Status of compliance of Medical Record Documentation of Multispeciality Tertiary Care Hospital in Mumbai

Synopsis Submitted to

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by

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TITLE - Status of compliance of Medical Record Documentation of Multi Speciality Tertiary Care Hospital in Mumbai.

INTRODUCTION

Medical records are crucial records that include general information on a patient's history, medication plans, diagnostic procedures, clinical results, pre and post-operative care, patient progress notes and follow-ups. Medical records regarding health are vital documents that provide information about each patient individually as well as contact information for medical staff. The purpose of this project is to highlight the significance of medical record documentation in hospitals and to emphasise how important it is to deliver top-notch patient care. The study examines how well a multi-speciality tertiary hospital adheres to NABH standards, which ensure accurate and complete medical records. The initiative aims to improve documentation procedures by determining areas for improvement and evaluating compliance rates.

REVIEW OF LITERATURE

The literature review aims to look research and scholarly articles regarding compliance in medical record documentation in multispeciality hospital. It will examine how Electronic health records (EHRs) and standardised procedures are used to improve documentation accuracy and compliance. We will also examine case studies to get insight into the efficiency of these approaches and various challenges that hospitals encounter in maintaining the highest quality of medical record documentation.

RESEARCH QUESTION

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

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

OBJECTIVES

1)To evaluate the current level of compliance in medical record documentation at a multispeciality hospital.

2)To analyze and compare the level of compliance across various parameters of patient file documentation.

MATERIAL AND METHODS

STUDY DESIGN

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

SETTING

The study will be conducted in a hospital setting, specifically focusing on the Medical Record Department.

STUDY POPULATION

Doctors, Nurses, Physiotherapist, Dietician, Anaesthetist

STUDY TOOLS

Auditing of Medical Record Documentation.

DURATION OF STUDY

1-2 months

SAMPLE SIZE

100-150 Medical Record Documentation

SAMPLING TECHNIQUE

Simple Random Sampling

DATA COLLECTION PROCEDURE

An audit checklist is 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. Along with this observing, interviews with hospital staff will be done to gain entire understanding of documentation methods.

OPERATION DEFINATIONS

In our study, we are assessing how effectively our hospital follows to the NABH guidelines for maintaining patient data. The exposure variable is how effectively we adhere to these standards, which we are evaluating by reviewing patient records. The outcome variable is the rate of compliance, which we get by comparing the records that meet the NABH standards to all of the records examined.

DATA ANALYSIS PLAN

According to hospital SOP, a checklist of indicators will be used to ensure patient file compliance. An excel sheet will be utilised for reviewing indicators in the three categories: complete, incomplete, and not applicable. Based on this categories, the overall analysis will be done by finding the percentage compliance of each indicator.

ETHICAL CONSIDERATIONS

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

IMPLICATIONS OF RESEARCH

Our research is going to significantly enhance patient care quality by ensuring that medical records meet NABH guidelines. This assures that patients receive correct and consistent care, hence improving overall patient safety and satisfaction. Our findings will help healthcare organisations to identify areas for record-keeping improvement, leading better staff training and more effective documentation procedures. By highlighting these necessary areas, our research can help hospitals in better meeting regulatory standards and promoting more healthcare standards. It can lead to better patient outcomes and more reliable healthcare services across the industry.

REFERENCES

https://www.jrfhha.com/doi/JRFHHA/pdf/10.5005/jp-journals-10035-1080

https://www.researchgate.net/publication/328556457_Improving_Completeness_of_Inpatient_Medical_Records_in_Menelik_II_Referral_Hospital_Addis_Ababa_Ethiopia

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8057196/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8994305/

https://pubmed.ncbi.nlm.nih.gov/36712708/