STATUS OF COMPLIANCE OF MEDICAL RECORD DOCUMENTATION IN A MULTISPECIALITY TERTIARY CARE HOSPITAL, MUMBAI

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

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Under the Supervision and Guidance of

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2024

Kokilaben Dhirubhai Ambani
hospital & medical research institute
MUMBAI

Every Life Matters

KDAH/HR/OL/2024/06/473

Date: 15.06.2024

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Himani Namdeo Balpande** has successfully completed her **2 months and 18 days** period of **Internship** from 26.03.2024 to 14.06.2024 in the **Department of Clinical Administration** at **Kokilaben Dhirubhai Ambani Hospital & Medical Research Institute,** under the guidance of Senior Manager - Clinical Administration, Dr. Ramkishor Pandey.

She has completed her tenure entirely to the satisfaction of the hospital management.

We wish her all the best in her future endeavor.

Best Regards,
For Kokilaben Dhirubhai Ambani Hospital & Medical Research Institute,

Rashma Nathani
Asst. General Manager - Human Resources

DECLARATION

I hereby declare that this dissertation **"Status of compliance of Medical Record Documentation in a Multispeciality Tertiary Care Hospital, Mumbai"** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Dr. Himani Balpande

MBA-HM27(IIHMR-U/01/2022-24/1509)

2022-2024

04/07/24

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **Status of Compliance of Medical Record Documentation in a Multispeciality Tertiary Care Hospital, Mumbai** is a record of the research work undertaken by **Dr. Himani Balpande** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

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ABSTRACT

BACKGROUND

Medical documentation are essential to ensure thorough, high-quality medical care for patients. The research study assesses the adherence of a multi-specialty healthcare facility in Hospital with NABH guidelines concerning health care records paperwork, that emphasise its significance for the safety of patients and their medical services.

OBJECTIVE

The objective of this research is to evaluate current degree of compliance in documenting medical records while assessing variances throughout various record keeping metrics.

METHODOLOGY

A retrospective observational study was carried out, assessing 148 inpatient documentation by deploying a checklist that was in accordance with NABH rules and regulations. Convenience Sampling was the approach taken. Data have been gathered through audits checklist and discussions with healthcare workers, and their levels of compliance were checked. The assessment comprised determining a percentage of adherence for each and every parameter.

RESULTS

The research project showed variations in rate of compliance throughout various documentation areas. High adherence has been noted in surgical precautionary checklists (99%), forms for consent (98-99% including sign and name) and anaesthesia records of treatment (96-97%).

Nevertheless, there were significantly lesser compliance rates for those mentioning the moment of initial assessment (30%) and planning for discharge (28%). Nursing professionals demonstrated good adherence in pain (91%), assessments of nutrition (87-89%) and fall risk (90%).

Further, initial inspections by nurse practitioners demonstrated a 53% compliance rate, whereas allergy-associated documenting in anaesthesia

documents was very low (4%). The paperwork of the initial assessment (71%), as well as the entire medical history of the patient (72%)were fairly compliant. Although doctors' procedures for discharge were well-compliant (97.6%), plans for discharge were not completed on time.

Professional physiotherapists' data showed a high level of compliance with levels of pain (82.4%) and possible range of movement activities (73.8%). Dietary professionals presented a high level of compliance in nutritional assessments and examination follow-ups but there were only small gap.

CONCLUSIONS

The healthcare facility displays good adherence across multiple documentation sections yet requires to make improvements in other areas like appropriate documentation and planning for discharge. The execution of the study's a few ideas might enhance record keeping the level of quality, leading to enhanced safety and care for patients.

Regular performance assessments and the implementation of the highest standards serves as vital for maintaining standards of excellence in health care records documentation.

In addition, ongoing operation instruction and awareness raising for healthcare providers about the significance of precise and prompt recordkeeping is important. Coordination among the departments might encourage enhancements making sure medical files are updated, reliable and accurate.

Resolving these discrepancies would enable the hospital to substantially enhance the standard of care, better comply with guidelines set by regulators and encourage a culture of top-notch performance regarding health care recordkeeping.

Highlighting proper record keeping can also help to improve the decision-making process, outcomes for patients, and overall delivery of healthcare efficiency.

KEYWORDS

Compliance, Medical Record Documentation, Patient safety, Surgical Safety Checklists, Consent Forms, Performance Assessment

ACKNOWLEDGEMENTS

Successful completion of a dissertation is a journey which provides valuable learning and hands-on work experience. No amount of words can really express how grateful I am to everyone who supported me to accomplish my dissertation thesis during such hard times.

First and most importantly, I am grateful to Dr. Ramkishor Pandey Sir,(Senior Manager, Clinical Administration Department of Kokilaben Dhirubhai Ambani Hospital, Mumbai). His invaluable guidance and constant encouragement were essential in assisting me complete this task on time. Without his cooperation, this project would not have been feasible.

I am truely grateful to my IIHMR University, Jaipur's Mentor Dr. Neetu Purohit Ma'am, (Professor), for helping me with all of the assistance I needed to proceed with my dissertation. With her expertise, I was able to impart knowledge on the many different aspects,which this project had opened and explored alot. Her guidance in getting me to think about completely different intellectual and the realistic elements of administration has propelled this project to this stage of successful completion.

Finally, I would want to express my heartfelt gratitude to my parents, family, friends, and all my well-wishers, who were the pillars of moral support and without their love, care and motivation I would not be able to accomplish this project and would have been extremely challenging throughout the process.

Dr.Himani Balpande
MBA HM-27

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ABBREVIATIONS

1	CQI	Continuous Quality Improvement
2	KPI	Key Performance Indicator
3	EHRs	Electronic Health Records
4	NABH	National Accreditation Board for Hospitals & Healthcare Providers
5	SOP	Standard Operating Procedure
6	VAS	Visual Analogue Scale
7	PCC	Primary Care Centre
8	ASA	Anaesthesia Safety Assessment
9	HOD	Head Of Department
10	JMS	Junior Medical Staff

INTRODUCTION

1.INTRODUCTION

In this world of healthcare, medical records are important for patients treatment and their care. This information gives a complete picture of a person's medical history, allowing medical professionals to deliver personalised and effective services. Medical records are essential for research purpose and timely diagnosis, informed decisions regarding treatment. As a healthcare professional, they should acknowledge the significance of ensuring up-to-date and correct medical records and for the purpose to provide the best healthcare services. Health care records are thorough documentation that track a patient's healthcare experience and their well-being .

It includes details regarding history, allergies, test findings, illnesses and interventions, prescriptions for patients, and even more. Healthcare documentation are crucial records that give specific details about patients as well as ways to communicate with hospital professionals.

This also plays a vital role in the patient's present and prospective health care. The standard of health treatment is determined by comprehensive reporting, precise, timely, consistent medical records. The details included in healthcare documents can be used to indirectly assess the quality services delivered.

Healthcare records are crucial papers which include broad details on the diagnostic procedures, patient's history, outcomes from clinical studies, pharmaceutical plans, before and after following surgery treatment, subsequent examinations and progress of the patient.

Medical evaluations are also helpful in pinpointing areas for development and as a result, giving a framework for implementing measures to foster and maintain these enhancements.

The most effective strategy to enhance the overall standard of medical record documentation is to carry out periodic reviews. The purpose of the medical inspection aims to assess the quality of health care, that is going to result in advancements throughout all aspects of hospital operations through encouraging solution of the shortcomings identified during the auditing process.

Therefore, healthcare record inspection is an excellent instrument for achieving and sustaining the high standards of medical care.

The purpose of a healthcare assessment aims to deliver enhanced medical services while further enhancing the financial condition of the organisation. Establishing a comprehensive record is extremely important not merely for accomplishing authorization and accreditation requirements, however for permitting a healthcare worker to prove that a patient received adequate care.

Record-keeping management encompasses leading ,arranging, preparing, governing, teaching, promoting, and executing other tasks of administration related to the growth and development, utilisation, storage and management of medical documentation. Effective documentation guarantees that the healthcare facility's operation runs seamlessly.

The hospital's documents also show how it is accountable for the way it operates, and they additionally provide valuable data for submitting reports, medical studies and health information technology. The health record enables medical professionals to prepare for along with assess the treatment of an individual and also maintaining continuity of treatment among several providers.

The accuracy and clarity of the details in the medical record of a patient impacts the standard of care patients experience. The simplest method for assessing adverse outcomes within healthcare facilities is to evaluate the medical records of patients. The manner in which facts are documented might impact the degree to which negative incidents occur.

Improper accuracy of information in medical records of patients have been correlated to a greater proportion of negative outcomes generated or caused by negligent treatment. The enhancements in the level of accuracy of information related to healthcare in the medical records of patients could have consequences on patient and management judgements regarding the provision of healthcare and the security of patients.

Medical records are an invaluable source of data for doctors and organisations. These assist practitioners in providing the most effective treatment to each patient, as well as facilities in collecting information for studies and evaluating their performance.

This information is also mandatory if there is ever a legal trouble.

In order to guarantee that such files are as beneficial as possible, it must be stored in a accurate , full and rule-compliant form,subsequently implies that whoever associated with healthcare who records data in these systems is responsible for doing so quickly, accurately and effectively.

By doing so, each individual can be assured that the records are reliable and could potentially implemented to assist patients and strengthen the health care system.

They must additionally inform the medical professionals if a vital component isn't present in the database.

The manner in which health care information are entered is necessary and it is evaluated according to NABH guidelines and this are considered the benchmark for excellence for how well a hospital serves for their patients.

Such documents may possess a major impact with regards to how a patient assumes about their stay in the hospital or the interactions with their healthcare provider.

In order to guarantee that these documents are well-maintained appropriate and comply with the required standards of NABH. The National Accreditation Board for Hospitals and Healthcare Providers (NABH), an integral board, set by the Quality Council of India (QCI), represents a such body that functions several kinds of certification programmes for healthcare facilities and other providers of healthcare.

The governing body operates with complete autonomous functioning and has assistance from the everyone who is involved, comprising the organisation, the public, its employees and the governing bodies.

NABH, although representing a governing body, possesses responsibilities with multiple bodies.

Through the help of this study, healthcare organisations could promote modified recordkeeping to boost guidelines for clinical practice and better quality of health care services.

REVIEW OF LITERATURE

2.REVIEW OF LITERATURE

S. A. Miraj (2022) performed a prospective observational descriptive research study at a hospital with multiple specialties in Delhi NCR, India, between June and August 2021. The study utilised a small random sample of 325 documentations to evaluate compliance to NABH standards in medical record paperwork and recommend areas for improvement. The findings indicated a number of concerns, including 25.72% of the data being inaccurate, the use of error-prone acronyms, and identifiable signatures on authorization forms. In addition, 14% of documents unable to meet the NABH guidelines, suggesting substantial weaknesses in quality compliance.

Hosein Dargahi, Mansour Zahiri, Saiedch Sharifi, and Farzad Faraji Khiavi (2021) performed a qualitative analysis in Ahvaz, southwest Iran, using 28 documents from five educational institutions. The research project was to find out characteristics which impact the correctness of healthcare documentation throughout the adoption of accrediting standards. More than fifty percent of the participants felt that the framework itself presented hurdles, with challenges including the huge volume of required records and the time-consuming nature of gathering specific health-related information.

Nomura et al. (2016) performed a field experiment in Brazil, assessing 224 data from medical and operating rooms between 2012 and 2013. Using PEPI Software Version, the study discovered that recordkeeping improved significantly in 24 of 29 areas following the hospital's accreditation.

Between 2014 and 2015, Attia et al. (2020) conducted a cross-sectional investigation in Saudi Arabia with 18 samples collected from a hospital environment. The study used random sampling and focused on health record data to determine how achieving certification requirements affected the general standard of digital medical information.

Ryan et al. (2018) performed a retrospective observational analysis at the Cleveland Clinic in the United States, analysing 821 data from 2015. The study used convenience sampling and quantitative analysis via conversations to measure surgical compliance and record accuracy among individuals receiving different medications across the United States. The research revealed that inadequate adherence and inaccurate medical information led to insufficient records of medication use for those individuals.

Mishra et al. (2009) performed a descriptive cross-sectional investigation at Bir Hospital's Liver Unit in Nepal, examining 130 cases during 2008. The study applied a list of criteria to evaluate the credibility of medical paperwork. The data found that in 66% of cases, the individual's departure status wasn't documented, and in 79.3% of cases, the healthcare workers signature was unreadable. Furthermore, 90% of those treated were discharged with no obtaining additional support, and there were multiple additional anomalies in the hospital discharge reports.

Sadagheyani H.E (2019) performed an analytical cross-sectional investigation at Iran's Besat Hospital, reviewing 1500 papers over 2011 to 2017 . The study used methodical sampling and a list of criteria to assess how approval affected the precision of healthcare document content. The outcomes showed substantial enhancements in all sorts of papers while evaluating the situations of paperwork prior to and after the introduction of revised permission methods.

Nugraheni et al. (2019) performed a qualitative research investigation in Indonesia that focused on the management of medical information in medical facilities. Through non-structured discussions and observations, the investigation concluded that standard criteria 8.4.3 and 8.4.4 was completely satisfied, whereas criteria 8.4.1 and 8.4.2 had been partially satisfied.

Lovestam et al. (2013) performed a retrospective study using observation in Sweden in 2009, analysing 147 cases from 6 medical centres and 4 primary healthcare facilities. The research project included a review tool to evaluate the documentation of dietary therapy in medical documents. The results demonstrated that numerous critical nutritional and dietary aspects hadn't been properly recorded, emphasising the importance of enhanced healthcare reporting by nutritional experts. The research proposed that a structured maintaining records strategy might enhance the implementation of dietary procedures for treatment.

3.RESEARCH QUESTION

What is the current level of compliance in medical record documentation at a multispeciality hospital?

How does compliance vary across different parameters of patient file documentation?

