Synopsis for Dissertation Submitted

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in

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By

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SYNOPSIS

TITLE: ASSESSMENT OF MEDICAL RECORDS(OPEN&CLOSE FILES AND PRESCRIPTION) FOR QUALITY IMPROVEMENT THROUGH INTERNAL AUDIT

- A Comparative study to assess the Quality of Medical records before and after internal Audit Investigate quality of medical record through internal audit

It is beneficial to healthcare institutions because through such processes, they are able to determine areas that require attention with regard to improvement. monitor key performance pointers, and in the long run boost the general quality of services provided to patients.

INTRODUCTION:

Through internal audit processes are beneficial to healthcare institutions because through such processes, they are able to determine areas that require attention with regard to improvement. monitor key performance pointers; and in the long run boost the general quality of services provided to patients. The present paper shall focus on the significance of intake of: evaluating medical documents, especially in connection with the existence of open and closed files, and prescription. interventions, to ensure improvement of practice in healthcare facilities.

They lay the foundation of patient care since documented medical records are essential tools in the doctor patient's relationship. the detailed records of patient's diagnosis, key findings and management plans medications. These kinds of records have to be, and should be up-to-date, and must be retrievable with ease available to the providers to enable provision of quality services to the patients. It is evident that the elements of analysis of both open and closed medical records are used in the discharge of this task. To find faults and omissions that can interfere with the delivery of patient care, I used registered medical records are defined as actual open accounts that are documented as currently being active constantly replenished by the health care professionals from affiliated

health facilities.

RESEARCH QUESTION:

- **How to improve quality of medical record through internal audit**
- **Find out the difference of medical record quality before and after internal audit in apex hospitals, Jaipur**
- **What are the key challenges of open file, close file and prescription audit in apex hospital Jaipur**
- **Find out the efficacy of internal audit as tool to improve quality of medical record**

OBJECTIVES:

1. Identifying discrepancies, errors, and omissions in medical records and prescriptions.
2. Ensuring the accuracy, completeness, and timeliness of documentation.
3. Improving the legibility and organization of medical records and prescriptions.

HYPOTHESIS:

All the medical records {open file close file} was collected from IPD and MRD at APEX HSPITAL Jaipur.
This paper has highlighted the following recommendations on internal audits and internal auditors. Internal audits and their findings and recommendations should be periodically communicated to the hospital leadership and the medical staff. Such transparency will enable the employees to own the medical records quality improvement agenda as well as the adoption of corrective measures.
The study would aimed to investigate the difference of medical record's quality before and after internal audit in apex hospital Jaipur.

MATERIAL AND METHODS:

STUDY DESIGN:

Study Area- APEX Hospital, Jaipur

Study Population – APEX Hospital Patients

Inclusion- All the patients who completed and submitted the feedback form.

Exclusion- Day Care Files and Lab Reports

Duration Of the Study- 3 months

Sample Size- 200

Sampling Techniques- Random sampling

Type of Study – Quantitative

SETTING: Internal audit function at Apex Hospital can be carried out regularly and the function should be provided with authority to scrutinize the medical records independently without interference.

STUDY POPULATION

- Inclusion criteria: All the patients who completed and submitted the feedback form

- Study tools: the internal audit should consider the adequacy of the polices and procedure relating to the management of records of patients. Such assessment may entail the assessment of the clarity of documentation guidelines, data entry stream, and adequacy of staff training programs. Any weakness that may be identified throughout this process needs to be quickly remedied to help fortify the hospital information system's medical records.

DATA COLLECTION PROCEDURE:
The data will be collected through Data which were collected through open file, close file and prescription audit in apex hospital suitated in jaipur.

DATA ANALYSIS PLAN:

Information found in open and closed medical records, and prescriptions are vital in the evaluation of quality in health facilities. Thus, the primary and secondary goals of such kinds of evaluation through internal audit are diverse and are of paramount importance in providing the best possible care to the patients.

