A Descriptive Study On Assessing Documentation Compliance Of Medical Records Department As Per NABH Guidelines

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MONILEK HOSPITAL AND RESEARCH CENTER,JAIPUR

- The hospital was started in 1986 for devoted specialties of Urology, Nephrology and internal medicine.
- First Renal Transplant in the state of Rajasthan.
- It is 100 Bedded Multi Specialty hospital.
- The hospital has NABL accredited Laboratory.
- Mr. Lekhraj Odhrani-Trustee, Dr. S L Tolani-CEO, Dr. Praveer Chandra-Medical Director, Mrs. Kavita Kaushik- Director Operations, Mr. B A Manwani-ADM (Top Management of the Hospital)

A DESCRIPTIVE STUDY ON ASSESSING DOCUMENTATION COMPLIANCE OF MEDICAL RECORDS DEPARTMENT AS PER NABH GUIDELINES

- **As a general rule "the most successful man is, the man who has the best information".**
- Medical Record include sufficient data written in sequence of occurrence of events to justify the diagnosis, treatment and outcome. It is an accurate, prompt recording of the team's medical observations about the patient and results of treatment.
- It is an important means of communication between the health providers, a legal document and a tool for medical research and training

- The medical record has four major sections :
- administrative, which includes demographic and socio economic data like name of the patient, age ,sex, date of birth, patient's permanent address, and registration no. (MHRC No.)
- legal data, including a signed consent for treatment by appointed doctors and authorization for the release of information
- clinical data, of the patient who is admitted to the hospital
- financial data, relating to the payment of fees for medical services and hospital accommodation

The main purpose of the medical record is to record the facts about a patient's health with emphasis on events affecting the patient during the current admission and for the continuing care of the patient when they require health care in the future.

- The main objective of MRD in the hospital is to make the medical record available as and when required by the patient, doctors, hospital administrators, Medico legal purposes as-
- **For patient**- The Medical Record serves to document the clinical history and activities of patient treatment, avoid omission or repetition of diagnostic and therapeutic measures, assists in continuity of Care even in future illness and also serves as evidence in medico-legal cases.
- **For The Doctor-** It assures quality and adequacy of diagnostic and therapeutic measures undertaken and serves as an assurance of continuity of medical care.
- **For Hospital Administrator-** It evaluate proficiency of medical staff for administrative and clinical purposes and it also evaluate the services of the hospital in terms of accepted norms and standards.

DOCUMENTATION COMPLIANCE OF MEDICAL RECORDS

- All the entries in the medical record must be properly dated, timed and signed.
- The entries should be done immediately or soon after the care is given.
- The entries should be accurate, and objective
- No abbreviations should be used or only approved abbreviations can be used
- The Information Management System chapter of NABH has some standards and objective elements which are essential to be followed in the Medical Records Department to ensure proper storage, management , retention, retrieval of medical records.
- Entries in the medical records should be done by only authorized people like doctors, nursing staff.

OBJECTIVES OF THE STUDY

- To study the existing system of documentation of medical record department.
- To identify the bottlenecks in the existing system of medical records.
- To provide recommendations to overcome the bottlenecks and implement the changes required in the medical records department.

The whole purpose of the study was to find out whether the Medical Records Department of the hospital is following the standards and policies of 10th chapter of NABH ,i.e., Information Management System.

RESEARCH METHODOLOGY

- Study Design- Descriptive Study
- Location of the study- Monilek Hospital and Research Center, Jaipur.
- Duration of the study- February 2018 to April 2018 (3 months)
- Study Subject- Doctors, Nursing Staff, Medical Record Department Staff
- Data Collection Tool- The data was collected through the Primary and Secondary sources-
- Primary Data Source
- Medical Record Audit Checklist, Self-Assessment Toolkit of NABH, Direct Observations
- Secondary Data Source
- Medical Records Issue Register, Medical Record Retrieval Register

DATA COLLECTION
MEDICAL RECORD AUDIT CHECKLIST

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

- **IPD No.**
- **PATIENT NAME**
- **CONSULTANT/ SPECIALITY**
- **WARD**
- **ADMISSION CONSENT**
- **PATIENT AND FAMILY EDUCATION**
- **FINANCIAL COUNSELLING FORM**
- **INITIAL ASSESSMENT SHEET FOR EMERGENCY CASES**
- **INITIAL ASSESSMENT FORM (DOCTORS)**
- **INITIAL ASSESSMENT COUNTERSIGNED BY CONSULTANT**
- **DOCTORS' PROGRESS SHEET**
- **NURSING ASSESSMENT ON ADMISSION**
- **TIMELINESS (WITHIN 30 MINS)**

- NURSING DAILY ASSESSMENT
- NURSING NOTES
- VITAL MONITORING CHART
- NUTRITIONAL SCREENING
- NUTRITION ASSESSMENT
- PHYSIOTHERAPY ASSESSMENT (IF APPLICABLE)
- PHYSIO DAILY CARE PLAN
- BLOOD TRANSFUSION MONITORING SHEET
- RESTRAINT MONITORING
- CONSENT FORM COMPLETELY FILLED
- ANAESTHESIA RECORD
- OT NOTES
- WHO SURGICAL SAFETY CHECKLIST
- MEDICINE CARD
- DISCHARGE SUMMARY

NABH SELF ASSESSMENT TOOLKIT ON INFORMATION MANAGEMENT SYSTEM

IMS chapter of NABH has 7 standards which are scored in 0,5, 10 where 0 is Non-Compliance, 5 is Partial Compliance and 10 is Full Compliance –

- **Policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.**
- **The organization has a complete and accurate medical record for every patient.**
- **The medical record reflects continuity of care.**
- **The organization has a processes in place for effective management of data**
- **Documented procedures exist for retention time of records, data and information.**
- **Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.**
- **The organization regularly carries out medical audits.**

PATH FLOW OF THE WHOLE STUDY

- The whole study to access the documentation compliance and working of the MRD of the hospital is done in two phases-
- BEFORE THE IMPLEMENTATION OF NEW PROCESS FLOW OF RECORDS AND CHANGES DONE IN MEDICAL RECORDS DEPARTMENT
- AFTER THE IMPLEMENTATION OF NEW PROCESS FLOW OF RECORDS AND CHANGES DONE IN MEDICAL RECORDS DEPARTMENT
- The study was started with understanding of the existing process flow and system of documentation in MRD and then gap analysis was done on the basis of 10th chapter of NABH i.e., Information Management System.
- This chapter has 7 standards which were scored on 0,5, 10. The scoring was done in both before and after implementation of new process flow to make comparison.