4.OBJECTIVES

To assess and compare the level of compliance across various parameters of patient file documentation

METHODOLOGY

5.METHODOLOGY

MATERIAL AND METHODS

STUDY DESIGN

We conducted a retrospective observational study, examining medical records of a hospital to assess compliance with NABH standards for inpatient care documentation.

SETTING

The study was conducted in a Kokilaben Dhirubhai Ambani Hospital, Mumbai, Maharashtra with the help of Clinical Administration and Quality Department, specifically focusing on the Medical Record Department.

This hospital is 750 bedded multispeciality tertiary care hospital known for its advanced medical facilities and high- quality healthcare services.

STUDY POPULATION

Records of Patients files

STUDY TOOLS

Auditing of Medical Record Documentation(MRD)

DURATION OF STUDY

2 months

SAMPLE SIZE

148 Medical Record Documentation

SAMPLING TECHNIQUE

The research project uses a convenience sampling method to choose records from patients for conducting audits. This strategy assures that each patient's data in the entire population gets a similar opportunity of being selected for the sample.

DATA COLLECTION PROCEDURE

An audit checklist was used as an essential data collection method for analysing patient records in order to find out the compliance rates of in-patient medical record documentation with NABH standards within a hospital.

A Checklist consisting of various indicators was used in order to collect the data. By the means of simple random sampling in-patients files were audited in order to check the compliance of the file.

Secondary data were captured through EMR(Electronic Medical Record).

DATA ANALYSIS PLAN

According to hospital SOP(Standard Operating Procedure) a checklist of indicators was been used to ensure patient file compliance.

An Microsoft Excel was been used for cleaning the data, data analysis and visualizations of data and for reviewing indicators in the three categories: complete, incomplete, and not applicable.

Based on this categories, the overall analysis was been done by finding the percentage compliance of each indicator.

ETHICAL CONSIDERATIONS

We got permission from the Hospital's Medical Record Department ,Quality Department and Clinical Administration Department to audit the patient's file. Throughout the study we had maintained privacy, confidentiality, safety and we tried our best to be fair and honest and minimizing biasness.

RESULTS

6. RESULTS

The compliance had been assessed with respect to below parameters. The compliance was evaluated using multiple parameters outlined in NABH guidelines for inpatient care documentation.

The following involved the completeness of patient data, such as treatment plans, medical histories ,the clarity and accuracy of healthcare entries, the availability of consent forms with information and summary of discharge documents.

The evaluations are done to maintain the highest standards and consistency in records of patients in accordance with NABH standards.

6.1 CONSENT FORM

The bar graph 6.1 depicts the rate of compliance and noncompliance rates for several criteria of the consent form records in a multispecialty hospital.

It demonstrates high compliance rates for the general consent - signed by patient/relative/guardian that is 98% and the general consent named by patient/relative/guardian that is 99%.

Still, compliance rates reduce substantially for the general consent - date is mentioned, compliance is 89% , as well as in the general consent - time is mentioned compliance is 76% (D/T).

The results shows that, although majority forms of consent have been correctly signed and labelled, there is time for advancement in making sure that times and dates are regularly reported.

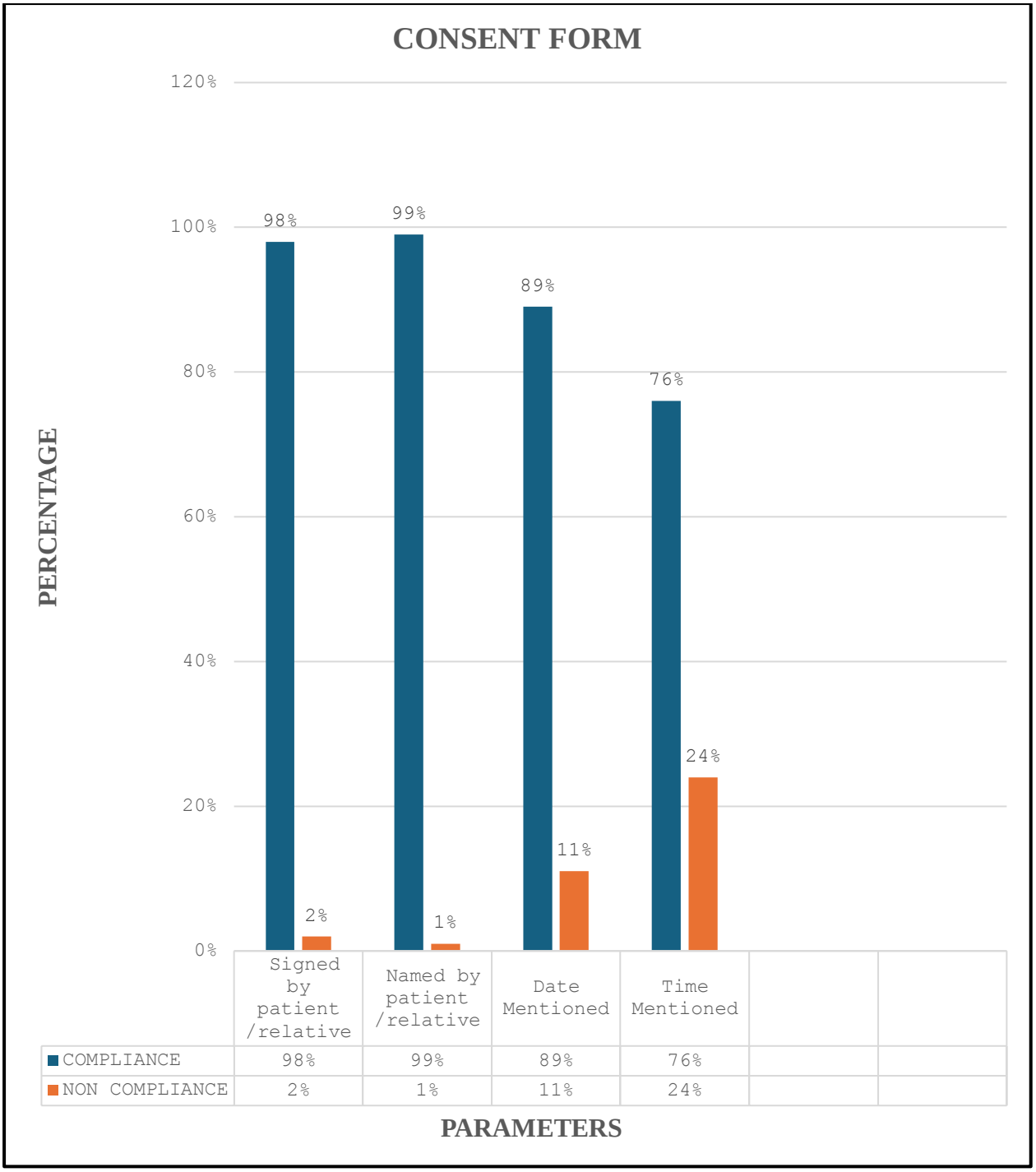

FIG: 6.1 CONSENT FORM

6.2 INITIAL ASSESSMENT FORM

The figure 6.2 above depicts the rate of compliance and noncompliance rates for several components of the Initial Examination Report in a multispecialty hospital. According to the data, compliance appears to be good for recording "Complete History" (72%) and for "Provisional Diagnosis".(71%).

Still, there is a considerable discrepancy in compliance for "Time of Initial Assessment Reported by Doctor" (30%) and the discharge rate Planning (28%), highlighting that these segments require significant development.

The graphic shows that, although certain components of initial evaluation document are effectively subsequently followed, others, notably the ones needing specific to time data, have significant shortcomings.

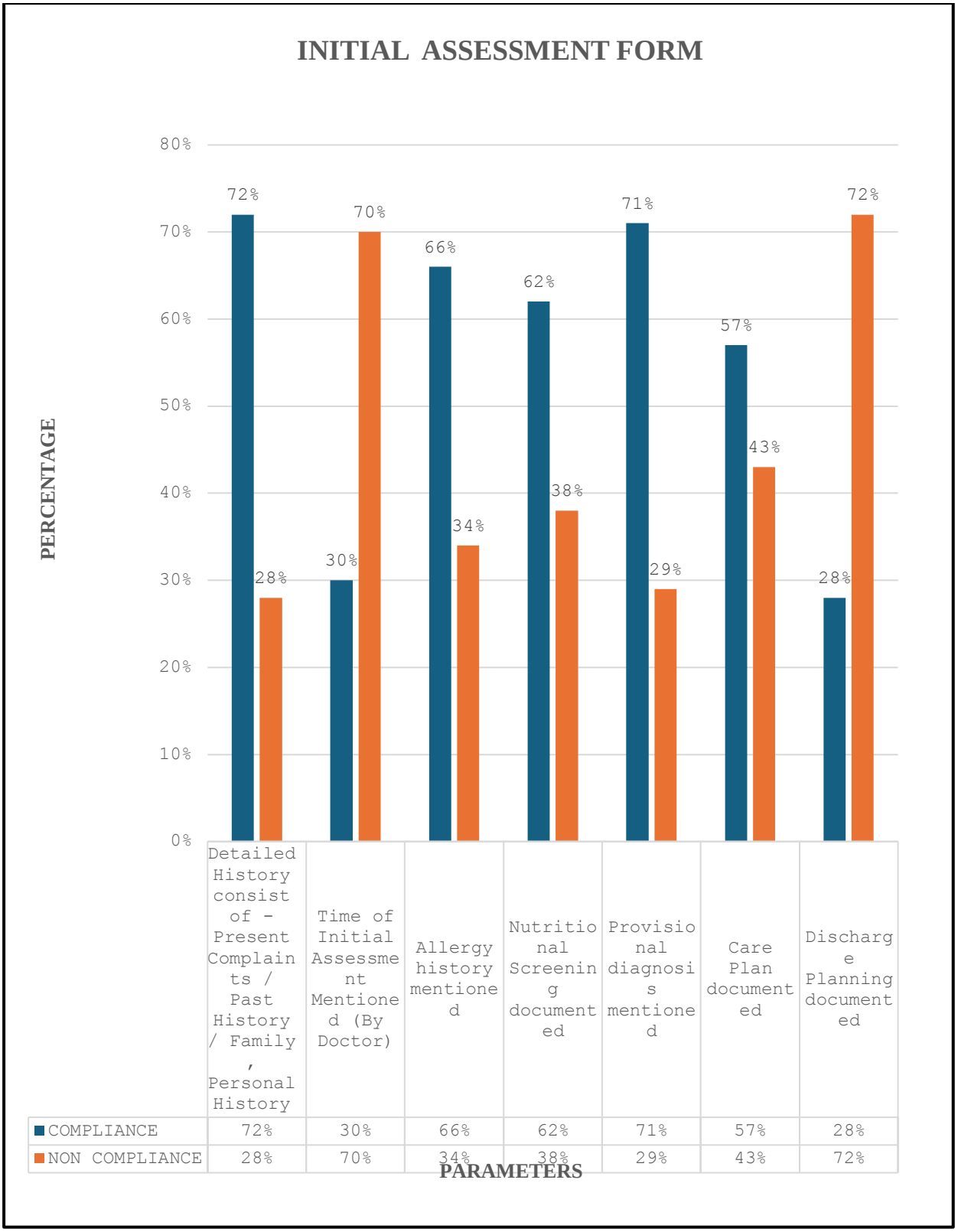

FIG: 6.2 - INITIAL ASSESSMENT FORM

6.3NURSING NOTES

The figure 6.3 data shows compliance and noncompliance rates for various nursing record measures. Early assessments for nurses performed around one hour reveal an almost , with 53% complying and 47% not complying. Pain evaluation and reassessment experienced a good compliance rate of 91%, while just nine percent noncompliance.

Fall assessment of risks records is comparably high, having compliance rates of 90% and noncompliance. rate of 10% Finally, recognising required data reveals compliance of 89% and noncompliance of 11%. This implies that, while early assessments are inconsistent, other essential records maintain high compliance rates.

