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

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MEDICAL RECORDS

CONTENTS

INTRODUCTION

- Medical records are vital in healthcare for understanding a patient's history and providing personalized treatment.
- This include important details like medical history, allergies, test results and treatments. Keeping these records accurate and up-to-date not only supports patient care but also helps in research and legal compliance.
- Regular checks of medical records are essential to ensure high standards of care and find areas where improvements can be made. Good record-keeping ensures smooth healthcare delivery and accountability, making it easier for doctors to make decisions and coordinate care.
- Accurate documentation is crucial for assessing how well patients are doing and preventing mistakes that could harm them.

REVIEW OF LITERATURE

Author (Year)	Study Location/Sample Size	Methodology	Purpose	Conclusion
S. A Miraj (2022)	**Location-** Multispecialty hospital in Delhi NCR, India. **Sample Size** 325 documentations	**Study Period-**June-August 2021 **Study Design-**Prospective observational descriptive study **Study Setting-**MRD Department **Sampling Technique-**Simple Random sampling; **Study Tool-**NABH standards checklist	To evaluate adherence against NABH guidelines in paperwork and suggest areas of enhancement in quality of healthcare	Numerous levels of issues with the record keeping, involving findings (25.72% incomplete), the utilisation of susceptible to mistakes abbreviated words and the identifiable signatures on the authorization forms, and fourteen percent of documents failed to meet the NABH guidelines.
Ryan et al. (2018)	**Location-**USA **Sample Size** 821	**Study Period-**2015 **Study Design-**Retrospective observational Studies **Study Setting-**Cleveland Clinic Setting **Sampling Technique-**Random Sampling **Study Tool-**Quantitative analysis through interview schedule	To evaluate complying to medical procedures and documentation precision in multiple medications individuals throughout the USA.	Incomplete compliance and not proper health data led to insufficient data of medication treatment among this group of patients.

REVIEW OF LITERATURE

Author (Year)	Study Location/Sample Size	Methodology	Purpose	Conclusion
Sadagheyani H.E (2019)	**Location-** Iran **Sample Size-** 1500 documentations	**Study Period-** 2011-2017 **Study Design-** Analytical Cross Sectional Studies **Study Setting-** Besat Hospital **Sampling Technique-** Systematic Sampling **Study Tool-** Checklist	To evaluate the significance that authorization for enhancing the accuracy of medical record documentation in Iran country.	There was seen major progress in every kind of document was noticed following the paperwork condition when in comparison with initial procedures.
Lovestam etal. (2013**)**	**Location-**Sweden **Sample Size-** 147	**Study Period-** 2009 **Study Design-** Retrospective Observational Studies **Study Setting-** 6 Hospitals and 4 PCC's **Sampling Technique-**NA **Study Tool-** Audit Instrument	To assess the recording of nutritional treatment in healthcare file of Swedish	Numerous essential elements of the diet and nutrition hadn't been clearly stated. Dietary professionals of Swedish required for enhanced health information submitting for records of diets. This indicated that the organised record- keeping approach could be beneficial for the execution of the procedure.

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?

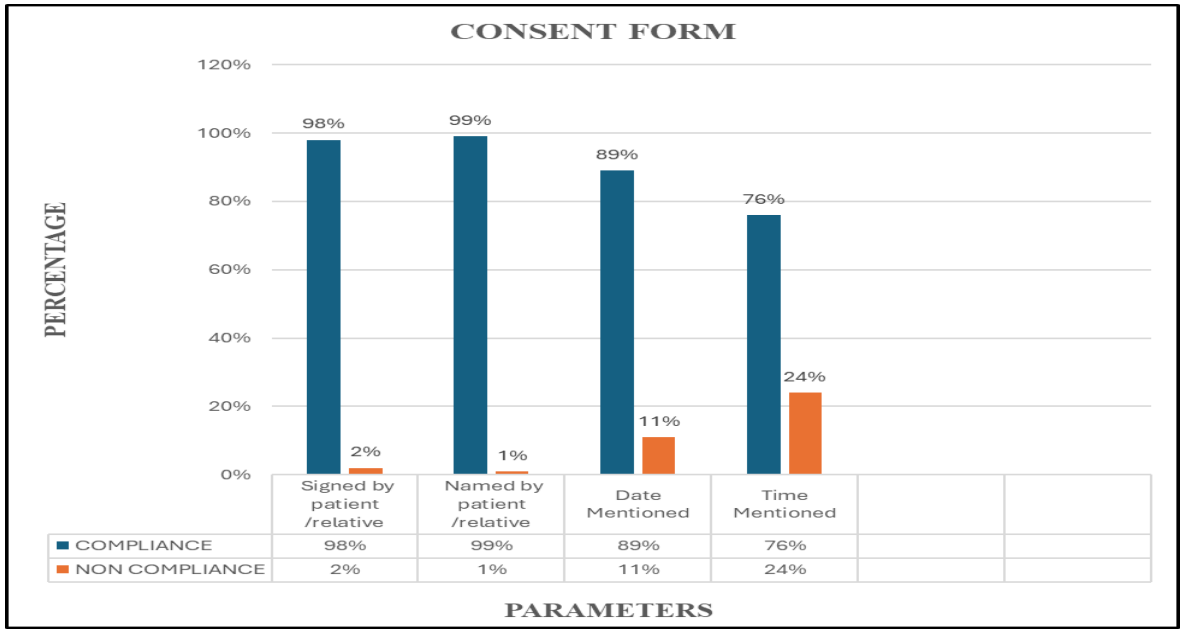
OBJECTIVES

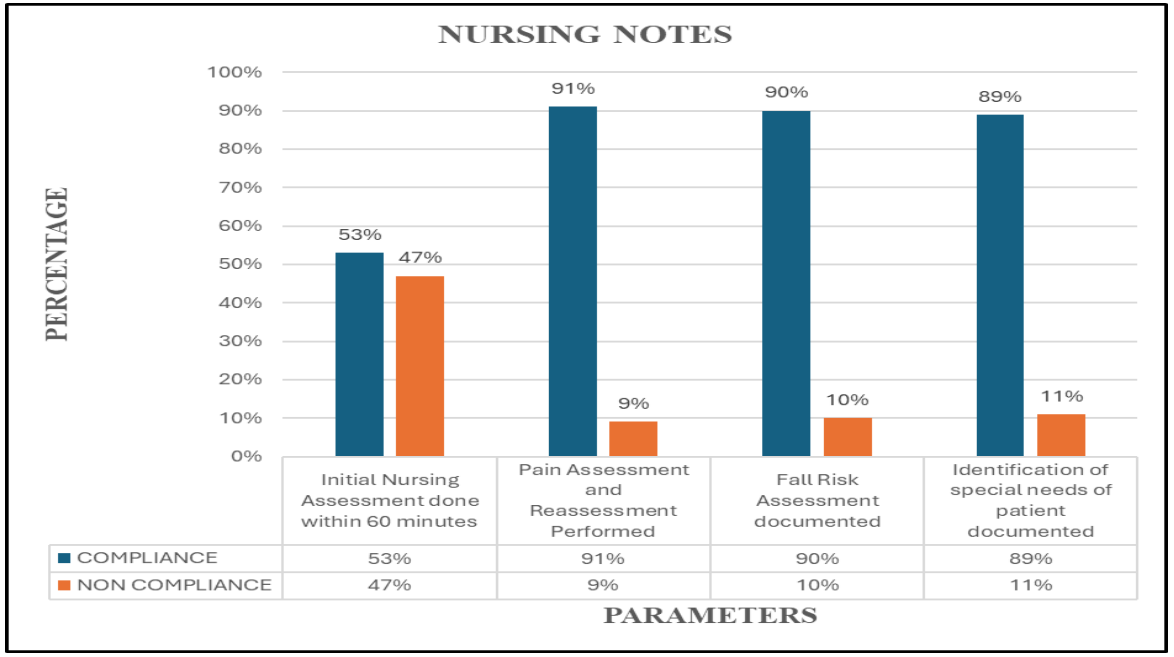
To assess and compare the level of compliance across various parameters of patient file documentation

