DISSERTATION

ON

ASSESSMENT OF MEDICAL RECORDS PROTOCALS QUALITY IMPROVEMENT THROUGH INTERNAL AUDIT

Organization Name: APEX HOSPITAL, JAIPUR

Submitted by:

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INTRODUCTION

Importance of Medical Records in Healthcare to improve answerability , accountability and transparency of the treatment process

The evaluation of medical records and prescriptions is crucial in enhancing healthcare quality and ensuring patient safety. Medical records, encompassing both open and closed files, are fundamental in documenting patient history, diagnoses, treatment plans, and medications. Open records, which are active and continually updated, and closed records, which belong to discharged patients, both play pivotal roles in internal audits and quality improvement. Accurate and comprehensive medical records facilitate better patient care coordination, minimize medical errors, and support compliance with legal and regulatory standards. Internal audits of these records and prescriptions help identify and correct discrepancies, errors, and omissions, leading to improved patient outcomes, satisfaction, and ongoing quality enhancement in healthcare facilities.

Crucial Role of Medical Records:

- Essential for quality patient care and service improvement.
- Document patient history, diagnosis, treatment plans, and medications.

Key Components:

- **Open Records:** Active patient files, continuously updated.
- **Closed Records:** Files of discharged patients, used for historical data analysis.

Benefits of Accurate Medical Records:

- Enhances patient safety and care coordination.
- Facilitates internal audits to identify areas needing improvement.
- Supports compliance with legal and regulatory standards.

Objectives of the study

1. To understand the level of compliance to the medical record protocol

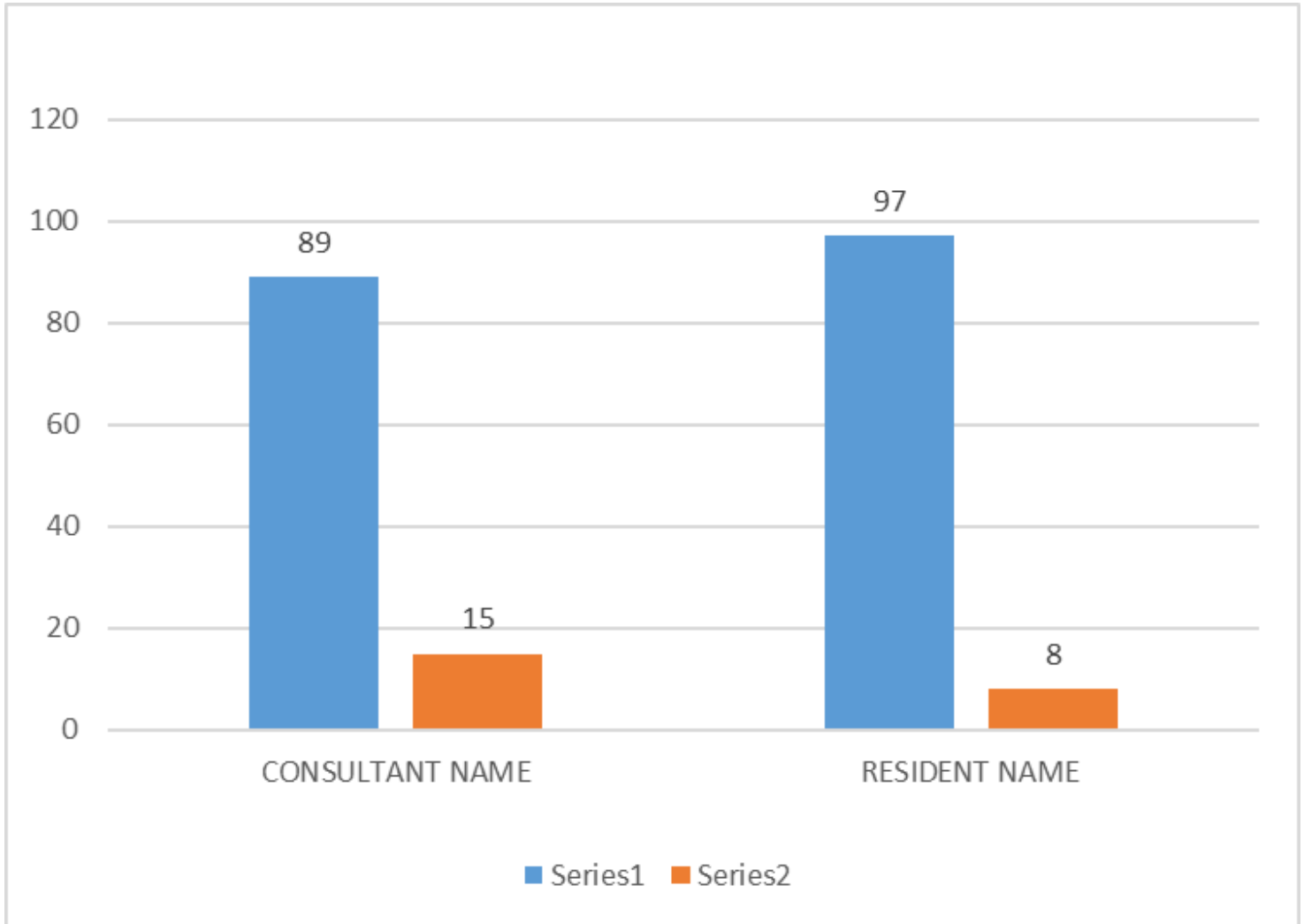
1. Ensure accuracy, completeness, and timeliness of medical documentation.
2. Identify and correct discrepancies, errors, and omissions.