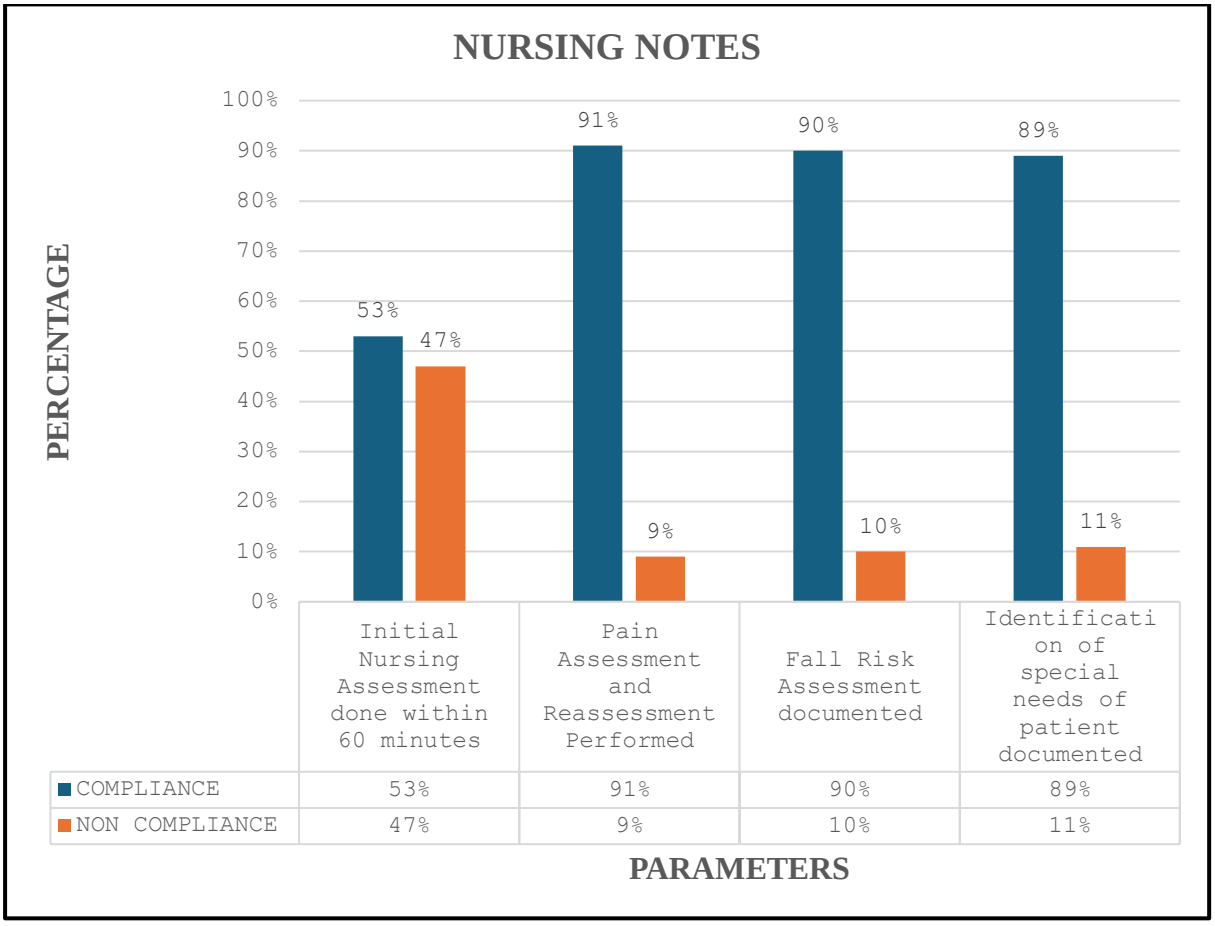

FIG:6.3- NURSING NOTES

6.4 NUTRITIONAL ASSESSMENT

The figure 6.4 named Nutritional Assessment displays compliance statistics for two main nutritional evaluation parameters. The first indicator demonstrates that nutritionists execute 87% of nutritional level of compliance, whereas 13% are non-compliant. The additional statistic shows that there is 86% of compliance thereafter which have been recorded, compared to a 14% of noncompliance rate. The results presented indicate an good rate of compliance to the nutritional assessment standards , including barely any number of cases where compliance have not been seen. In all, the findings of the data emphasises that there is regular ongoing recording and monitoring done in case of nutrition status.

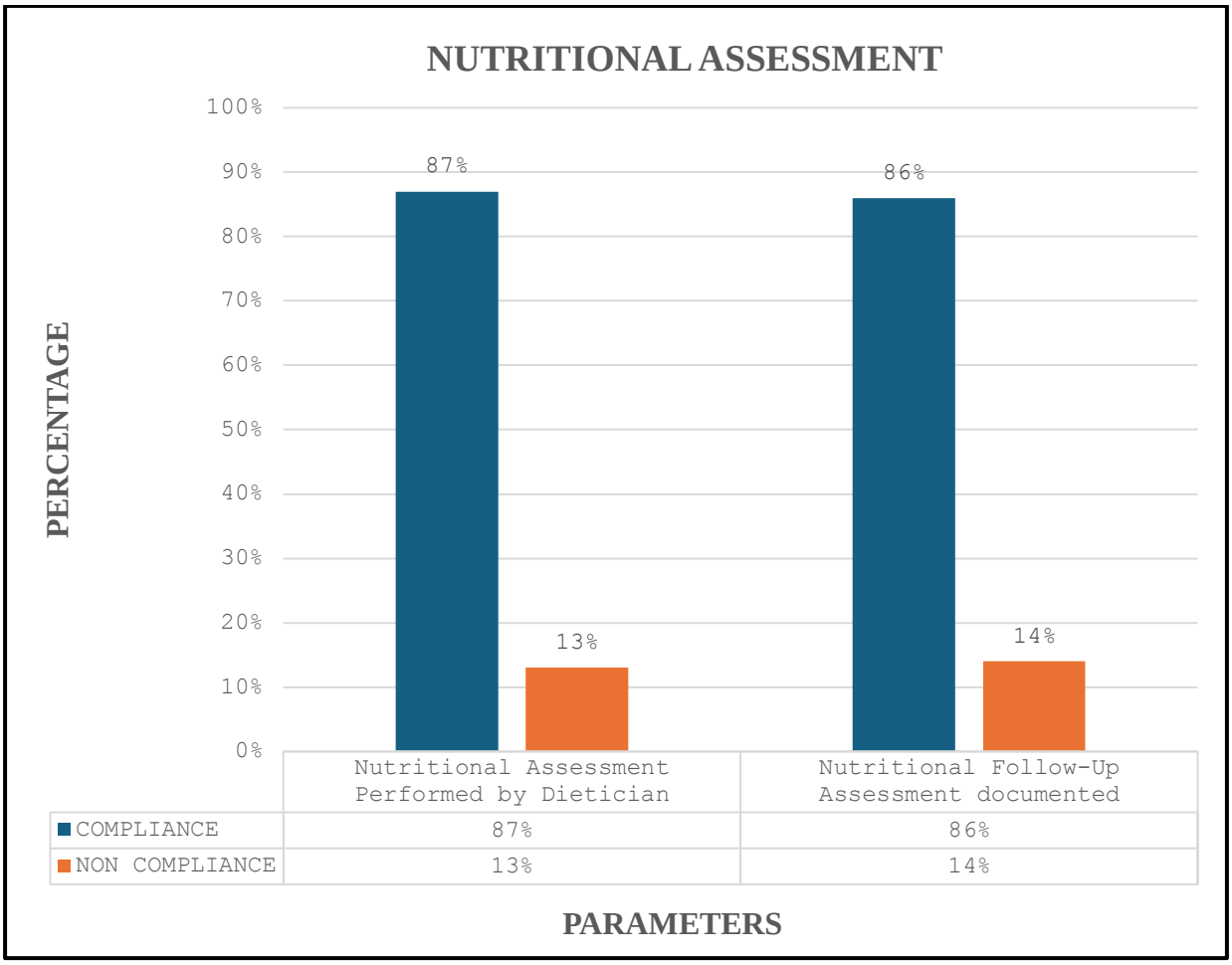

FIG:6.4- NUTRITIONAL ASSESSMENT

6.5 ANAESTHESIA DOCUMENTATION ASSESSMENT

The figure 6.5 data demonstrate the rates at which various components of anaesthesia care are documented. Documenting pre-anesthesia assessment and consent forms has an extremely good compliance rate of (96-97%). But compliance rates are less for in some areas, which include having the anaesthesia doctor obtain consent of (64%) and reporting the Anaesthesia Safety Assessment (ASA) score with (88%).The adherence rate for reporting allergies has been particularly low (4%).

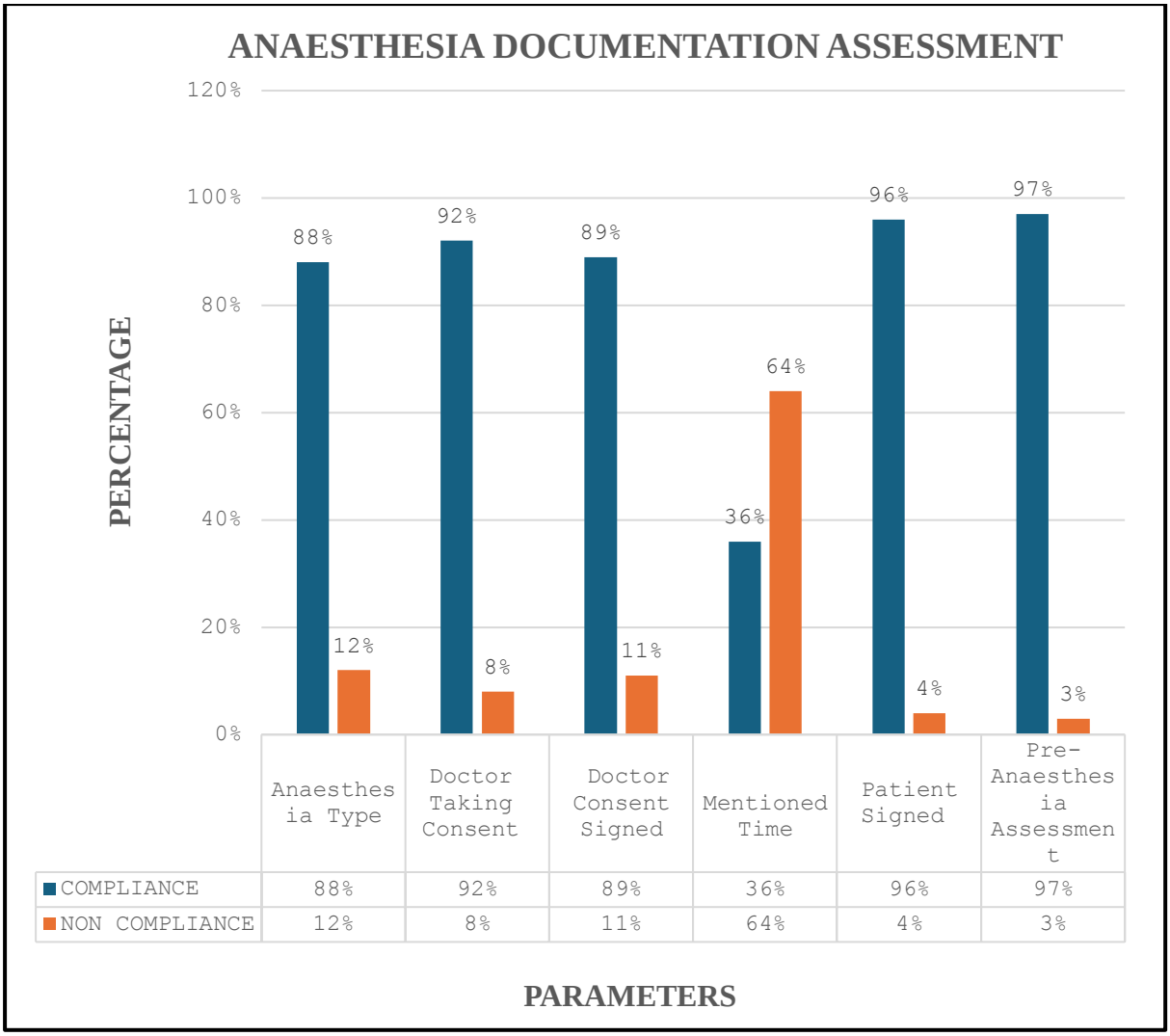

FIG:6.5- ANAESTHESIA DOCUMENTATION ASSESSMENT

6.6 OPERATIVE NOTES

The figure 6.6 data shows a high level of compliance in multiple necessary sections. The key consultant's operational notes demonstrate compliance rate of 91% , while only noncompliance of 9%. We can see that while plan of care of post operative documentation is somewhat less, with compliance of 75% and noncompliance of 25%.The checklist of surgical safety is closely followed, with compliance rates of 99% in all three categories: observable checklist, sign-out and sign -in paperwork, and time and day of operation documentation, each with onlyone percent noncompliance. This shows strong adherence to operative recording guidelines, with just minimal potential for enhancement to rehabilitation following surgery documentation.

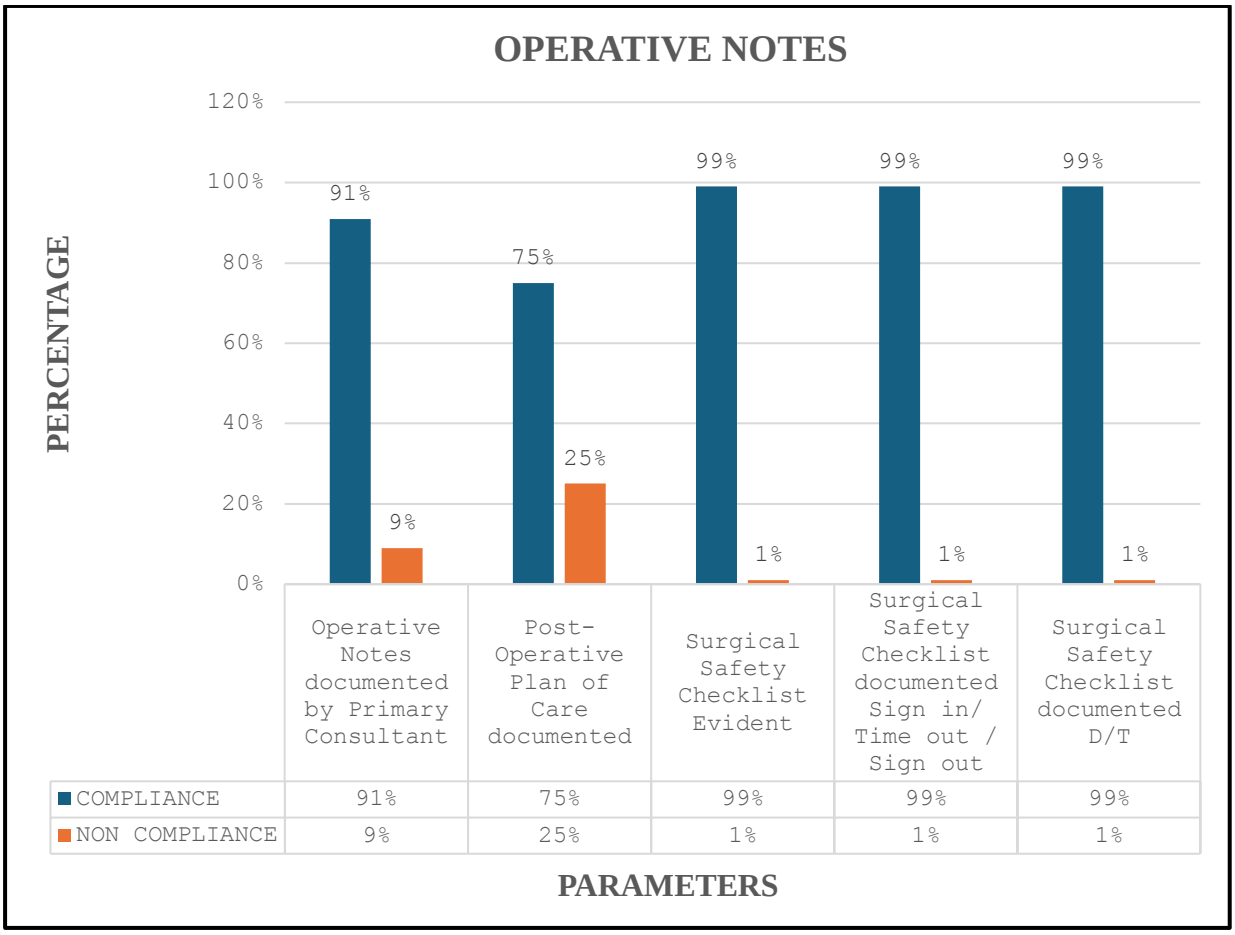

FIG: 6.6- OPERATIVE NOTES

6.7 MEDICAL RECONSILIATION AND TREATMENT RECORD

The data in the figure 6.7 depicts the rates of completion for treatment records and healthcare reconciliation and Here exists a particularly high rate of compliance with (99.32%) for recording medical reconciliations.