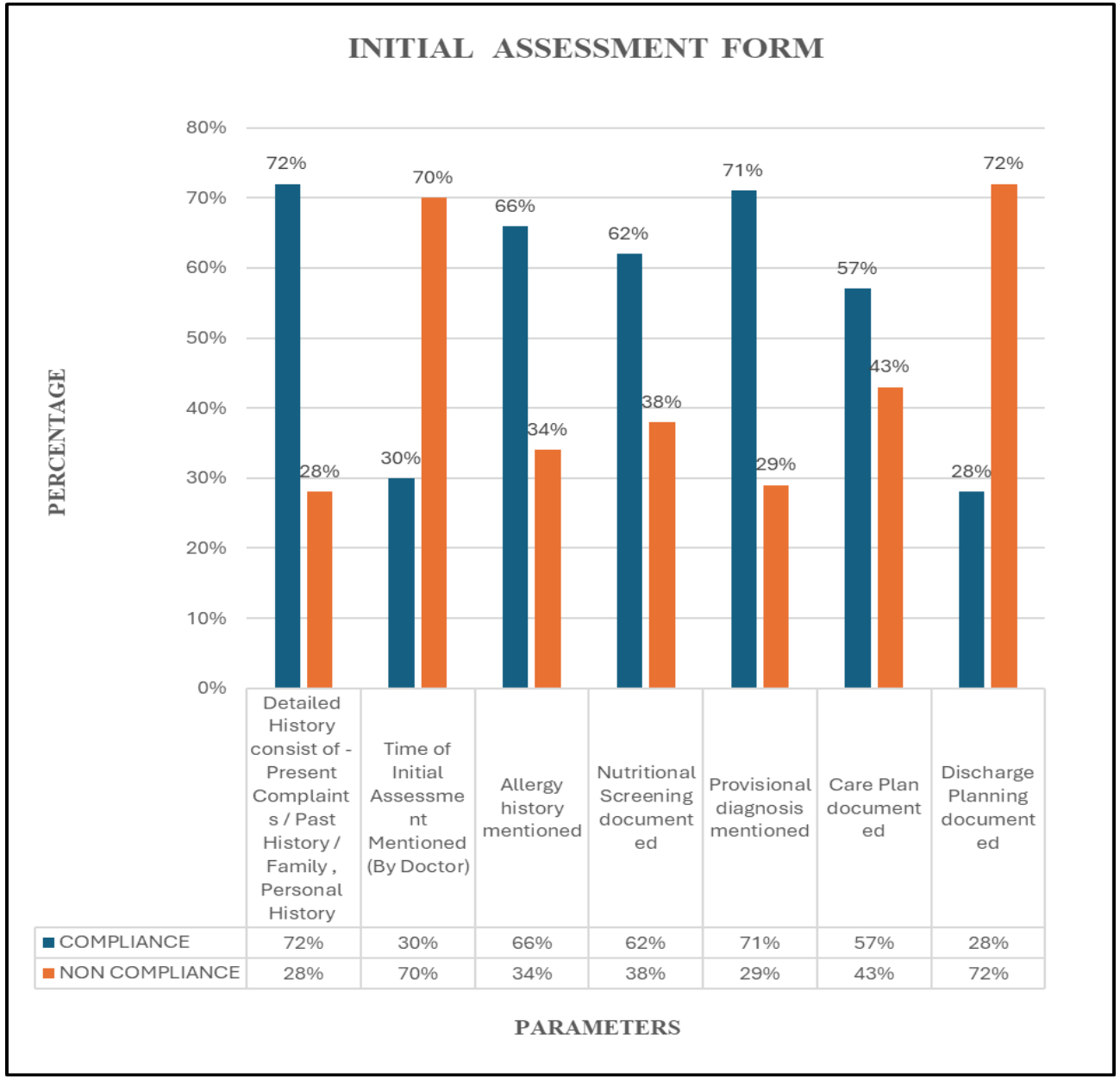
METHODOLOGY

- **Study Design**: Retrospective observational study of hospital medical records to evaluate compliance with NABH standards for inpatient care documentation.
- **Setting**: Conducted at Kokilaben Dhirubhai Ambani Hospital, Mumbai, Maharashtra, focusing on the Medical Record Department known for its advanced healthcare services.
- **Study Tools**: Used an audit checklist to assess compliance of inpatient medical records with NABH standards.
- **Duration of Study**: Span of 2 months.
- **Sample Size and Sampling**: Sampled 148 medical records using convenience sampling.
- **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.
- **Data Analysis Plan**: Utilized Microsoft Excel for cleaning, analyzing, and visualizing data. Compliance was assessed across three categories: complete, incomplete, and not applicable, to determine percentage compliance for each indicator.

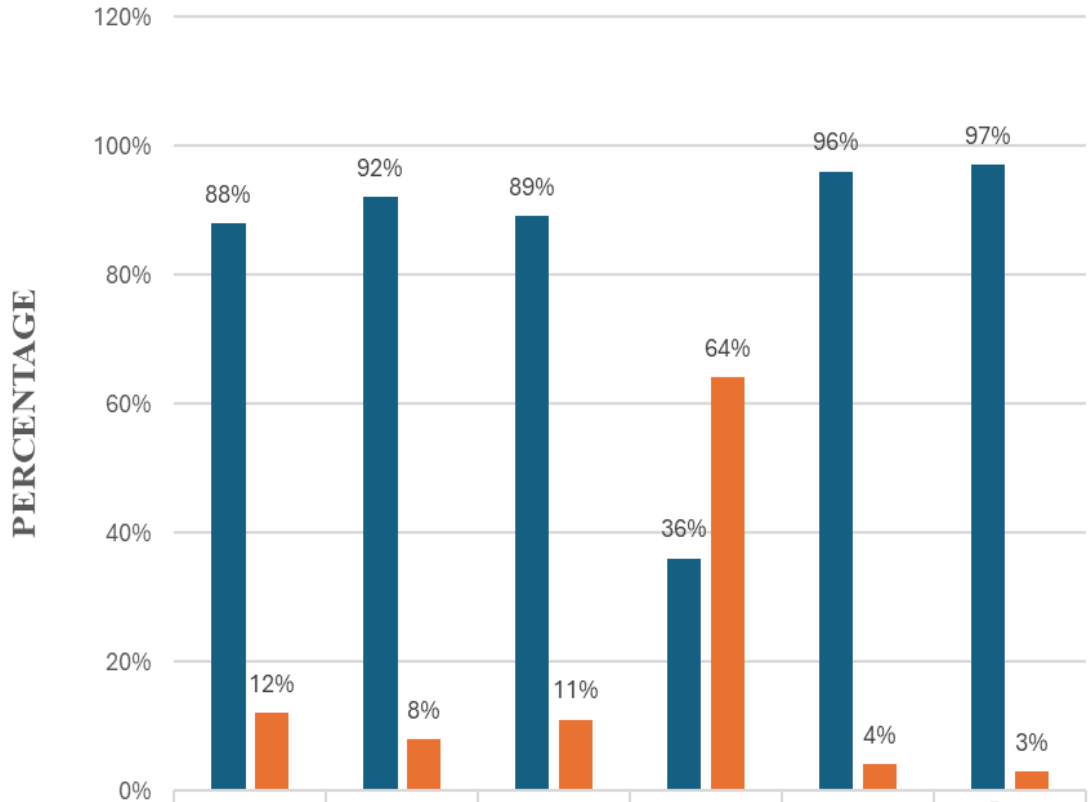
RESULTS


CONSENT FORM
PERCENTAGE
120%
100%
80%
60%
40%
20%
0%
98%
2%
99%
1%
89%
11%
76%
24%
Signed by patient /relative
Named by patient /relative
Date Mentioned
Time Mentioned
COMPLIANCE 98% 99% 89% 76%
NON COMPLIANCE 2% 1% 11% 24%
PARAMETERS


NURSING NOTES
PERCENTAGE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
53%
47%
91%
9%
90%
10%
89%
11%
Initial Nursing Assessment done within 60 minutes
Pain Assessment and Reassessment Performed
Fall Risk Assessment documented
Identification of special needs of patient documented
COMPLIANCE 53% 91% 90% 89%
NON COMPLIANCE 47% 9% 10% 11%
PARAMETERS


INITIAL ASSESSMENT FORM
PERCENTAGE
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
28%
30%
70%
66%
34%
62%
38%
71%
29%
57%
43%
28%
72%
Detailed History consist of - Present Complaints / Past History / Family , Personal History
Time of Initial Assessment Mentioned (By Doctor)
Allergy history mentioned
Nutritional Screening documented
Provisional diagnosis mentioned
Care Plan documented
Discharge Planning documented
COMPLIANCE 72% 30% 66% 62% 71% 57% 28%
NON COMPLIANCE 28% 70% 34% 38% 29% 43% 72%
PARAMETERS

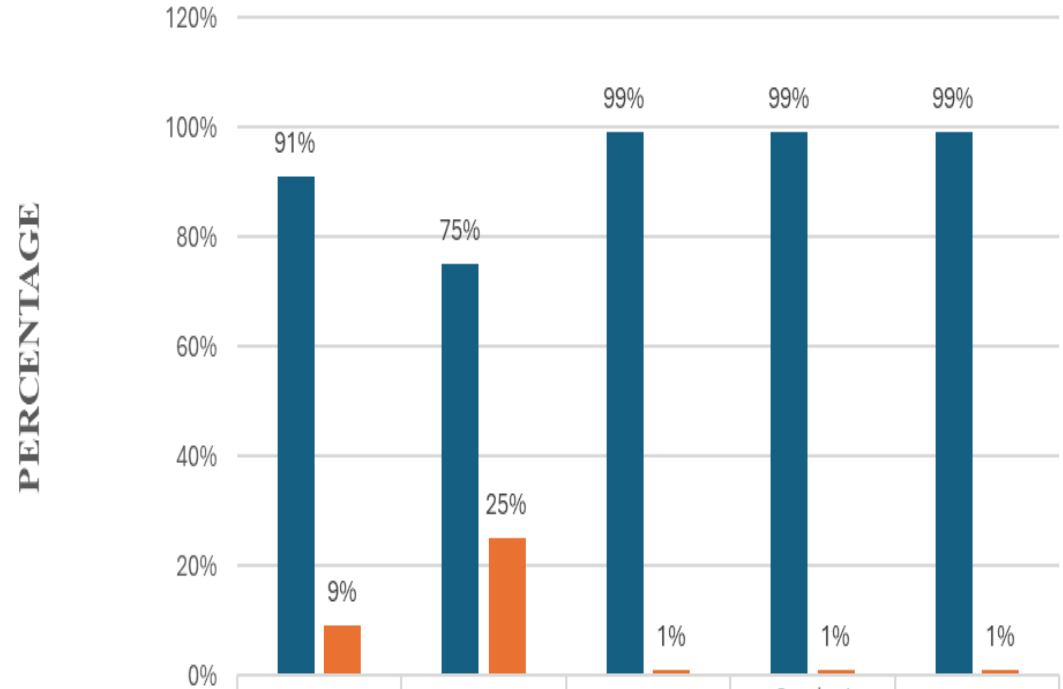
ANAESTHESIA DOCUMENTATION ASSESSMENT



	Anaesthesia Type	Doctor Taking Consent	Doctor Consent Signed	Mentioned Time	Patient Signed	Pre-Anaesthesia Assessment
COMPLIANCE	88%	92%	89%	36%	96%	97%
NON COMPLIANCE	12%	8%	11%	64%	4%	3%