CONTINUE…

- Along with the Medical Record Audit Checklist and Self Assessment Toolkit, some parameters were selected and analyzed to find the results before and after formulating new process flow and changes done in MRD to find out whether the medical records department is working properly.
- The parameters which are selected to check the existing process in the MRD are-

❖ TAT for files received in MRD after discharge of the patient

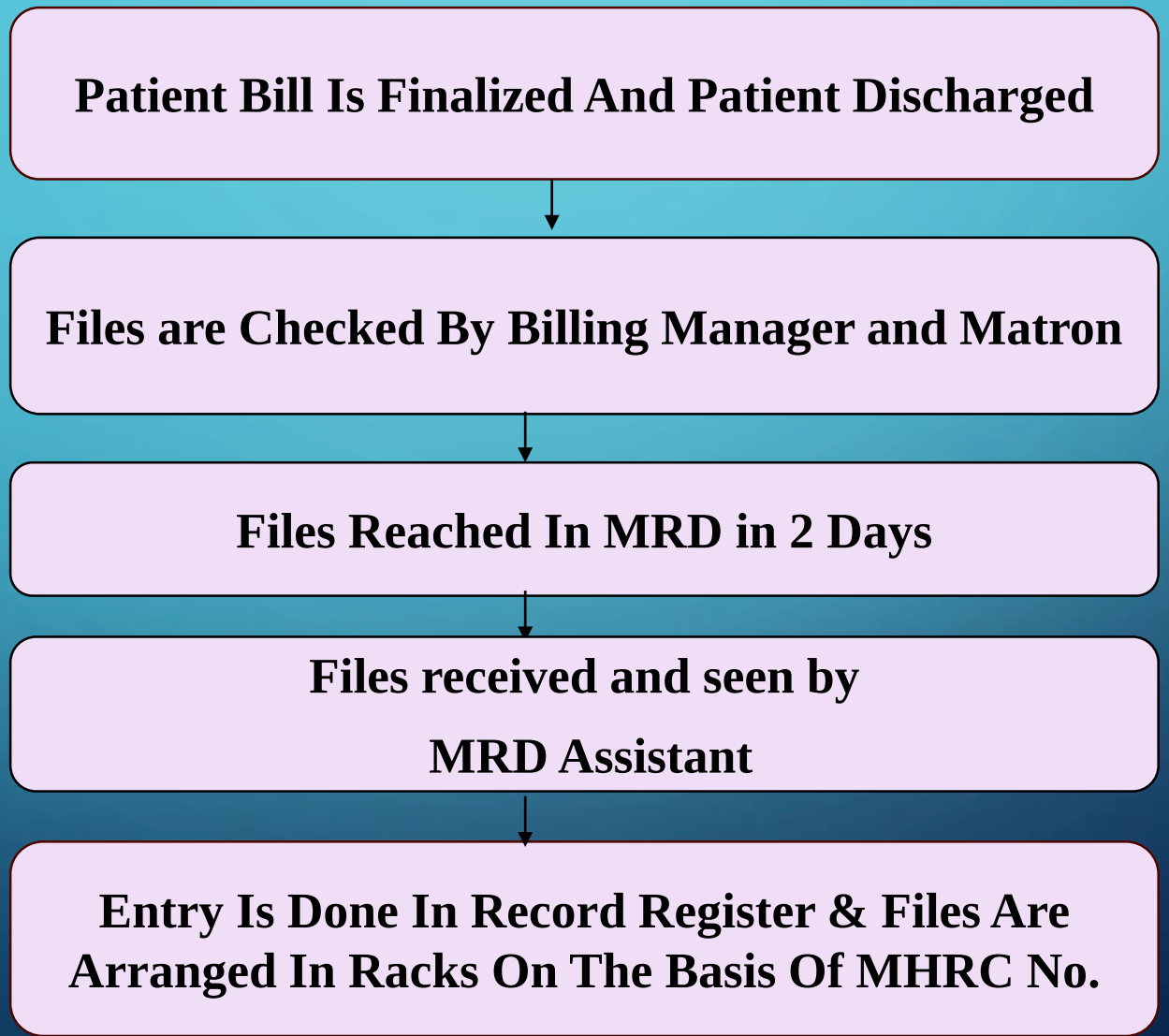
❖ Time taken for Retrieval of records as and when required

❖ Document Compliance in terms of completeness by Nursing staff

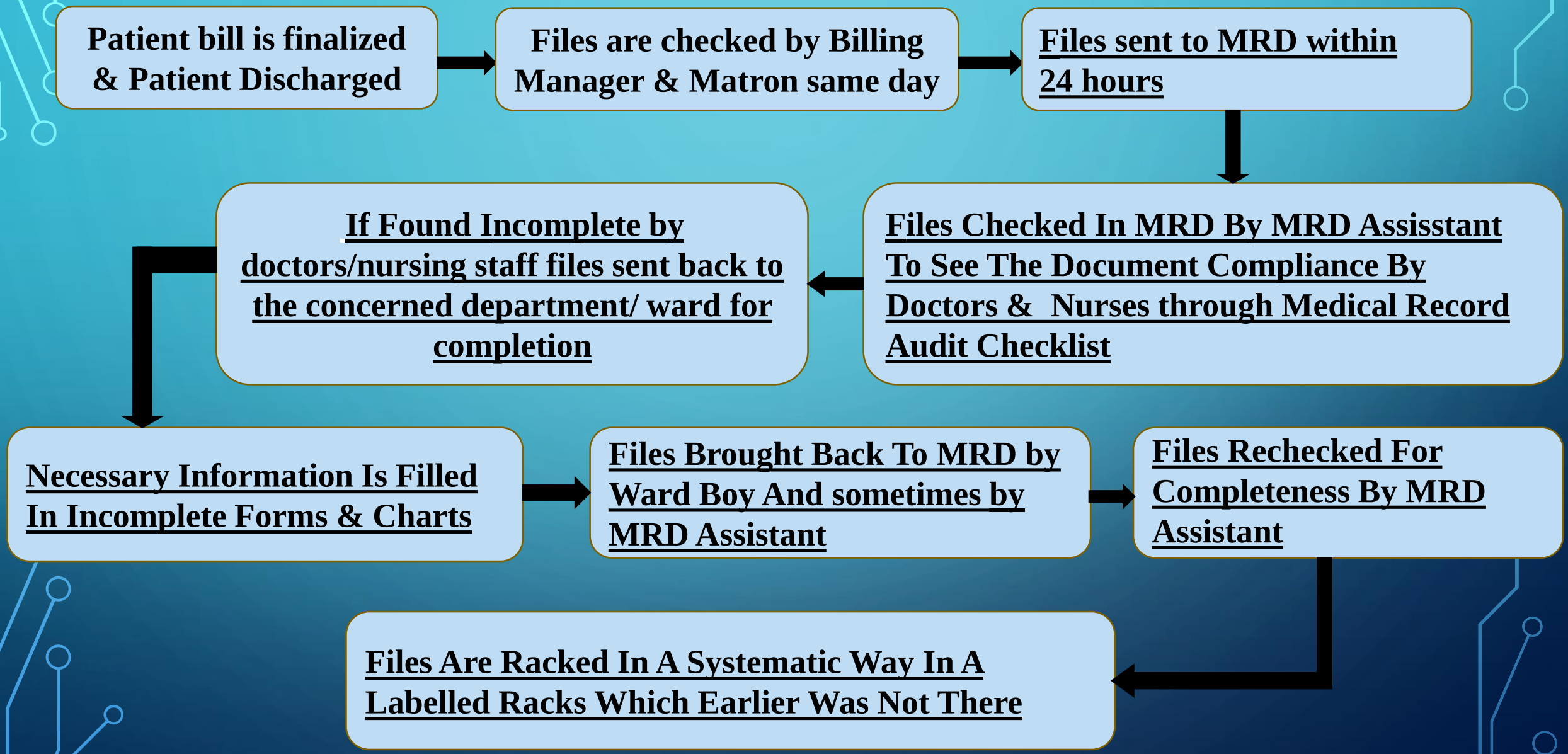
❖ Document Compliance in terms of completeness by Doctors