2. To assess the level of seniority in doctors who adhere to the protocols more

1. Monitor and improve healthcare quality.
2. Enhance communication and coordination among healthcare providers
3. Foster compliance with legal and regulatory requirements.

3. To suggest measures for improvement in the accountability during the treatment process

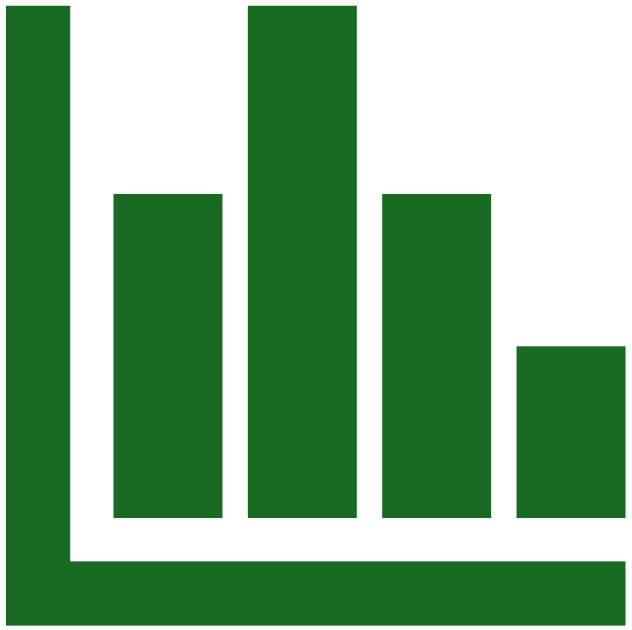
1. Minimizes medical errors and adverse outcomes.
2. Improves patient satisfaction and safety.
3. Contributes to continuous quality improvement initiatives.



Record of latency between Consultant Doctor & Resident Doctor Respectively

PROBLEM STATEMENT

During my internship it was observed that there were problems in the medical records including incomplete consultant names, inaccurate date/time entries, and missing signatures. These documentation gaps compromise patient care continuity, accountability, and the hospital's health information integrity. Despite established standards, inconsistent adherence poses risks to patient safety and legal compliance. This study aims to assess the effectiveness of internal audits in improving medical record quality, identifying areas of non-compliance, and proposing targeted improvements for reliable and accurate documentation at Hospital.