The assessment of medical records, the purpose of the activity and part that internal audit plays in it.

First of all, the evaluation of clients' records is crucial to keeping it updated, comprehensive and compliant with the law.

The evaluation of prescriptions also plays an important role in stabilizing the situation and maintaining patient protection and high quality of work.

The intended purpose of auditing of medical records and prescriptions for quality is directed towards the improvement of the results that are being delivered to the patient, their satisfaction, and needed safety.

Through proper analysis of the problems that arise in documenting the patient data and the prescriptions, healthcare institutions can complement the quality of healthcare given to the patients.

ETHICAL CONSIDERATIONS: Informed consent is to taken from Apex hospital in jaipur. Privacy of data is regularly maintained in wards.

REVIEW OF LITERATURE:

1. Madhav M Singh, Saroj Patnaik, Bhandaru Sridhar in 2017 december states that Medical records are technically valid health records which must provide

an overall correct description of each patient's details of care or contact with hospital personnel. And it form a very important and critical document in hospital. These records are vital for legal purposes and for future planning of the hospital medical care. All possible steps should be taken to ensure that all hospital medical records are maintained in systemic and orderly manner. The importance of the medical records should also be communicated to all staff. Periodic audits of the medical records will help to determine the possible deficiency in keeping records, which can be improved and worked upon by the hospital. And he also recommend

- Root cause analysis to be done to find out the reason for lapse in certain departments.
- Sensitizing the clinical and clerical staff regarding the importance of correct record keeping should be stressed to the interns both from a patient care and research perspective.
- Hospital-wide standardization of the medical record keeping including admission and discharge summary.
- Rewarding the best performing department/unit and educating and training the responsible staff to make a complete record of every patient should be
- emphasized in hospital.
- There should be quarterly medical audit of the documentation procedure.
- The interns/residents responsible for filling in the inpatient records should be taught how to adequately fill in the records in a scientific manner.
- A weekly check of the medical records by consultant to assure that it is being completed.
- In addition, sections in the pro forma should be filled in according to their title, to maintain clarity of notes.

2. Abeer K. Al-Baho, Maleka Serour in 2002 they concluded that Audit is a process of critically and systematically assessing our own professional activities with intention to improving personal performance and finally the

quality. Audit is a cycle which consists of a series of particular steps which should be completed to achieve the desirable changes. Selected topics should be relevant and should address areas where improvements are needed. The identification of explicit audit criteria is the core feature of any systemic approach to audit. Standards set should be realistic and attainable. Data collection should be kept to the minimum necessary to fulfill the aims of the particular audit. All participants should be prepared to implement appropriate changes. Implementing changes is the most challenging stage in the audit cycle. Once the results are presented to the team, it has to decide whether it is satisfied with that performance, especially regarding those results that are close to the standards set, or to continue with any necessary steps to achieve higher standards. This is particularly suitable if the initial standards had been set at lower than 100%. For low results sometimes it is reasonable to reset the agreed standards at realistic percentages. The team has to discuss the ways through which they have to work, make a change and achieve the agreed standards. It has to discuss the advantages and disadvantages of each one and choose the most appropriate ones. It has to consider the most practical methods, and all involved in that stage must be familiar with the aims of doing that and their roles. The team has to decide about the date of the second data collection and when audit should be repeated in the future. The audit leader has to monitor the process and get others to share the ideas, which is so important in effecting change8 and keeping the enthusiasm.