❖ ICD (International Classification of diseases) Coding

EXISTING PROCESS FLOW OF RECORDS IN MRD BEFORE IMPLEMENTATION OF NEW PROCESS



NEW PROCESS FLOW IMPLEMENTED IN MRD



DATA ANALYSIS AND INTERPRETATION (BEFORE)

- **NABH SELF ASSESSMENT TOOL KIT ON INFORMATION MANAGEMENT SYSTEM CHAPTER**
- 7 Standards
- 45 Objective Elements
- Scoring was done for every objective element in 0- Non Compliance, 5-Partial Compliance and 10- Full Compliance

Results and Findings (Out of 45 Objective Elements)

- **No. of Non- Compliance(0)- 30** **% of Non-Compliance- 67%**
- **No. of Partial Compliance(5)- 15** **% of Partial Compliance- 32%**

DATA ANALYSIS AND FINDINGS FOR THOSE 5 SELECTED PARAMETERS (BEFORE)

A sample size of 100 was taken for analyzing the parameters.

- **PARAMETER-1: TAT FOR FILES RECEIVED IN MRD AFTER DISCHARGE (BEFORE)**

This parameter shows that when the in-patient files reached MRD after the bill is finalized and patient get discharged.

Time taken to reach MRD	Within 24 hours	Within 48 hours	More than or After 48 hours
No. of Files	27	42	31

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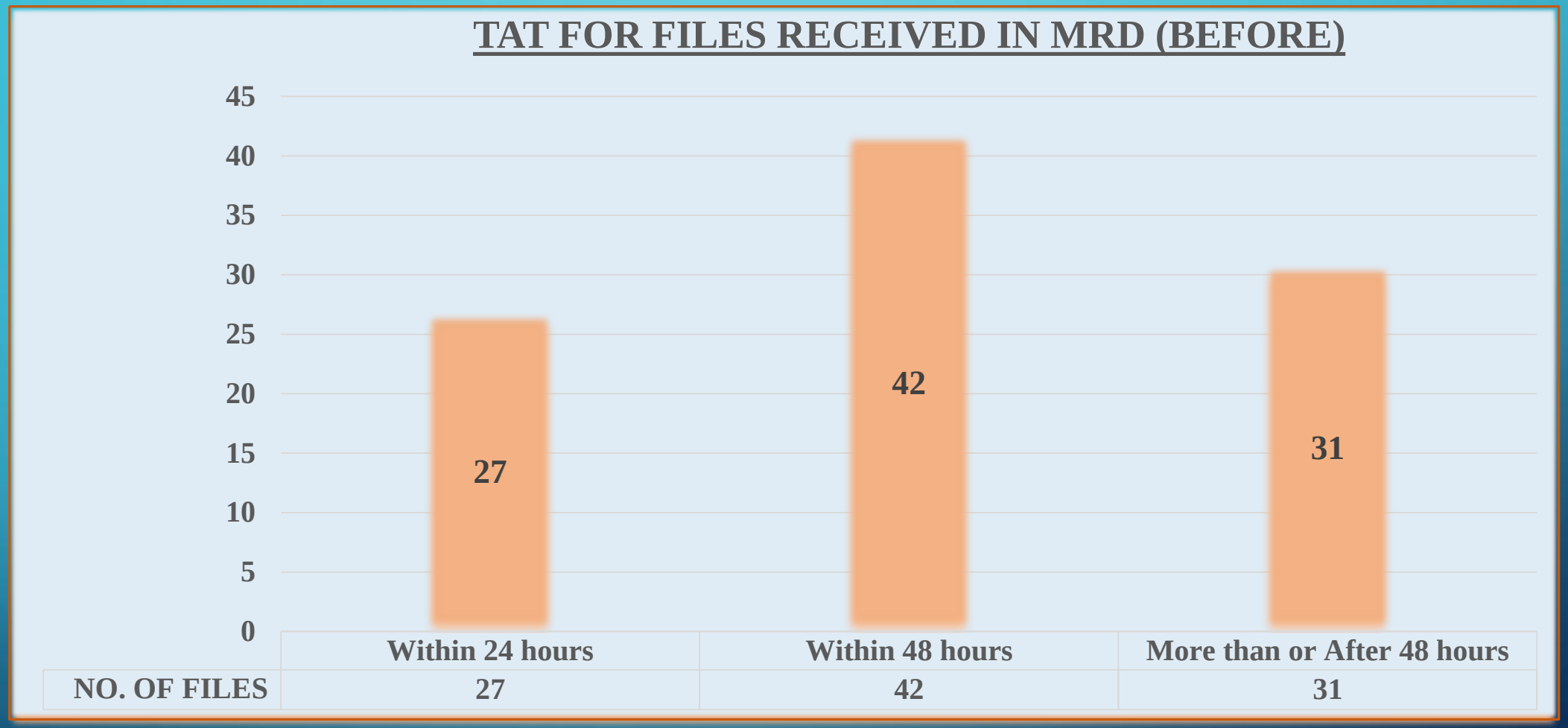

Interpretation- This graph depicts that out of 100 medical records or files that I have analyzed for my study, 27 files reach to MRD within 24 hours of discharge, 42 files reach to MRD within 48 hours and 31 files reach to MRD in more than 48 hours of the discharge of the patients.

➢ PARAMETER-2 TIME TAKEN FOR RETRIEVAL OF PATIENT FILES (BEFORE)

Whenever someone wants some particular file, the time taken was recorded in each case i.e., from the time a request of file comes till the time it is being handed over to the person after completing the entry work.

- It was very difficult to retrieve the files because there was no labelling on the racks as well as the Medical Record Tracer Card was also not used in the MRD.
- The ideal time taken to retrieve a medical record as set by the quality department of the hospital is 20 min.

- **The average time recorded for the retrieval of file was found to be 32 MIN.**

➢ PARAMETER-3 DOCUMENT COMPLIANCE IN TERMS OF COMPLETENESS BY NURSING STAFF (BEFORE)

- The Nursing staff is an important staff when it comes to patient care.
- The nursing staff are responsible to complete-
- Nursing Assessment on Admission,
- Vital Sign Monitoring form,
- Investigation form
- Nursing Notes
- Nursing Daily Assessment

In order to see the compliance status of the documents in the files random selection of the files was done. For this purpose Medical Record Audit Checklist was used.