METHODOLOGY

Research Questions:

1.How can the quality of medical records be improved through internal audits?
2.What differences exist in medical record quality before and after internal audits at APEX Hospital, Jaipur?
3.What are the key challenges in auditing open files, closed files, and prescriptions at APEX Hospital, Jaipur?
4.How effective are internal audits as a tool to improve the quality of medical records?

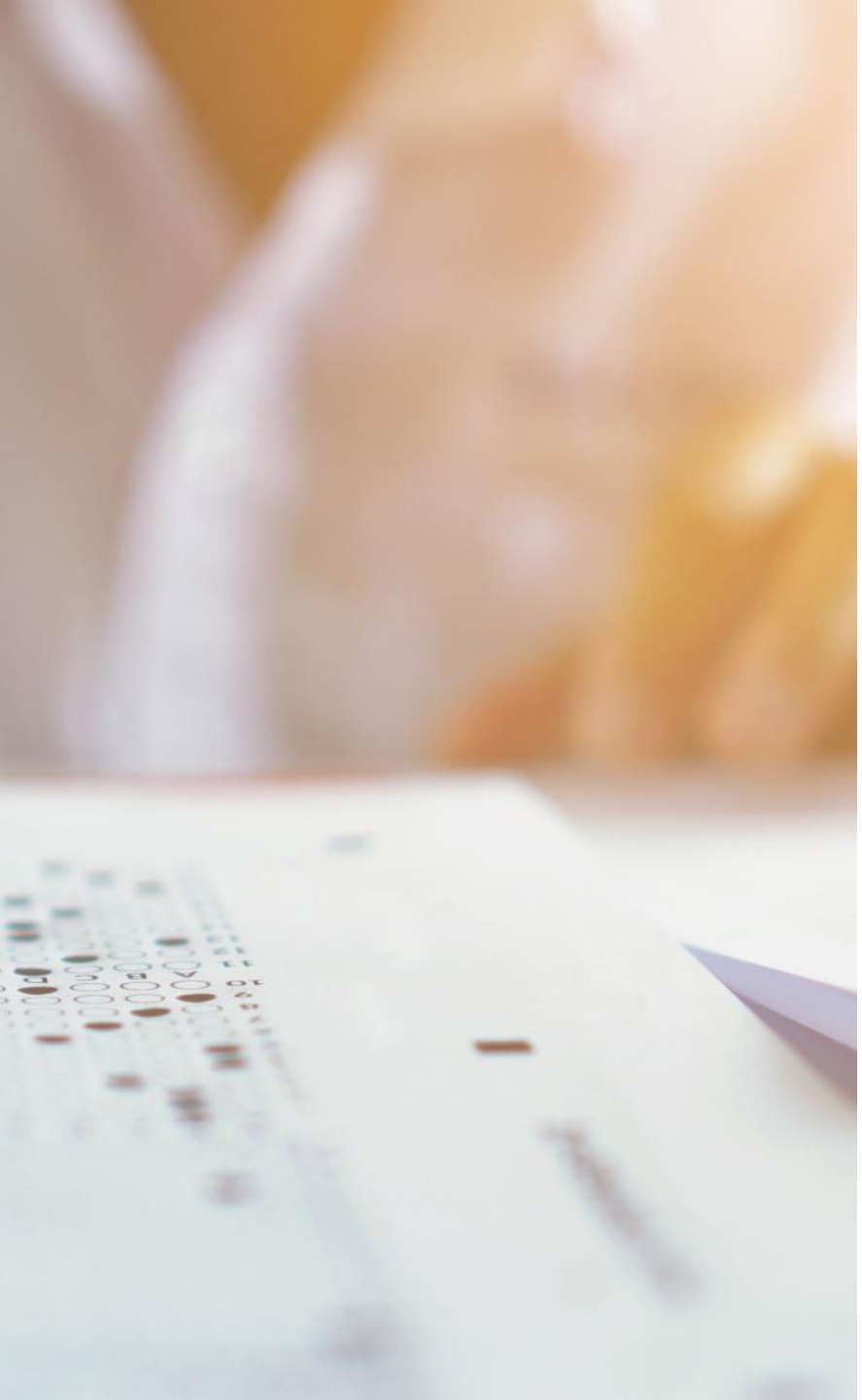
Objectives:

To identify methods to improve medical record quality through internal audits.

