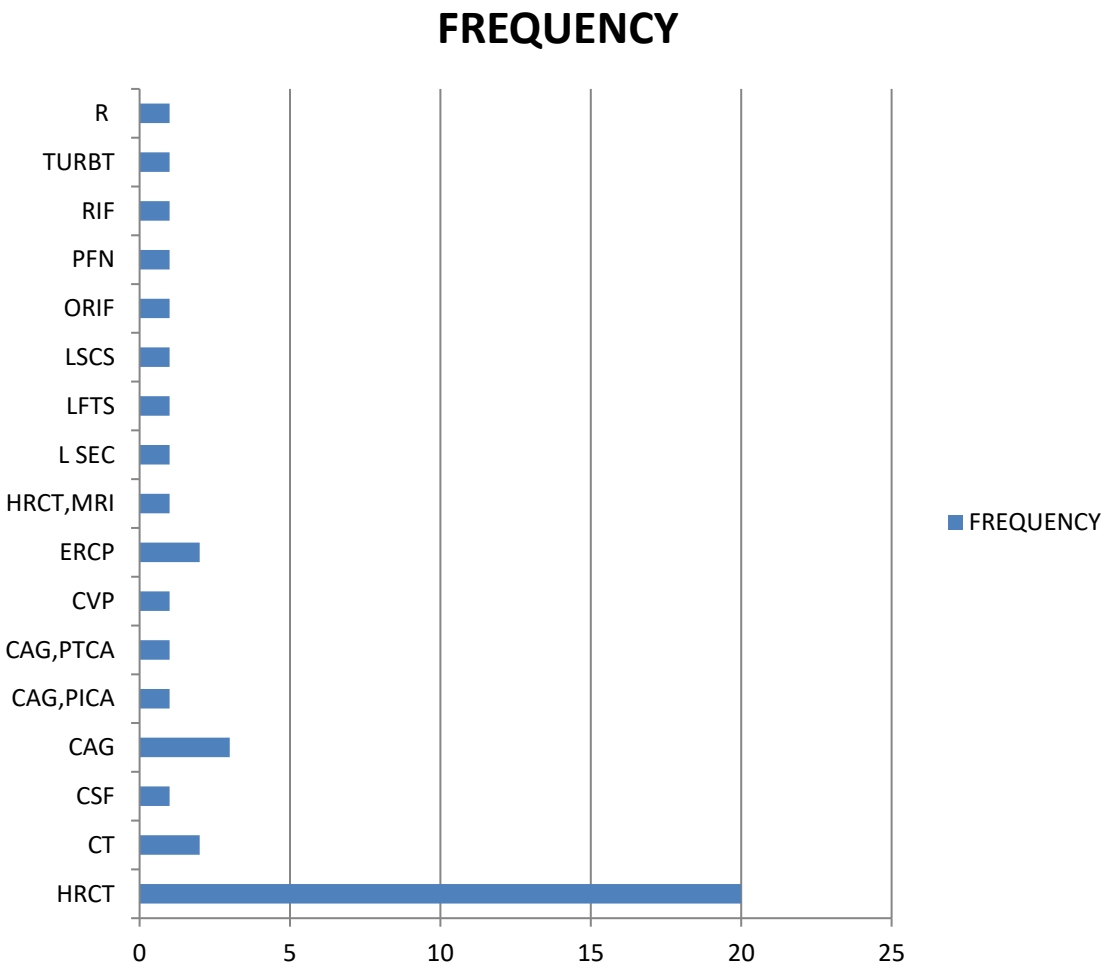

Diagnostic consent
(N=56)
2.52%
16.19%
1.08%
19.06%
17.27%
19.42%
10.07%
14.39%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned
Procedure Explained in Patients Language
Consent within Time Frame


Restrain consent
(N=3)
0.00%
15.38%
0.00%
15.38%
15.38%
23.08%
15.38%
15.38%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned
Procedure Explained in Patients Language