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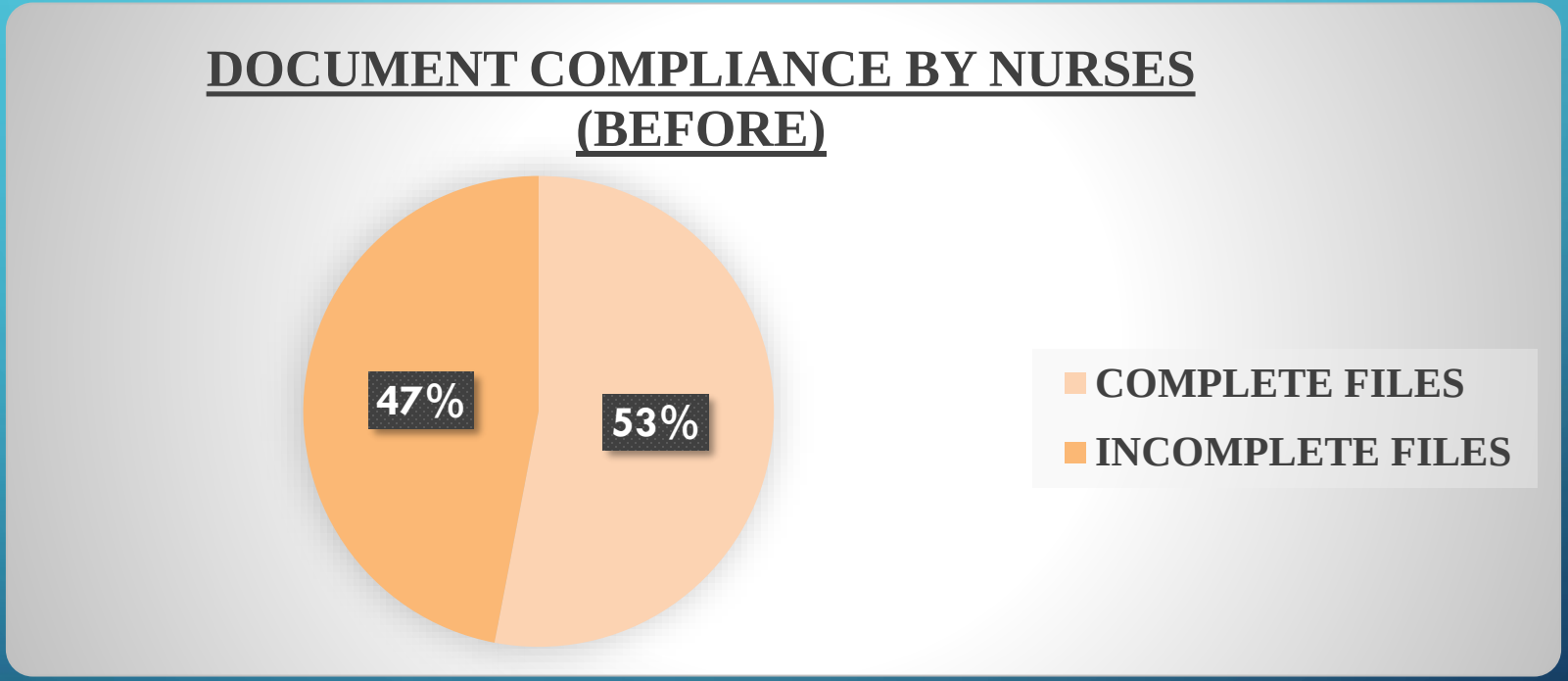
	COMPLETE FILES BY NURSES	INCOMPLETE FILES BY NURSES
NO. OF FILES	53	47



Interpretation- This pie-chart shows that out of 100 files, 53 files are complete and 47 files are incomplete. This also depicts that they are aware of the importance of the information needs of the patients but then too they don't make proper entries in the forms

➢ PARAMETER-4 DOCUMENT COMPLIANCE IN TERMS OF COMPLETENESS OF MEDICAL RECORDS BY DOCTORS (BEFORE)

- From the Medical Record Audit Checklist, the forms which are checked to analyze the completeness of forms by doctors are-
- **INITIAL ASSESSMENT FORM (DOCTORS)**
- **DOCTORS' PROGRESS SHEET**
- A sample of 100 files are taken.

	COMPLETE FILES	INCOMPLETE FILES
NO. OF FILES	42	58

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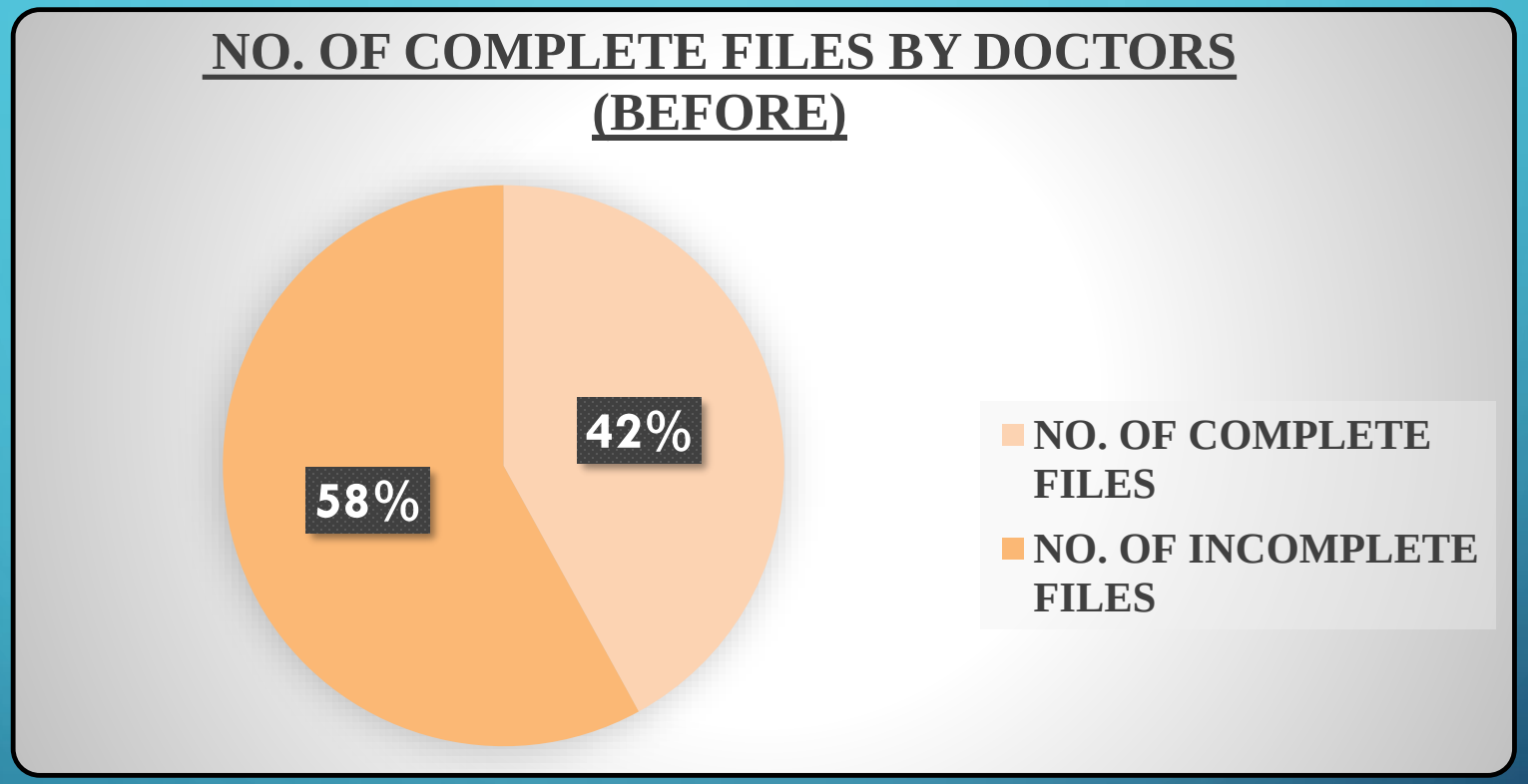