Additionally, there remains a satisfactory rate of compliance of (83%), with every procedure and orders properly maintained throughout discharge. But there is a substantially less rate of adherence with (75%) with having JMS signature mentioned alongside every prescription in patients receiving treatment order document.

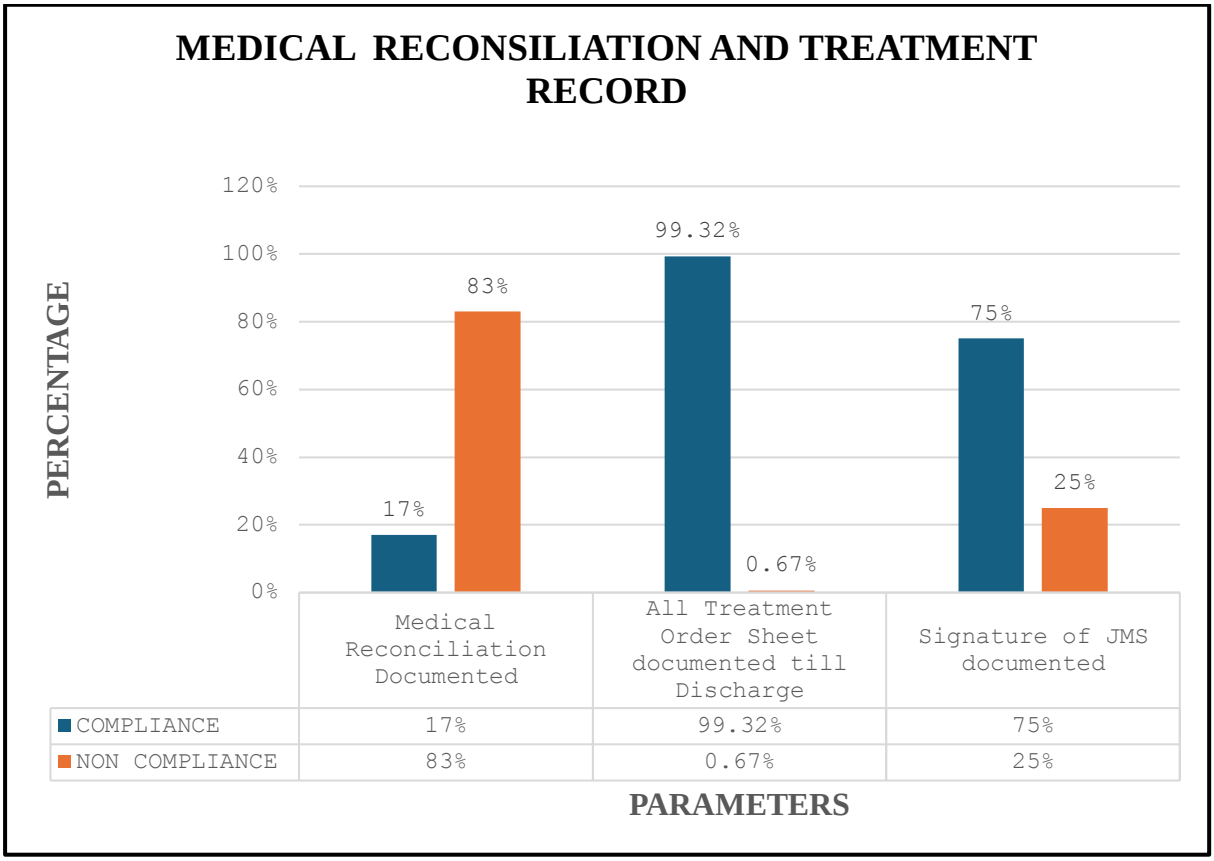

FIG:6.7- MEDICAL RECONSILIATION AND TREATMENT RECORD

6.8 DISCHARGE SUMMARY

In figure 6.8 almost all summary discharges (98.65 percent to 100 percent) include every necessary parts, such as investigations findings, prescriptions for patients, and further investigation advice. A lesser proportion (0.67percent - 1.35 percent) of summaries of discharge remove certain necessary details. The most common lacking of (1.35 percent) involves obtaining details in regards to a critical situation.

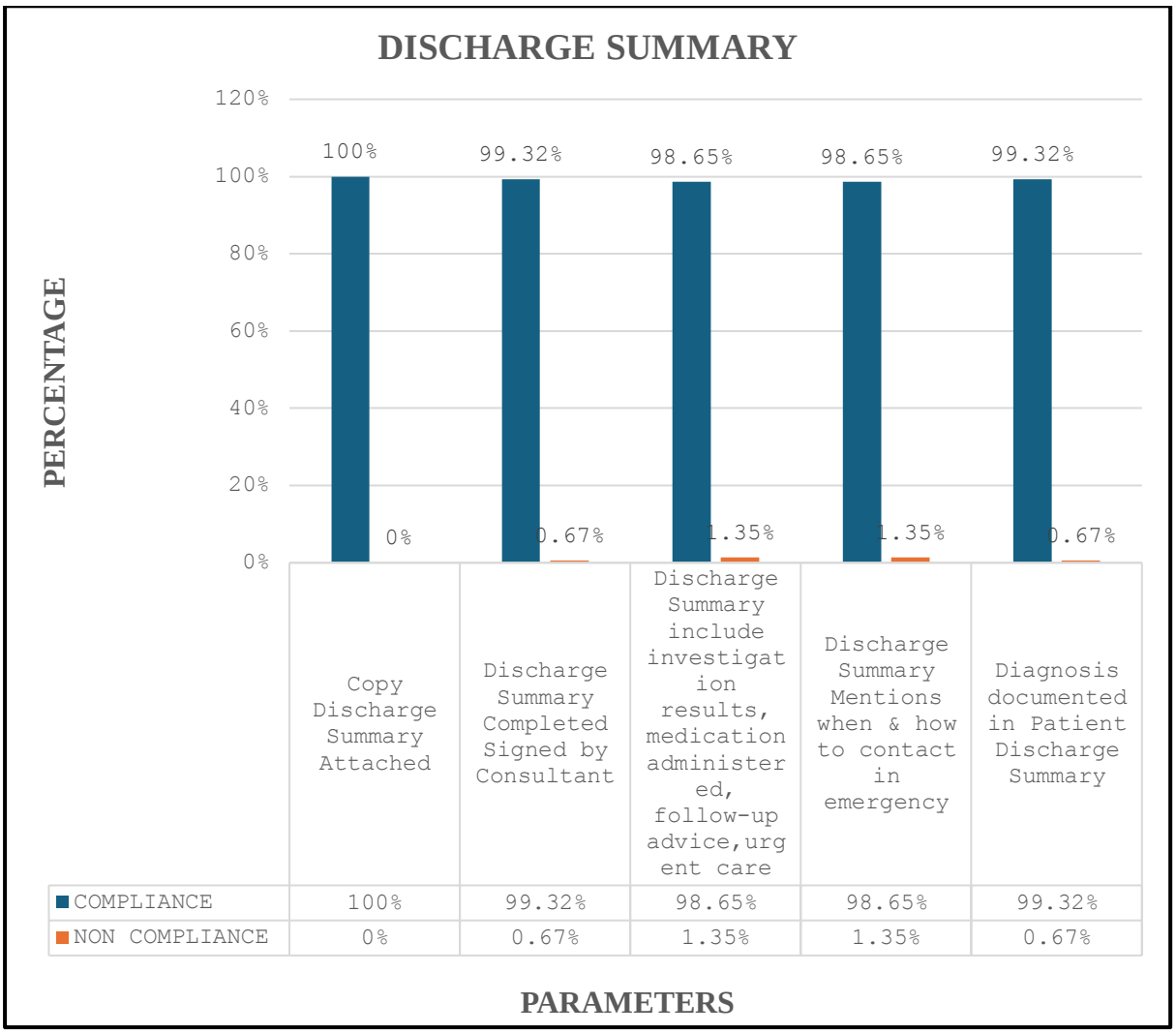

FIG:6.8-DISCHARGE SUMMARY

Based on Various parameters, compliance was asssessd, Here are the clinical audit checklist done on 148 cases(n=148 patient's files)

1.Consent Form

2.Admission Request Form

- Sign, Name, Date and Time by pt/relative/guardian

3.Initial Assessment Form

- History
- Findings
- Investigations
- Plan of Treatment
- Doctors-Name,Sign,Date, Time
- Discharge Summary
- Allergies, if any
- History
- Sign-JMS
- Name-JMS
- Date-JMS
- Time-JMS
- Vitals recorded
- Plan of Care
- Special needs
- Special needs of time of discharge (on initial assessment
- Assessment done within 2 hours-JMS
- Assessment done within 24 Hours Consultant
- Alternatives given
- Risk Explained
- Benefits Explained

4.Nursing Notes

- Nursing Care Plan
- Nursing Assessment Chart
- Nursing Administration Sign
- Nursing Administration Time

5.Nutritional Assessment

- Dietician Referral
- Documentation of Diet on This Sheet
- Referral For Doctor
- Nutritional Screening Done
- Initial Nutritional Assessment Done
- Nutritional/ Diet Order Mentioned on Plan of Care
- Nutritional reassessment Done
- Patient Education on Diet and Nutrition Given

6.Anaesthesia Documentation Assessment

- Pre-Anesthesia Assessment Document

7.Operative Notes

- Operative Notes documents
- Operative Notes Sign By Surgeon
- Post Operative Plan Of Care Document
- Surgical Safety Checklist Completed

8.Medical Reconsiliation and Treatment Record

- For ICU-Counter Sign By Doctors
- Intervention dose / Action Taken

9.Discharge Summary Given

- Referral Done Within 24 Hours Of Routine
- Contains Follow-Up Advice

6.9 DISCHARGE PLANNING

The figure 6.9 bar graph depicts how far this discharge planning is recorded. Compliance with discharge planning is fairly good with (97%). But still only a tiny minority (3%) of patients had their discharge planning completed within the minimal period.

This implies that most patients strategies for discharge are recorded, although there could still be possibilities for development to make sure proper satisfaction.

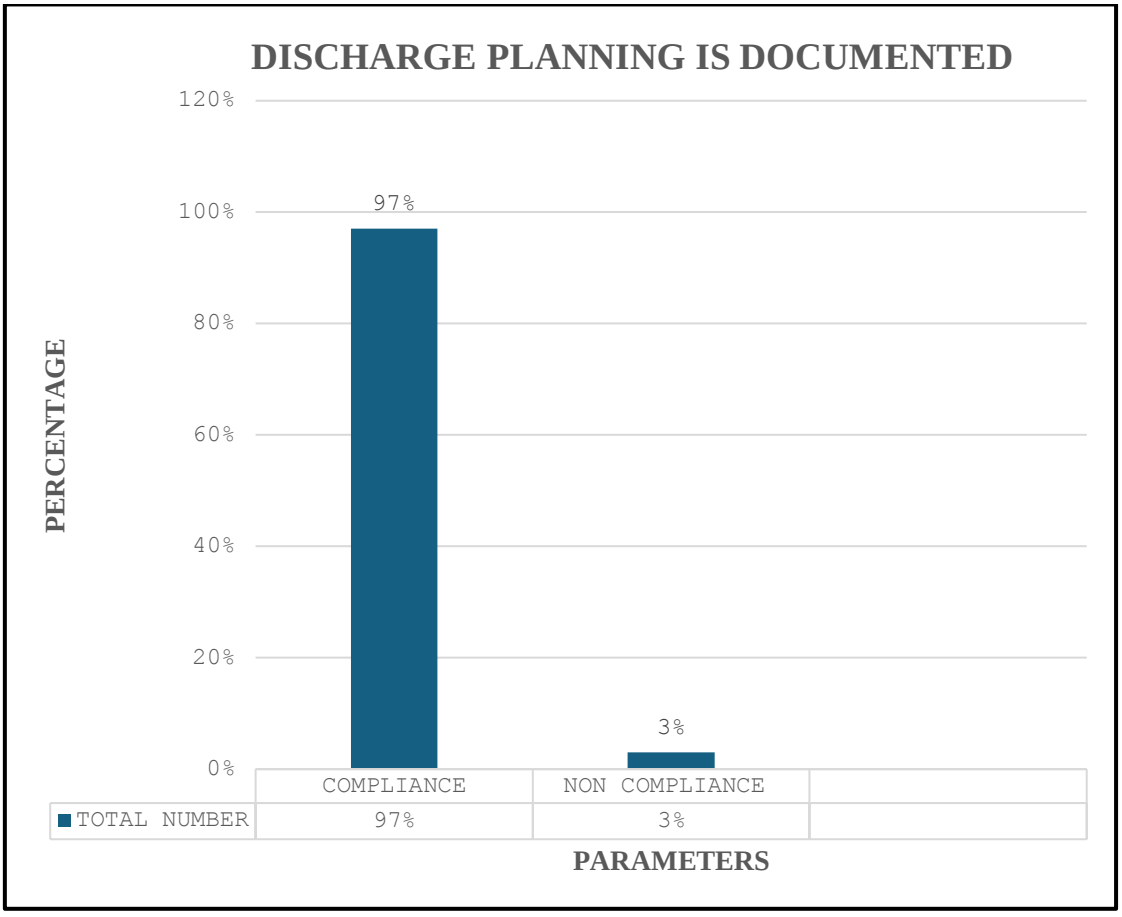

FIG:6.9- DISCHARGE PLANNING IS DOCUMENTED

6.10 DOCTOR PERFORMING INITIAL ASSESSMENT

The figure 6.10 data indicates that how often after performing initial assessments doctors record their personal information . A larger number of doctors (71%) recorded their personal information while (29%) doctors did not recorded their details. This indicates a significant level of compliance with the given work.