PARAMETERS

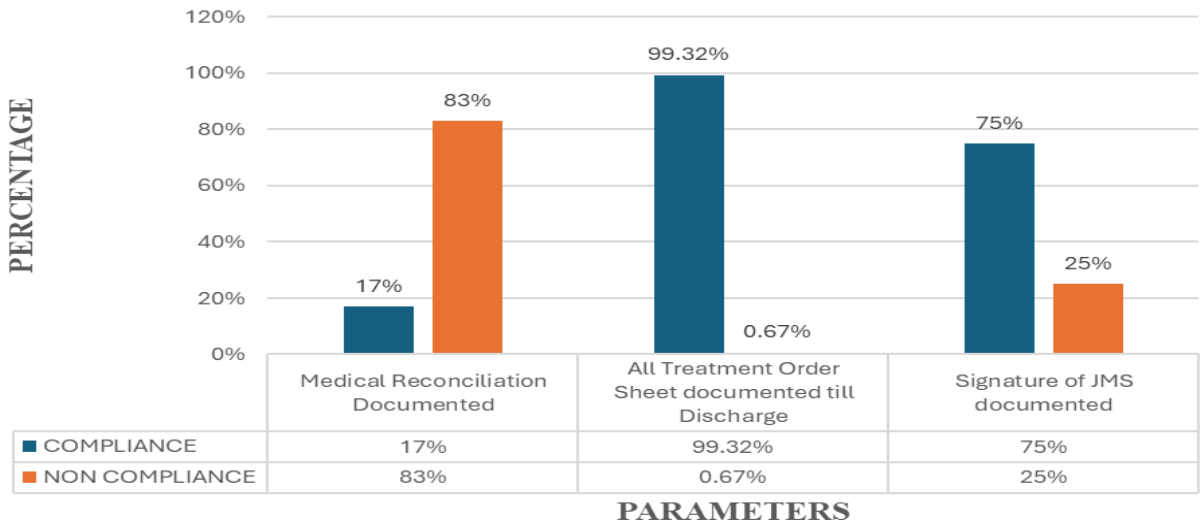
OPERATIVE NOTES



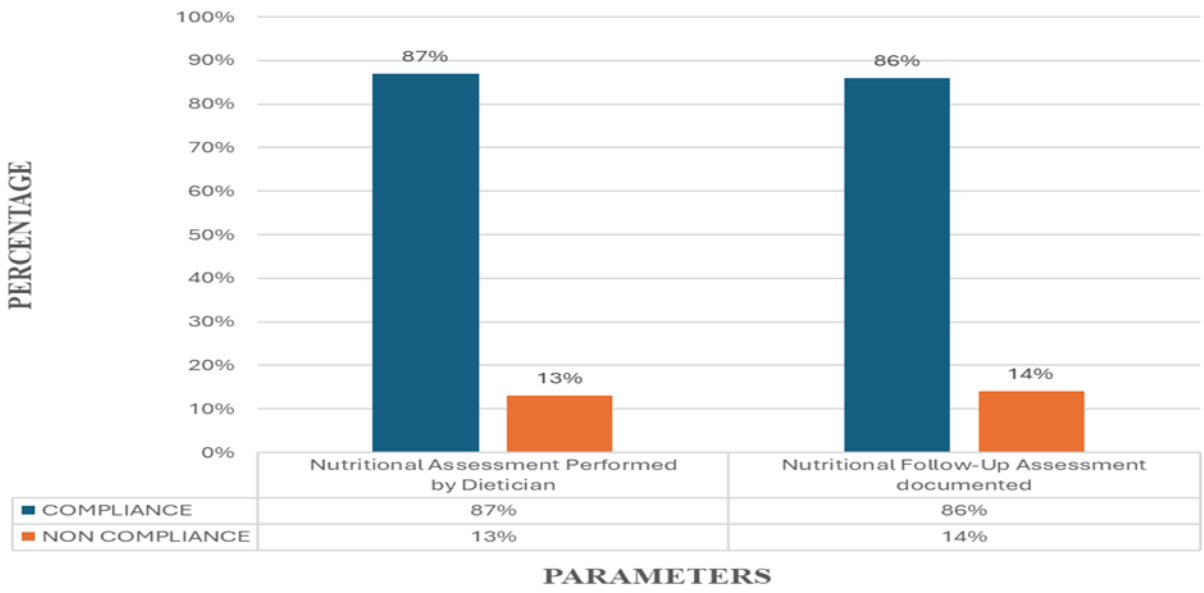
	Operative Notes documented by Primary Consultant	Post-Operative Plan of Care documented	Surgical Safety Checklist Evident	Surgical Safety Checklist documented Sign in/ Time out / Sign out	Surgical Safety Checklist documented D/T
COMPLIANCE	91%	75%	99%	99%	99%
NON COMPLIANCE	9%	25%	1%	1%	1%

PARAMETERS

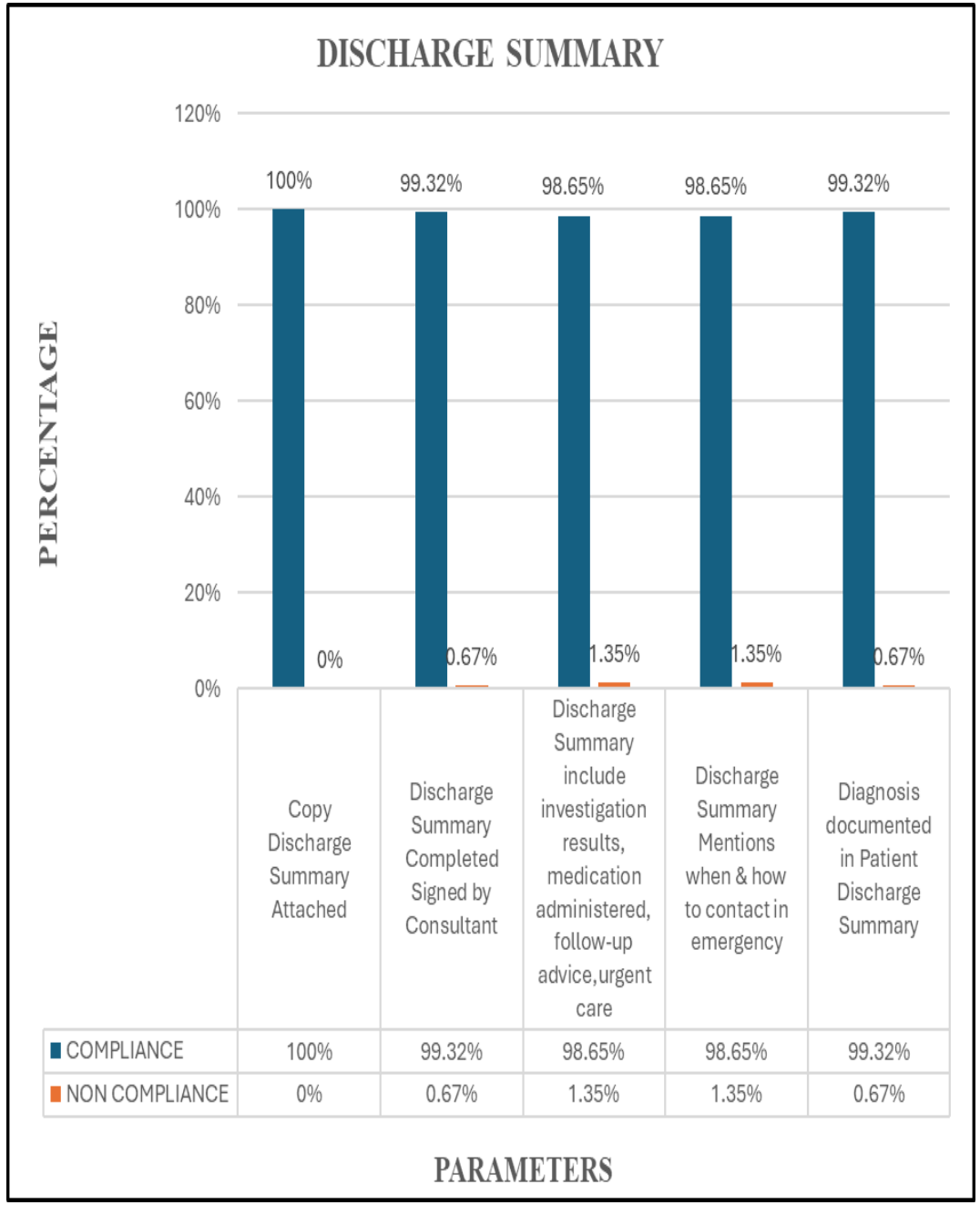
MEDICAL RECONSILIATION AND TREATMENT RECORD