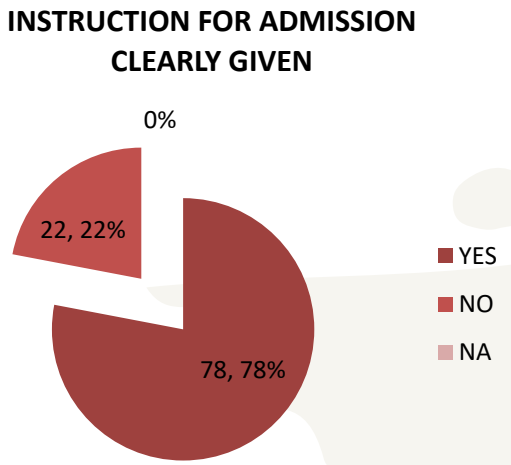

High Risk consent
(N=19)
2.63%
13.16%
7.89%
13.16%
11.84%
13.16%
18.42%
19.74%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned
Procedure Explained in Patients Language
Consent within Time Frame

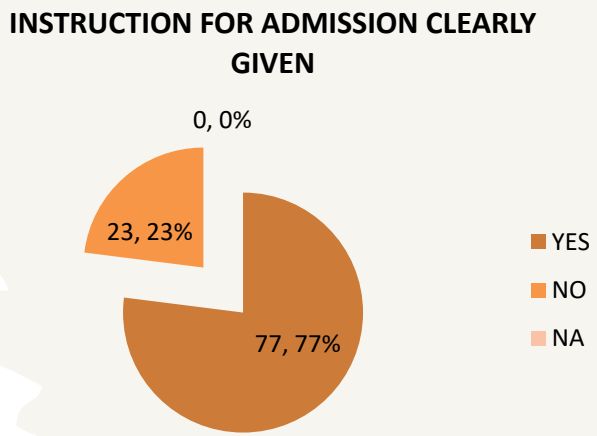

Operation/Procedure consent
(N=70)
10.96%
16.16%
2.74%
15.62%
13.70%
9.32%
15.89%
15.62%
SNDT of Patient
SNDT of Attendant
SNDT of Witness
Name of Procedure
SNDT of Person Performing the Procedure
Risk and Benefit Mentioned

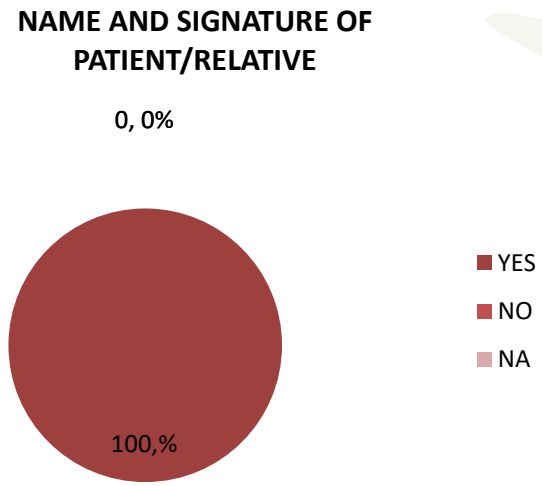
Most used abbreviation in the consent forms was HRCT.

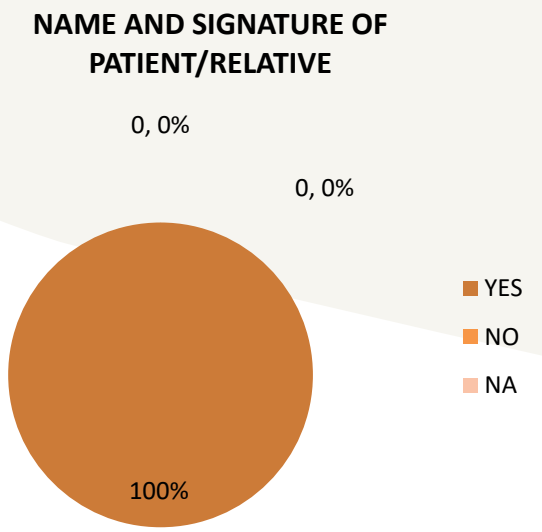


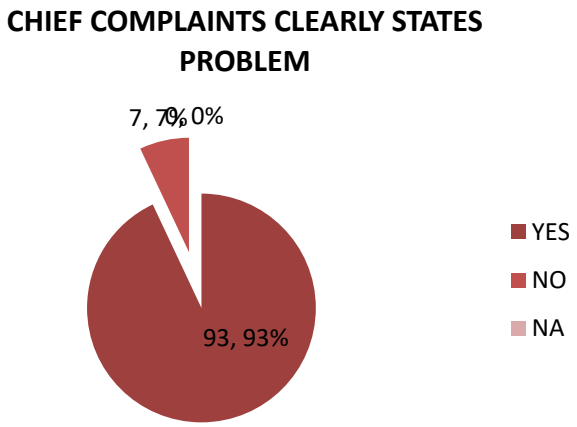
To check the compliance rate in patient's files

