

An Audit to Assess the Compliance of In-patient Files

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Abbreviations

- IPD : In-patient department
- OPD : Out- patient department
- OT : Operation theater
- TAT : Turn around time

Introduction

- The old saying “If it’s not documented in the medical record it was not done.”
- The medical record is a living document that tells the story of the patient.
- Complete and accurate medical records will meet all **legal, regulatory** and **auditing** requirements.
- Quality documentation promotes **effective communication** between caregivers.

Introduction (continue)

- Documentation **quality, accuracy** and **development needs** can be monitored through an auditing instrument.
- **Audit** - a systematic and critical examination to examine or verify.

Documentation System In Paras Hospitals

- Hospital uses paper- based hand written in- patient medical records.
- After discussion with Managers of Quality department, they highlighted the issues related to incomplete documentation in the hospital.
- There should be 100% compliance of documentation in hospital, but there is the gap between present compliance and hospital set standard.

Problem Statement

Earlier audit of patient documents revealed **inconsistency, incompleteness** and often **difficult to read** as they are hand written. Most of the hospital staff employed in the hospital is enrolled with **little formal training** to documentation of in-patient file.

Review of Literature

- The clinical note is the **primary tool** used to document care, communicate plans [11, 12], and provide guidance for follow-up treatment and care.
- **Quality** of clinical encounter notes relates to patient safety [4, 5], medical education [6-8], medico-legal issues [9, 10], and justification of reimbursement.
- **Gaps** in the quality of clinical documentation could, therefore, adversely affect patient care and healthcare outcomes.
- The **audit** is the tool to control the quality of the work of the medical team and is used with the objective of improving quality of provided services.
- Clinical audits would be compromised in certain hospitals by the use of medical files [14].

Review of Literature (continue)

- There are two types of auditing: a retrospective and operational or recurrent. [13].
- When identifying elements associate with quality of clinical documentation, authors commonly cite attributes such as legibility, correctness, completeness, readability, appropriateness and accuracy [13].
- The audit allows us to define the first steps of a quality improvement project for patient records [15].
- Study done by (Boulay F, et al 1997) and analysis of the 467 forms returned by 39 hospitals, showed that the quality of medical file recordings should be improved as a large amount of data or important documents were missing [14].

Research Question

What is the current compliance of in-patient file documentation of hospital staff involved in direct patient care?

Aim

The audit is to ensure that all clinical records are maintained to the highest standard as well as providing a benchmark to continually improve the quality and accuracy of clinical records.

Objectives

- To find out the compliance of in- patient documents among the staff of hospital using a self designed data collection tool.
- To compare the difference between the compliance of in-patient records and the standard compliance set by the hospital.

Methodology

- **Study Type:** Descriptive study was conducted to understand the activities and identify the problems.
- **Location of Study:** In-Patient Department of Paras Hospitals, Gurgaon
- **Duration of Study:** 3rd March 2015 to 2rd May 2015
- **Sample size:** 225 in- patient files

Methodology (continue)

- **Sampling technique:** A universal coverage of all inpatient files undergoing treatment in the hospital.
- **Inclusion criteria:** The patients whose treatment is going on not discharged were selected.
- **Exclusion criteria:** Discharged patient and medical record files were excluded from the study.

Methodology (continue)

Technique of Data Collection:

- **Primary data** regarding the documentation involved in the in-patient file was collected for two months with the help of self designed sheet.

The sheet consist points about the documents of nurses, doctors, and other staff.

This was followed by calculation of compliance for each hospital category staff.

- **Secondary data** was collected from the hospital to understand the standard activities.

- **Data Analysis:** MS Excel

Hospital Standard

- **100% compliance** of all In-patient documents

- **Formulas:**

Compliance (%) = (Sum of calculated score/ Total Score)*100

Non-Compliance (%) = (Set Standard-Compliance)