3. Suman Agarwal, Ranjit Singh, Chandra Kant Upadhyay in 2021 study finds and suggests that if an organization desires to survive for a longer period it is imperative to do persistent investigation of its service quality. There also needs to be a proper synchronization between the patient expectation and the perception of the management. Singh et al. (2020) have worked upon six new dimensions using Fuzzy analytical hierarchical process and termed it as 'HealQual' for catering to the current scenario. So, managers must continue

doing the environmental scanning to understand the recent trends in customer taste. Health service quality perceptions are antecedents to patient satisfaction which in turn decide whether patients are loyal to healthcare providers (Naidu, 2009; Suhail & Srinivasulu, 2021). There is a need to improve service quality in healthcare units to bring patients' loyalty and expanding the market share (Arab et al., 2012), increasing profit and bringing more patients (Ravishankar et al., 2018). Service quality needs to be improved to assure the patient of getting desired level of medical service (Wu, 2011). However, there exists an overall service quality gap between patients' perceptions and their expectations and there is a need to improve service quality across all the dimensions identified in the study (Ranjith, 2018; Lim & Tang, 2000; Aghamolaei et al., 2014). This may require modification or deletion of the previous dimensions of service quality (Khambhati, 2017) or the addition of a new dimension (Carman, 1990). Hence, service quality is one of the most important success factors for healthcare industry and it must be upgraded according to the changing environment and needs of the patients and emphasis should be on creating greater customer experiences. A Kaleidoscopic view of the research in the area of service quality in respect of healthcare unit is given in Figure 3. This framework enables healthcare serviceproviders to understand how patients and their attendants evaluate the quality of healthcare services provided in respect of every dimension. Healthcare administrators can use the instruments proposed to obtain feedback on their performance on service quality parameters so that they can benchmark themselves with their competitors. Based on the citation analysis, a special focus on efficient operations apart from employees related processes needs to be given for a better efficiency and output. The future scope of the study lies in exploring various other service quality models available in the literature. Selection of appropriate model that satisfies service quality along with customer loyalty is the key to the successful implementation of quality

management in healthcare organizations. The analysis and analytical evaluation can help to determine the mechanisms and causal relationships with the discussed factors in implementation processes with the following research agenda implications.

4. Nicole Rose, Daniel S.J. Pang in 2021 study highlights that the overarching goal of clinical audit is quality improvement, resulting from observing and evaluating processes and outcomes against explicit criteria. Thus, the end result should be an improvement in the quality of care. Understanding the audit cycle process provides a framework for ethical review. It is simplistic to assume that clinical audit does not require ethical review. Though clinical audit often differs from prospective clinical research in that animals are not randomized to receive different treatments
5. Mokholelana M. Ramukumba Souher El Amouri in 2018 they concluded that Various strategies are applied to monitor the quality of documentation in nursing practice documentation audit is one of the important techniques in quality improvement processes. Nurses described their participation in the documentation audit. Data showed that the audit process employed followed the general audit framework; it provided structure and content for data collection, analysis and presentation. The preparation and planning for the audit were found to be areas of strength. This study revealed several facilitators in the implementation of documentation audit by this team. Irrespective of the level of confidence or competence they verbalized, there was good planning, and the aim and methodology of the audit were well articulated. Strong reliance on literature supported the decisions the team undertook to enhance reliability and validity of the audit process and tool. The standards and policies from the hospital and SEHA provided the framework for the audit criteria. These were used as benchmarks to assess the quality of documentation. Thus, there was acceptable organizational support for the audit. The participants in this study demonstrated commitment

regardless of the multiple roles and time constraints. This study found that nurses were generally content with the guidelines and the audit process they adopted. They reported some successes in that the subsequent audits showed some improvements in the documentation. Conversely, there were challenges such as continuous updates in the documentation procedures, which necessitate modification of the audit tool. The complexity of electronic documentation in relation to paper-based audits is acknowledged. This study showed the significance of documentation audit in ensuring completeness of patients' records, the role of nurses in audits and the opportunity audits provide to compare documentation guidelines with the quality of documentation in nursing practice.