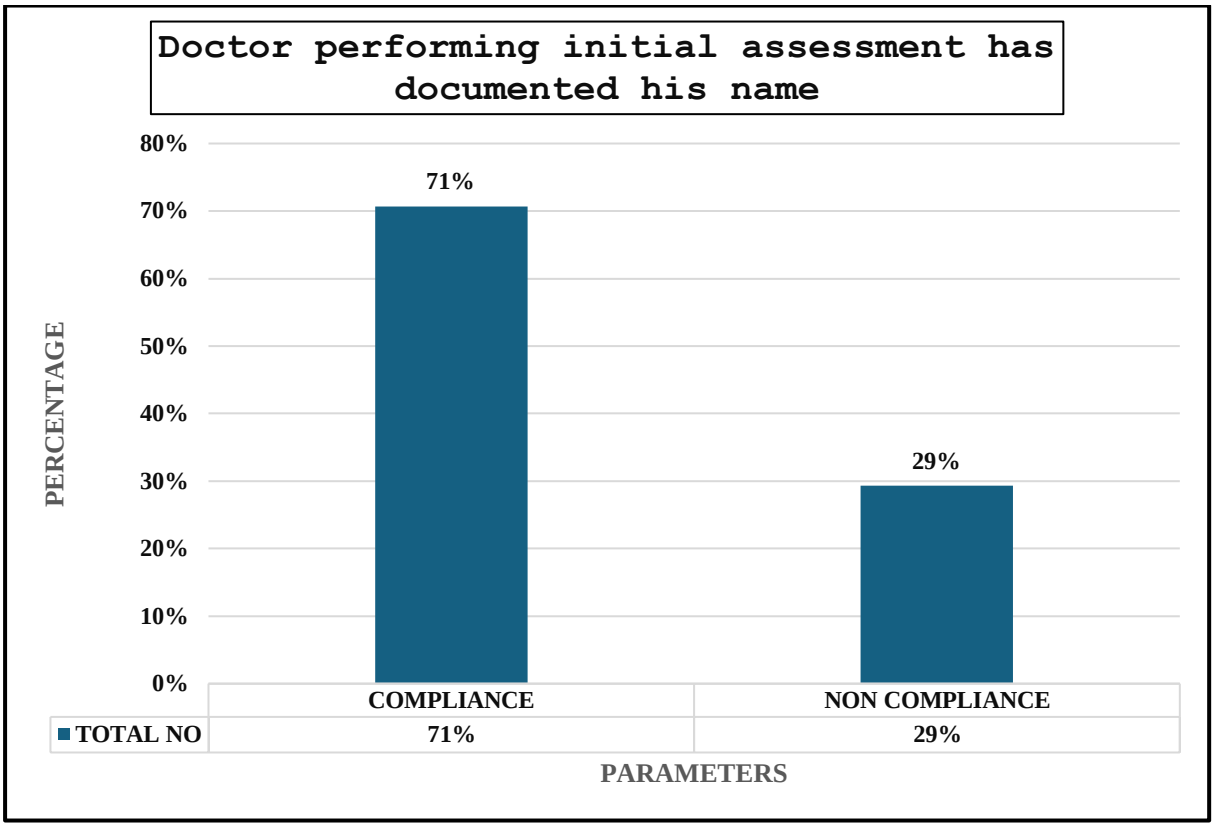

FIG:6.10- Doctor performing initial assessment has documented his name

6.11 DOCTOR TAKING CONSENT EXPLAINED & DOCUMENTED-RISKS

The figure 6.11 findings demonstrate that patients comply with informed approval when healthcare professionals discuss and record risks.

More than half of patients (75%) followed the medical professional's advice and recorded the issues as the ones who did not (25%). This indicates an adequate compliance rate for informed consent in such a situation.

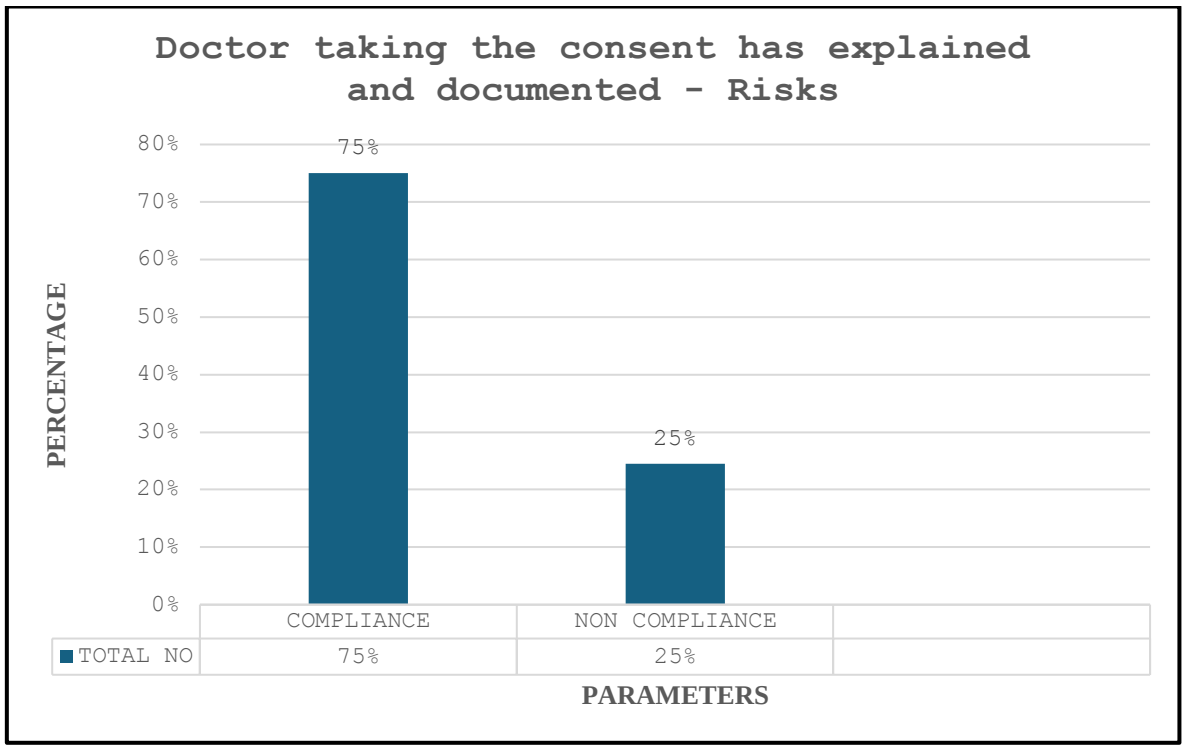

FIG:6.11- Doctor taking the consent has explained and documented - Risks

6.12 REASSESSMENT DOCUMENTED(DOCTORS PROGRESS NOTES)

The figure 6.12 data represent the rates of completion for reassessment in for patients progress notes. A significant proportion of patients (96%) had a reassessment documented, while a very small fraction (4%) do not adhere. This indicates a significant rate of compliance for recording reassessment in this situation.

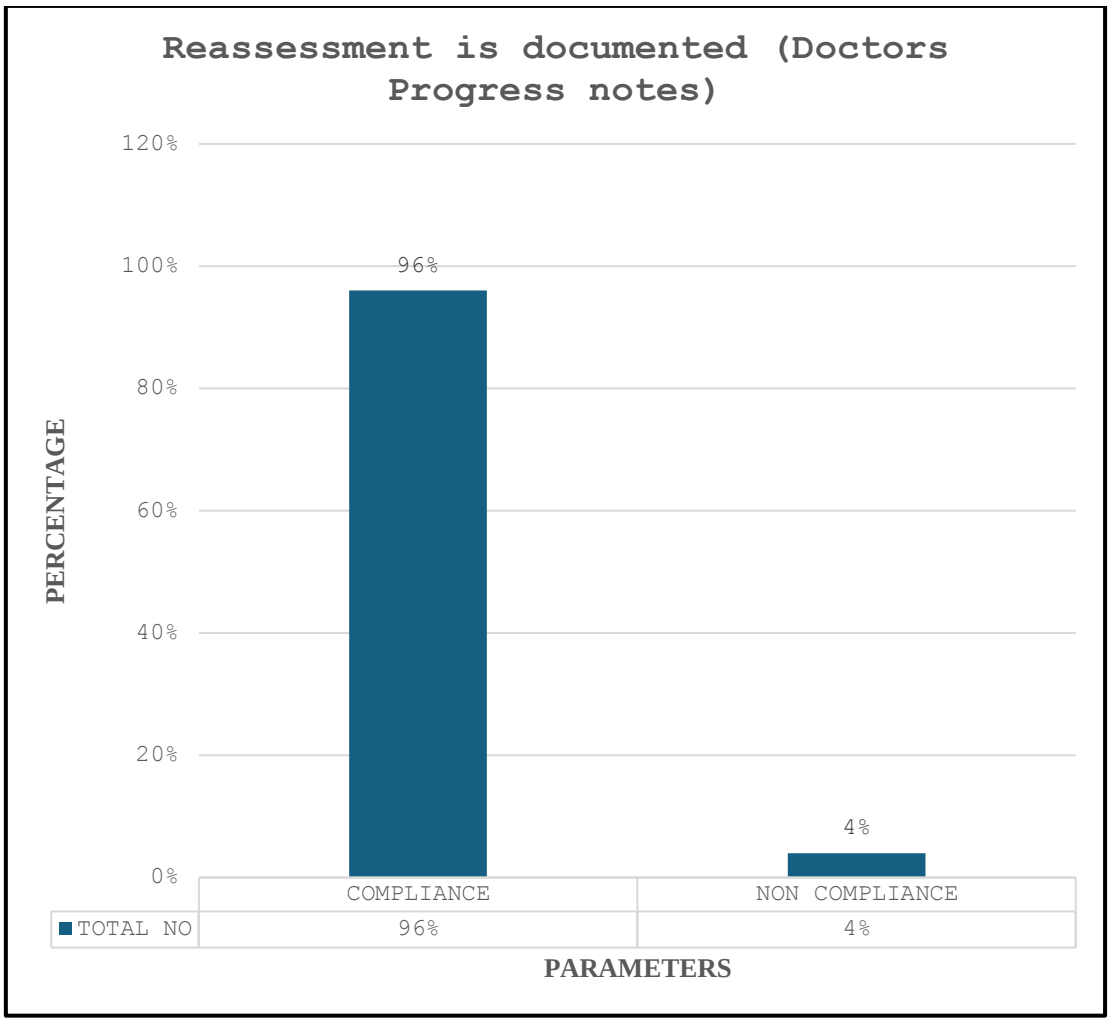

FIG:6.12- Reassessment is documented (Doctors Progress notes)

6.13 PAIN REDUCED BY DATE OF DISCHARGE

The figure 6.13 bar graph depicts the level of discomfort levels recorded through patients during their discharge from the hospital. A greater proportion of patients (73.8%) indicated minimal discomfort upon discharge than the number who experienced pain during admission (26.2%). It demonstrates that the medication was efficient at decreasing pain for a significant number of patients.