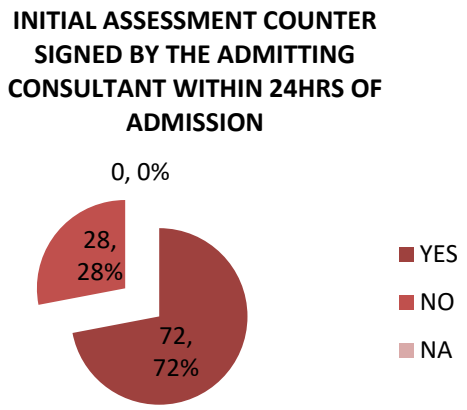


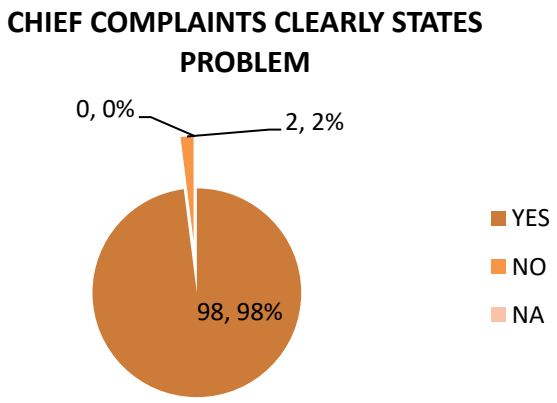


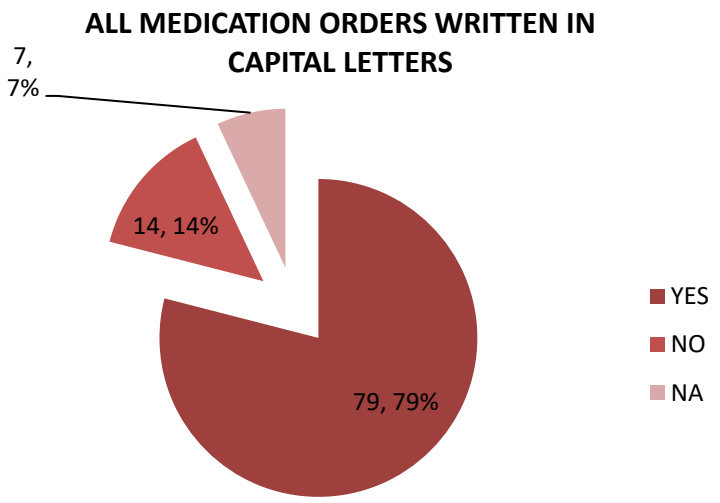


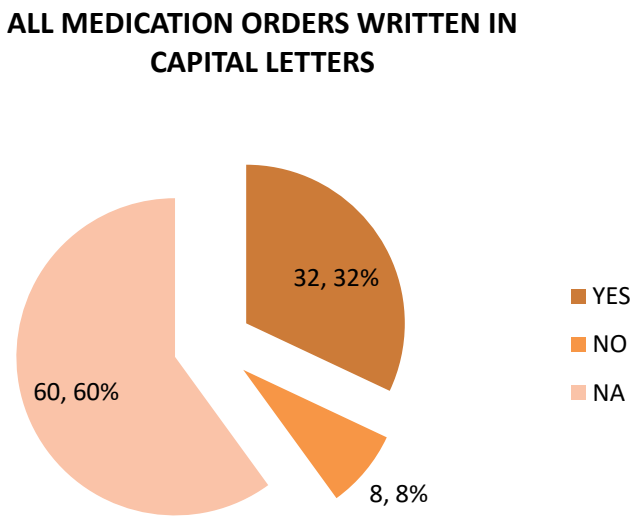



CHIEF COMPLAINTS CLEARLY STATES PROBLEM
7, 7%
0, 0%
93, 93%
YES
NO
NA


INITIAL ASSESSMENT COUNTER SIGNED BY THE ADMITTING CONSULTANT WITHIN 24HRS OF ADMISSION
0, 0%
28, 28%
72, 72%
YES
NO
NA


CHIEF COMPLAINTS CLEARLY STATES PROBLEM
0, 0%
2, 2%
98, 98%
YES
NO
NA


ALL MEDICATION ORDERS WRITTEN IN CAPITAL LETTERS
7, 7%
14, 14%
79, 79%
YES
NO
NA


ALL MEDICATION ORDERS WRITTEN IN CAPITAL LETTERS
32, 32%
60, 60%
8, 8%
YES
NO
NA

DISCUSSION

Health records serve for different purposes. Their primary purpose is to document the care and services provided to patient's health records must be maintained for evidential purposes too. Health records must be maintained in a manner that complies with applicable regulations, accreditation standards, professional practice as well as legal standards. The present study confirmed a clear weakness in documenting the ongoing medications on the medical card ,instruction on the admission form is also not clearly mentioned and there is no proper documentation of consent forms SNDT of patient, SNDT of witness and the procedure explained in patients own language is the consent which was least filled by the doctors and nursing staff, it was also observed that in most of the consents forms abbreviations were commonly used which are not allowed according to the standards of NABH and it was observed that the most used abbreviation which was seen in the three hundred forty seven consent was HRCT.

CONCLUSION

An apparently documented medical record will reduce many of the inconvenience associated with claims processing and may serve as a legal document which can validate and is the legal document which proves the care provided by the hospital.

The result of this study shows that there was no full documentation present in the consent forms in the files of the patient's full compliance is achieved in some of the parameters and noncompliance was present in most of the areas.

This study also implies that hospital should pay attention to compulsory documentation of the patient health record data in the respective forms which will further improve the completeness and accuracy in the health record documentation and will also help to achieve NABH standards

The present study confirmed obvious incompleteness of documenting medical data for the inpatient records. This is specifically found in different consent forms where SNDT of witness, SNDT of patient as well as the procedure explained in patient language consent was not properly documented and in patient's files awareness about the complete documentation on medical records was present only in certain areas whereas other areas had not been given much importance while documenting or been neglected.