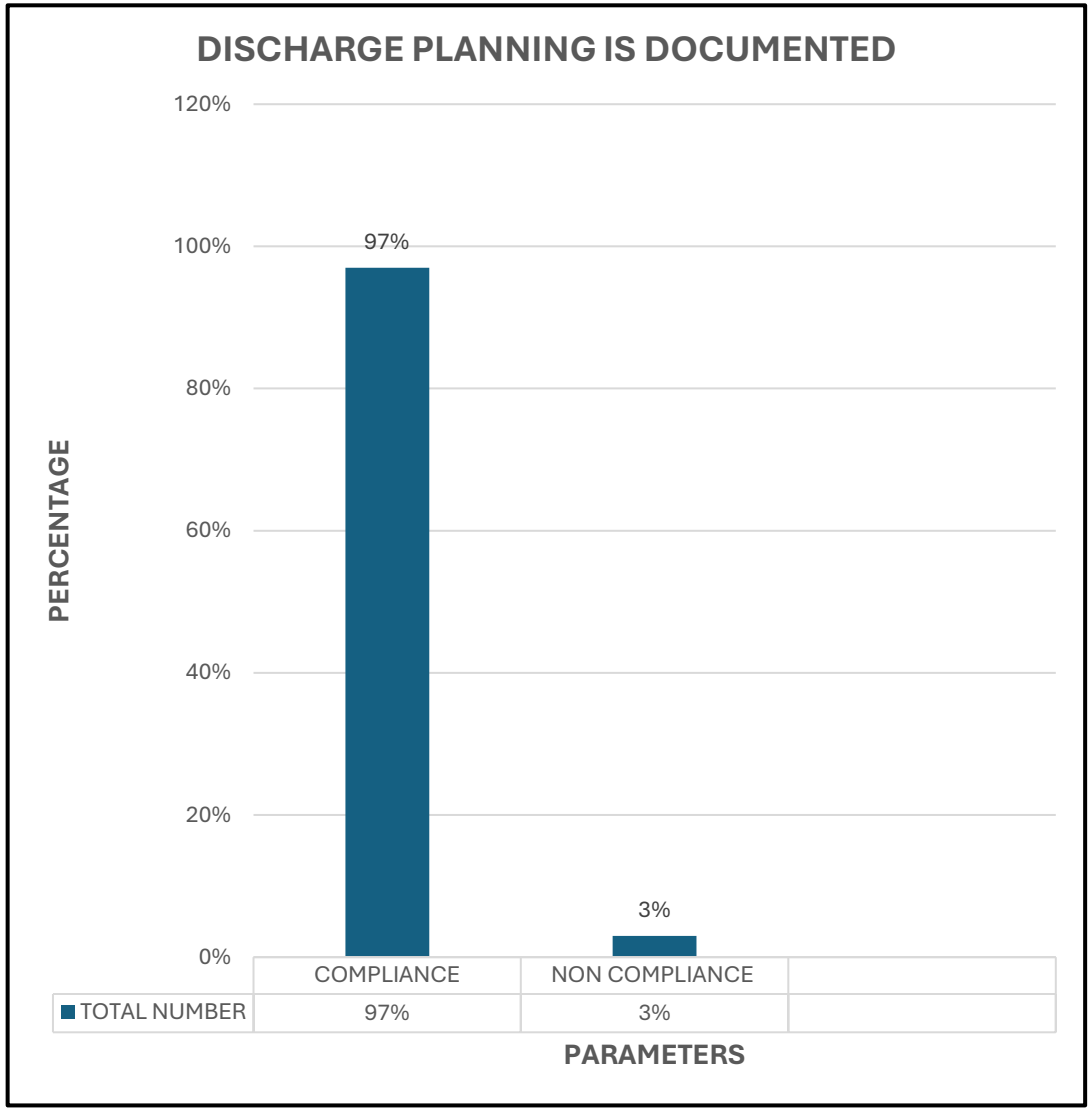


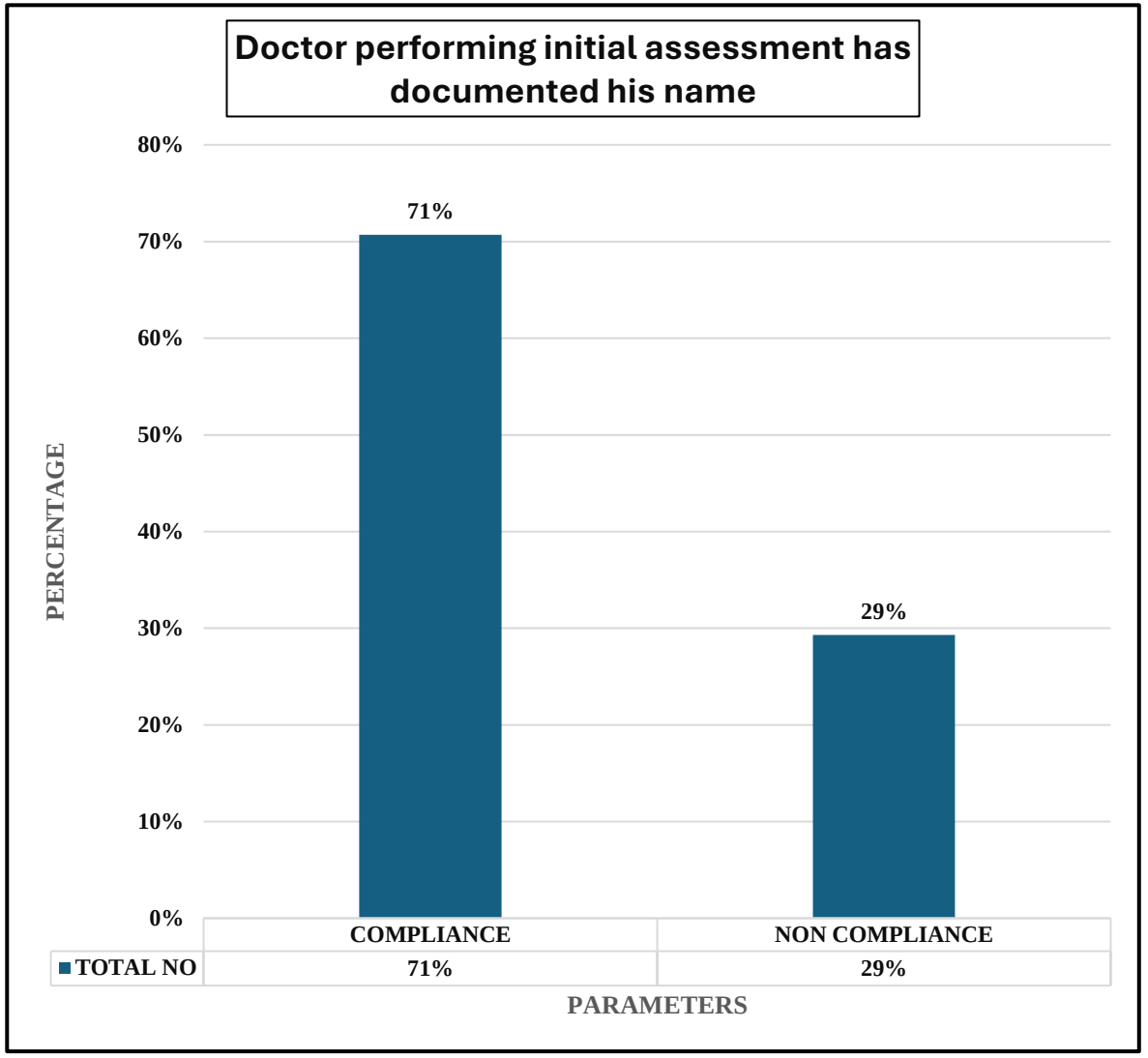
NUTRITIONAL ASSESSMENT

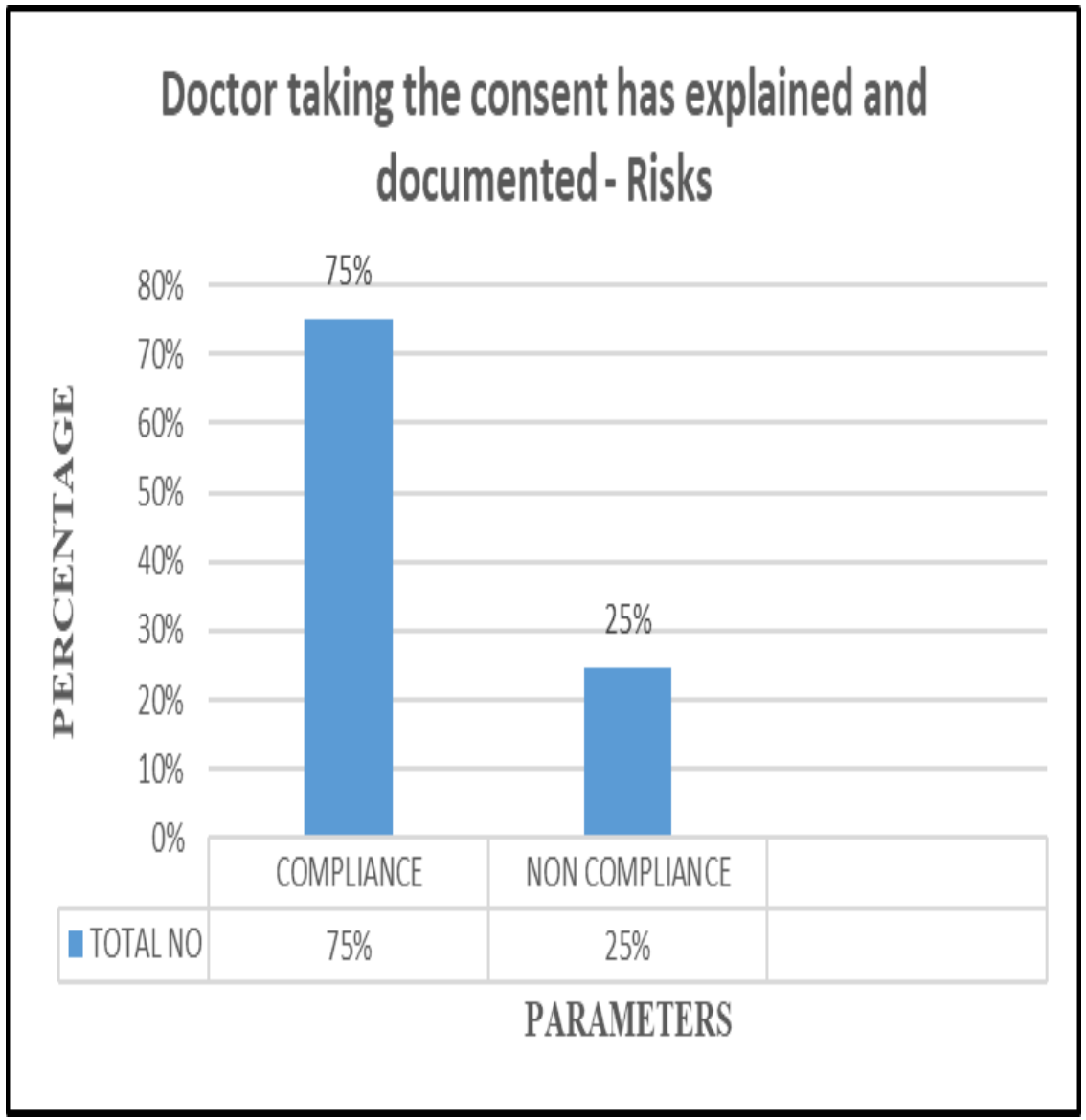


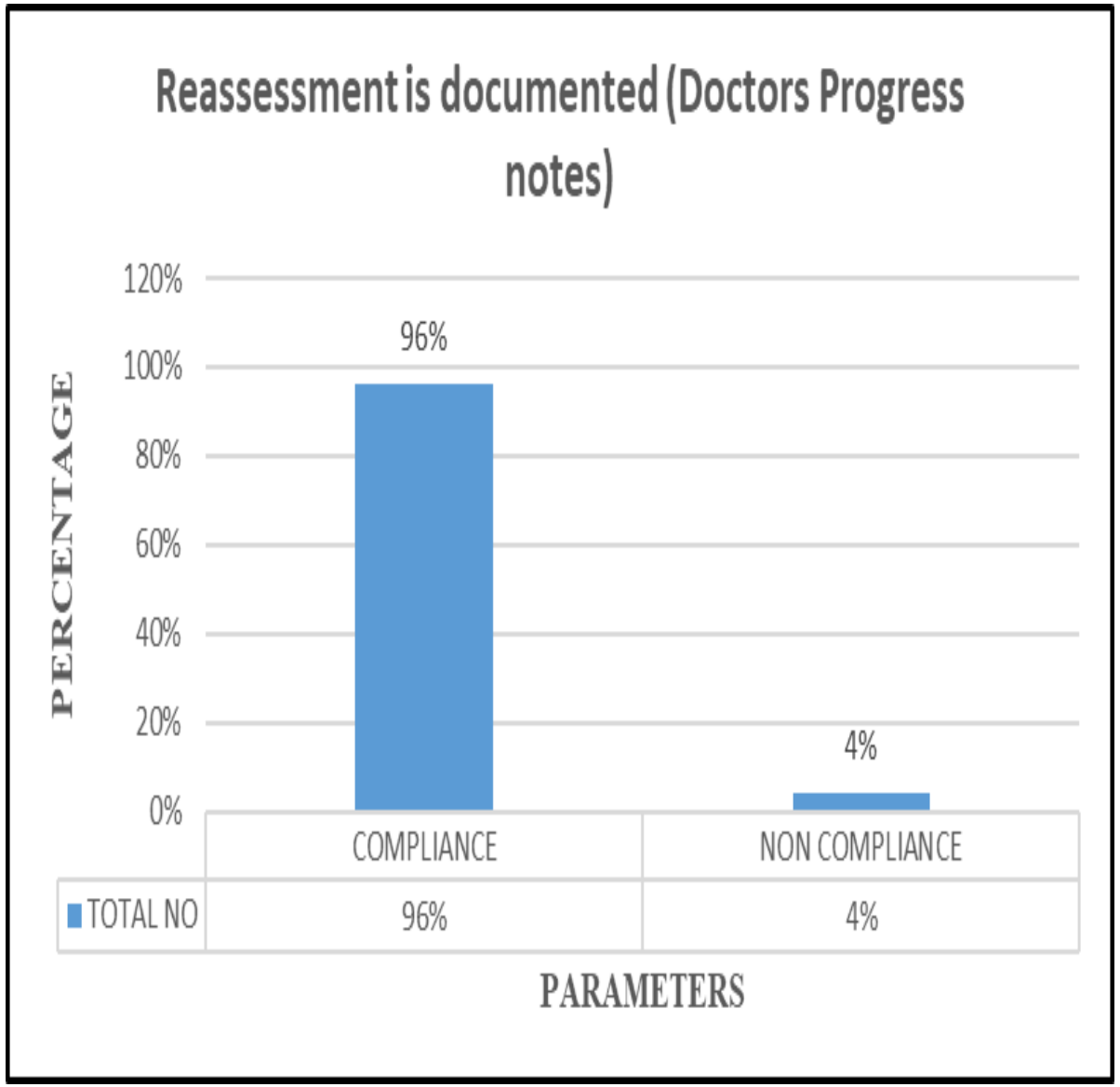
DISCHARGE SUMMARY