To compare the quality of medical records before and after internal audits.

To identify the key challenges in auditing different types of medical records at APEX Hospital.

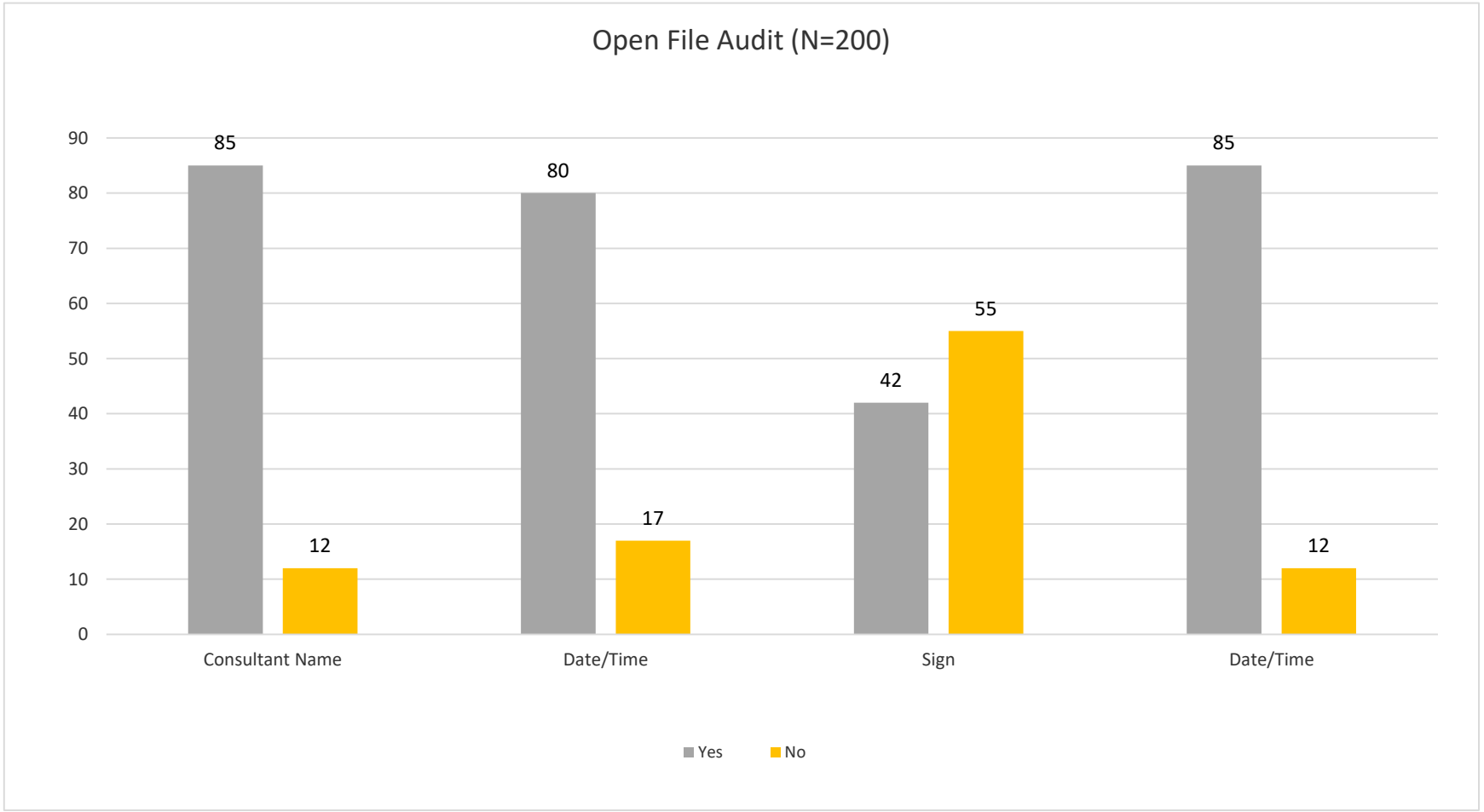
To evaluate the efficacy of internal audits in improving the quality of medical records.