- **Scoring of in-patients documents points:**

0=not filled or document absent

5=Partial filled

10=complete filled

Hospital In-patient File Documentation Consists:-

Table 1: In-Patient file content

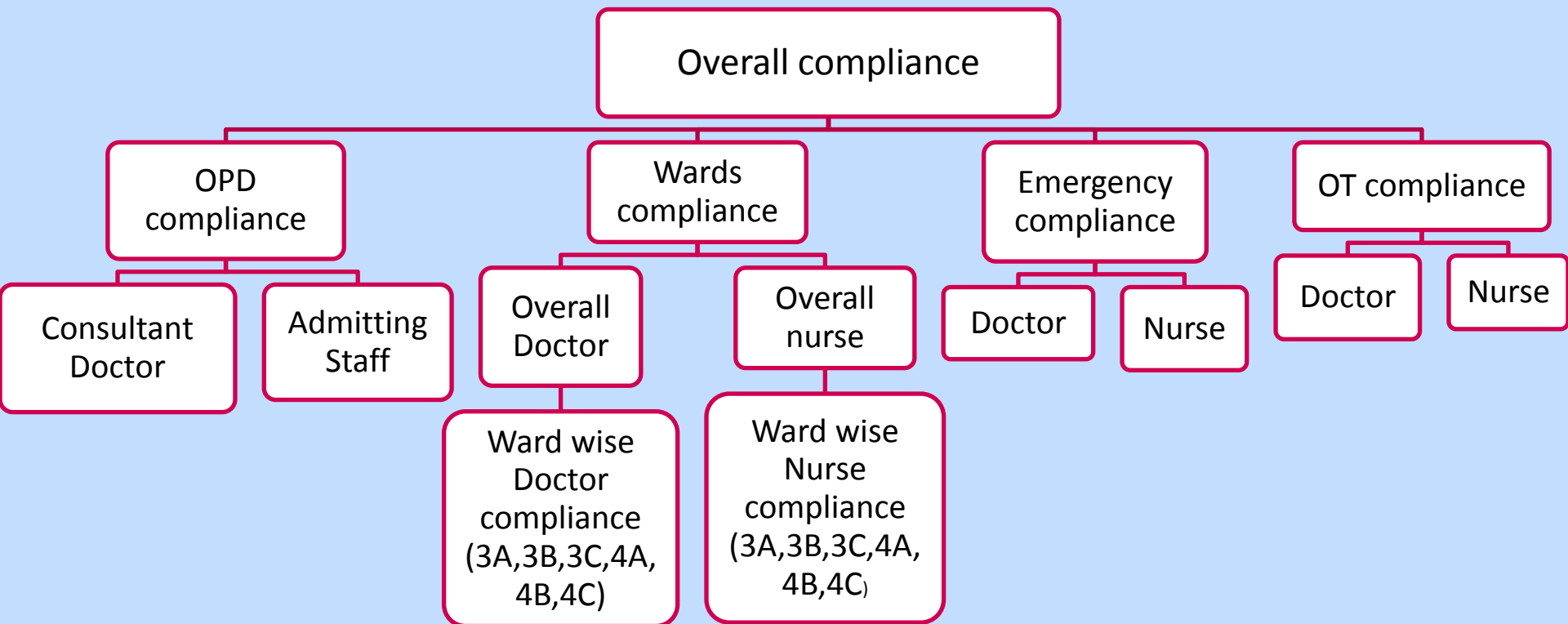
Hospital In-patient Department	Hospital Staff Category	In- Patient Study Points
OPD	OPD Admitting Staff	1. Admission Consent Form
	OPD Doctor	1. OPD Card 2. Admission Request Form (with plan of care)
IPD	IPD Doctor	1. Doctor assessment within defined TAT 2. Pain assessment 3. Name, signed, dated, timed 4. Physician Order Sheet- (capital, dose, time, route, frequency) & allergy
	IPD Nurse	1. Nursing assessment (<30min of admission) 2. Screening for pain on admission 3. Allergy Screening 4. Nursing Reassessment with name, date and sign
	Dietician	1. Nutritional screening (<24hours of admission)

Hospital In-patient File Documentation Consists:- (cont..)

Hospital In-patient Department	Hospital Staff Category	In- Patient Study Points
Emergency	Emergency Doctor	1. Doctor emergency assessment sheet
	Emergency Nurse	1. Nurse emergency assessment sheet
OT	OT Doctor	1. Consent (Procedure/ Surgery/ High Risk) 2. Details of implants 3. Details [Diagnosis, operation performed] 4. Tissue sent for histopathology 5. Condition at the end of surgery 6. Disposition 7. Date, Time and Sign of Doctor 8. Post Surgery Notes by doctor 9. Surgical Safety Checklist 10. Blood and Blood Products Consent
	OT Nurse	1. Pre-operative checklist (Surgical patient) 2. Date, Time and Sign of Nurse 3. Post-operative plan of care
	Anesthetist	1. Pre-anesthesia assessment 2. Anesthesia Plan

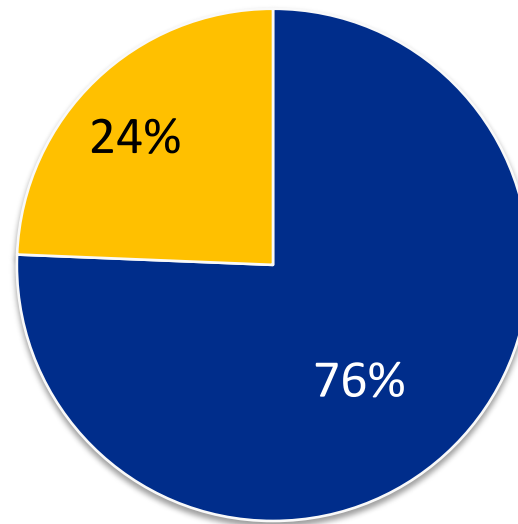
Data Compliance Calculation

Figure 1. Flow Chart showing data compliance calculation way



Results

1. Overall In- Patient File Audit Compliance



■ Compliance ■ Non-Compliance

Figure 2. Proportion of inpatients documents showing full compliance of documentation standards