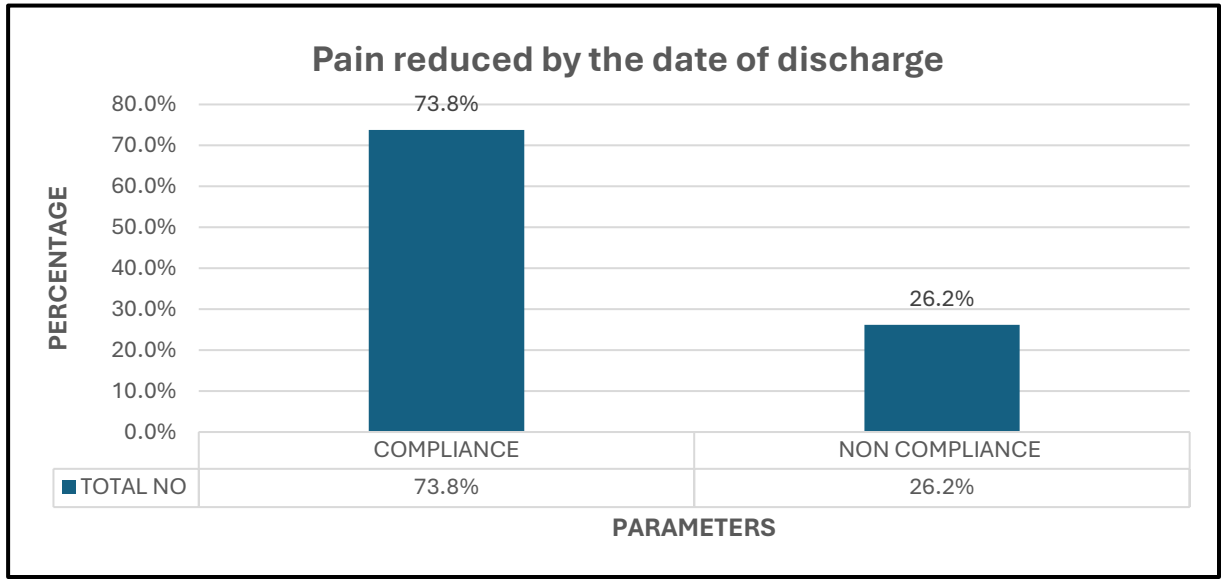


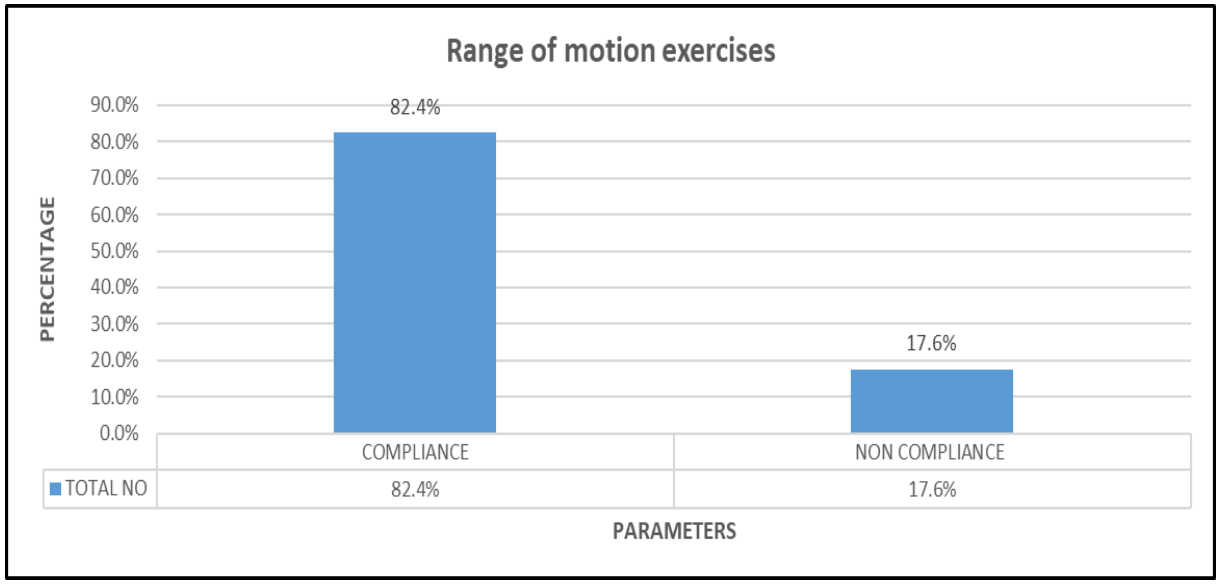

DISCHARGE PLANNING IS DOCUMENTED
120%
100%
80%
60%
40%
20%
0%
97%
3%
PERCENTAGE
COMPLIANCE
NON COMPLIANCE
TOTAL NUMBER
97%
3%
PARAMETERS