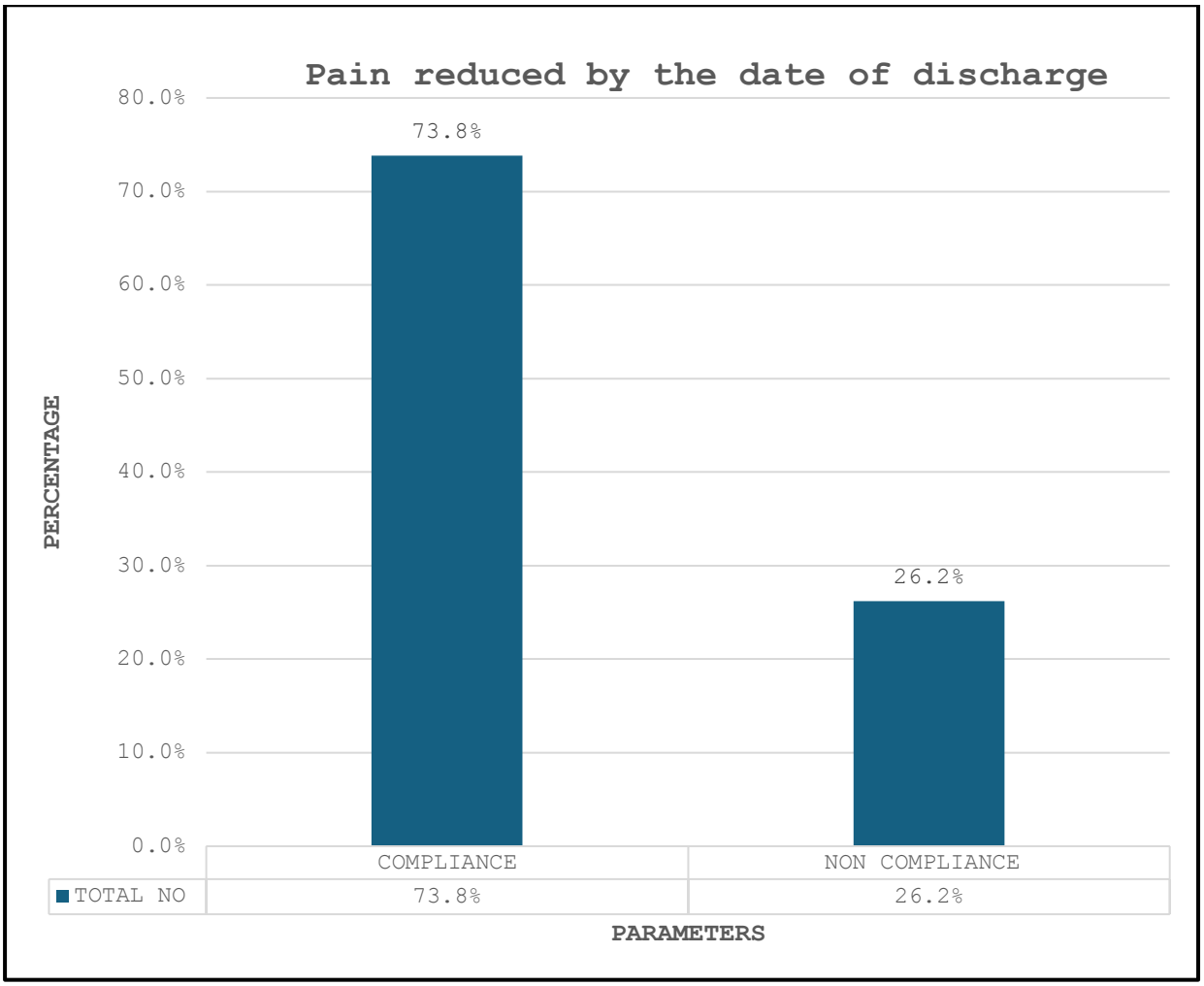

FIG:6.13- Pain reduced by the date of discharge

6.14 RANGE OF MOTION EXERCISES

The figure 6.14 bar graph depicts range of movement at rate of completion for both compliant and non-compliant patients. Compliant patients finished various ranges of motion exercises at a higher percentage (82.4%) than patients who weren't compliant (17.6%). This implies that performing range of movement exercises relates to increased patient compliance.

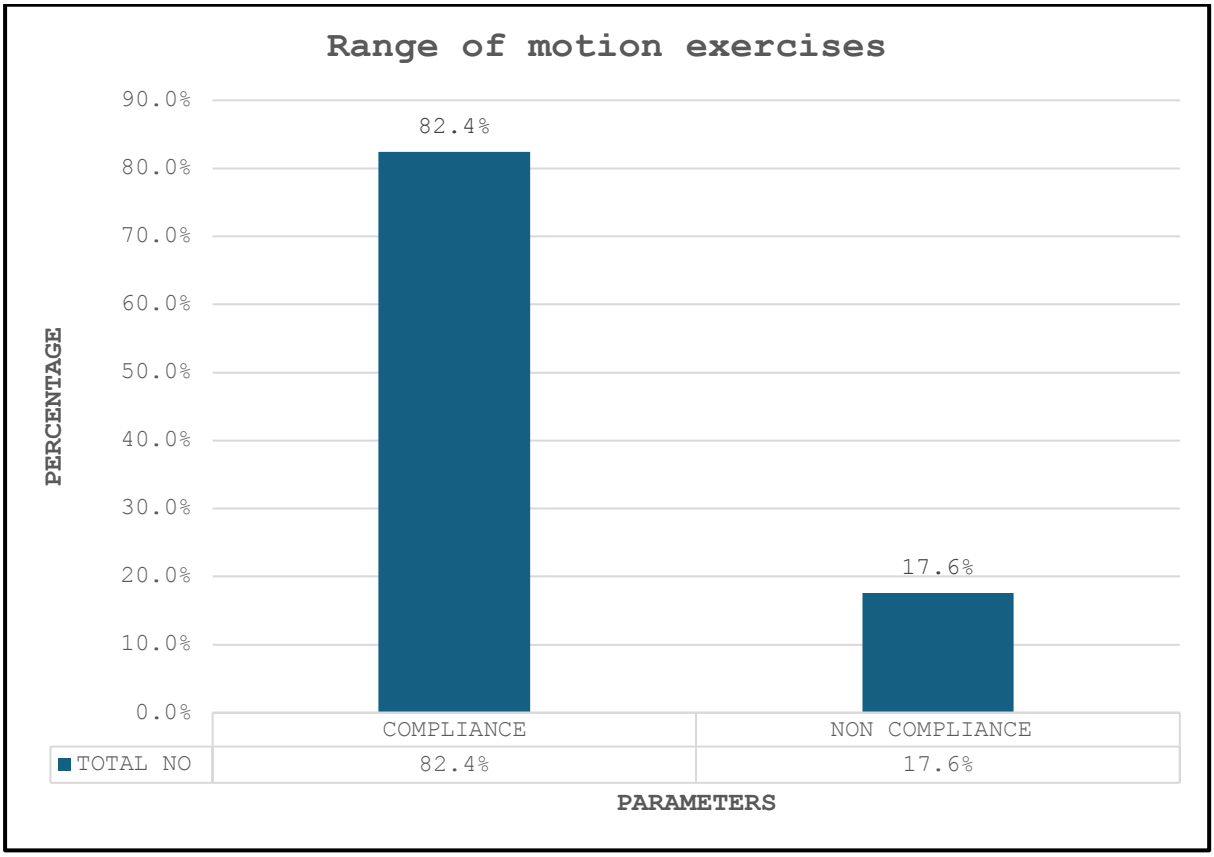

FIG:6.14- Range of motion exercises

6.15 PAIN ASSESSMENT SCORE (VAS SCORE)

The figure 6.15 depicts the total number of patients whose complain about experiencing pain contrary to those who reported it did not, as determined by compliance with VAS pain assessment reporting. Though the data is not completely maintained, both compliant (75%) and non-compliant categories (25%) seemed to have an equal proportion of patients reporting pain. This indicates that pain is commonly stated regardless of VAS score or documentation compliance.

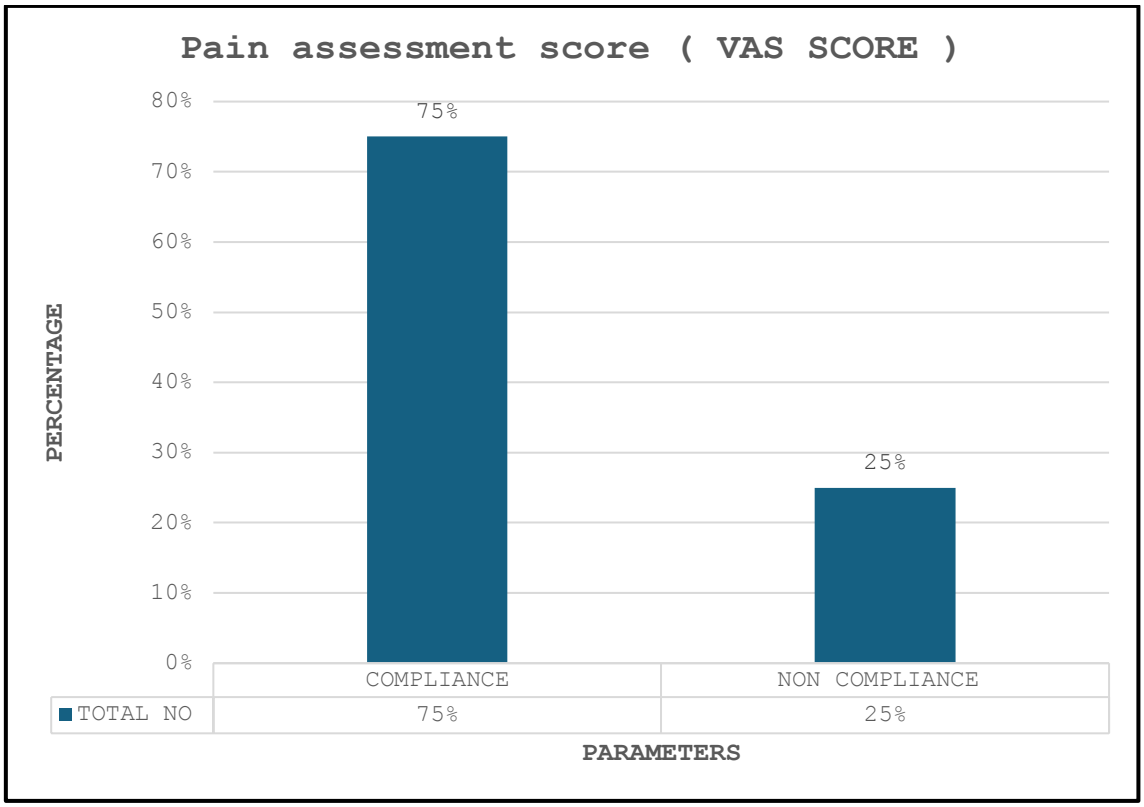

FIG:6.15- Pain assessment score (VAS SCORE)

6.16 INITIAL NURSING ASSESSMENT DONE WITHIN 60 MINUTES

The figure 6.16 displays the number of patients examined by a nurse during the initial sixty minutes following their arrival. It seems out that 80% of the individuals appeared on time, however 20% made wait for over an hour. This data indicates an important difference, resulting in a slightly larger percentage of patients receiving timely evaluations compared to those who did not. The outcomes illustrate the importance of developing strategies for boosting the efficiency of primary nursing assessments with the goal to make sure that every patient get immediate medical attention

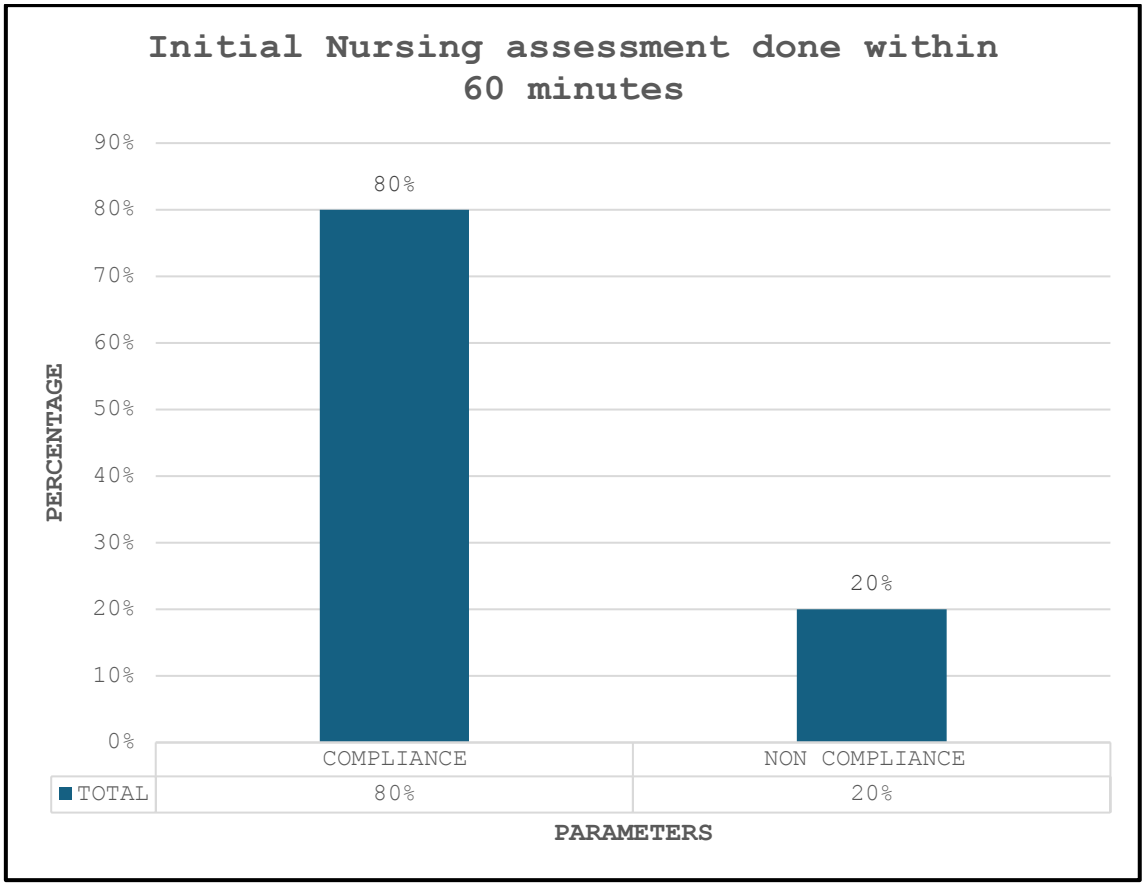

FIG:6.16- Initial Nursing assessment done within 60 minutes

6.17 PAIN ASSESSMENT & REASSESSMENT PERFORMED

The figure 6.17 in the graph depicts adherence to the pain evaluation and reassessment processes. This shows the total number of people that had been examined and evaluated for suffering against those who did not . The majority of people showed 75% compliance followed the suggested practices, while 25% could not. It implies that an even greater percentage of patients obtained evaluations of pain and revised assessments compared to individuals who did not.