2. Compliance comparison with 4 main categories; OPD, Emergency, IPD, OT

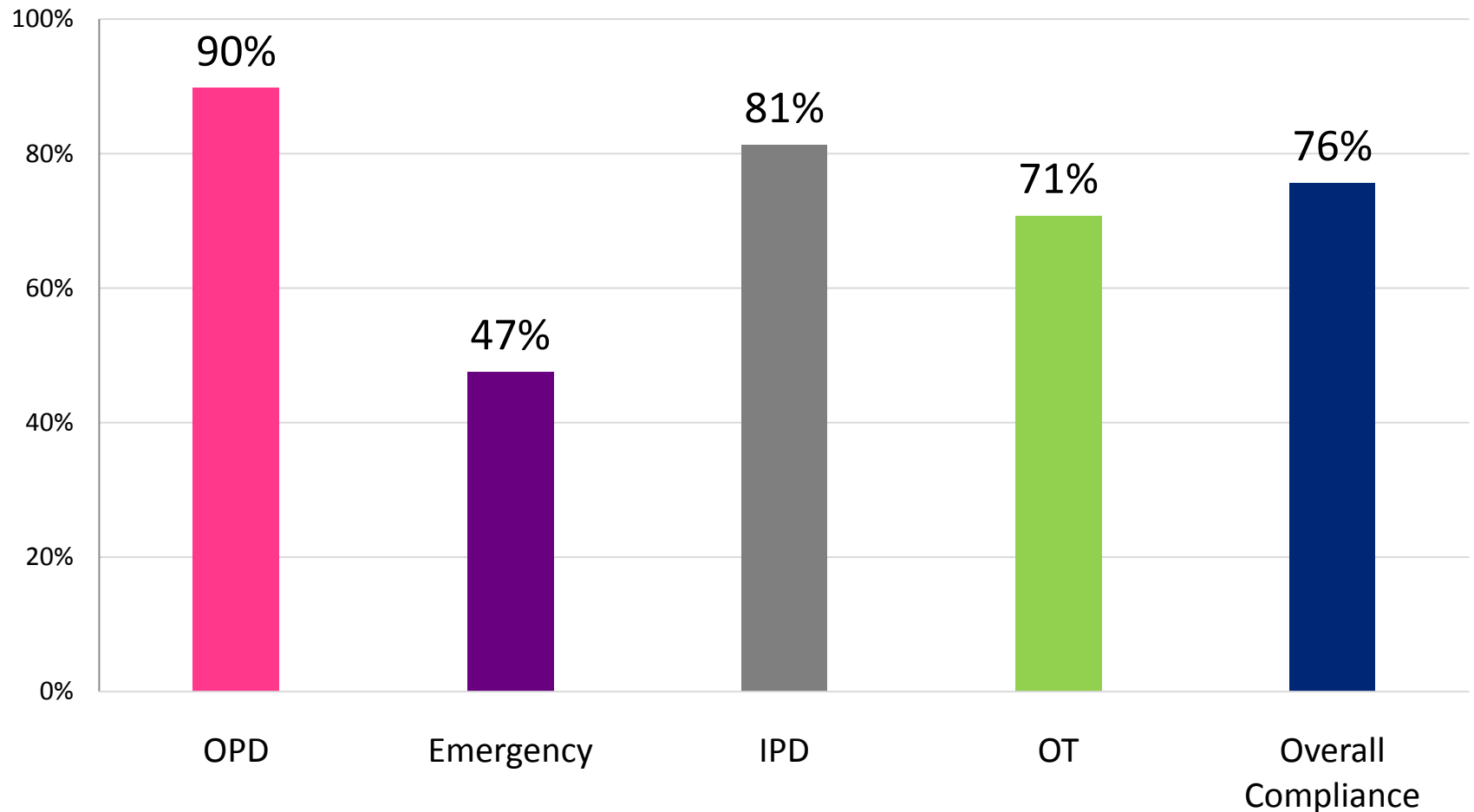


Figure 3. Comparison between Compliance of OPD, Emergency, IPD and OT against overall compliance