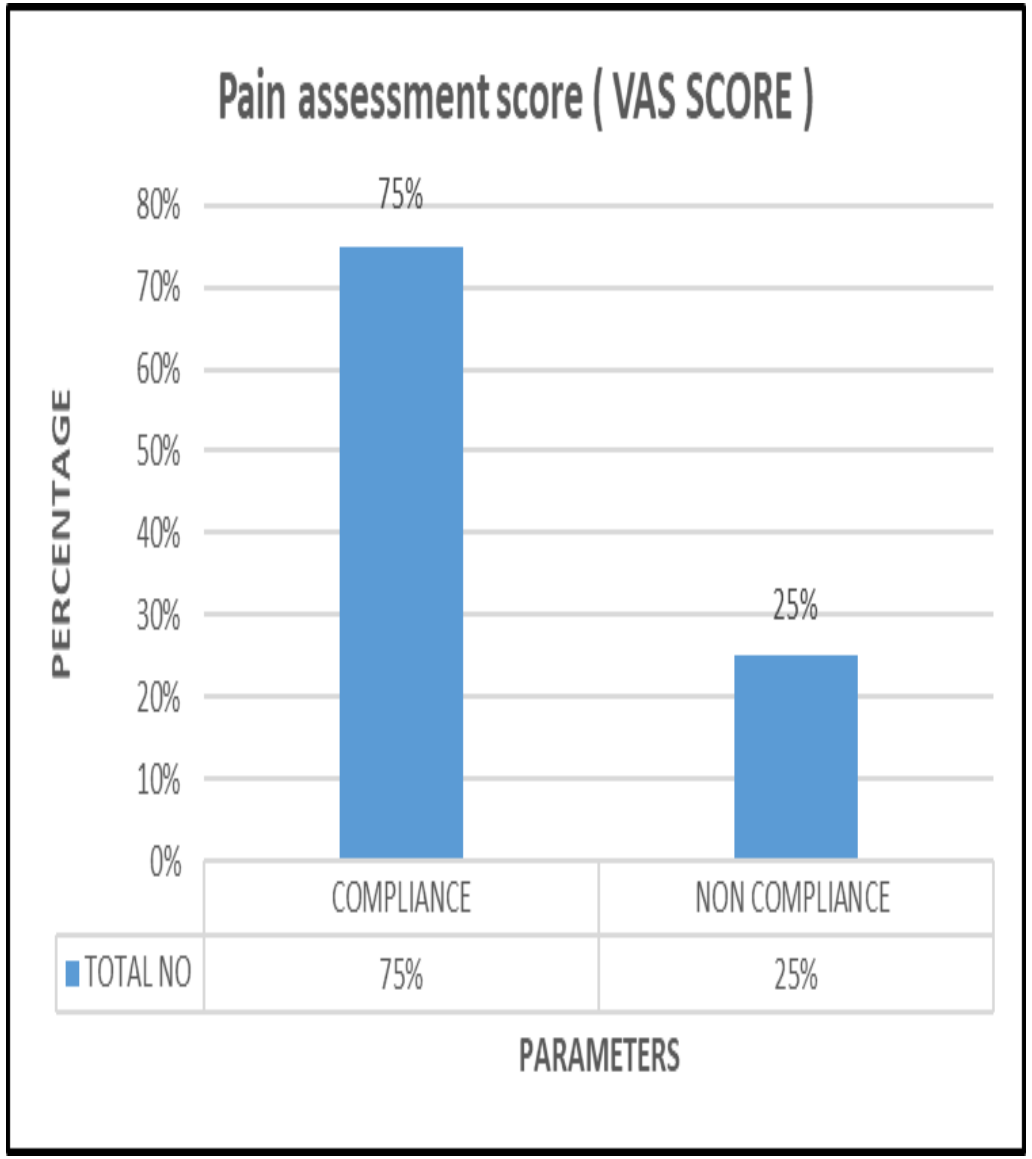

Doctor performing initial assessment has documented his name
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
29%
PERCENTAGE
COMPLIANCE
NON COMPLIANCE
TOTAL NO
71%
29%
PARAMETERS

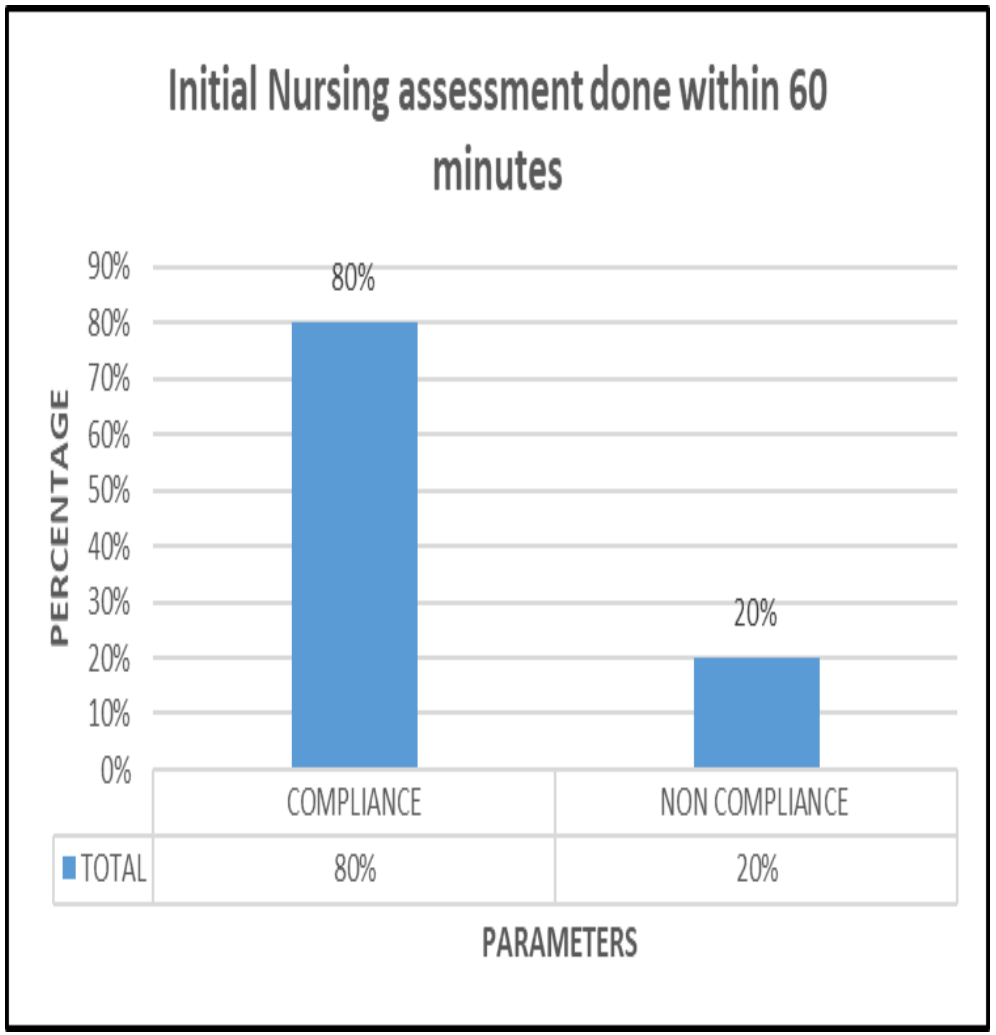

Doctor taking the consent has explained and documented - Risks
PERCENTAGE
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
25%
COMPLIANCE
NON COMPLIANCE
TOTAL NO
75%
25%
PARAMETERS

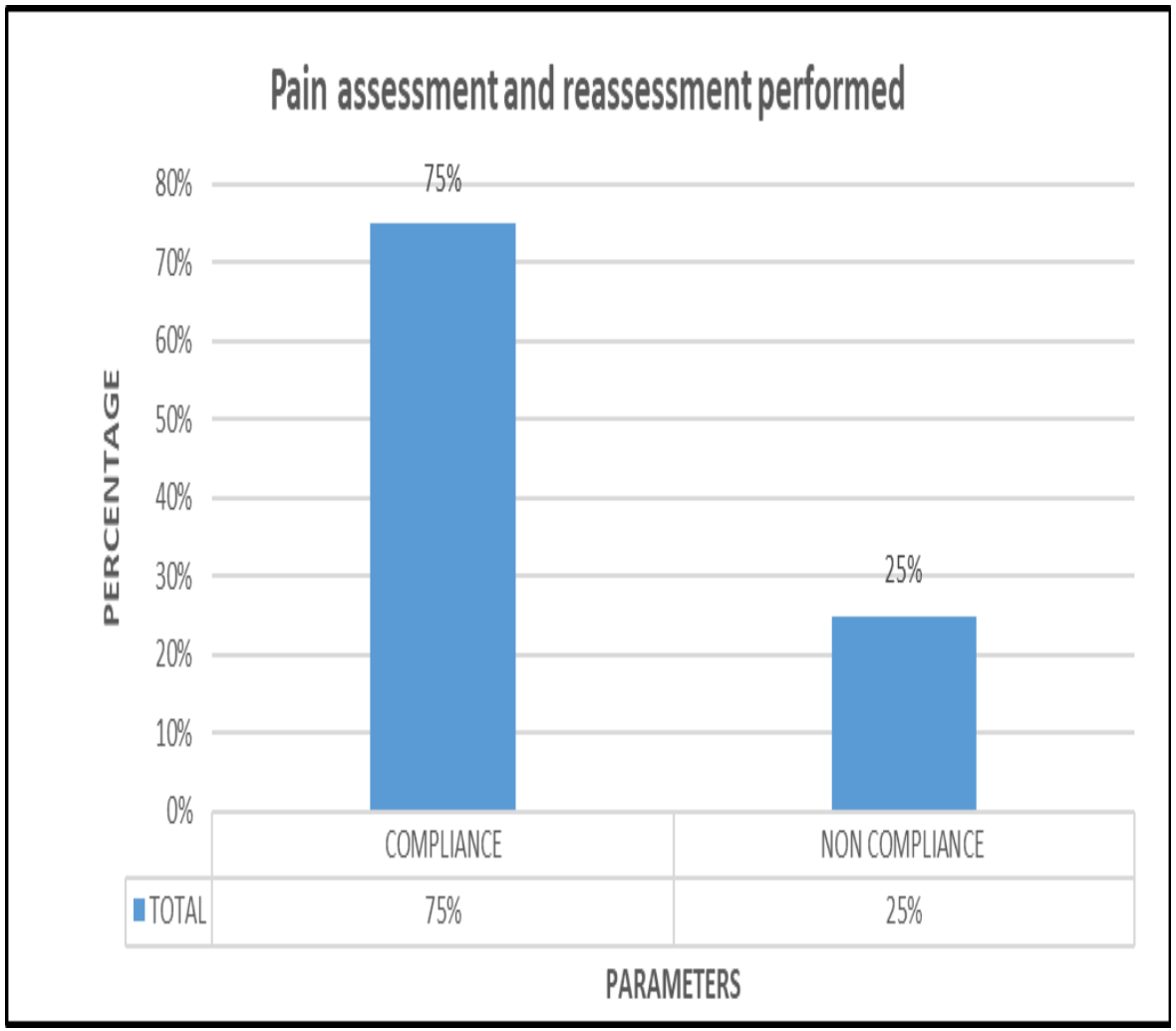

Reassessment is documented (Doctors Progress notes)
PERCENTAGE
120%
100%
80%
60%
40%
20%
0%
96%
4%
COMPLIANCE
NON COMPLIANCE
TOTAL NO
96%
4%
PARAMETERS