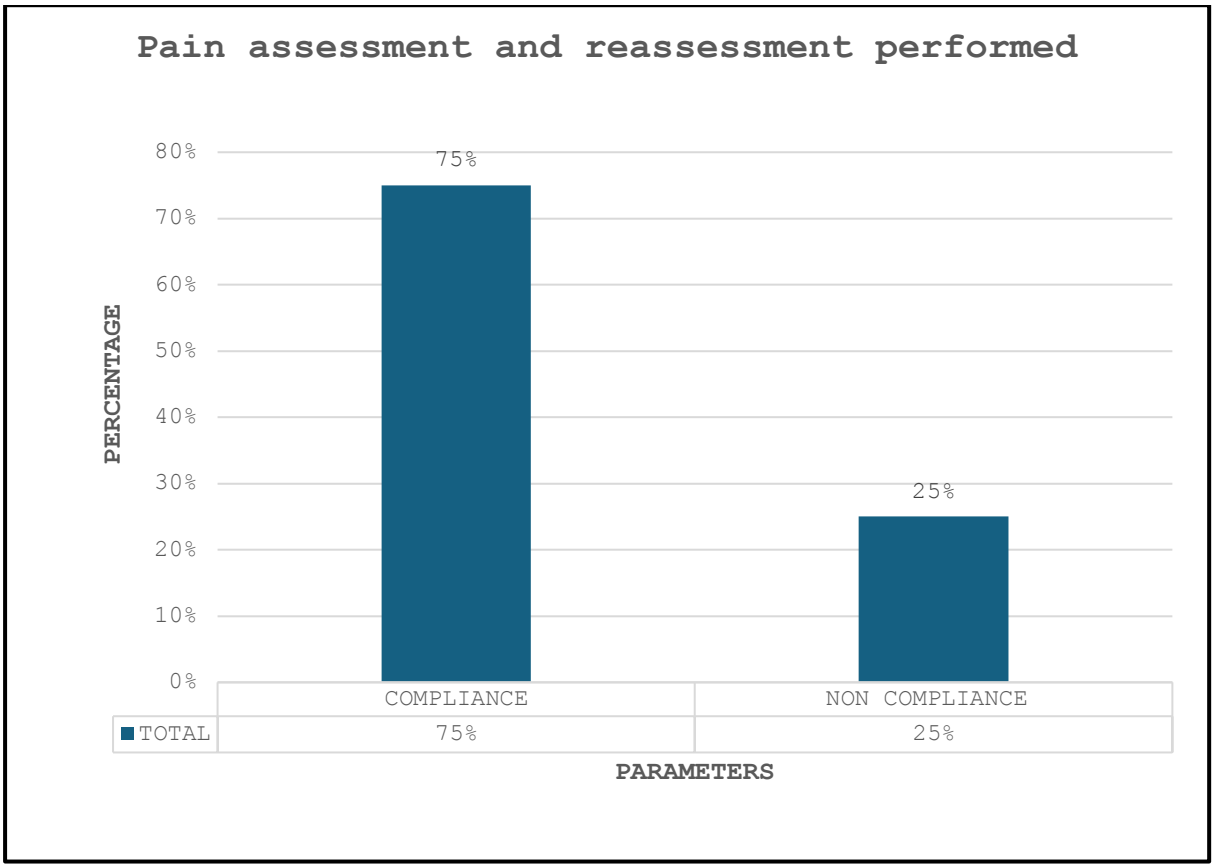

FIG:6.17- Pain assessment and reassessment performed

6.18 FALL RISK ASSESSMENT DOCUMENTED

The figure 6.18 in the graphic is irrelevant to a fall risk assessment. The bar graphic illustrates adherence with a recorded fall assessment of risk. It almost certainly related to the medical sector, in which undergoing an assessment of fall risks is a precautionary measure that prevents patient falls. In the image, 77% patients have a recorded fall risk assessment, while 23% do not. This shows that the great majority of patients have had a recorded fall risk assessment. However, there are still a small minority who do not. Fall risk assessments are a vital safety measure, thus it would be wise to make sure that all people have one recorded.

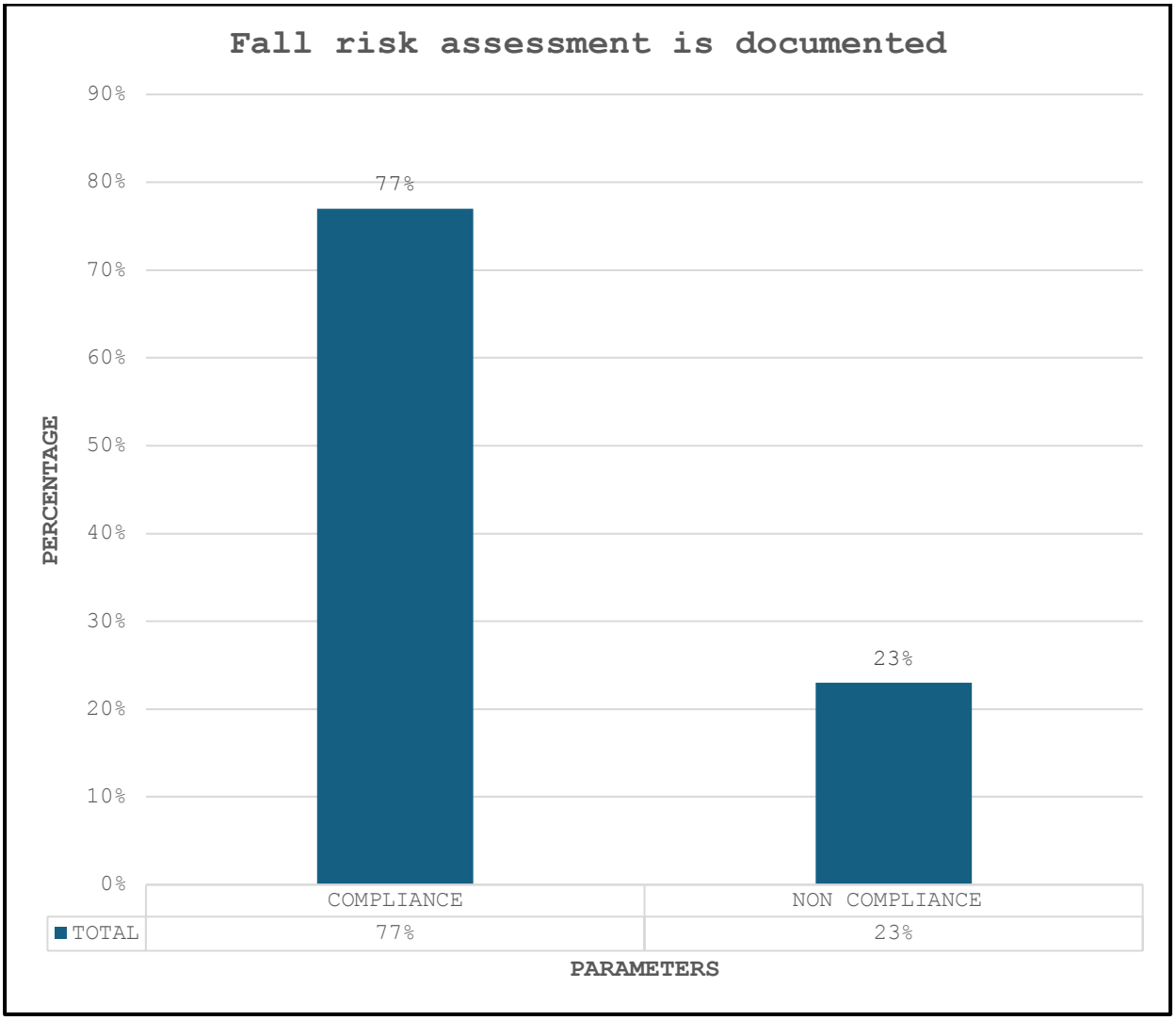

FIG:6.18- Fall risk assessment is documented

6.19 IDENTIFICATION OF SPECIAL NEEDS OF PATIENTS DOCUMENTED

The figure 6.19 depicts the manner in which a hospital recorded when patients need particular assistance. Among of 148 people, 80% were provided with particular requirements recorded as 'COMPLIANCE', whereas 20% people did not have paperwork. It means that the majority of patients are having their particular requirements noted, although there still exists space for development because minority does not. Possessing sufficient paperwork is essential in maintaining that every individual get the medical assistance that they require.

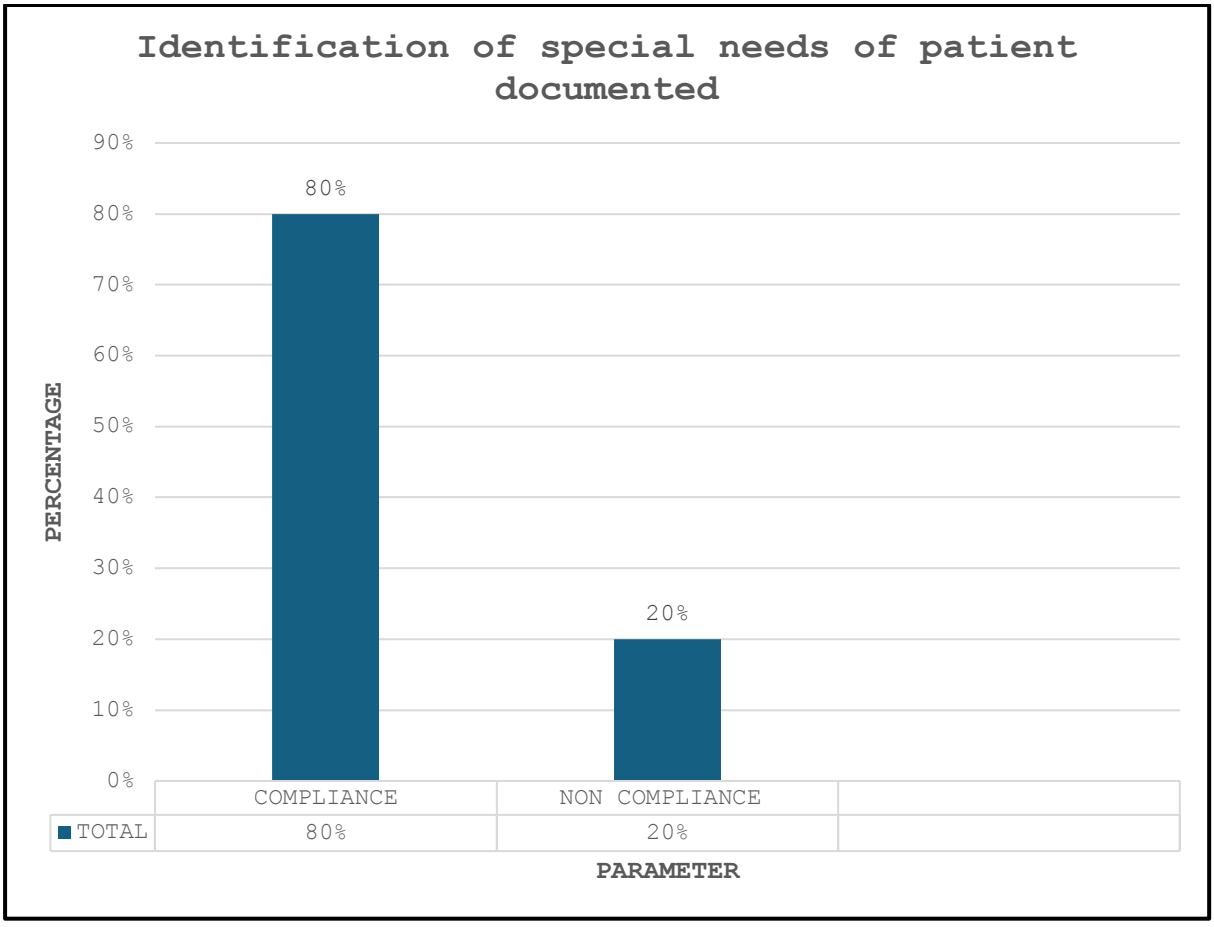

FIG:6.19- Identification of special needs of patient documented

6.20 NUTRITIONAL ASSESSMENT PERFORMED BY DIETICIAN

The figure 6.20 illustrates the effectiveness with which the organisation maintains the nutritional evaluation guidelines. In the graph, "COMPLIANCE" indicates individuals who have had a recorded assessment of nutrition from a dietician. A total of 90% people received a recorded assessment, whereas 10%

did not not received “NON COMPLIANCE”. This implies that the majority of patients had a assessment of nutritional , however there continued to be a gap because some did not. Maintaining these guidelines is essential for making sure every patient obtain appropriate nutritional assistance.