Interpretation- This pie-chart shows that in the sample of 100 files, no. of complete files by doctors are 42 and no. of incomplete files are 58.

➢ PARAMETER-5 INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)-10 CODING IN MEDICAL RECORDS

- Clinical coding is the translation of diseases, health related problems and procedural concepts from text to alphabetic/numeric codes for storage, retrieval and analysis of health care data.
- Medical records are coded for the ease of retrieval of information on diseases and injuries. At present the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) (or an adaptation) given by WHO is used.
- **Results and Findings-**

The sample size of 100 files was collected, no single file has ICD-10 coding as this procedure wasn't started yet in the hospital.

CHANGES DONE OR RECOMMENDATIONS GIVEN IN THE MEDICAL RECORD DEPARTMENT

❖ PROPER LABELLING OF RACKS

In the Hospital, The files are stored in racks and retrieved by Registration No. or MHRC No. of the patient which is a unique identifier. After the proper labeling it became easy to retrieve the files.

- **Labeling of racks was done in the following manner-**
- **RACK**- Racks are labelled as 1, 2, 3, 4 …and so on.
- **SHELF**- Shelves are labelled as A, B, C, D,……and so on.
- **MHRC No.**- For ex- 13492 ⟶ 13506 (In one Shelf files from this Registration No. to this Reg. No. are kept)
- For Ex- 1/1A/13467 ⟶ 13479

➢ MEDICAL RECORD TRACER CARD

- Whenever a medical record is not found in its place, the tracer card is the only source of information to the medical records assistant to track the exact location and the recipient of the medical record taken. So, Medical Record Tracer Card is implemented in the MRD.
- The tracer card contains four columns-
- **The first column** denotes the date at which that particular medical record is taken out
- **The second column** denotes the MHRC No.
- **The third column** denotes the patient full name
- **The fourth column** denotes the Name and Sign of the Recipient of that medical record

The tracer card is used whenever someone wants a medical record the entry was done in tracer card and put at the place of that medical record and after the medical record is replaced in its original location, Tracer card is pulled out.

- A systematic flow for the document compliance in the medical records was advised and implemented and checked out regularly whether it is followed properly or not.
- Suggestion of ICD-10 coding was given.
- The Medical Record Audit Committee is under formation and regular meetings will take place in future to discuss the problems and ways to improve it.
- The training program for the nurses and doctors was implemented for proper maintaining of the medical records in a chronological manner.

DATA ANALYSIS AND INTERPRETATION(AFTER)

- **NABH SELF ASSESSMENT TOOL KIT ON INFORMATION MANAGEMENT SYSTEM CHAPTER**
- After making all the changes in the process, again the scoring was given to all 45 Objective Elements in 0,5, 10 to check the improvement in the working of the MRD and also to check effectiveness of the study as well.

Results and Findings (Out of 45 Objective Elements)

- **No. of Non- Compliance(0)- 7 % of Non-Compliance- 15%**
- **No. of Partial Compliance(5)- 32 % of Partial Compliance- 71%**
- **No. of Full Compliance(5)- 6 % of Full Compliance- 14%**

DATA ANALYSIS AND FINDINGS FOR THOSE 5 SELECTED PARAMETERS (AFTER)

After making the changes in the existing process flow of records and formulating new policies in the MRD the sample size of 100 was taken again and analyzed for the same parameters.

➢ PARAMETER-1: TAT FOR FILES RECEIVED IN MRD AFTER DISCHARGE

Time taken to reach MRD	Within 24 hours	Within 48 hours	More than or After 48 hours
No. of Files	84	11	5

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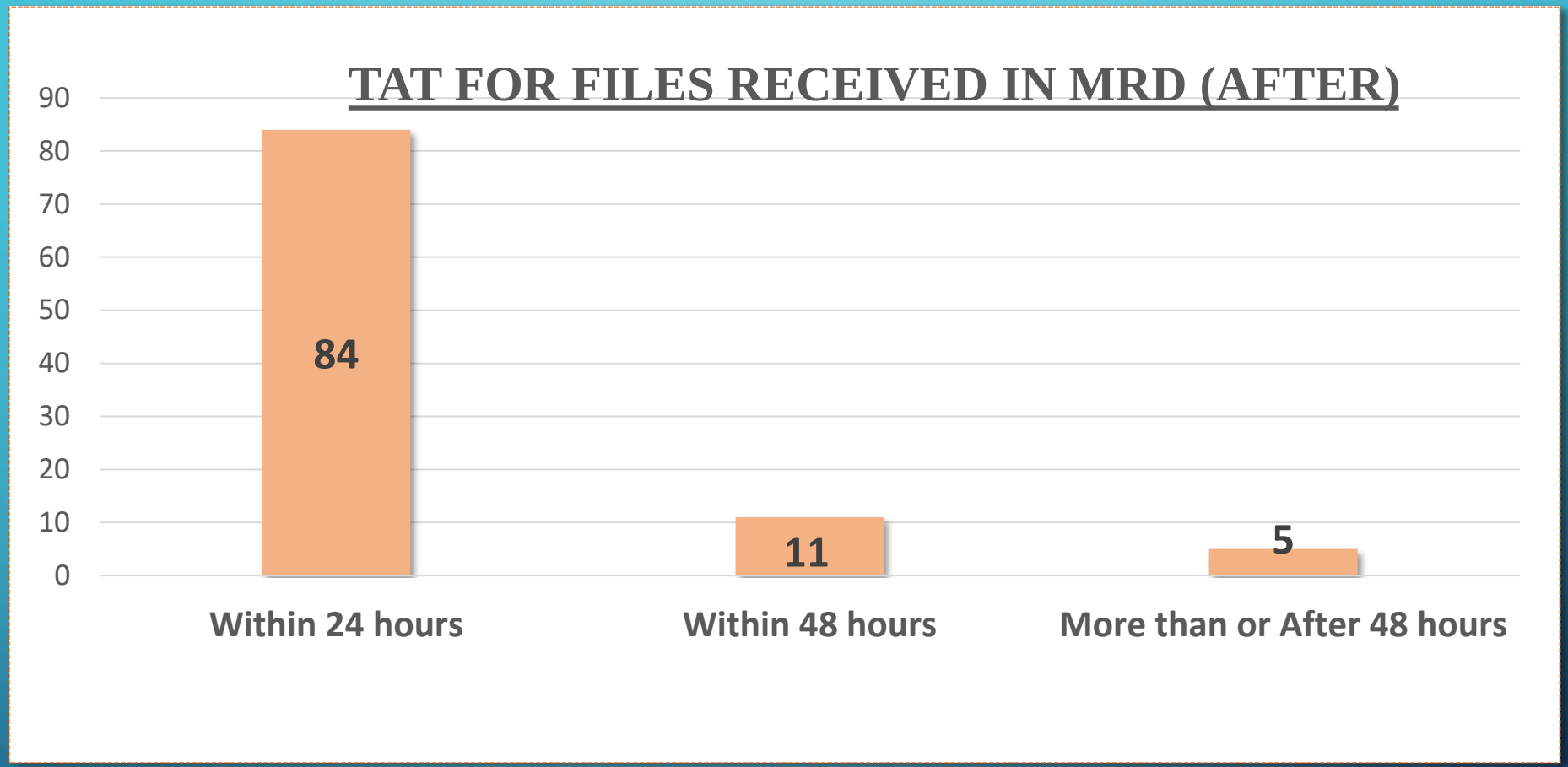