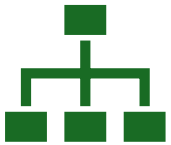


METHODOLOGY:

- **Location:** APEX Hospital, Jaipur
- **Study Population** Patients (IPD &OPD)of APEX Hospital
- **Inclusion Criteria:** Prescription of Patients who consulted a doctor
- **Exclusion Criteria:** Daycare files and lab reports.
- **Duration of Study:** 3 months
- **Sample Size:** 200 patients
- **Sampling Techniques:** Random sampling
- **Type of Study:** Secondary research

RESULTS


Open File Audit (N=200)
90
80
70
60
50
40
30
20
10
0
85
12
80
17
42
55
85
12
Consultant Name
Date/Time
Sign
Date/Time
Yes
No



INTERPRETATION:

Consultant Name Documentation

- 42.5% compliance (85 out of 200 files)
- 6% (12 files) without the consultant's name
- *Implication*: Medium scale of compliance; lack of clarity in medical decisions, affecting continuity and accountability.

Date/Time Documentation

- 40% compliance (80 out of 200 files) in the first instance
- 8.5% (17 files) without date/time documentation
- The second instance mirrored findings with 42.5% compliance and 6% without date/time
- *Implication*: Essential for accurate medical records; discrepancies affect traceability and audit quality.

Sign Presence

- 21% compliance (42 out of 200 files)
- 27.5% (55 files) without sign documentation
- *Implication*: Highest non-compliance rate; critical for authenticity and legal approval; requires immediate improvement.

DISCUSSIONS & RECOMMENDATIONS

Key Observations and Recommendations

Consultant Name Documentation

Moderate compliance at 42.5%

***Recommendation*:** Increase awareness and training on the importance of documenting consultant names.

Date/Time Recording Practices

Discrepancies in compliance rates (40% and 42.5%)

***Recommendation*:** Review and improve documentation procedures to resolve systemic issues.

Critical Gap in Signature Documentation

Only 21% compliance

***Recommendation*:** Implement regular training sessions and compulsory checks to ensure sign documentation, enhancing the reliability and validity of medical records.

CONCLUSION

Consultant Name Documentation

- Mixed compliance: 42.5% recorded correctly, 6% absent.
- Importance: Ensures accountability and follow-up on medical decisions.
- Issue: Some staff may require further education or reminders.

Date/Time Recording

- Importance: Maintains a sequential timeline of patient care.
- Findings: 40% compliance in first instance, 42.5% in second; non-compliance of 8.5% and 6%.
- Issue: Discrepancies affect traceability and patient management.

Sign Documentation

- Importance: Confirms authenticity and validation of medical records.
- Findings: Very low compliance at 21%; 27.5% missing signatures.
- Issue: Indicates lack of stringent checks or oversight in daily practices.

RECOMMENDATIONS

Training and Education

Regular sessions to emphasize the importance of complete and accurate documentation.

Standard Work Procedures

Implement standardized procedures, guidelines, and checklists to ensure uniformity.

Regular Audit and Feedback

Conduct regular audits with feedback to identify and address non-compliance areas.

Technology Solutions

Utilize EHR systems with required fields, automated reminders, and validation checks to enhance accuracy.

Thank You