6. Kabiru Danladi Garba and Yahya I.in 2018 his study reveals that Information is of obvious importance for the appropriate treatment of all patients. The true cost of generating information to support hospitals is not always quantifiable; its value in this particular case is not measurable. The advantages attached to medical records can never be overemphasized. Medical record is an important primary tool in the practice of medicine and hospitals, the whole idea behind it is to provide better care of the patient through careful recording of every detail having to do with his/her case. As such medical records are essential to ensure that patient information are maintained and systematically used. He further states that system designers must consider how individually identifiable patient information will be protected and also meet regulatory requirements before using electronic medical records. Technological compliance solutions are some of the measures that have been adopted to safeguard electronic medical records. One such technological compliance solution is data encryption, whereby Internet Transfer Protocols are managed, in order to limit access to records. In this case, the activities concerning electronic medical records are tracked to identify who received disclosed data. Another way of safeguarding electronic medical records is through the

use of biometrics (e.g. fingerprint ID recognition) to secure access to computers on networks and information storage devices.

7. S.A. MIRAJ in 2022 explained that Clinical audits enable a more responsible and patient-centric healthcare paradigm by comparing patient care processes to self-defined standard norms. They also provide essential input to medical practitioners, hospital administrators, and policymakers. Educating clinical staff about the necessity of accurate form recording and hospital-wide consistency of medical record providing a summary of admission and discharge is vital. Utmost care should be taken to ensure that the hospital medical records are maintained in a systemic and scientific manner; the use of technological methods soft wares can be of great help in removing errors. The importance of correct medical record-keeping must regularly be exercised and communicated as well to all the concerned staff, monitored by senior consultants to avoid lapses. This can help to determine the possible deficiency in keeping records and rectify them beforehand, instead of getting piled up and being pointed out by clinical audits.In an earlier study conducted by Singh et al8 , it was found that in a multispecialty hospital, out of the several wards – like the medical, gynecology, obstetrics, surgical, pediatrics, and psychiatry – gynecology and pediatric wards were not found appropriate and up to date. There was clearly a large discrepancy between the standard of record-keeping in various departments, mostly due to avoidable errors, made in sheer carelessness and casual approach. It has also been noted by Robertson et al9 and Walker et al10 that in surveyed hospitals, it is a common feature that the interns/residents are mainly responsible for filling in the in-patient records, which are not sincere in their duties, resulting in errors and deficiencies. They should be taught how to adequately fill in the records in a scientific manner, which must be monitored by weekly checks of the medical records by consultants to assure that they are being completed The findings of the present analysis also suggest a similar situation where carelessness by

most of the staff leads to such lapses in medical records and audits. With no serious monitoring being followed, these resulted in audit lapses of callous nature, violating the NABH guidelines, ultimately affecting the efficiency of the health care system. With proper training judicious and honest use of audit information, the stakeholders of the health care system can make improvements in health care delivery, benefitting both the government and the patients by the synergistic use of health information system-generated data. As medical records form a very important and critical document in any hospital, they are vital for legal purposes, as well as for future planning of the hospital medical care system. Utmost care should have been taken to ensure that all hospital medical records are maintained in a systemic and scientific manner, using some of the state-of-the-art technologies which are easily available. This was totally wanting in the present random sampling of the audit files. The importance of the medical records should have also been communicated to all the concerned staff. No periodic audits of the medical records were done by the senior staff, which could have helped to determine the possible deficiency in keeping records. The hospital was found to have been facing certain problems like not having clear objectives and planning, lack of clarity on the methods of record-keeping coupled with lack of organizational support, which acted as possible challenges for lapses in clinical audit causing common discrepancies. In this regard, it was stated that the health care industry gradually generated large amount of complex and diverse data, such as record keeping, compliance, and regulatory requirements of clinical audit in the absence of proper infrastructure and management, is not done properly for the benefit of the patients. It was suggested by some authors3 that expenditures can be significantly lowered by employing proper health informatics software whereby statistical techniques could be judiciously used for the management of big data suggesting appropriate predictive models and training which could benefit everyone including

patients, hospitals, system making it a sustainable.

IMPLICATIONS OF RESEARCH: This research will be useful for the hospital through a successful internal audit program, Apex Hospital can see improvements in medical records' credibility and enhance the quality of patient care to a greater extent. Introduction of this strategic approach would cement the status of the hospital not only in the clinical studies, but also within the community.

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