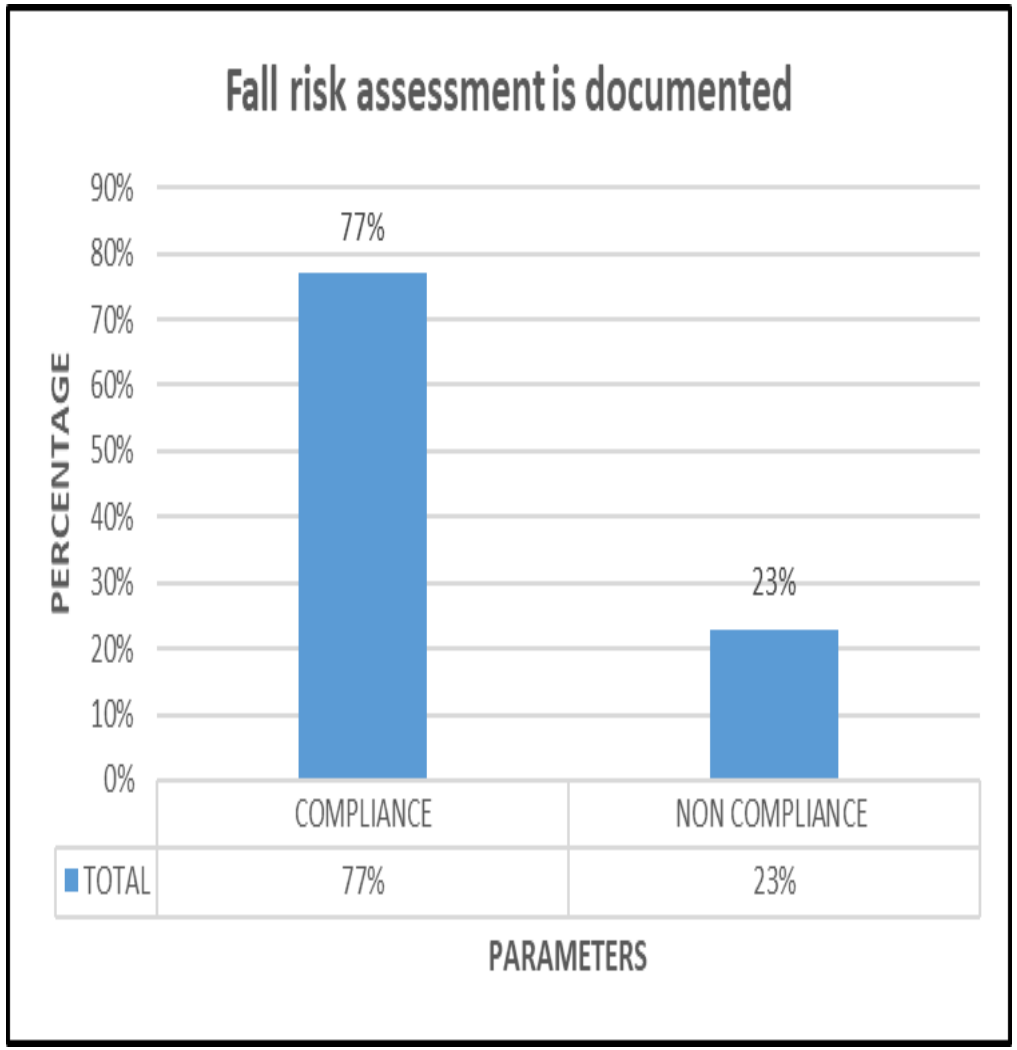

Pain reduced by the date of discharge
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
PERCENTAGE
73.8%
26.2%
COMPLIANCE
NON COMPLIANCE
TOTAL NO
73.8%
26.2%
PARAMETERS

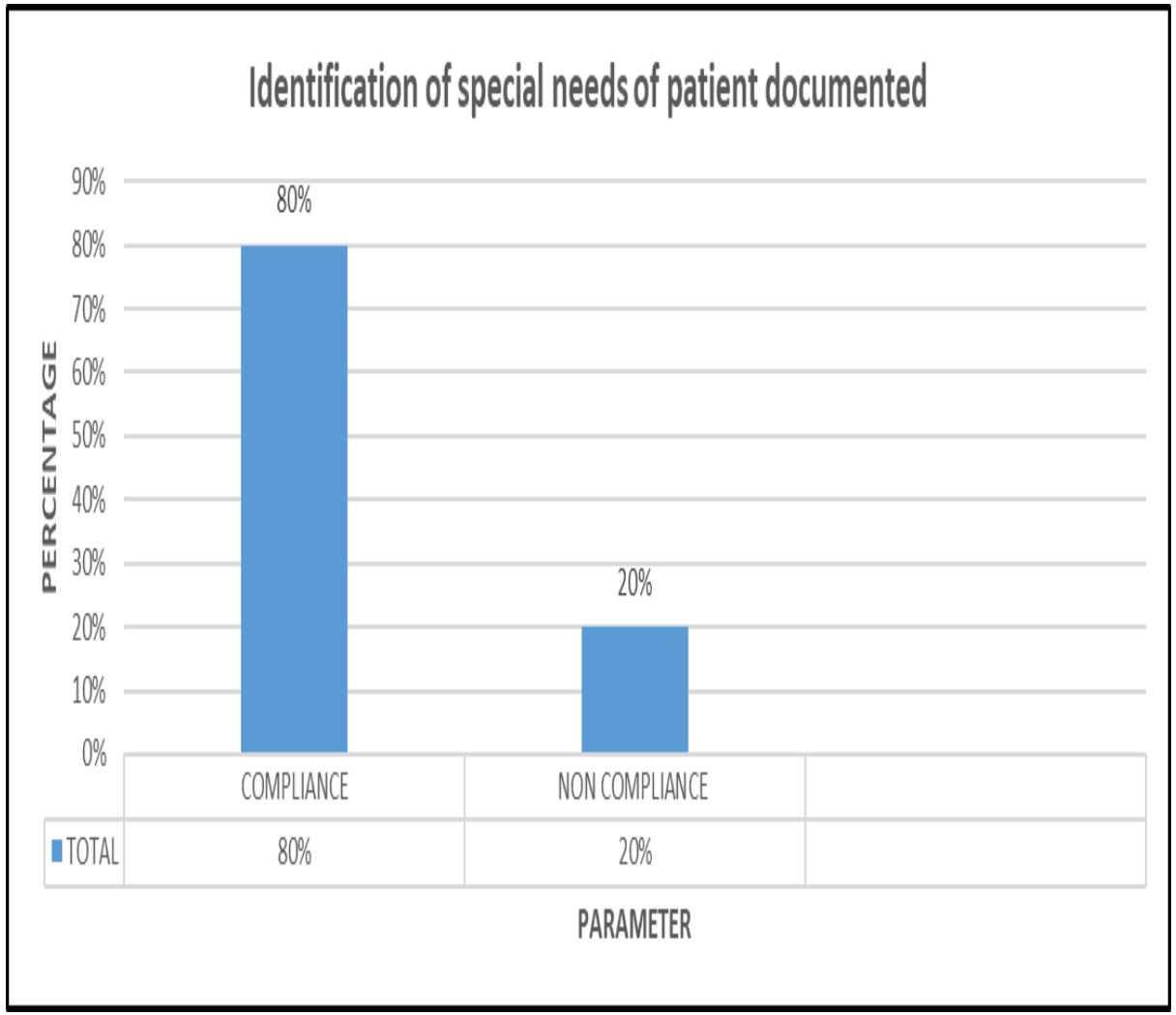

Range of motion exercises
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
PERCENTAGE
82.4%
17.6%
COMPLIANCE
NON COMPLIANCE
TOTAL NO
82.4%
17.6%
PARAMETERS