Interpretation- After making some necessary changes in an existing process and implementing some policies, 84 files reach to MRD within 24 hours of patient discharge, 11 files reach within 48 hours and the no. of files reach to MRD in more than 48 hours are only 5.

PARAMETER-2 TIME TAKEN FOR RETRIEVAL OF PATIENT FILES (AFTER)

- This parameter was also reviewed after implementing new process, labelling of racks and also the use of Medical Record Tracer Card. The old and the new data was compared and found that the average time for retrieving the medical record also reduces from earlier average time of retrieval.
- THE IDEAL TAT FOR RETRIEVAL OF FILES IS 20 MIN.(set by Hospital's Quality Department)

The average time of retrieving the medical record was 14 Min.

PARAMETER-3 DOCUMENT COMPLIANCE IN TERMS OF COMPLETENESS BY NURSING STAFF(AFTER)

- After implementation of the new process and training of the nursing staff the document compliance by nursing staff improves as they become more aware and responsible.
- Again the same forms were analyzed which was analyzed before to check the completeness of medical records by nurses.

	COMPLETE FILES	INCOMPLETE FILES
NO. OF FILES	91	9

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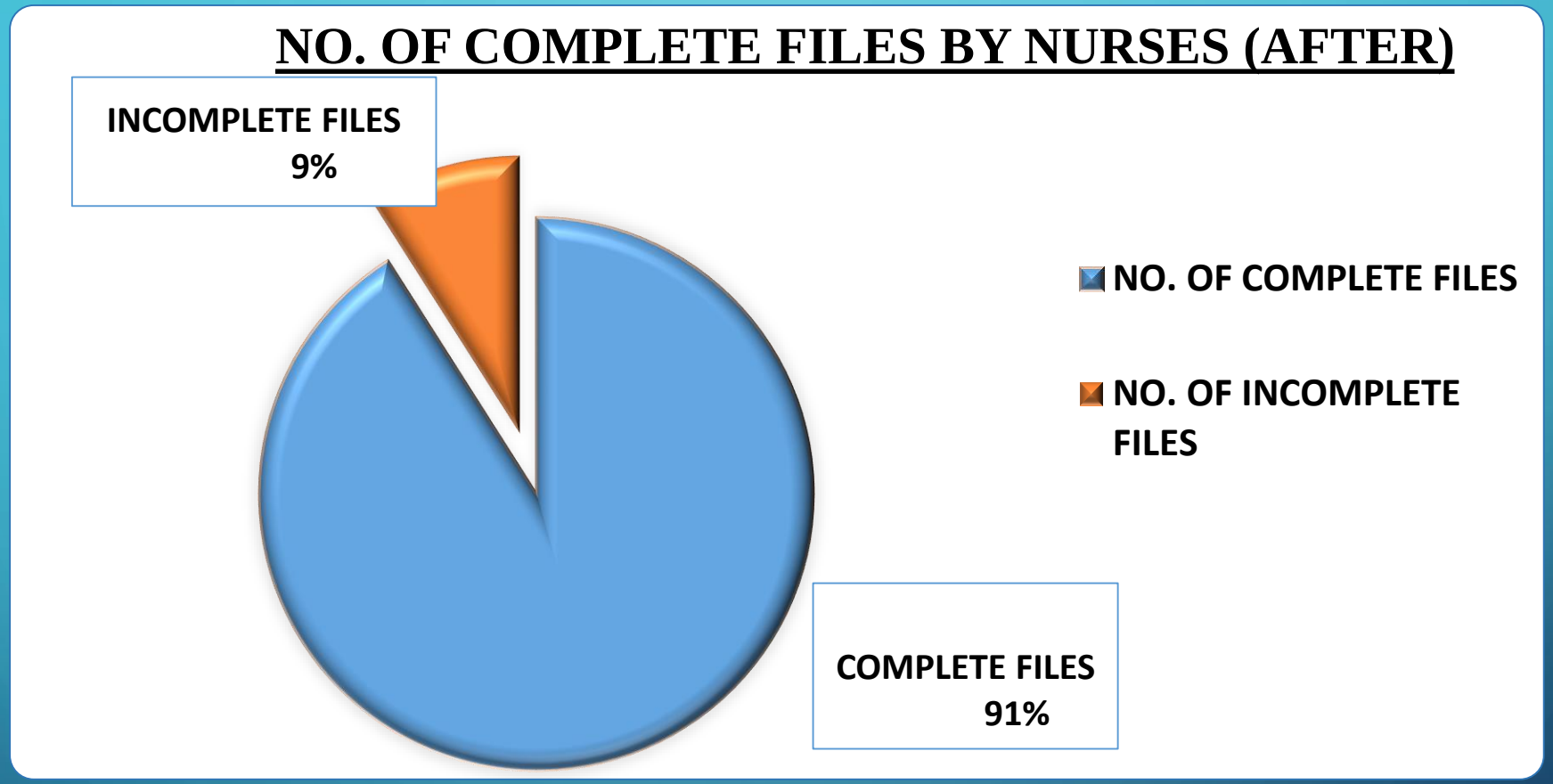