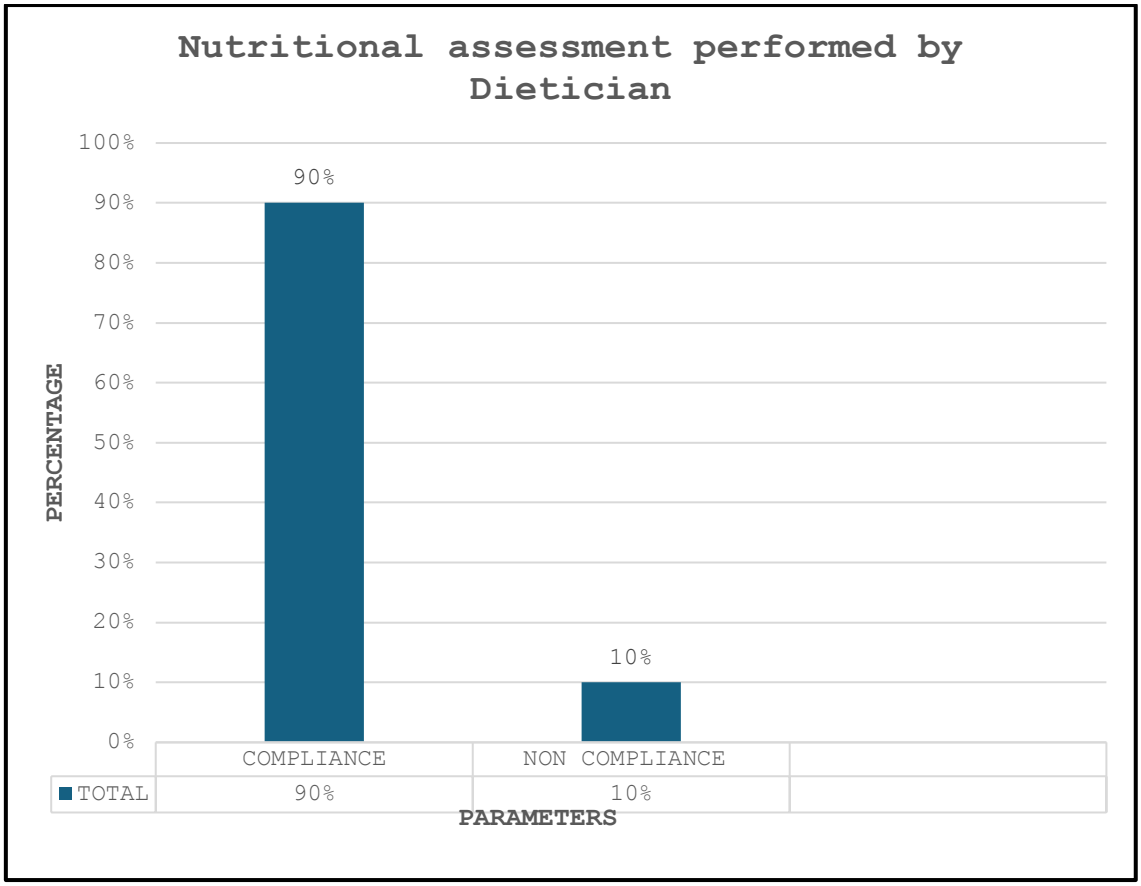

FIG:6.20- Nutritional assessment performed by Dietician

6.21 NUTRITIONAL FOLLOW-UP ASSESSMENT DOCUMENTED

The figure 6.21 illustrates the extent to which a healthcare organisation records when patients received nutritional follow - up evaluations. The graphic shows recorded further evaluations designated "COMPLIANCE".

Among of 148 individuals, 70% had recorded following up which shows COMPLIANCE, while 30% individuals data was missing it was not recorded which shows "NON COMPLIANCE".

It indicates that the majority of patients have kept records of follow-up evaluations, nevertheless there remains few that require paperwork to be done.

Possessing accurate records is crucial for tracking the progress of patients and guaranteeing they're getting correct nutritional support

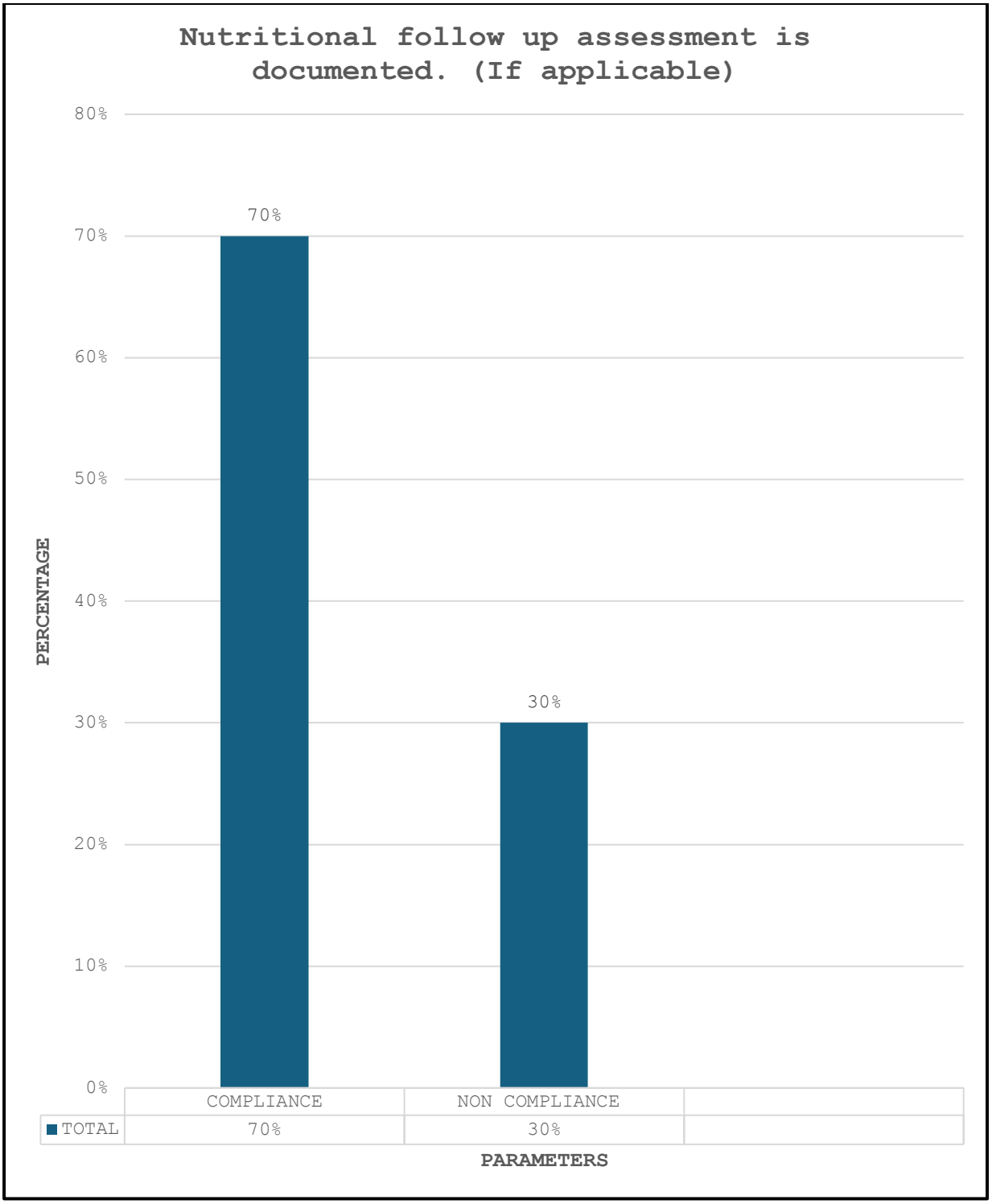

FIG:6.21- Nutritional follow up assessment is documented. (If applicable)

DISCUSSIONS

DISCUSSIONS

The report includes a complete examination of both compliance and noncompliance rates in several healthcare paperwork procedures at a multispecialty hospital. This review comprises forms for consent, at first assessment reports, assessments of nutrition, medical records , surgical safety checklists, anaesthesia care records , healthcare reconciliation and treatment records.

The forms for consent demonstrate high adherence rates for name and sign (98-99%), but less compliance for and time (76%) and date (89%), mention. Initial investigation findings indicate appropriate compliance in documenting preliminary diagnosis (71%)all aspects of the history (72%),but considerably less compliance in recording the time of first evaluation (30%) and planning for discharge (28%).
The records of nurses demonstrate variable compliance when performing initial assessments (53%), whereas pain assessment (91%) and fall assessment of risks (90%) remain high.

Assessments for nutrition show significant adherence rates (87-89%), with a low proportion of noncompliance. The anaesthesia treatment paperwork shows good compliance in pre-anaesthesia assessment (96-97%) but less compliance in various fields, especially poor adherence to documenting allergies (4%).

Checklists for surgical safety reveal nearly flawless adherence (99%) in every aspect.

Medical reconciliation and medical records and show high adherence rates (99.32%), but post-operative treatment plan paperwork has somewhat lower rates (75%).

Doctors duties regarding preparing for discharge are usually well-compliant (97.6%), but only a small percentage of patients complete the process of discharge planning within the required time frame.

Doctors records of personal information following first assessments is satisfactory (70.7%).

Compliance with informed approval is satisfactory (75.5%). Re-evaluation in progress of patient's notes is reported with a high level of compliance rate.

Physiotherapists records of patients pain levels and range of movement exercises following discharge suggests high compliance

The nurses contribution to regular individual evaluation during their initial hour is demonstrated with a small percentage of patients getting timely assessments as well as high adherence in pain assessment and reassessment .

Fall assessments of risk have been completed for the majority of these individuals , suggesting their usefulness as a precautionary measure.

Dieticians' responsibilities in evaluations of nutrition and follow-up exhibit strong legal compliance considering only a small percentage of patients lacking paperwork.

The paperwork highlights the importance of keeping precise documentation to ensure the safety and welfare of patients.

Record keeping procedures have some abilities such as surgical safety checklists, consent forms, along with particular records of nursing.

It also suggests possibilities for enhancements, especially in regard to continuously documenting time-sensitive details and performing the discharge planning process between appropriate within specified times.

The research study emphasises the importance of ongoing tracking and documenting for sustaining excellent standards for medical recordkeeping.

RECOMMENDATIONS

RECOMMENDATIONS

To increase compliance in medical record documentation, a multidimensional strategy should be used. To begin, frequent staff training and orientation workshops focusing on the regulatory and legal components of compliance are required.

This ensures that all healthcare personnel understand the criteria they must achieve, avoiding errors and noncompliance.

Incorporating a system for real-time documentation feedback can significantly improve correctness and completeness. Providing instant feedback enables healthcare practitioners to address errors as they occur and maintain consistent high-quality data.

Furthermore, incorporating documentation compliance as a major performance metric helps increase responsibility. When documentation quality and completeness are linked to performance evaluations, employees are more inclined to prioritise upholding high standards in record-keeping.

Integrating medical record compliance into a continuous quality improvement (CQI) framework is also critical. This guarantees that compliance is not a one-time effort, but rather a continuous process of examination and improvement.

Regular audits and reviews can assist identify areas for improvement while also ensuring that compliance initiatives are effective and sustainable.

To connect health records compliance to patient security and high-quality results, highlighting the immediate effects of proper documentation on treatment of patients.

CONCLUSION

CONCLUSION

The health care documentation for the multispecialty hospital in Mumbai includes various positive and negative components. It's good that some areas, such as surgical safety checklists, have excellent compliance rates.

Nevertheless, there are few sectors that require improvement, such as immediate recordkeeping and planning for discharge, to ensure patients receive the highest quality of treatment.

The review of medical record documentation in a multispecialty tertiary care hospital revealed a high level of adherence to set criteria. The majority of patients signed consent papers (98-99%), while there were gaps in documenting particular times (76%) and dates (89%).

Initial assessments revealed that, while diagnoses (71%) and medical histories (72%), there were considerable gaps in noting the initial assessment time (30%) and discharge planning (28%).

Nursing records showed variability in early assessments (53%), but excelled in pain (91%) and fall risk evaluations (90%). Nutritional assessments indicated good adherence rates (87-89%) and low noncompliance.

Anaesthesia care demonstrated high pre-anesthesia assessments (96-97%), but poor allergy documentation (4%). Surgical safety checklists were almost faultless (99% compliance).

Medical records and reconciliation were very precise (99.32%), however post-operative plans could possibly be improved (75%). Discharge procedures were well-prepared (97.6%), but were frequently delayed in planning.

Physiotherapy assessments were thorough, documenting pain and range of motion exercises effectively. Nursing contributions demonstrated timely evaluations with high compliance in pain assessments.

Fall risk assessments were predominantly conducted, aiding in preventive care. Dieticians showed strong compliance in nutritional assessments and follow-ups.

Despite the overall high standards, several areas still require attention. The initial assessment timing and discharge planning need improvement to ensure a seamless patient experience. Allergy documentation in anesthesia care is another critical area needing enhancement.

Moreover, timely discharge planning is crucial to optimize patient flow and resource allocation. Strengthening these aspects will contribute significantly to elevating the quality of healthcare delivery and patient safety in the hospital.

The hospital should continue to build on its strengths while addressing these gaps to maintain and improve its compliance with medical record documentation standards.

Once the hospital implements the recommendations that we have provided, then might enhance the patient's healthcare data significantly good.

It is crucial for ensuring that patients receive secure and efficient treatment. It is additionally essential for a hospital to continuously assess its performance and implement the changes that are needed.

It enables them to continue fulfilling the requirements of their patients while simultaneously adhering to the highest standards regarding medical recordkeeping.

Whenever it concerns related to maintaining healthcare data at the healthcare facility, there's a lot more than simply completing all paperwork; it's also required ensuring that patients receive the proper treatment at the right time for them.

This implies keeping all the information ready to go and up to date, allowing healthcare professionals to decide on the most effective choices for their patients.

Furthermore, it has become necessary to comply with the regulations while maintaining all that in order with the rules and regulations, since such behaviour is what develops credibility among everybody.

The healthcare organisation should continually be searching for fresh methods to enhance its operations, having everybody contributing to enhance processes . To accomplish this, they might require training people, or possibly recruit more individuals to provide assistance and to use new technology

The health care facility could gain many things through reviewing documents with other top hospitals and implementing the best ideas available and not to miss the patients they should be included in the process, ensuring that their records are correct.

This is also essential that everybody in the healthcare organisation, across departments and levels, to collaborate as a team.

The data and metrics might assist the hospital determine where the healthcare professionals doing well and where they need to improve their performance and, it is essential to acknowledge and praise the efforts of those working there and the people who have been doing an excellent job maintaining the documentation.

At last, everybody from upper management supervisors to the lower management must understand that maintaining accurate documentation is important to ensure best highest quality of healthcare of patients.

IMPLICATIONS OF RESEARCH

Our research had significantly enhanced patient care quality by ensuring that medical records meets NABH guidelines. This assured that patients receives correct and consistent care, hence improving overall patient safety and satisfaction.

Our findings had significantly helped healthcare providers to identify areas for record-keeping improvement, leading better staff training and more effective documentation procedures.

By highlighting these necessary areas, our research had helped hospitals in meeting better regulatory standards and promoting more healthcare standards. It would eventually lead to better patient outcomes and more reliable healthcare services across the industry.

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