3. OPD In-patients documents compliance

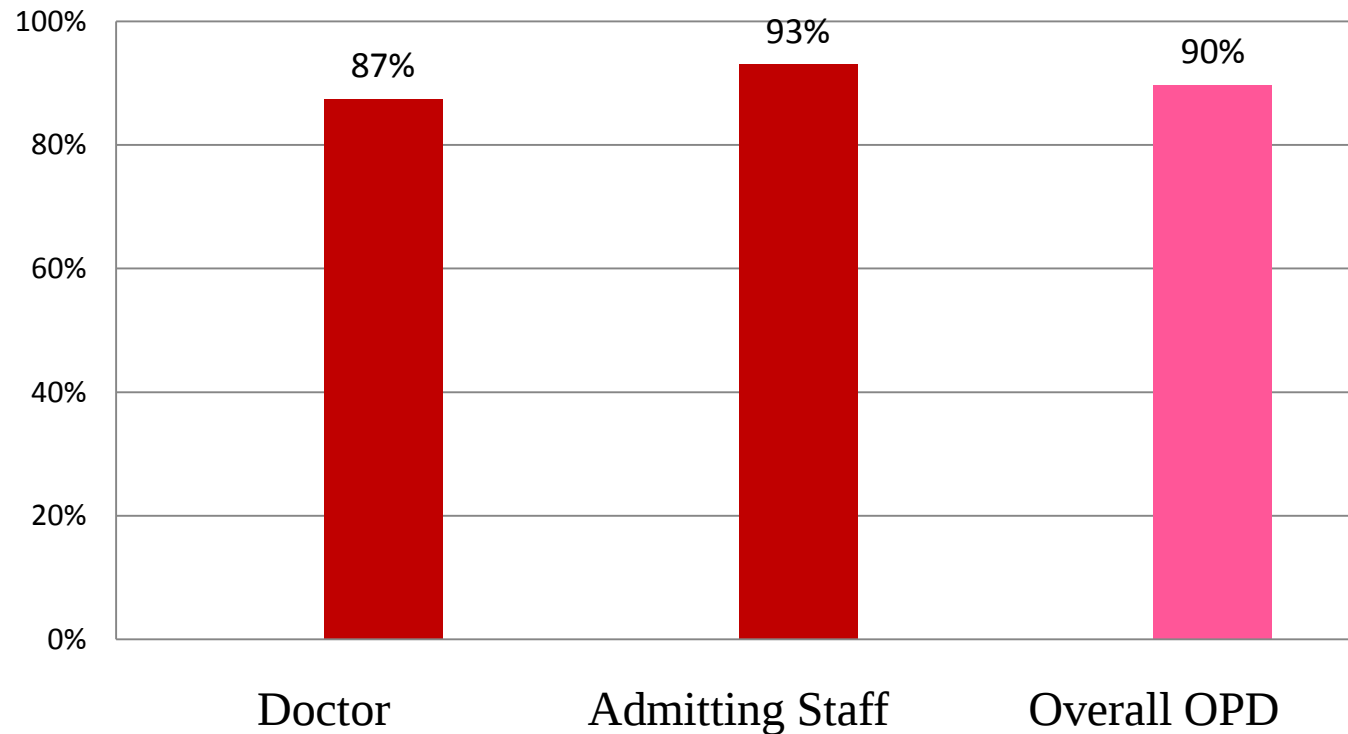


Figure 4. OPD In-patients documents compliance comparing Doctor and Admitting Staff