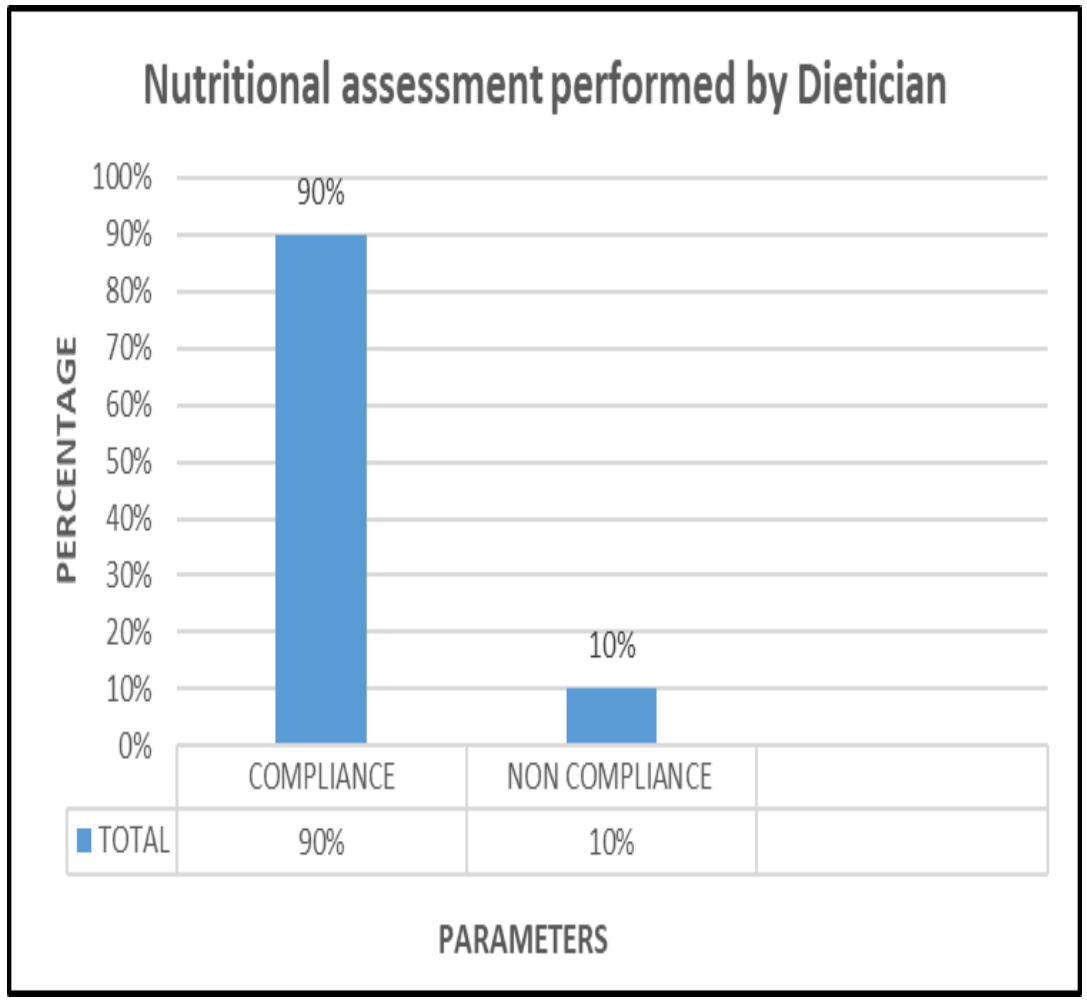

Pain assessment score (VAS SCORE)
80%
70%
60%
50%
40%
30%
20%
10%
0%
PERCENTAGE
75%
25%
COMPLIANCE
NON COMPLIANCE
TOTAL NO
75%
25%
PARAMETERS

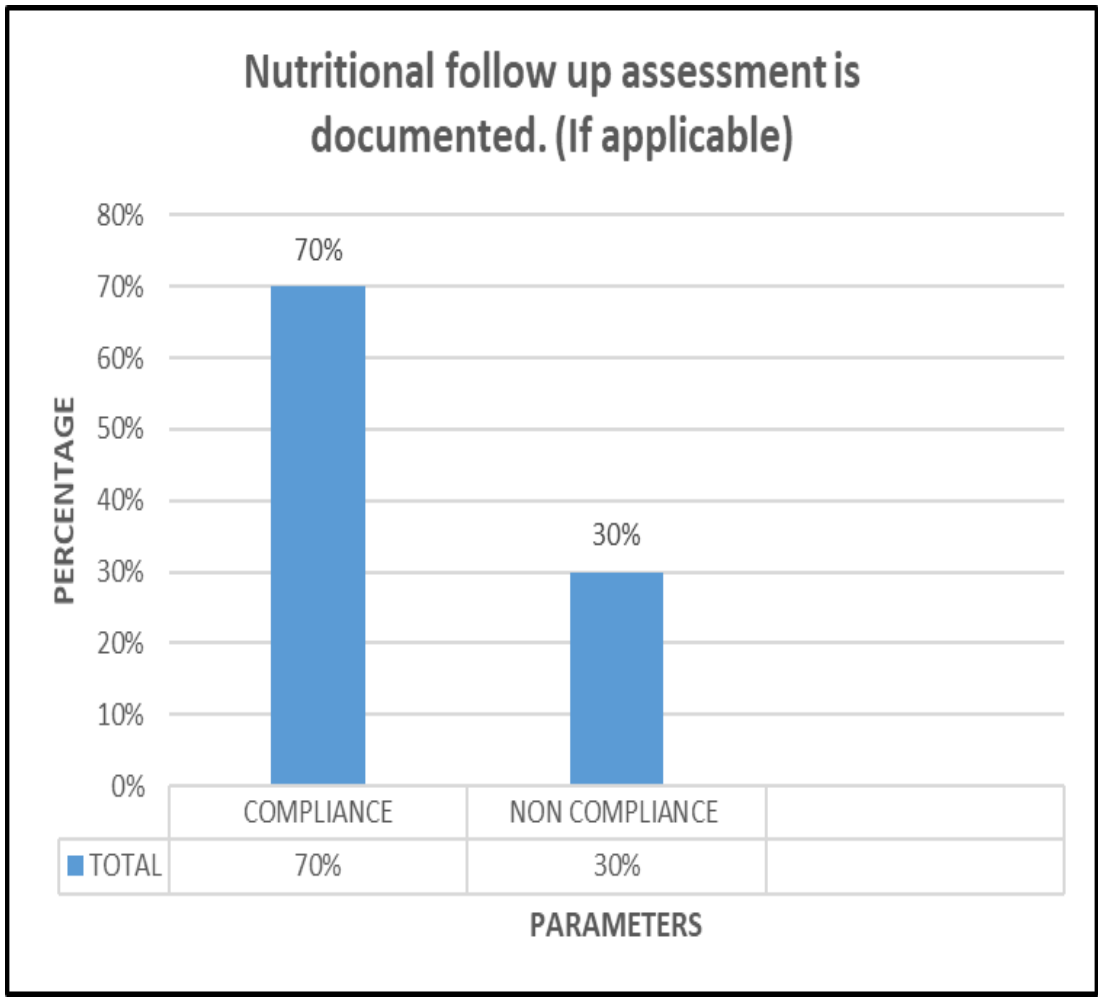

Initial Nursing assessment done within 60 minutes
PERCENTAGE
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
20%
COMPLIANCE
NON COMPLIANCE
TOTAL
80%
20%
PARAMETERS


Pain assessment and reassessment performed
PERCENTAGE
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
25%
COMPLIANCE
NON COMPLIANCE
TOTAL
75%
25%
PARAMETERS


Fall risk assessment is documented
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PERCENTAGE
77%
23%
COMPLIANCE
NON COMPLIANCE
TOTAL
77%
23%
PARAMETERS


Identification of special needs of patient documented
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PERCENTAGE
80%
20%
COMPLIANCE
NON COMPLIANCE
TOTAL
80%
20%
PARAMETER


Nutritional assessment performed by Dietician
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PERCENTAGE
90%
10%
COMPLIANCE
NON COMPLIANCE
TOTAL
90%
10%
PARAMETERS


Nutritional follow up assessment is documented. (If applicable)
80%
70%
60%
50%
40%
30%
20%
10%
0%
PERCENTAGE
70%
30%
COMPLIANCE
NON COMPLIANCE
TOTAL
70%
30%
PARAMETERS

KEY FINDINGS

❑ **Consent Form:**

-Almost all patients sign consent forms (98-99%), but there are gaps in recording specific time (76%) and dates (89%).

❑ **Initial Assessments**:

-Doctors diagnoses (71%) and medical histories (72%), is documented, but often miss noting the initial assessment time (30%) and discharge planning (28%).

❑ **Nursing Records**:

-Nurses vary in initial assessments (53%), excel in pain (91%), and fall risk evaluations (90%).

❑ **Nutritional Assessments**:

-High adherence rates (87-89%) with minimal noncompliance.

❑ **Anesthesia Care**:

-Good pre-anesthesia assessments (96-97%), but poor allergy documentation (4%).

❑ **Surgical Safety Checklists**:

-Nearly good compliance (99%).

KEY FINDINGS

- **Medical Records and Reconciliation**:

-High accuracy (99.32%), but room for improvement in post-operative plans (75%).

- **Discharge Procedures**:

-Good preparation (97.6%), but delayed discharge planning.

- **Physiotherapy Assessments**:

-Good records of pain and range of motion exercises and post-discharge.

- **Nursing Contributions**:

-Timely evaluations of patients with high compliance in pain assessment .

- **Fall Risk Assessments**:

-Majority assessed aiding preventive care.

- **Dietician Responsibilities**:

-Strong compliance in nutrition assessments and follow-ups

RECOMMENDATIONS

- Dashboard Compliance
- To reduce non compliance in medical records, focus could be on regular staff training with orientation on regulatory and legal aspects of compliance.
- Real-time Documentation Feedback
- Compliance of documentation as a Performance Metric
- Compliance of medical records to be included under framework for continuous quality improvement (CQI)

CONCLUSION

- The assessment of medical record documentation in a multispecialty tertiary care hospital showed high overall compliance, with most patients signing consent forms and strong documentation in diagnoses and medical histories.
- However, there were significant gaps in recording specific times, initial assessment times, and discharge planning.
- Nursing and nutritional records had high compliance rates, but initial assessments varied.
- Anesthesia care lacked in allergy documentation despite strong pre-assessments.
- While surgical checklists and medical reconciliation were nearly good, improvements are needed in post-operative plans and timely discharge planning

THANK YOU