RECOMMENDATIONS

Based on the findings following suggestions were made from the study.

The best practice is to insert separators which will not only provide a clearly defined location for every form.

A hospital-based quality improvement project to increase the medical record documentation completion is recommended to be implemented by the group of trained personnel and periodic random assessments by the quality unit of NH.

The well-designed forms should be in use that will save the time of staff and make easier for every assessor who go through that file to locate the king of information they are seeking for procedure.

Health care providers should be trained by keeping check on them regarding documentation of patient's file.

REFERENCES

- Singh P, John S. Analysis of Health Record Documentation Process as Per the National Standards of Accreditation with Special Emphasis on Tertiary Care Hospital. Int J Health Sci Res. 2017;7(6):286-92.
- Khan MA, Nilima N, Prathibha J, Tiwary B, Singh M. Documentation compliance of in-patient files: A cross sectional study from an east India state. Clinical Epidemiology and Global Health. 2020 Dec 1;8(4):994-7.
- Ramasamy R, Rajendiran G, Kagne RN. PRACTICE OF DOCUMENTATION AT CASUALTY OF TERTIARY CARE HOSPITAL–AN INTERVENTIONAL STUDY. Medico Legal Update. 2021 Jan 9;21(1):816-21.
- Nygren E, Henriksson P. Reading the medical record. I. Analysis of physician's ways of reading the medical record. Computer methods and programs in biomedicine. 1992 Sep 1;39(1-2):1-2.
- Hut-Mossel L, Welker G, Ahaus K, Gans R. Understanding how and why audits work: protocol for a realist review of audit programmes to improve hospital care. BMJ open. 2017 Jun 1;7(6):e015121.
- Al Hilfi RA, Mahmoud RA, Al-Hamadi N, Majeed A, Saihoud SA. Assessment of the documentation completeness level of the medical records in Basrah General Hospital. The Medical Journal of Basrah University. 2018 Dec 1;36(2):50-9.
- Saravi BM, Asgari Z, Siamian H, Farahabadi EB, Gorji AH, Motamed N, Fallahkharyeki M, Mohammadi R. Documentation of medical records in hospitals of Mazandaran university of medical sciences in 2014: a quantitative study. Acta Informatica Medica. 2016 Jun;24(3):202.
- Vahedi HS, Mirfakhrai M, Vahidi E, Saeedi M. Impact of an educational intervention on medical records documentation. World journal of emergency medicine. 2018;9(2):136.

THANK YOU