4. Emergency documents Compliance

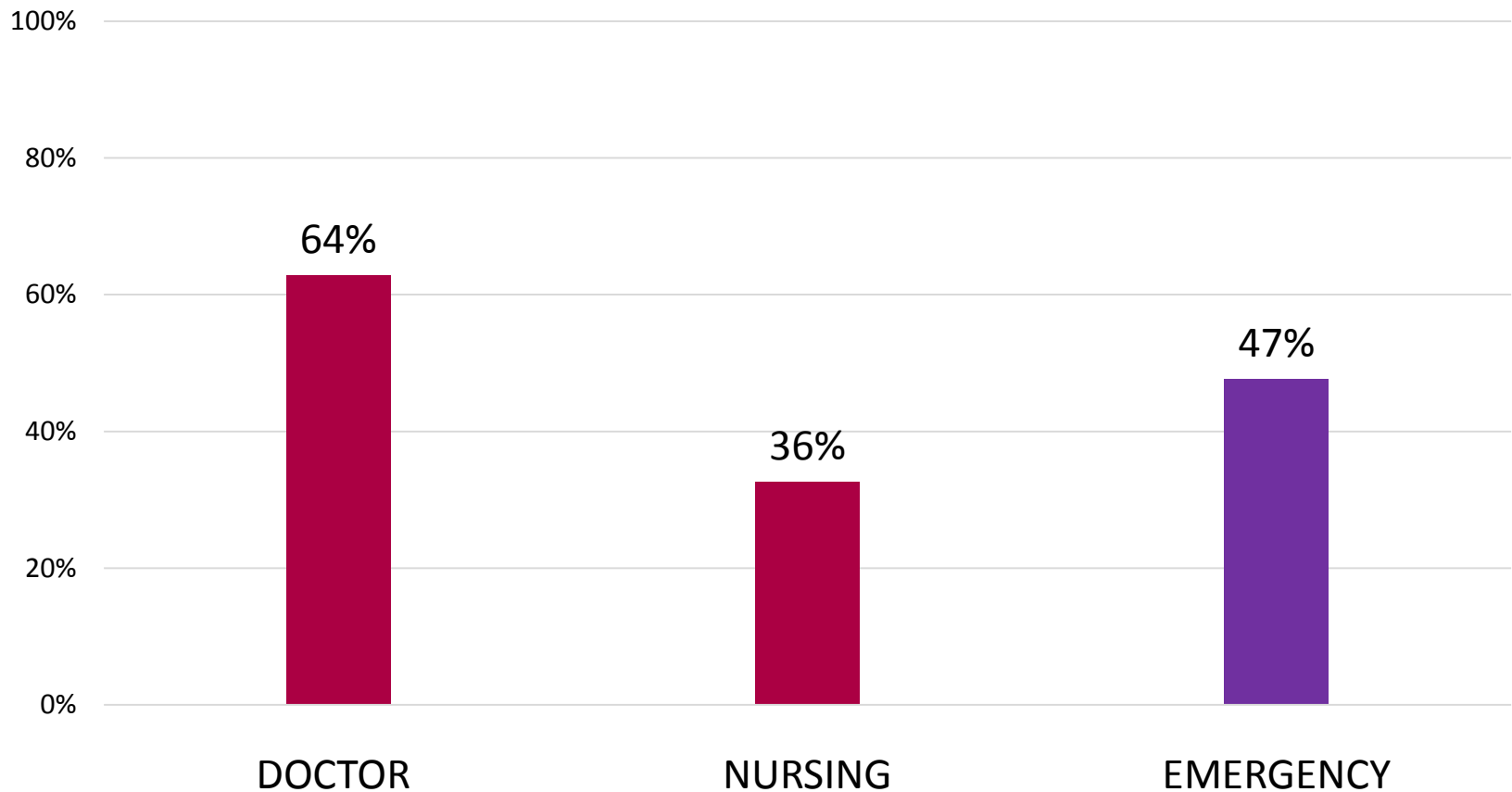


Figure 5. Emergency documents Compliance comparing documentation done by doctor and nurse

5. IPD wards documents compliance

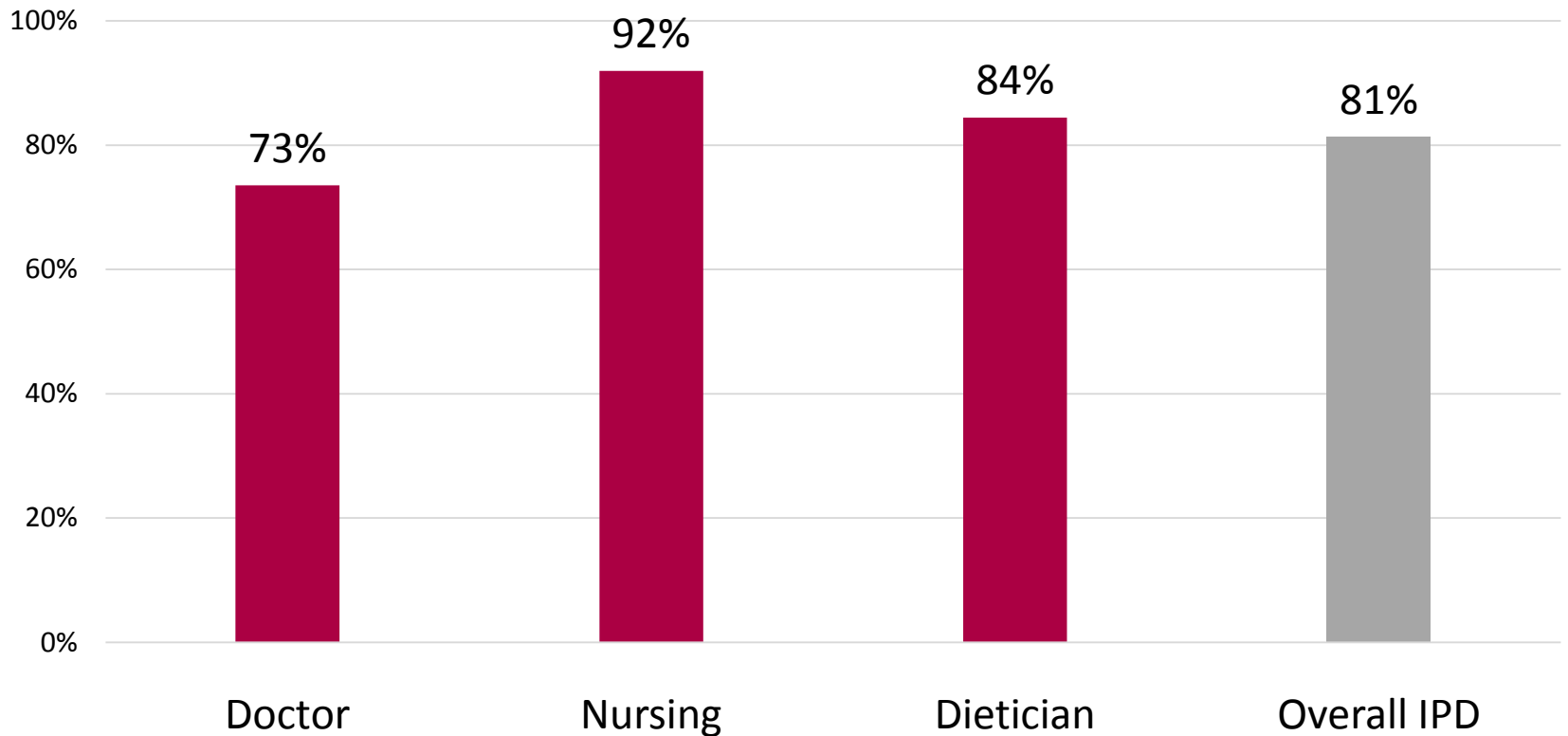


Figure 6. IPD Wards Documents Compliance comparing documentation done by doctor, nurse and Dietician