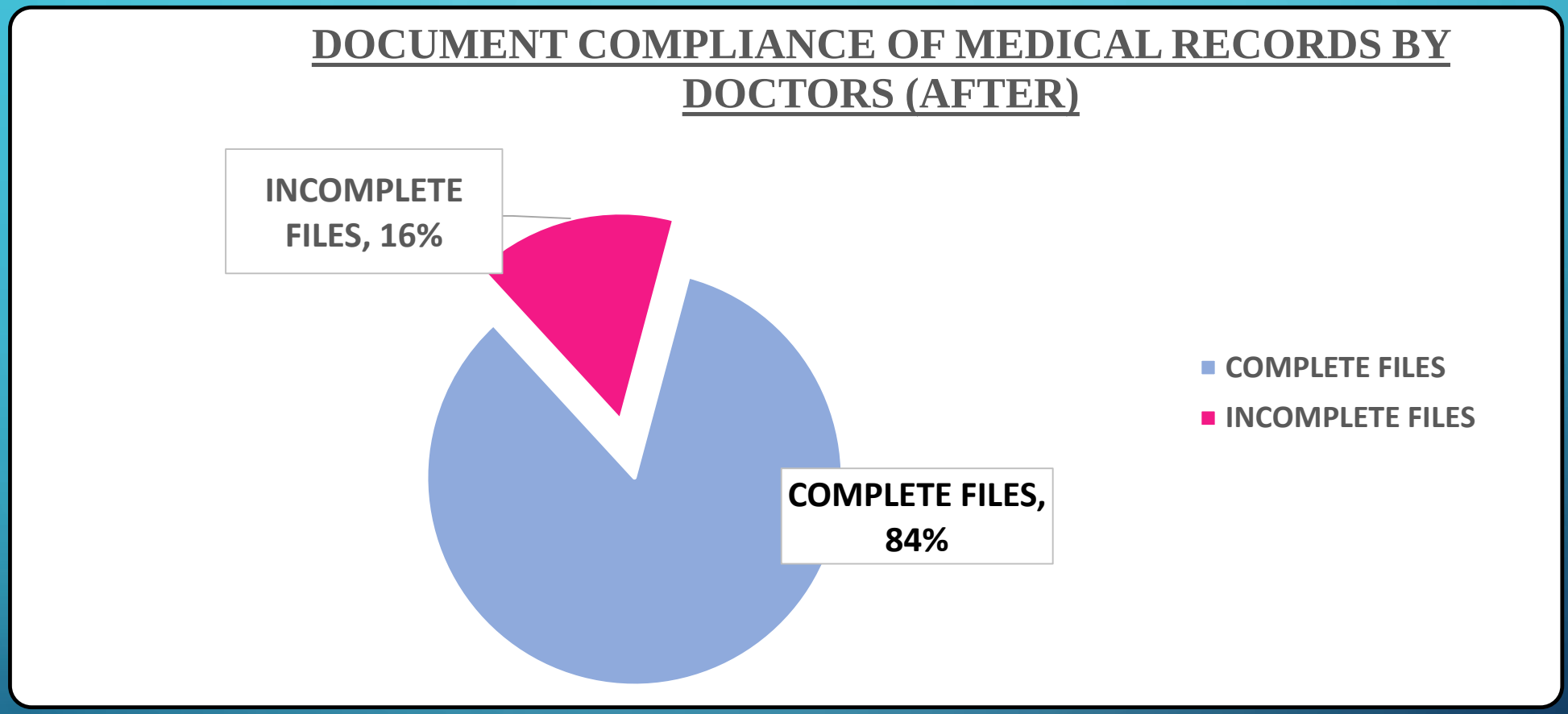
Interpretation- The above pie-chart depicts that complete files are 91 and incomplete files are only 9 as a result of changing the existing process and sending files again to the nursing staff for completion which in turn leads to major document compliance by nurses.

PARAMETER-4 DOCUMENT COMPLIANCE IN TERMS OF COMPLETENESS OF MEDICAL RECORDS BY DOCTORS(AFTER)

- After changing the process flow the same forms are analyzed to see whether there is an improvement in the no. of complete files or not.
- After analyzing the old and new data for the completeness the good improvement was found.

	COMPLETE FILES BY DOCTORS	INCOMPLETE FILES BY DOCTORS
NO. OF FILES	84	16

CONTINUE...



Interpretation- The above pie-chart depicts that the no. of complete files are 84 and only 16 files are incomplete out of 100 files in document compliance by doctors after the formulation of policies and making required changes in the MRD of the hospital.

PARAMETER-5 INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)-10 CODING IN MEDICAL RECORDS

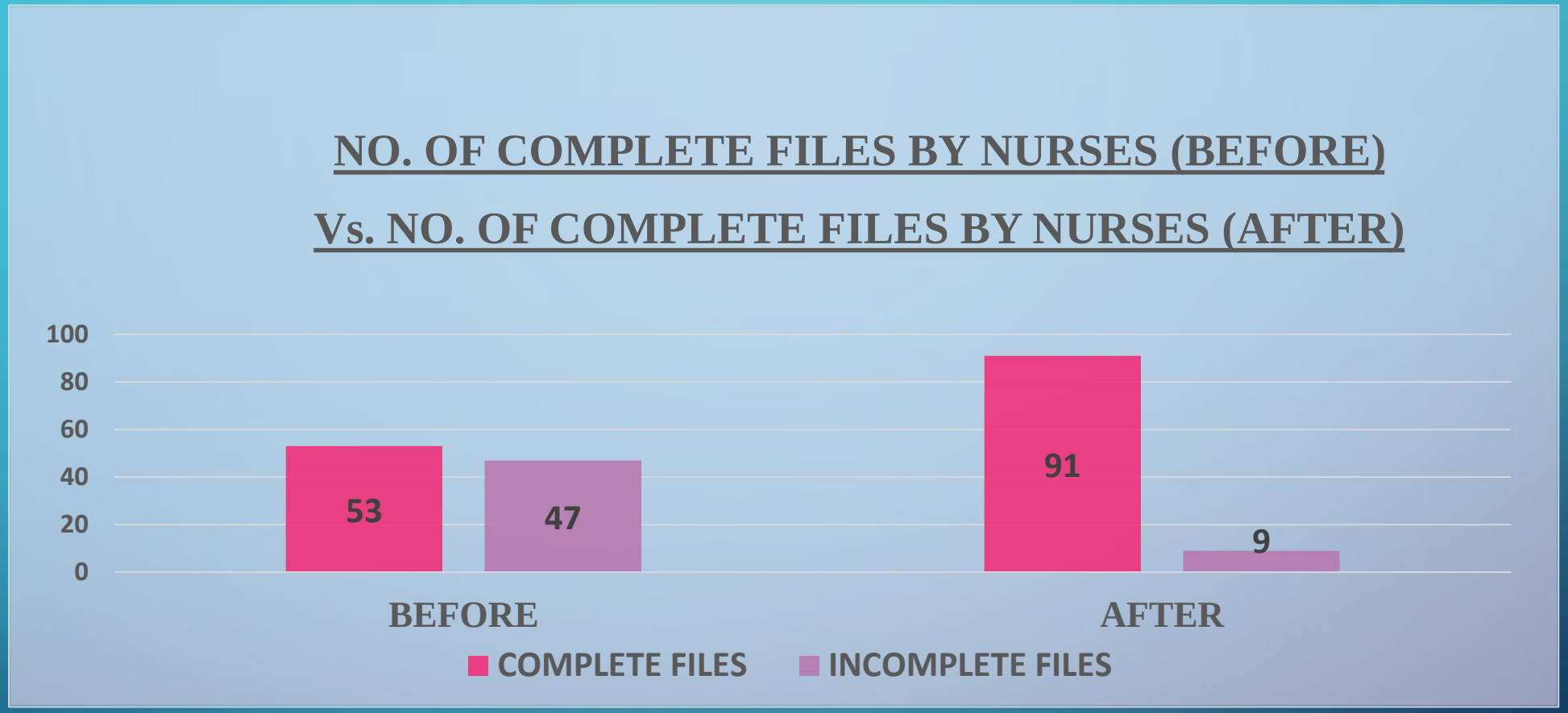
The procedure of ICD-10 coding has not been started yet, however the concept and approved and will be started and implemented in near future.