6. Compliance of in-patient files according to Ward Wise

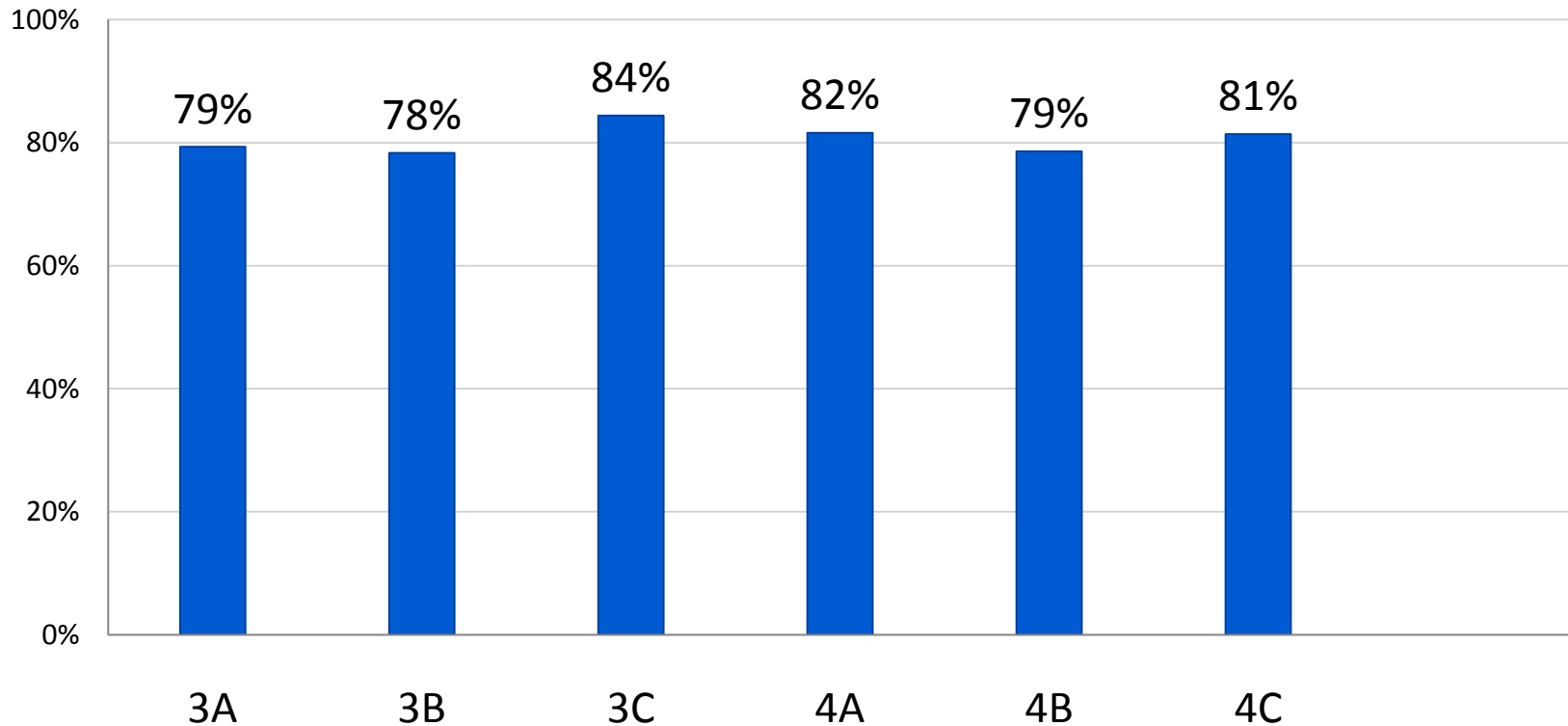


Figure 7. Ward Wise In-patient Files, Compliance

7. Doctor and Nurse In-patient documents Compliance in Wards

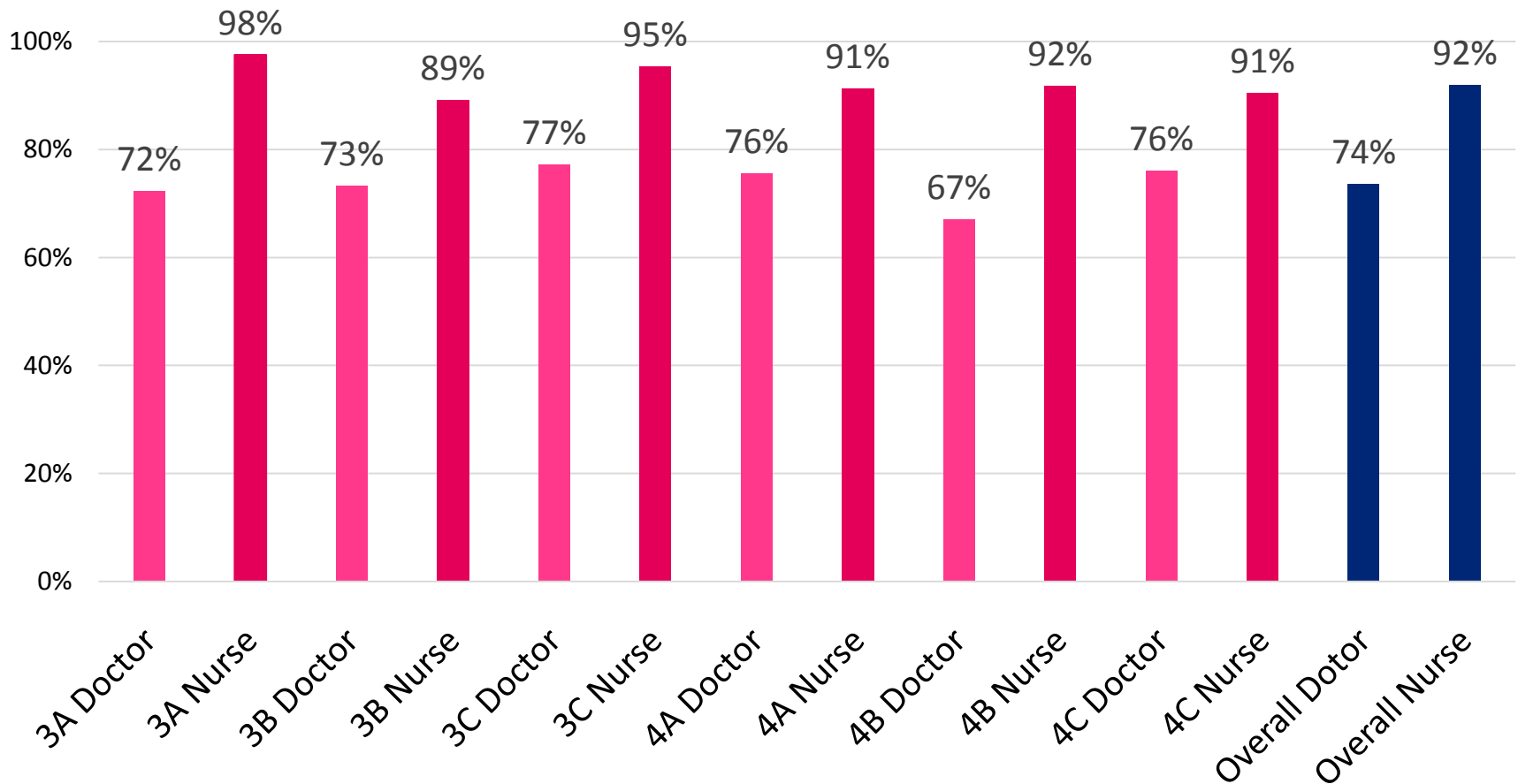


Figure 8. Doctor & Nurse In-patient Files Compliance in Wards

8. Overall OT Compliance comparison with Doctor, Nurse and Anesthetist

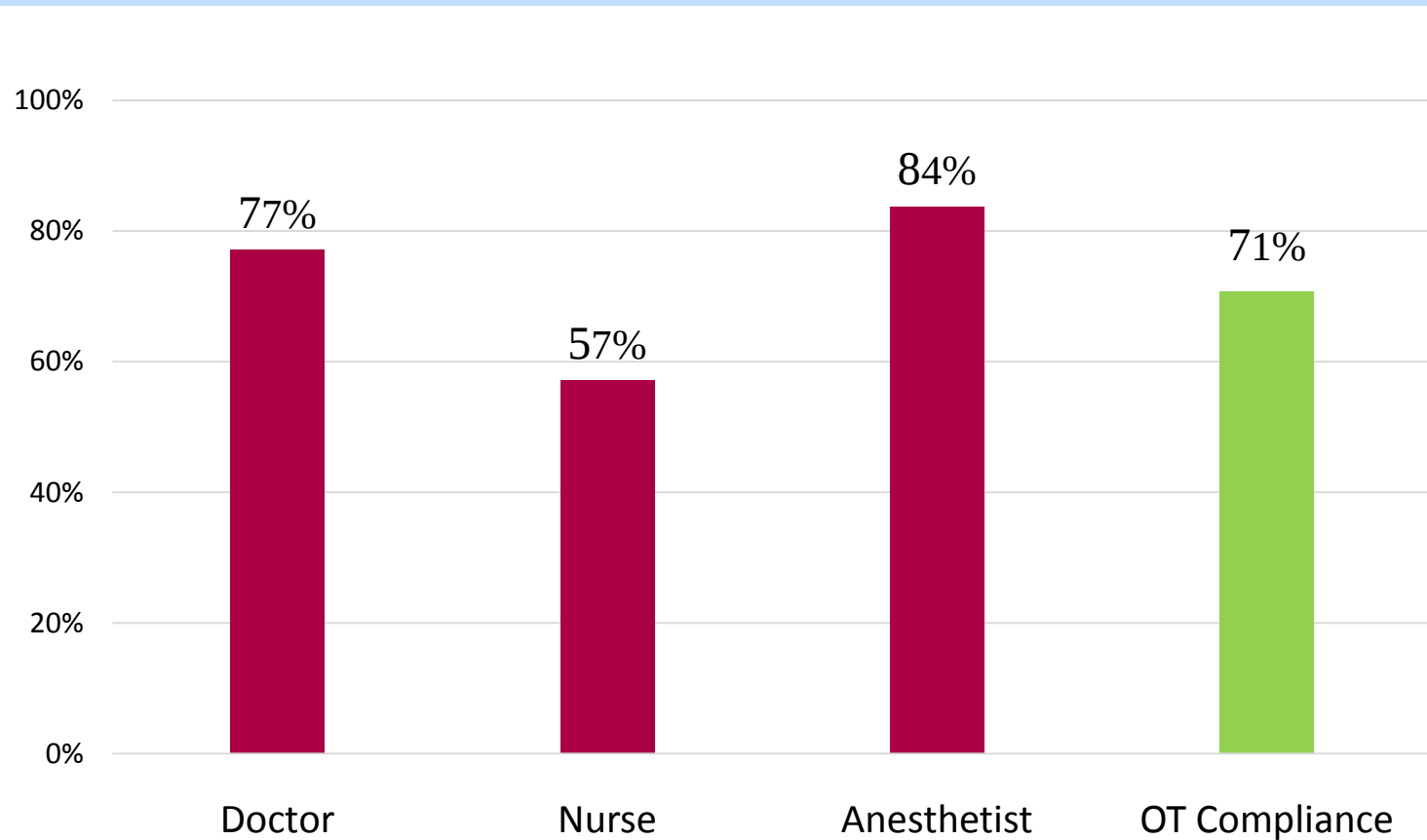


Figure 9. OT patients documents compliance comparing documentation done by doctor, nurse and anesthetist

Other Observation Result

During the study period two documents; restraint form and medication administration form format changed without training in all the areas of hospitals, which causes more documentation mistakes.

- Vertical format
- Range of movements

- Horizontal Format
- Range of motion exercises

[illegible]

Findings

Table 2: Overall Findings of the study

In-patient Documents	Compliance Calculated	Comment
Overall compliance	76%	Non-compliance is 24%.
Emergency overall	47%	• Emergency and OT is pulling down the overall compliance below 80%. • In Emergency, Nursing compliance; 33% is far less than doctors compliance; 63% which is also very less as compare to other departments.
Emergency Doctor	63%	
Emergency Nurse	33%	
OT overall	71%	
OT Doctor	77%	
OT Nurse	57%	
Anesthetist	84%	• In Wards, Doctors are pulling down the overall compliance of doctor; 74% in wards and Nursing overall compliance in wards is 92%.
OPD overall	90%	
Wards overall	81%	
Wards Doctor	74%	
Wards Nurse	92%	
Ward Dietician	84%	

Discussion

- There is study done by (Boulay F, et al 1997) and analysis shows quality of medical file recordings should be improved as a large amount of data or important documents were missing: reason for hospitalization (having compliance 74% of files), operation report (found in 83% of files) and discharge summary (found in 67% of files).
- The study in Paras hospital also large amount of important data was missing; OPD documentation (having compliance 90%), emergency documentation (found in 47% of files), IPD documentation (found in 81% of files) and operation theatre documentation (found in 71%).

Discussion (continue)

- Monitor deficiencies and improvements. Educate practitioners who fall below accepted standards set by the practice. Solutions, the exact needs of the facility will be matched to the appropriate solutions.
- This way, physicians and nurses can document properly.

Suggestions

- Conduct a baseline medical record audit.
- Staff education and training.
- Document format would be consistent
- Practice- based learning and improvement
- Direct feedback such as that provided by 'report cards' on performance.
- Responsibility for quality is shared by individuals and organization and as nurses constitute the majority of ward staff, their involvement is necessary to represent patient care.

Limitations

- Staff was not supportive therefore it took time to understand the process of documentation.
- Medical documents audit cannot assess the quality of important aspects of the encounter.
- The current lack of consistency in medical documents organizational format will continue to hamper the standardization of medical audit.

Ethical Considerations

- Permission will be obtained from the Head admin of quality department of hospital.
- Privacy, confidentiality will be guarded.
- Scientific objectivity will be maintained with honesty and impartiality.

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**THANK
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