DOCUMENT COMPLAINCE BY NURSES (BEFORE) VS. DOCUMENT COMPLAINCE BY NURSES (AFTER)

- The no. of complete files and incomplete files by nursing staff before the implementation of new process was compared to total no. of complete files and incomplete files by nurses and then the graph was plotted.

CATEGORY	DOCUMENT COMPLIANCE BY NURSING STAFF (BEFORE)	DOCUMENT COMPLIANCE BY NURSING STAFF (AFTER)
COMPLETE FILES	53	91
INCOMPLETE FILES	47	9

CONTINUE...



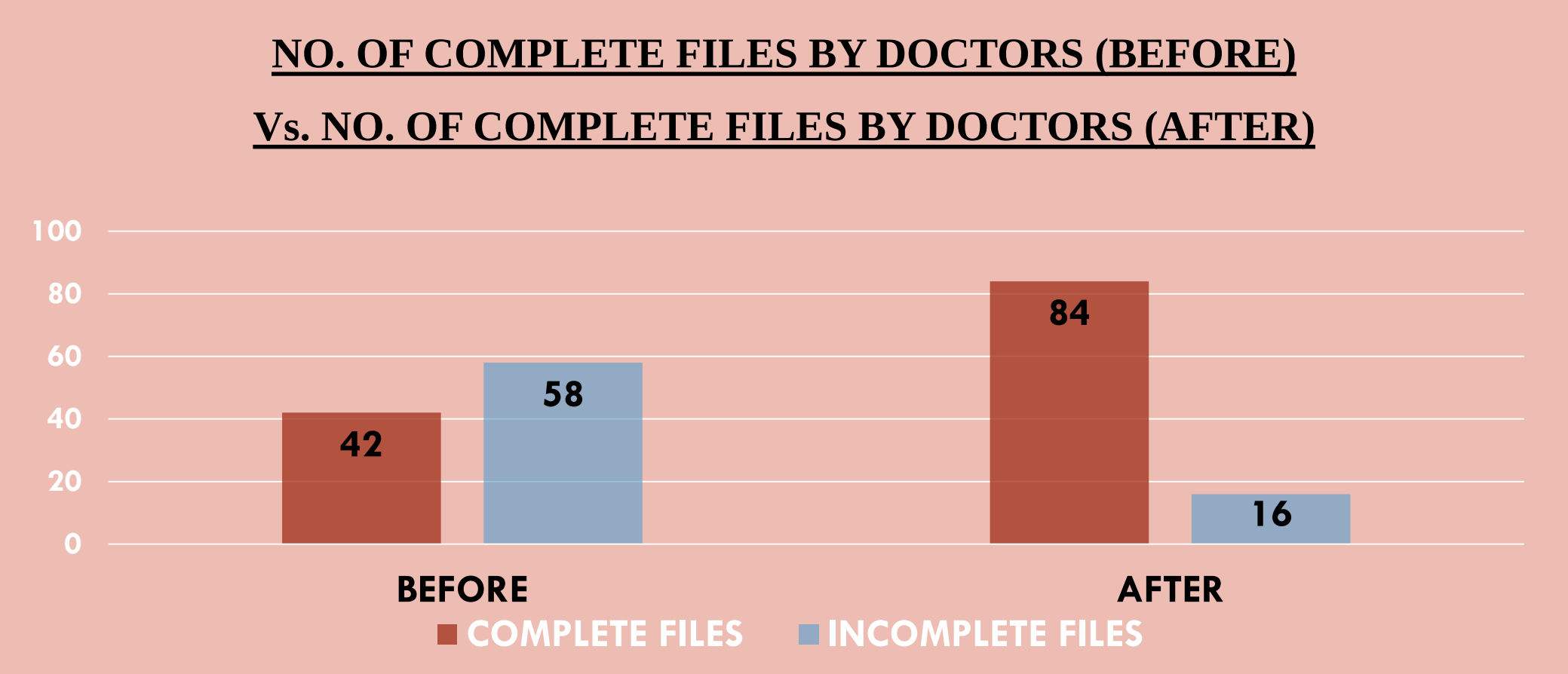
Interpretation- This graph shows that before implementing new process in the MRD, complete files by nurses are 53 whereas after implementation the number increased to 91 and before implementing new process incomplete files are 47 and after implementation it reduces to 9.

DOCUMENT COMPLAINCE BY DOCTORS (BEFORE) VS. DOCUMENT COMPLAINCE BY DOCTORS (AFTER)

- The no. of complete files and incomplete files by doctors before the implementation of new process was compared to total no. of complete files and incomplete files by doctors and then the graph was plotted

CATEGORY	DOCUMENT COMPLIANCE BY DOCTORS(BEFORE)	DOCUMENT COMPLIANCE BY DOCTORS(AFTER)
COMPLETE FILES	42	84
INCOMPLETE FILES	58	16

CONTINUE...



Interpretation- This graph shows that before implementing new process in the MRD, no. of complete files by doctors are 42 whereas after implementation the number increased to 84 and before implementing new process incomplete files by doctors are 58 and after implementation it reduces to 16.

CONCLUSION OF THE STUDY

- Medical Records are an essential part of patient's plan of care therefore it is very important to complete the medical record.
- After understanding and analyzing the whole process, the new process was implemented which results in remarkable improvement in the working of the MRD of the Hospital.
- The average time of retrieval of medical records before making and implementing the new procedure is 32 min which later reduces to 14 min after implementation of the new process and introducing tracer card in the Medical Record Department of the hospital.
- The no. of complete files by doctors and nurses are also increased after the change in the whole scenario.

LIMITATIONS IN THE STUDY

- The major problem in the MRD of the hospital is the shortage of skilled and trained staff as there is no special person who is handling the medical records department of the hospital.
- The labelling of racks was not there in the medical records department earlier so it was very difficult and time-consuming to retrieve a medical record as and when required.
- There was no such policy that who can make entries in the medical record of the patient. Only Authorized people like Doctors, Nurses should be allowed to make entries.
- The nursing staff was not at all trained in relation to make entries in the medical record.
- No controlled access is there in the MRD earlier. Anyone can easily retrieve a medical record.

Thank you